2009

Challenge, tension and possibility: an exploration into contemporary western herbal medicine in Australia

Sue Evans

Southern Cross University

Publication details
Evans, S 2009, 'Challenge, tension and possibility: an exploration into contemporary western herbal medicine in Australia', PhD thesis, Southern Cross University, Lismore, NSW.
Copyright S Evans 2009
Challenge, Tension and Possibility: An Exploration into Contemporary Western Herbal Medicine in Australia

Susannah Jessie Evans
BA (LaTrobe)
Dip Ed (LaTrobe)
Member of the National Institute of Medical Herbalists (UK)
Member of the National Herbalists’ Association of Australia

Southern Cross University

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

March 2009
DECLARATION

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or in part, for a degree at this or any other university.

I acknowledge that I have read and understood the University’s rules, requirements, procedures and policy relating to my higher degree research award and to my thesis. I certify that I have complied with the rules, requirements, procedures and policy of the University (as they may be from time to time).

Sue Evans

Signature: ........................................................................................................

Date: ........................................................................................................
ACKNOWLEDGEMENTS

This work presented here has been a long time gestating, and the issues discussed here have been chewed over for many years with friends, colleagues and students. While it is impossible to recognise all those who have contributed, some special thanks are in order.

Time spent in the Centre for Sociocultural Studies at the Catholic University of Temuco (UCT), Chile was crucial to the initial development of my perspective on Australian herbal medicine. Thanks to both Dr Teresa Duran at UCT and the late Dr Alex Arellano at SCU for facilitating those experiences.

As a result of this project, I have a new respect for librarians. Janice Knopke from the Southern Cross University Library, and Janelle Cleary from the Parliamentary Library Melbourne, have been particularly helpful. Anne Cowper acted as NHAA’s librarian and gave me access to the NHAA archives, searched for missing documents, and extended hospitality on many occasions.

Emeritus Professor Sandra Speedy and Dr Kath Fisher of SCU, Associate Professor Neil Marshall of University of New England, and Dr Hans Baer of University of Melbourne, each gave generous support and wise advice (not always taken) at critical points in the project.

Valued colleagues in Natural and Complementary Medicine at SCU have shared their expertise and knowledge and have given lots of support particularly when times got tough. Thanks to Ian Howden, Cathy Avila, Airdre Grant and Sue Shaw for commenting on various pieces of writing, to Fran Page-de Mars for her practical assistance, and to Dr Joan O’Connor for her advice, encouragement and thoughtful feedback. Friends have supported me through the long winding paths this project has taken me down, thanks particularly to Judy Singer, Tracey Potter, Jan and Rex Marshall-Radcliffe and
Victoria O’Connor who have all listened to ideas presented here. Heartfelt thanks to Greg and Dawn Whitten, and the mob at Goulds in Hobart for their generosity and unquestioning support, and to Madhu Lilly for lending me a house in which to write; to Nina Nissen for being a wonderfully critical friend who knows the heartache; and most especially to Dr Sonya Brownie for always being there, always encouraging, and for keeping me on track.

Thanks also to my supervisors. Dr Tom Jagtenberg introduced me to the world of social theory as a tool to enable the telling of the story of Australian herbal medicine. Associate Professor Baden Offord quietly insisted I find my voice.

Finally, my love to Tom, Ben and Jon, who keep the faith and inspire me with their lives.
DEDICATION

To the community of Australian herbalists.
**ABSTRACT**

This thesis is about the contemporary challenges facing herbal medicine. Specifically it concerns the difficulties faced by Australian herbalists in their attempts to maintain authority over the knowledge base of their craft and a connection with traditional understandings of the uses of plant medicines, while at the same time engaging with biomedicine and the broader Australian healthcare system. It contributes to the study of the nascent field of qualitative studies in contemporary western herbal medicine by making three main arguments.

Firstly, Australian herbal medicine is characterised by its origins as a European colonial practice and its history of professional marginalisation during most of the 20th century. Secondly herbal practitioners have been unable to capitalise significantly on a surge of public popularity in the closing years of the 20th century which brought with it the interest of industry, the scrutiny of regulators and the renewed attention of biomedicine. Herbalists continue to struggle for recognition in the face of these more powerful interests. Thirdly it is argued that herbalists are attempting to gain legitimacy and acceptance as a healthcare profession through a process of underpinning their knowledge base with science, which is replacing their traditional philosophical basis. This has the effect of weakening the ability of herbalists to maintain their identity as an independent profession and makes its knowledge base vulnerable to appropriation by other healthcare professions.

Gross’ model of the cultural location of traditions in contemporary societies is used to clarify the situation of herbalists and to identify problems consequent to the political choices they have made or which have been forced upon them. Gross suggests that traditions which place themselves close to power have difficulty in maintaining their own character and integrity, but that other cultural locations are also problematic and limit full participation in society.
It is argued that there are compelling reasons to move beyond Gross’ analysis and to find ways to strengthen the independence of the herbal profession. Given the financial problems facing the current healthcare system in Australia and the looming ecological challenges, radical changes to the current system are required. The central concepts of herbal practice, in particular vitalism and holism, lead to approaches to healthcare which are potentially both cost-effective and ecologically sustainable. A robust and independent profession of western herbalists, with their philosophy articulated and restored, could provide a valuable and sustainable contribution to Australian healthcare.
## Glossary of Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANTA</td>
<td>Australian Natural Therapists Association</td>
</tr>
<tr>
<td>ATMS</td>
<td>Australian Traditional-Medicine Society</td>
</tr>
<tr>
<td>Ayurveda</td>
<td>a traditional system of medicine of India</td>
</tr>
<tr>
<td>Biomedicine</td>
<td>modern Western medicine</td>
</tr>
<tr>
<td>CAM</td>
<td>Complementary and Alternative Medicine</td>
</tr>
<tr>
<td>CBD</td>
<td>Convention on Biological Diversity</td>
</tr>
<tr>
<td>CWHM</td>
<td>Contemporary western herbal medicine</td>
</tr>
<tr>
<td>EBHM</td>
<td>Evidence based herbal medicine</td>
</tr>
<tr>
<td>EBM</td>
<td>Evidence based medicine</td>
</tr>
<tr>
<td>GMP</td>
<td>(Code of) Good Manufacturing Practice</td>
</tr>
<tr>
<td>A herbal</td>
<td>a book containing information about individual medicinal plants</td>
</tr>
<tr>
<td>Herbalist</td>
<td>a health practitioner who engages in extemporaneous compounding of herbs for therapeutic purposes for individuals under his or her care and who is trained in herbal medicine principles, philosophy and practice (Lin et al., 2005, p. 2)</td>
</tr>
<tr>
<td>Herbal medicines</td>
<td>products made from medicinal plants</td>
</tr>
<tr>
<td>IK</td>
<td>Indigenous knowledge</td>
</tr>
<tr>
<td>Modality</td>
<td>therapeutic discipline, including herbal medicine, homeopathy, nutrition, therapeutic massage</td>
</tr>
<tr>
<td>Naturopath</td>
<td>a practitioner having core training in naturopathic principles and philosophy, and in at least three of the following four modalities i) herbal medicine ii) nutritional medicine iii) homeopathy iv) massage (Lin et al., 2005)</td>
</tr>
<tr>
<td>NHAA</td>
<td>National Herbalists Association of Australia</td>
</tr>
<tr>
<td>OTC</td>
<td>Over-the-counter</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Phytopharmaceuticals</td>
<td>plant pharmaceuticals, plant drugs</td>
</tr>
<tr>
<td>Phytotherapy</td>
<td>modern, rational, scientific herbal medicine (see Appendix 1)</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised controlled trials</td>
</tr>
<tr>
<td>TCM</td>
<td>Traditional Chinese Medicine</td>
</tr>
<tr>
<td>TCAM</td>
<td>Traditional, Complementary and Alternative Medicine</td>
</tr>
<tr>
<td>TEK</td>
<td>Traditional ecological knowledge</td>
</tr>
<tr>
<td>TGA</td>
<td>Therapeutic Goods Administration</td>
</tr>
<tr>
<td>TK</td>
<td>Traditional knowledge</td>
</tr>
</tbody>
</table>
ARTICLES ARISING FROM THE THESIS


**Conference proceedings:**


# Table of Contents

Prologue ........................................................................................................................................ 7  
Chapter 1 Introduction............................................................................................................. 10  
  1.1 Background .................................................................................................................... 10  
  1.2 The central questions .................................................................................................... 15  
  1.3 Key Literature .............................................................................................................. 18  
  1.4 Legalities of practice in Australia .................................................................................. 22  
  1.5 Nomenclature ............................................................................................................... 23  
    1.5.1 Herbalists ............................................................................................................. 24  
    1.5.2 Contemporary Western herbal medicine ............................................................ 24  
    1.5.3 The relationship between herbal medicine and naturopathy ......................... 25  
  1.6 Scope of the thesis ........................................................................................................ 27  
  1.7 Thesis framework ......................................................................................................... 28  
  1.8 Personal story ............................................................................................................... 30  
  1.9 Structure of thesis ......................................................................................................... 34  
Chapter 2: setting the scene: Western herbal medicine in Australia................................. 41  
  2.1 Introduction .................................................................................................................. 41  
  2.2 Who are the herbalists? Some demographic detail ..................................................... 42  
    2.2.1 Professional identification .................................................................................... 43  
    2.2.2 Gender and clinical experience .......................................................................... 43  
    2.2.3 Economic viability of practice ........................................................................... 44  
      2.2.3.1 Nature of practice – what do herbalists do in practice? ......................... 45  
      2.2.3.2 Diagnosis – how do herbalists interpret symptoms? ............................ 46  
  2.3 Origins: Herbal medicine as a colonial practice ......................................................... 47  
  2.4 Herbal Medicine’s Dark Years: the inevitability of marginalisation ...................... 52  
    2.4.1 The Gaze versus Galen – a dialectic? .................................................................. 54  
    2.4.2 Involvement of the state in medicine ................................................................. 56  
  2.5 Conclusion .................................................................................................................... 60
Chapter 3 The re-emergence of herbal medicine

3.1 Introduction

3.2 A new context for herbal medicine

3.3 The existing Australian healthcare system

3.4 The commodification of medicinal plants

3.5 State concerns: safety, risk and herbal medicine

3.5.1 The risk society

3.5.2 The politics of practitioner risk

3.5.3 Implications of risk

3.5.4 Risks associated with herbal ingestion

3.6 Conclusion

Chapter 4 Tradition and knowledge

4.1 Introduction

4.2 Tradition in herbal medicine

4.3 The question of ‘progress’

4.4 Rules of truth

4.5 Rules of truth: Science

4.5.1 Evidence-based Medicine (EBM)

4.6 Rules of truth: traditional knowledge

4.6.1 Vitalism

4.6.2 Holism

4.6.3 Vitalism as morality

4.7 Remembering and forgetting

4.8 An illustration: The Australian Journal of Medical Herbalism (AJMH)

4.9 Conclusion

Chapter 5 On the margins and professionalising

5.1 Introduction

5.2 Professionalisation

5.2.1 Changing nature of professions

5.2.2 The question of elites – sisterhood vs professionalisation

5.2.3 Loss of intellectual autonomy
List of Tables

Table 3.1 Mainstreaming of CWHM via legislation government committees 65
Table 3.2 Summary of terms related to risk in herbal medicine ....................... 78
Table 4.1 Hierarchies of evidence in Evidence-based medicine ...................... 97
Table 4.2 Comparison of TEK and folklore ..................................................... 102
Table 4.3: Concepts related to Vitalism in European herbal medicine ............ 105
Table 4.4: Comparison of systems related to holism ........................................ 108
Table 4.5: Therapeutics articles in the AJMH .................................................. 115
Table 5.1 Cultural location of surviving traditions ........................................... 120
Table 7.1 Categories of synonyms for vital force used by practitioners .......... 183
Table 8.1 Victorian medical legislation effecting herbal practice: 1856-1905 .... 206
Table 9.1 Gross’ locations of traditions applied to herbal medicine ............. 225
Table 9.2 Comparison of use of herbal use: professional and OTC ............... 236

List of Figures

Figure 2.1 Krause’s triangle ............................................................................. 58
It is September 2001 in Temuco, Chile. I speak very little Spanish, and few people I meet speak English. I am here because colleagues, medical anthropologists from the Centre for Sociocultural Studies at the Catholic University of Temuco, believe that my experience as an Australian herbalist and academic will contribute to collaboration undertaken with the Mapuche. The Mapuche are an indigenous people of Chile and are attempting to use their traditional approach to medicine alongside biomedicine. I am unsure what I will be able to contribute, but am very excited to come and observe and learn.

I am a guest at a meeting of Mapuche. An old man stands up in the meeting and describes his symptoms, some of which seem very personal, and asks me for a diagnosis. I am totally unprepared for this. Such interactions between practitioner and patient in Australia do not occur in public places. The conversation is even more complex because we are working with two translators here – one translates English to Spanish, the other Spanish to Mapudungung, the language of the Mapuche. I do not know the culturally appropriate response to the old man. However his symptoms do sound to me similar to those of chronic fatigue syndrome, and when he tells me that the machi (Mapuche shaman) has told him that someone has taken his spirit, I feel on familiar territory. I have similar discussions with my own patients who present with this problem – I talk to them about whether something has occurred to take a deep joy from their life.

Later, I am with a small group of Mapuche and people from the university, and we are on our way to a Mapuche community. It has been raining heavily. An hour ago the university van became impossibly bogged in the mud and was extracted only with the assistance of a pair of oxen. We are surrounded by green paddocks and gentle hills. As usual, I have very little idea what is going on. When the van will go no further on the muddy, unmade road, we all get out and walk through the fields to a small house. I am told this is the house of a machi. An exchange takes place, and we walk away.
with a 2 litre soft drink bottle, three quarters full of a dark brown liquid. We have just picked up some herbal medicine. Again I am on familiar territory. People have been coming to my place ‘to pick up the medicine’, which consists of bottles of dark brown liquid, for decades.

A year later, I am back in Chile with the same group, working on another aspect of the same project. I have been taking Spanish classes, so my language is better but not yet fluent. A Mapuche woman challenges my right to participate, and asks me to explain my attitude to indigenous rights, and intellectual property, and by what ‘patrimonia’ I practice herbal medicine. In this context, I understand ‘patrimonia’ to loosely mean ‘cultural right’. I have often been questioned about my qualifications as a herbalist, but never about my patrimonia…

I tell her I am respectful of the rights of indigenous people, including intellectual property rights. I go on to say I am an Australian herbalist of European extraction, and I use the plants of my culture and not of my land. That is, I use European plants and I do not use medicinal plants indigenous to Australia. I tell her my right to practice is based in my knowledge of the stories of those plants. I can tell stories – using Shakespeare, the Bible, popular culture - of St John’s wort, thyme and dandelion, in ways that I cannot of banksia and waratah. I do not know the stories of Australian indigenous plants the way I know the stories of European plants: they are not part of my cultural heritage. She seems satisfied with my answer, and in the ensuing weeks I am asked for stories about the specific European plants we discuss.

It is springtime, and the weather here in Temuco reminds me of this time of year in Melbourne where I was born and lived most of my life: cold winds, sunshine, rain. Four seasons in a day. Temuco is the same latitude as Melbourne, the city is about the same age as Melbourne and, like Melbourne, was built by European colonisers. The feeling of familiarity returns: in some ways I feel more at home here than in the Australian subtropics, where I currently reside.

As I walk the streets in Temuco, this familiarity intensifies: I am surprised, overjoyed and comforted to see many of the same medicinal plants growing in gardens, and as weeds, here as in Melbourne. They include marigolds, elder trees, cleavers, plantain,
dandelion, chickweed and shepherd’s purse. Women on the streets sell fresh thyme and home grown chamomile. The plants I recognise are not indigenous to Chile, they are European plants. I think about how they got here.

A couple of years later I am in Spain for a conference. I have come here partly because I think that it will help me to understand Chile. My personal heritage is Anglo-Australian and I learned much about myself and of Australia by visiting England. I think I will understand more of Chile when I have visited Spain.

I have some free time following the conference and travel to Extremadura near the Portuguese border. I choose this part of the country because I want to be in the towns that were the birthplaces of so many of the conquistadores who have a place in the history of the New World - Cortez, Pizzaro, Valdivia. I travel to the town of Trujillo to wander the ruins of the castle which was the home of Pizzaro, whose life is so entwined with the early Spanish colonisation of Chile. I find there many of the medicinal plants which I had recognised in Temuco, and which I had known in Melbourne.

I ponder the contradictions of my chosen profession – I am an urban herbalist, descended from colonists who did not adopt the medicinal plants of their land. I use the plants of European culture, 200 years on. I practice a traditional craft, in a first world country, in the 21st century. I am writing a thesis…
CHAPTER 1 INTRODUCTION

1.1 Background

This thesis concerns the history and practice of contemporary Western herbal medicine (CWHM) in Australia, and highlights the experiences and concerns of Australian herbalists. It explores the attempts of herbal practitioners to move from a position of professional exclusion to one of inclusion, and in particular the effects these changes are having on the practice of herbal medicine.

The research presented here reflects on the dynamic relationship between culture and medicine. I argue that herbalists were marginalised more than a century ago as a result of a particular combination of cultural circumstances which involved the economy, the State, and the interests of competing groups of professionals. Its subsequent move towards mainstreaming is similarly consequent to a change in those cultural circumstances. These changes are less to do with any fundamental shift within biomedicine and more do to with changes affecting in particular the economy, the state and the status of the medical profession. Further, I argue that herbal medicine’s acceptance as part of mainstream healthcare is conditional on its knowledge base being re-interpreted in ways that are congruent with mainstream science and biomedicine. This reinterpretation appears to challenge the long-term ability of practitioners to maintain their professional identity, and can be understood as an example of the tensions experienced by traditions which culturally locate themselves, in Gross’ (1992) terms, close to power.

Prior to the 1980s, practitioners of European herbal medicine in Australia were few in number, with minimal resources and little political power: their activities were of little public interest. Their survival at all is surprising as there had been repeated calls during the 20th century for their work to be made illegal. Mainstream medical and scientific opinion appears to be that the
discipline was an anachronism and its practitioners were eccentrics, with herbal medicine on the way to extinction, at least in the developed world.

However to paraphrase Mark Twain, reports of its death were an exaggeration (The Oxford Dictionary of Quotations, 1979, p. 554). By the latter years of the 20th century in Australia, as in other parts of the developed world, a herbal renaissance was well established. Many authors associate the beginnings of this resurgence in popularity for natural medicine with the rise of the counterculture, fuelled by a disillusion with the promise of biomedicine and also by new emphasis on patients’ rights (Baer, 2001; Griggs, 1997; McKee, 1988; Saks 2003). However by the early 2000s the utilisation of herbal medicine by the Australian public crossed a range of sectors (Adams, Sibbritt & Young, 2007; Forster, Denning, Wills, Bolger & McCarthy, 2006; MacLennan, Myers, & Taylor, 2006; MacLennan, Wilson, & Taylor, 1996; MacLennan, Wilson, & Taylor, 200; van der Sluijs, Bensoussan, Liyanage & Shar 2007).

The increase in public demand for herbal medicine from the last decades of the 20th century has not been accompanied by a large-scale rejection of biomedicine. Siahpush (1998) suggests that the popularity for alternative approaches to healthcare can be usefully understood as a public demand for a level of medical pluralism, with consumers having access to both biomedicine and natural medicine. Rather than the replacement of one medical monopoly with another, consumers want access to a range of options.

Stakeholders with an interest in herbal medicine include herbal practitioners, manufacturers, regulators, educational providers, consumers, growers, and other healthcare professionals, both orthodox and complementary. They represent a wide range of interests and opinion on the issues facing the herbal medicine profession and industry, and a range of questions are raised regarding the future of herbal medicine. Should the practice of herbal medicine become part of mainstream Australian healthcare? If so, in what
form? Who should practice it? In what context? What types of conditions is herbal medicine best placed to treat? What is the appropriate training for its practitioners? What funding arrangements should be made – for practitioners and for consumers? Should herbs be used only as substitutes for pharmaceuticals, or do they have other therapeutic applications? These questions represent some of the tensions inherent in the issues facing practitioners today, and their answers inform the direction of political decision making with regard to herbal medicine. In part, the subject matter of this thesis can be understood as an exploration into these tensions and these choices.

From the 1980s, increased public demand (Dixon, 1986) meant that practitioner groups, small in number and generally conservative in outlook, found themselves the focus of intense interest and scrutiny from the public, and from other professional and regulatory bodies. Inevitably, divisions between practitioners appeared, particularly with regard to the appropriate ways to respond to these changing circumstances. Some herbalists, remembering the professional marginalisation and criticisms they had faced in the past, wished to have as little as possible to do with medical practitioners, the larger health system and the government and preferred to stay outside the glare of official interest. For other practitioners, the increase in popular interest in herbal medicine encouraged a degree of confidence and optimism that fundamental changes in their position were both possible and desirable. I remember meetings of the National Herbalists Association in the early 1980s where suggestions were made to open up dialogue with medical practitioners. These suggestions were strongly countered by some older practitioners who appeared to fear that the motives of medical practitioners with regard to herbal medicine would be necessarily destructive for herbalists.

In spite of these concerns, some herbalists, particularly those more recently qualified, supported a push to improve educational standards and to look
towards science for validation and legitimation. This, they believed, would lead to a revitalisation of the craft. They decided to counter the accusations of herbal medicine as being quackery and its practitioners as charlatans, by ‘fighting science with science’. Depending on one’s point of view, this represents a decision of great political courage, or great political naivety. Given herbal medicine’s small base in terms of numbers of practitioners, and its very limited resources, one herbalist has since referred to a similar move in the UK as one of ‘taking on armour plated science with bows and arrows’ (Paul Chenery, UK Herbal List, 3 April 2006). Whatever perspective is taken, whether the underpinning of herbal medicine with science is understood to be appropriate or inappropriate, it is important to acknowledge the extent of the task which such an undertaking involved.

New training courses burgeoned during the 1980s, as a wide range of individuals were attracted to study (and teach) herbal medicine both as a stand-alone profession and as part of naturopathy (Evans, 2000). Some courses emphasised biomedical sciences and others did not. While herbal medicine was initially characterised by the revival of the ancient practice of using simple plant preparations to alleviate illness it can also, thirty years later, be seen as part of a process of reinterpretation as a thoroughly modern approach to self care and medical care (Jagtenberg & Evans, 2003). The current emphasis on phytochemistry and evidence-based medicine indicates attempts to re-cast herbal medicine as more mainstream than New Age (VanMarie, 2002). This thesis demonstrates that such reinterpretation is both complex and contested.

These recent changes to herbal medicine can be understood in a broad historical and geographic context. Medicinal plants are used in all cultures at all times, which requires that the way their activity is understood – how herbs work – varies cross-culturally, depending on the way a particular society understands disease and the processes of healing. Herbs are used as the basis for the development of many pharmaceuticals in biomedicine; they are
understood as agents to stimulate physiological functioning in natural medicine; and they are used in the context of rituals and ceremonies within shamanic medicine. The underpinning of the knowledge base of herbal medicine with science, and the incorporation of biomedical knowledge and phytochemical understandings into its practice, can be understood as ways in which the knowledge base is being reinterpreted to suit the needs of 21st century Australia.

All systems of medicine are developed to fit their sociocultural context, and change as the context in which it is practiced changes. Today, Western herbal medicine in Australia is undergoing renewed popularity, and part of this renewal requires that it be reinterpreted to fit the context of contemporary Australian society. The challenges and tensions discussed in this thesis are consequences of this process.

Further, herbalists base their knowledge of medicinal plants on the use of these plants over extended periods of time: that is, on traditional use. All herbals, even the most modern and scientific herbals acknowledge this basis for much of herbal knowledge (Blumenthal, 2000; Braun & Cohen, 2007; Mills & Bone, 2000). One aspect of traditional use is the folk and empirical use of the plants, and another is their use within more formal traditions. Griggs (1997) identifies two specific traditions which have informed Western herbal medicine. These are humoral medicine (identified within the Hippocratic Corpus from the 5th century BCE, through to the 17th century) and the physiomedicalist and eclectic tradition of the 19th century. A third influence is now that of contemporary science, especially plant chemistry. It is argued in this thesis that CWHM is informed by a mosaic of understanding about the activity of medicinal plants and approaches to health and disease which arise from a melange of these influences.
1.2 The central questions

The increased acceptance of CWHM over the last thirty years is remarkable, and well illustrated by the changes in the language used to refer to the practice and practitioners. Herbal medicine was referred to as ‘quackery’ up until the 1970s, and later became ‘alternative’ medicine, then ‘complementary’ medicine and more recently ‘integrated’ medicine. These changes in language are a clear indication of the movement of herbal medicine from derided outsider (‘quack’) to acceptance (‘integration’). Although it may seem that the most recent descriptor (‘integrated’) marks full acceptance, it is useful to remember that integration can also indicate a loss of identity.

The questions which drove this project were - How is the practice of European herbal medicine adapting to 21st century Australian society? In what ways are practitioners adapting to the modernisation of herbal medicine? Is the recent popularity and public acceptance of herbal medicine affecting its practitioners, particularly the ways in which they approach their craft?

These questions were explored utilising theorists and methodologies found within the social sciences. While it was originally intended that this thesis would provide a snapshot showing how Australian herbalists understood their practice, the work has developed to provide a broader sociocultural perspective. As a pioneering thesis it provides an overview of the field and has been conceived as a contribution to herbal medicine rather than an abstract sociology of the field. Because herbal medicine is a new discipline within the tertiary sector, part of the work of this thesis has been to develop its conceptual history and a history of ideas which could be used in conjunction with broad social science methodology, as a contribution that may guide future work. Towards this end a broad focus was developed which involved history, politics, cosmology, epistemology and methodology.
The thesis contributes to the development of identity among Australian herbalists by providing an understanding of their professional origins and history. It highlights the context in which herbalists work and identifies the influences - both challenging and supportive – which affect them. Consequently, these practitioners will be able to take a more nuanced approach to the decisions they make regarding the development of the profession and the likely implications of their choices for its future.

This work also contributes an understanding of herbal practice and herbal practitioners to the public, healthcare professions and regulators. The importance of inter-professional understanding becomes more urgent as increasing numbers of patients choose to employ herbal medicine and conventional medical interventions concurrently. In addition to this, there is a ‘crisis in healthcare’ which receives much media attention. The crisis involves spiralling costs in healthcare due both to expensive interventions and to increasing numbers of patients reporting chronic conditions which require ongoing treatment. This thesis demonstrates that herbalists are not yet participating fully in that system and suggests that consideration should be given to introducing mechanisms by which their contribution to the provision of healthcare can be enabled. The fact that their interventions are low-tech and low cost compared to biomedical interventions, and their potential to contribute to the care of patients with chronic conditions gives urgency to the need to overcome the current sticking-points to full participation.

From a global perspective, this work serves as an example of the ways in which biomedicine interacts with a more traditional practice, and the difficulties of merging different approaches to healthcare. While attention has been given to the interface between different systems of medicine for example in Asia (Connor & Samuel, 2001; Scheid, 2002) a contribution of this work is to the relationship between these systems of medicine by non-indigenous practitioners within a non-traditional society – that is, the comparison of two systems of medicine which arose within the same cultural context (Western
society), but which have very different aims and different political experiences.

This thesis highlights the difficulties of integrating these traditional practices and information into a modern context. There is a basic tension within contemporary Western herbal medicine as it attempts to become part of the provision of healthcare. This tension is between tradition and science as appropriate bases for knowledge generation. The knowledge of the medicinal plants and their appropriate use is based in traditional understandings. Contemporary medical knowledge is based in science, which, I will argue, rejects traditional ways of knowing. As herbalists attempt to reinterpret their craft in ways appropriate to this place and time, they are faced with the challenge of combining their traditional knowledge with scientific understanding.

I do not engage in this dissertation with the debates regarding the ideological nature of science –debates which have been well argued by for example Kuhn (1962), Lyotard (1997), Capra (1982), Foucault (1991b, 1994) and Jagtenberg (1983, 1987). While some aspects of these debates and their impact on herbal medicine are discussed in 2.4.1, 3.5.4 and 4.5.8, my focus in this dissertation is firmly on the political importance of the dominance of science for the practice of herbal medicine.

In this thesis, the practice of contemporary European herbal medicine in Australia is presented as both a traditional practice, practitioners of which have long sought acceptance and inclusion within mainstream healthcare, and as an emerging new profession. The recent popular acceptance of all forms of natural medicine, including herbal medicine, has presented herbalists with an opportunity to have this dream of inclusion realised. Given the sophistication and complexity of the health care system, consideration needs to be given to the appropriate place for herbal medicine in healthcare provision in Australia.
1.3 Key Literature

Research specific to the practice of herbal medicine in Australia is sparse, and this thesis contributes to filling that gap. While there is an extensive literature regarding the development of a scientific basis for the activity of specific medicinal plants, and the efficacy of specific interventions (see Chapter 4), and on the utilisation of a range of CAM therapies, including herbal medicine, by specific populations (Lin, Bensoussan, Myers, McCabe, Cohen et al., 2005), this is not the case with regard to the professional practice of herbal medicine. Research on this topic is limited and recent. Reports to and from governments regarding the need for regulation are sources of descriptive material of the profession (Evans, 2000).

Of the major reports carried out into natural medicine over the last 30 years (Bollen, 2003; Dixon, 1986; Lin et al., 2005; Ward, 1975; Webb, 1977), only the most recent specifically concerns the issues of herbalists as a group distinct from naturopaths. The Report into the Practice and Regulatory Requirements of Western Herbal Medicine and Naturopathy (Lin et al., 2005), was charged with the task ‘to investigate and understand the practice of naturopathy and Western herbal medicine and make recommendations for its regulation’. Referred to in this work as the La Trobe Report, it gives a detailed description of the characteristics of the herbal workforce including education and training and professional organisation, as well as information about its public utilisation, and an assessment of its risks and benefits. Data from this report is used in this thesis as a primary source of information about practitioners and their practice, particularly detailed in Chapter 2.

With regard to the origins of herbal practice, Griggs’ (1997) classic text on the history of Western herbal medicine gives a broad overview of the history and politics of herbal practice, particularly in Britain and the United States. Her perspective largely focuses on the political position and activity of herbalists, and their vicissitudes as a result of their relationship with biomedicine.
Her interests coincide to some extent with those of Martyr (2002), who documents the history of a range of non-mainstream medical practitioners in Australia from 1788 to 2000. Martyr is interested that ‘The war between these practitioners and the medical population continued throughout the twentieth century and persists into the twenty-first’ (p. 8). Martyr gives an overview of the range of non-biomedical therapies practiced since colonisation and includes in her discussion of non-indigenous herbal practice in Australia all traditions of herbal medicine, including Chinese, Indian and Islamic herbalists. Largely drawn from archival material, this account documents existence of herbalists as an occupational group since colonisation, and also documents the range of ways in which herbal medicines have been employed historically. However the range of professions identified as ‘quackery’ in Australia means that the coverage of herbal medicine is cursory and problematic. It is not only the lack of differentiation between herbal traditions which is problematic, but also her failure to differentiate between practitioners and researchers. In a discussion of the use of ‘Australian herbal guides’ in the 1980s (pp. 278-279), she fails to differentiate between the work of Dorothy Hall (1980a) and Gregory Ah Ket (1983), Australian herbalists adapting the Western herbal tradition to an Australian audience, with that of Cribb and Cribb (1983), who are botanists researching into the medicinal uses of indigenous plants. This is an important distinction to be made, as Cribb and Cribb (1983) are not practitioners and therefore do not have practical experience of using plants with patients, as therapeutic agents, whereas Hall (1980a) and Ah Ket (1983) are practitioners with this experience.

The literature which is most relevant to this thesis addresses the issues of the herbal profession in the US and UK. They are *Re-presenting herbal medicine as phytotherapy: a strategy of professionalisation through the formation of a 'scientific' medicine* (VanMarie, 2002); *Herbal Voices: American Herbalism through the words of American Herbalists* (Dougherty, 2005) and *Reshaping Herbal Medicine: Knowledge, Education and Professional Culture* (O’Sullivan, 2005). These works highlight the conflicts being faced by herbalists as they attempt to reinterpret
their practice in ways which will appropriately respond to public demand and also allow them to make a living. VanMarie (2002) and O’Sullivan (2005) concentrate on UK herbalists, while Dougherty (2005) considers the position of herbalists in the US. They, like the current work offer a critical perspective regarding the conflicted position within which herbalists find themselves.

Vanmarie’s (2002) work is focussed on the practice of herbal medicine in the UK and the views of its practitioners particularly with regard to its recent history and the changes to its knowledge base. His particular interest is in the relationship between knowledge construction and professionalisation, and he relates the ‘scientisation’ of herbal medicine to the attempts of herbalists to attain professional status, the ‘re-presenting of unorthodox to become accepted as orthodox’ (p. 169).

Vanmarie (2002) identifies the origins and sources of support for the development of phytotherapy and its differentiation from traditional herbal medicine, as well as the divisions that this has caused within British herbal medicine. He argues that while the knowledge base of herbal medicine is being reinterpreted to fit within scientific understanding this has not changed the actual practice of herbal medicine, given that following the completion of their training practitioners are free to practice how they please. He further claims that the divisions engendered by the different approaches to the construction of the knowledge base are not substantial, and indicated that the ties that bind herbalists – their commonalities as practitioners who use herbal medicines - are stronger than the forces that divide them. Griggs (1997) makes a similar claim with regard to the tensions in British herbal medicine current in 1997.

A more complex picture of herbal medicine in the UK is painted in the essays edited by O’Sullivan (2005). This volume arises out of the work of the European Herbal Practitioners Association in forwarding the cause of statutory regulation for herbalists of four traditions – Western herbal
medicine, Traditional Chinese Medicine, Ayurveda and Tibetan medicine within the context of European Union legislative requirements. O’Sullivan’s (2005) collection focuses on the development of a new profession of herbal medicine and the possibilities for its formalisation and incorporation into mainstream healthcare provision within the UK. These are the voices of those who are heading the movement towards statutory self-regulation of the British herbal professions.

The issues addressed focus on the formation of professional identity and the ways in which herbalists wish to present themselves and the role they wish to carve out – and which is possible to carve out – as they negotiate with government and major stake holders and balance this with the needs and desires of their fellow herbalists. O’Sullivan (2005) relates the changing landscape for all professions and the power of special interest groups, to the possibilities for professional herbal practice. She argues that the changing nature of professions limits professional autonomy and affects the nature of professional knowledge as a result of the responsibilities of professional practice. Major issues for consideration for herbalists include the relationship between traditional and contemporary (especially evidence-based) ways of knowing, as well as the autonomy and independence of practice, and the distinctiveness of herbal practice in its contribution to patient health.

Dougherty (2005, p. 8), focuses on the ‘critical issues of contemporary American herbalism’ from the point of view of those involved in herbal medicine and has many parallels with this project. A herbalist herself, Dougherty interviewed professional members of the American Herbalists Guild and presents the views of practitioners. Her identified major issues of contemporary American herbalism parallel the issues of contemporary Australian herbalism raised here, and include the place of science and tradition, issues around professionalisation, and issues around the supply of medicinal plants. As in the present work, she reports that these issues are controversial for herbalists, and they hold a range of views.
The current work differs from Dougherty’s (2005) in terms of the national identity and location of the groups considered. While US and Australian herbalists share many similarities (for example both are societies which originated as British colonies and herbalists in both countries use many European herbs; both groups of herbalists have a history of being marginalised), their cultural differences are also reflected in their professional experiences, for example the differing experiences regarding the legality of practice.

1.4 Legalities of practice in Australia

Herbal practice in Australia, like naturopathy, is legal but unregulated. Legitimation is tightly bound with legal recognition, i.e. statutory regulation. The NHAA first formally sought the protection and recognition of statutory regulation for herbalists in NSW nearly 80 years ago (see 8.4.1.2).

Currently herbalists practice under common law, which means that the profession is open to all, without educational or other requirements. Given the highly regulated nature of medicine, herbalists have seen statutory regulation as a necessary precursor to participation in healthcare provision within Australia, and Baer (2006) suggests that this is associated with practitioners hoping that this will allow them access to Medicare – the system of government rebates for medical services.

It should not be assumed that statutory regulation or even a broader interpretation of professionalisation is uncontroversial within herbal medicine. While a survey of practitioners indicated that they thought government regulation would overall have a number of positive outcomes, they were not confident of the influence of regulation on, among other factors, freedom of practice and the influence of biomedicine on herbal practice (Bensoussan, Myers, Wu, & O’Connor, 2003).
Some practitioners have reacted with caution, even suspicion, regarding the likely outcomes of such moves, particularly their ability to maintain their identity in the larger arena. These suspicions, particularly with regard to the attitude of biomedicine with regard to future cooperation, are echoed by Saks (2002, p. 11)

...having failed to stem the populist tide of demand for alternative medicine sustained by considerable political support, (biomedicine’s) best defence against such therapies was to absorb them in selected and emaciated form within orthodox medicine itself.

The views of the second group of herbalists are extremely unpopular with those who do not share them, and Conway (2005, p. 195) puts this position in a recent essay referring to the situation in the UK.

Herbal medicine has survived, and is now beginning to thrive, in spite of its enforced outsider status.

Herbalists have been outsiders by dint of necessity perhaps, but now that the potential exists for significant movement of the profession, a determination to remain in this familiar and comfortable space begins to look less like a credible position, and more like outlaw chic. Are we, as Western herbal practitioners, attached to seeing ourselves as rebels and outsiders, and seduced by the glamour of this? The author has at time despaired of the wilful cultivation of a countercultural stance by some herbalists that would seem to have Patti Smith’s Rebel shout as its anthem: ‘Outside of society, that’s where I want to be’.

1.5 Nomenclature

The nomenclature used to describe herbal medicine and its practice is not straightforward. There are two layers of complexity here, which will be discussed in turn. The first concerns the range of approaches to herbal
medicine among herbalists, and the extent to which an individual practitioner is influenced by a scientific world-view and the extent to which (s)he is influenced by traditional philosophies of practice. This complexity is common to traditions of Western herbal medicine, at least in the English-speaking world. The second layer of complexity concerns the relationship between herbal medicine and naturopathy, and this appears to be more specific to Australia and a result of the history of natural medicine in this country.

1.5.1 Herbalists

A herbalist in this thesis is defined as a health practitioner who engages in extemporaneous compounding of herbs for therapeutic purposes for individuals under his or her care (Lin et al., 2005, p. 2).

Western herbal medicine refers to the practice of European herbal medicine – that is, using plants largely native to Europe, within a philosophical traditional arising from European thought. Practitioners of Western (or European) herbal medicine use European plants and this use is underpinned by European concepts. In this way they are differentiated from herbalists within Traditional Chinese Medicine (TCM) and Ayurveda, who use different species of medicinal plants and describe the therapeutic uses of these plants within their own tradition.

1.5.2 Contemporary Western herbal medicine.

The changes which are occurring within herbal medicine are reflected in changes to the terms used to refer to its practice. The terms used to describe differing approaches to the practice of European herbal medicine are ‘phytotherapy’ and ‘traditional herbal medicine’. The term ‘contemporary Western herbal medicine’ (CWHM) is used in this thesis to refer to the current practice of herbal medicine, which includes both of these approaches. These differences in emphasis, and their origins, are described in Appendix 1.

In practice, the differences between phytotherapy and traditional herbal medicine are ones of emphasis (Griggs, 1997). This research demonstrates that
herbal practitioners use both scientific herbal medicine and traditional herbal medicine, and VanMarie has found that, within the UK, not all practitioners differentiate between the two terms (VanMarie, 2002). These trends and preferences may be reflected in an individual practitioner’s approach, but it appears that herbalists do not reject either tradition or science in their practice.

In this thesis, the term contemporary Western herbal medicine (CWHM) will be used to describe the general practice of herbal medicine in Australia, and the terms phytotherapy and traditional herbal medicine will be used to emphasise specific approaches as appropriate.

1.5.3 The relationship between herbal medicine and naturopathy

The relationship between herbal medicine and naturopathy requires comment as an overlap occurs between the professions. A naturopath is defined here as a practitioner having core training in naturopathy principles and philosophy, and in at least three of four practice modalities: (i) herbal medicine; (ii) nutritional medicine; and (iii) either massage or homeopathy (Lin et al., 2005, p. 2).

Thus in Australia, herbal medicine is practised both as a stand-alone profession, and as a modality within naturopathy. This differs from the situation in the US and the UK where the terms herbalist and naturopath may indicate more distinct practices and professions. In Australian the boundary between the professions is less fixed. This overlap is confirmed by Bensoussan et al (2003) who found that naturopaths use herbal medicine in their practice and herbalists also regularly use homeopathy and nutritional medicine.

The two disciplines developed separately in Australia, with the practice of herbal medicine predating naturopathy. Western herbal medicine in Australian dates from first European settlement in 1788 (see Chapter 2) while the term ‘naturopathy’ originated in the US around 1900, and the first
naturopaths set up practice in Australia in the early 20th century (Evans, 2000).

Within this thesis, as within the field of herbal medicine in Australia, there is a level of flexibility with regard to the names that practitioners use to describe themselves and their practice. Some practitioners describe herbal medicine as one therapeutic modality among those they employ, and will therefore move in their discussion between a discussion of ‘herbal medicine’ and one of ‘naturopathy’. They may specialise in herbal medicine within their practice, but still discuss it within the overall field of naturopathy.

Other practitioners identify less with naturopathy and more with herbal medicine, either because of their post-qualification experiences, or because they have focussed on the practice of herbal medicine since their training. These practitioners may use the terms herbal medicine exclusively in their discourse.

These issues are influenced by a practitioner’s training. In a number of large private colleges, qualifications for herbal medicine and naturopathy are nested together – thus for example at Nature Care College in Sydney and the Australian Institute of Applied Sciences a student may qualify for an Advanced Diploma in naturopathy, and with the addition of a number of other units, can use this award towards a qualification in herbal medicine.

Thus in this thesis it will be noted that there is often a ‘slippage’ between discussion of herbal medicine and herbalists, and a discussion of naturopathy and naturopaths, particularly when current clinical practice is discussed. This reflects the way in which these terms are used by practitioners, and has consciously not been ‘corrected’, in an attempt to be consistent with current practice.
1.6 Scope of the thesis

The thesis concerns issues around the practice of contemporary Western herbal medicine (CWHM) in Australia and is limited to a consideration of herbal medicine in this particular context. It excludes self-prescription of herbal medicines and the use of over-the-counter (OTC) herbal products. It also excludes the recommendation or prescription of herbal medicines by, for example, doctors and chiropractors, who rarely individually formulate herbal medicines for their patients. Further, it does not consider the situation of herbalists from other traditions, e.g. practitioners of Traditional Chinese Medicine (TCM) from the Chinese tradition, or Ayurvedic medicine from India. Nor does it consider the use of herbal medicines among indigenous Australians. It also excludes any substantive discussion of other modalities within the broader field of Complementary and Alternative Medicine (CAM) apart from the discussion of the overlap between Western herbal medicine and naturopathy as previously discussed. Rather it is focussed primarily on the practice of herbal medicine by those who call themselves western herbalists.

In addition there are two major theoretical approaches which are excluded from this account. Firstly, this thesis does not address the criticisms of the Left towards herbal medicine, along with other holistic therapies. From this perspective, herbal medicine ignores the structural and political constraints on health, and thereby does not live up to its claims of taking a holistic approach to healthcare. These authors argue that by continuing to emphasise the individual nature of disease and individual responsibility for health, and ignoring the societal and environmental causes of disease, herbal practitioners are failing to address the origins of ill-health (Baer, 1989; Brown, 1979; Porter, 1997; Saks, 2003; Willis, 1989).

Secondly, there is a long history of association of women, healing and plants, (Achterberg, 1990; Bennett, 1991). Not only is there a predominance of women
as practitioners and consumers of herbal medicine (see Chapter 2), but historical arguments can be made for a gendered perspective on the relationship between herbalists and orthodox medicine, particularly with regard to the European witchunts (Bennett, 1991; Daly, 1978). Further, the ideas put forward in the field of eco-feminism (Diamond & Orenstein, 1990; Reuther, 1992) may contribute to an understanding of the ideas presented here but again, they are not addressed in this thesis.

Both of these are rich topics for exploration, but an adequate consideration of either of these perspectives must be left for another book or someone else’s thesis.

Finally, the history of herbal medicine is a focus of this dissertation (2.3 and 8.3) and references to the history of biomedicine (Friedson 1988; Brown,1979; Willis, Sigerist, 1951; Foucault, 1962, 1991a) provide a useful counterpoint and also contextualise herbal medicine’s historical changes. Discussion of the history of biomedicine itself has been necessarily limited in order not to detract from the centrepiece of the work – herbal medicine itself.

1.7 Thesis framework

The move of herbal medicine into academia is arguably the result of its recent acceptance by both popular and commercial interests, the reasons for which have been widely canvassed (Baer, 1989; Capra, 1982; Illich, 1975; Moynihan & Cassels, 2005; Saks, 2003). Herbal medicine has been located outside academia until recently, identified as the rejected ‘Other’ by one of the most powerful academic disciplines, biomedicine. It is now being offered a level of inclusion (although it is as yet unclear as to how far this inclusion will reach), contingent on its compliance with the ‘rules’ of scientific and medical discourse. Acceptance of these rules requires substantiation of knowledge in a different way, and excision of much that has characterised it in the past.
One of the challenges of this work has been the task of mapping a new field – that of Australian herbal medicine, which has not previously been included as an area of academic scholarship and research. It is not just that this thesis draws on information from a variety of fields. This is not an interdisciplinary or multidisciplinary study which incorporates the perspectives of two or more already established fields. Rather this is what Hodge (1995) terms a ‘transdisciplinary’ study, drawing from a wide variety of disciplines, not all of whom share or agree on the appropriate ‘rules of truth’ (see chapter 4).

The thesis draws largely on the social sciences, particularly to describe and analyse the political history of herbalists, including their relationship to biomedicine, and to the State. In part, it is the story of their professional struggle for the right to contribute to the healthcare of the community and for acknowledgement and recognition in the face of stiff opposition. It is also an investigation into the politics of identity of a new professional group which has had a unique history of repeated marginalisation and persecution, balanced by periods of great popularity. While the present work will address issues and difficulties relating to contemporary herbal medicine in Australia, it is worth noting that herbal medicine has had a difficult history in Europe going back many centuries to the witch trials of the 13th-15th centuries.

The fact that the thesis draws on diverse fields is necessary for a number of reasons. Firstly the questions which the thesis sets out to address are best answered by recourse to the methodologies and perspectives offered by the social sciences, in particular cultural studies, sociology, politics, philosophy and history. Secondly the field of herbal medicine itself is informed both by tradition and by science, and claims to have a holistic rather than reductionist perspective to medicine. It is therefore appropriate that it draws on diverse methodologies and approaches. Thirdly the nature of the herbal consultation, which is at the core of herbal practice and therefore the subject matter of this project, is itself highly complex and draws on information from a wide variety of sources.
1.8 Personal story

I have been a herbalist for many years, and am well known among Australian herbalists, and my professional relationships, my politics, and my understanding of the field are inevitably brought to the investigation and writing of this thesis. My experiences and my position have not only affected the writing of this thesis; they also mean that I am simultaneously privileged and limited in my interactions with others in the field. The strengths and limitations of my ‘insider status’ are detailed in Chapter 6.

I was born and spent most of my life in Melbourne. My ancestors were among the early European settlers of the Australian colonies. On my father’s side, a great-grandmother’s great-grandparents were transported to Australia as convicts with the First Fleet. On my mother’s side, a great-grandmother’s parents emigrated from Scotland to Victoria at the time of the Victorian gold-rush. Thus my familial cultural inheritance is firmly Anglo-Australian.

My childhood was unremarkable except for my father’s occupation. As a ship’s captain he was away from home for long periods and returned irregularly with wonderful stories and trinkets from far away places. In the secure, unchanging suburban Melbourne of my childhood there were no grandparents with herbal plasters, or doctors of any kind, in my circle of family and friends, and no contact with herbal medicine except for the miraculous Tiger Balm\(^1\) which my father had brought back from Singapore in the early 1960s and swore would cure any ill, from headache to stomach-ache. However my father, like many Australians, had a very dry sense of humor, and I was often left wondering whether his enthusiasm was real.

In the early 1970s I studied social science and became a vegetarian. This led to an interest in diet and alternative medicine. I started a career in social work, quickly burned out, and went to the UK. After a short stint in a health food

\(^1\) A Chinese herbal ointment used for a range of problems. It is now widely available in Australia, but was unheard-of here in the 1960s.
restaurant in London, I began training in herbal medicine. It was mid 1970s. I studied with the School of Herbal Medicine which at that time was located in Tunbridge Wells, Kent. My qualification was membership of the National Institute of Medical Herbalists, the oldest association of herbalists in the English speaking world, formed in 1864. By the time I finished the course, herbal medicine was not widely used in either Britain or Australia and my family found it difficult to understand my giving up a ‘perfectly good’ career in social work to become a herbalist. Among the herbal community there was talk of a herbal ‘renaissance’ underway, but this was not a view widely shared by the public.

I returned home in the early 1980s, and it was not easy to establish a clinical practice. However by the end of a decade my small home practice had outgrown the front room and I had joined the first multidisciplinary clinic in Melbourne, the Whole Health Clinic in Fairfield. There I worked with medical practitioners as well as a homeopath, chiropractor and psychologist in a clinic that aimed to address the patient holistically. While each of practitioners within the clinic maintained a separate practice, the clinic had a strong commitment to establishing effective means of cross-referral and demonstrating that practitioners from diverse backgrounds could work together and achieve positive outcomes for patients. They were heady days, as we were aware we were breaking new ground and enthusiastically established a public profile through seminars and research projects. Our position was sometimes seen as controversial: on two occasions, in the early years of the practice, the medical practitioner who headed up the clinic was called in by the Medical Registration Board of Victoria to ‘please explain’ his professional behaviour in working with unregistered health practitioners.

At the same time I was teaching at a large naturopathic college, the Southern School of Natural Therapies (SSNT). Homeopathy was the focus of teaching at SSNT when I arrived. Herbal medicine in Victoria had been absorbed into the practice of naturopathy, and there were neither practitioners nor training
courses in herbal medicine to be found in Melbourne. The National Herbalists
Association of Australia (NHAA) was (and is) based in Sydney, and when I
joined I was their only member residing in Victoria.

I remember that during my first year of teaching at SSNT, I asked a class of
final year naturopathy students to think of the practices of herbal medicine
and homoeopathy as a continuum. I asked those who envisaged practicing
only herbal medicine to stand against one wall, and those who envisaged
practicing only homeopathy, against the other, and the rest of them to place
themselves to represent their idea of practice. Some students pressed
themselves firmly along the ‘homoeopathy’ wall, but none were more than
mid-way between homoeopathy and herbal medicine, none in the half of the
room that represented an emphasis on herbs. This same class, when
discussing a case, often told me that ‘this case is too difficult for herbs; you
would have to use homoeopathy’. I was shocked at finding this attitude
within final year naturopathy students, and was determined to introduce
them to the possibilities of healing offered by medicinal plants.

For ten years I coordinated the teaching of herbal medicine, and was able to
facilitate its development within the broader umbrella discipline of
naturopathy. In those years (1985-1995), although there were very few
resources available to me as a lecturer in herbal medicine, I was given
enormous freedom by the college in establishing a herbal curriculum.
Graduates became confident they could specialise in herbal practice, should
they so desire.

These graduates then both allowed and required the development of an active
herbal community, which primarily operated through the Victorian
Herbalists Association. I was president of that Association from its inception
in 1988 until 1996. The VHA organised regular meetings, newsletters,
conferences, seminars, lobbied government, and later became the Victorian
chapter of the NHAA.
In 1996 I accepted a position at Southern Cross University (SCU) as foundation lecturer in herbal medicine in the first Bachelor of Naturopathy course at a university. The challenges to develop an appropriate academic underpinning for the practice of naturopathy have been considerable. SCU mounted the degree in the face of considerable opposition, especially by the medical profession. Within the staff grouping, the challenge has been to adapt aspects of biomedical knowledge to the needs of naturopathic students and to underpin modality knowledge with appropriate academic foundations. The initial staff included both academics with a background in the health sciences but no naturopathic experience, and naturopathic practitioners with a deep understanding of their craft, but naïve and inexperienced in terms of academic life. Despite goodwill on both sides, the development of a disciplinary culture which reflects natural medicine has been challenging, as paradigms and ideas of ‘truth’, deeply held by staff members from different disciplines to which they are passionately loyal, have often clashed.

I have long wondered about the relationship between herbal medicine and biomedicine, and why herbal medicine – which to me seems such a natural and normal way to treat illness, is considered odd, or outright dangerous and weird. Why are simple plant medicines so denigrated in our society yet so enduringly popular among so many people? Why does mainstream acceptance appear to depend on our distancing ourselves from our roots?

I have questioned why, if there is truly a ‘green revolution’, herbalists and naturopaths find such difficulty in making a living. I have been distressed at what I understand to be misinterpretation and misuses of herbal medicines and I have been frustrated at the exclusion of herbal practitioners from forums and decision-making which relate to herbal medicine. And I have been inspired by my own experiences in clinical practice and by the stories of colleagues who find their work so rewarding.
The questions which are addressed in this thesis are those which have been recurring themes in my professional life, and the process of writing the thesis has allowed me to articulate the joys, discomforts and inconsistencies which have long inspired and bothered me, and which have been the topic of innumerable conversations with colleagues and friends. This research is an attempt on my part to explore, record and make sense of the unique professional challenges of being an herbalist in Australia in the 21st century.

1.9 Structure of thesis

Chapters 2 and 3 sketch the context to the practice of herbal medicine in Australia. Chapters 4 and 5 provide the theoretical ideas which underpin the project. Chapter 6 outlines the research program. Chapters 7 and 8 document the research findings. Chapter 9 contains the discussion, and Chapter 10 outlines the implications and contribution of the project to the fields of herbal medicine, the history of medicine, social science and public health.

As has been outlined above, I have a long personal history in this field. As a way of both acknowledging the influence of my professional history on the writing of this thesis, and of contributing these experiences to the work, a series of ‘tales from the field’ are included. I have been influenced by the work of Farmer (2003) who uses personal experience to illustrate his ideas, and states:

These are things I have seen with my own eyes. They are partial accounts, but they are eyewitness accounts (p. 17).

The first of the tales serves as a prologue to the thesis, and the rest are placed at the end of each chapter in order to minimise interruption to the text. However, each tale is illustrative of particular issues raised in the chapter, and allow for an interplay between theory and practice, and for my professional experience as a herbalist to contribute to, and ground, the discussion.
Chapter 2 Setting the scene: Western herbal medicine in Australia

Initially some basic demographic data is presented regarding Australian herbalists and their practice. This is followed by an account of the historical context of herbal medicine. European herbal medicine was introduced into Australia at the time of first European settlement, and has remained influenced by European rather than indigenous medical practices. As biomedicine established its dominance in the 19th and 20th centuries, the professional practice of herbal medicine became marginalised. The influence of the ascendency of biomedicine, and suggestions regarding its inevitability until the late 20th century, are outlined.

Chapter 3 The process of re-emergence

Societal changes in the last twenty-five years have led to a resurgence of popularity in herbal medicine in Western countries, and this process is reflected in the changing findings of successive government inquiries over nearly 50 years – from recommendations for the banning of naturopathy in Western Australia in 1961 to recommendations that it be recognised through statutory regulation in 2007.

The society in which herbalists are re-emerging makes particular demands on them, and requires that herbal medicine be re-interpreted in a form that responds to, and is relevant to 21st century Australia. The characteristics of contemporary Australian society which are identified as being of particular relevance are the dominance of biomedicine as defining the Australian healthcare system; the importance of industry, and the commodification of medicinal plants; and the notion of risk as a major driver in government regulation and community expectations.
Chapter 4 Tradition and knowledge

The challenges facing herbalists today may be divided into those related to factors internal to the profession, and those related to their relationship with the larger society. In chapter 4, theoretical ideas are presented which relate to factors internal to the profession.

Herbalists are engaging in a re-evaluation of their practice and knowledge base, which involves confronting the contradictions and dissimilarities of approach between traditional herbal practice – and the knowledge it is based on - and a practice that is more congruent with biomedicine, and largely influenced by chemistry. The issue of tradition has received little consideration within herbal medicine, yet the claims of herbalists are based in traditional knowledge. A major consideration for herbalists is that traditional knowledge is underpinned by an acceptance of vitalism, a concept long dismissed within science. The implications of this, and the differences between traditional knowledge and evidence-based medicine, are outlined. The idea of agnotology, or the study of the forgetting of knowledge, is suggested as contributing to the process currently being undertaken within herbal medicine. An illustration of the effect of ‘forgetting’ on traditional knowledge within herbal medicine is provided through the professional journal of Australian herbalists – the Australian Journal of Medical Herbalism – concludes this chapter.

Chapter 5 On the margins and professionalising

In this chapter the focus moves from issues internal to the profession to those external to the profession. The position of herbalists vis-à-vis the larger society underwent massive change from the late 19th century as medical practitioners became professionalised, and they were marginalised as a consequence of this. Their position is now changing as this process is modified, and they move from a marginalisation to become professionalised and problematically, scientised.
However professions themselves are in the process of change as the autonomy of previous generations of professionals is curtailed by a range of factors. This loss of autonomy as a consequence of professionalisation is challenging for herbalists in light of the issues regarding their knowledge base, as outlined in Chapter 4. Further, the whole idea of professionalisation, with its implicit elitism, is difficult for many herbalists.

The question of professionalisation is further examined in relation to the question of marginalisation. Here Gross’ (1992) analysis of the marginalisation of traditions in modern society provides a framework in which to consider the ways in which marginalisation can occur.

*Chapter 6 Researching.*

In Chapter 6 the methodology employed in the fieldwork is detailed. The research project consists of two major parts. The first part is of a series of 16 interviews with herbalists in Melbourne and Brisbane, in which they discussed their approach to practice, in particular the ways in which they juxtapose science and tradition within the clinical encounter. The process by which the interviews were conducted and analysed is described. Of the questions that arose as a result of the literature, an archival search was conducted and parliamentary records were examined in order to ascertain the position from which current practitioners are attempting to establish a foothold within the healthcare system.

*Chapter 7 Reflections on Practice*

An analysis of the interviews reveals that practitioners are informed by traditional herbal knowledge and that this is combined with aspects of modern science. This combination is understood by them to impact both in decisions regarding diagnosis and treatment. Practitioners discuss the importance of prescribing treatments that are tailored to the individual, and emphasise the necessity of stimulating health, or treating physiological
processes, as well as treating disease processes. The process of this synthesis is neither easy nor well articulated by respondents, and appears to develop in practice rather than be taught in herbal training courses. The philosophical underpinnings of herbal practice are not well articulated, and respondents did not demonstrate consistency with regard to their understanding of one of its core concepts, vitalism.

Chapter 8 The process of transition

Respondents indicate ambivalence as to the changes which are occurring in the profession, describing both advantages and disadvantages consequent to the demands and consequences of increased acceptance. In particular this relates to the increased emphasis on science, and the influence of manufacturers on the generation and transmission of knowledge. The use of a metaphor of movement in some interviews led to me asking the question – ‘where is the profession moving from?’, and this, in turn, led to an exploration of the history of herbal practice in Australia. This exploration takes the form of an examination of archival and parliamentary records and demonstrates that herbalists have been consistently organised in their attempts to protect and promote their clinical rights since the first medical registration Acts of the 1850s. These attempts have been unsuccessful. In addition, instances of harassment of practitioners in the media and in a professional situation are documented.

The location of this historical analysis here, rather than as part of Chapter 3, serves to emphasise the ‘story of the research’ and its contribution to knowledge. The impetus for this historical investigation was not to provide a context for the practice of CWHM as much as to explain the metaphor of movement which arose in the interviews. In addition, the story uncovered in this process is one that has not previously been told.
Chapter 9 Directions in CWHM

The specific history of CWHM which has been developed is that of an imported colonial practice, marginalised for most of the last century before a resurgence in popularity has brought it from the shadows into the limelight. In order to maintain their specific approach to healthcare, practitioners face a number of challenges – not only historical factors which influence the strength of the profession, but also political factors regarding the future which they desire for themselves. In this chapter the work of Gross (1992) is revisited in an analysis of the choices open to herbalists with regard to the future of the profession. Gross’ perspective on the fate of traditional practices in non-traditional societies is relevant as herbalists choose to locate themselves close to power, or at the margins. His work also allows an examination of the role of OTC herbal products as a new form of domestic medicine, and a consideration of the repeated threats of loss of herbal practice rights in relation to herbal medicine going ‘underground’.

Chapter 10 Conclusion

The findings of this project are divided into those which relate to matters internal to the profession, particularly the ways in which traditional and scientific understandings are combined within CWHM, and those which are external to the profession, that is, the influence of professionalisation on herbalists, in light of their past experiences of marginalisation. This project has also retrieved a previously untold history of the political activity of Australian herbalists – a history ‘from below’, the story of the group which did not win the battle. It is a story of determination and grit, of continuing despite all odds, of survival, and therefore also a story of hope.

The implications of the research are that the potential contribution of herbal medicine to contemporary healthcare in Australia goes beyond the application of an understanding of therapeutic activity of medicinal plants to disease states. Herbal medicine has the potential to contribute new ways of
understanding health and disease which are potentially economically and ecologically sustainable. However their ability to contribute in this way requires their maintaining their identity and independence of thought.

Finally, the contributions of the project to herbalists, to the history of medicine, to the field of social science, and to public health, are outlined.
CHAPTER 2: SETTING THE SCENE: WESTERN HERBAL MEDICINE IN AUSTRALIA

2.1 Introduction

As this thesis concerns the practice of Western herbal medicine in Australia in the early years of the 21st century, this chapter and the next provide a context in which to place herbal medicine and the more specific issues raised in the later chapters. These two chapters seek to answer such questions as - Who are the Australian herbalists? What are the origins of Western herbal practice in Australia? Is it legal? What is its legislative and broader political context? These chapters cover four areas – the demographics of the herbal profession; the early history of European herbal medicine in Australia; its marginalisation in the late 19th and early 20th centuries and its re-emergence a hundred years later; and finally some broad socio-political factors which affect contemporary practice.

In this chapter, some basic socioeconomic data regarding Australian herbalists from three recent surveys is provided. I discuss the origins of European herbal medicine in Australia and the introduction of European medicinal plants in the early colonial period. Following this, there is a brief consideration of the ‘dark years’, i.e. the years of greatest marginalisation. The next chapter consists of an overview of the changing regulatory landscape illustrating the gradual movement of herbal medicine from a practice which was clearly outside mainstream healthcare in the middle of the 20th century, to one which was re-embraced by the Australian public by century’s end. It also outlines significant factors which influence the ways in which herbal practice is able to develop. These factors are identified as the dominance of biomedicine, the commodification of herbal medicine, and the risk society.
The discussion in these two chapters provides an important context in which to consider the complexities and contradictions of vulnerability and power which characterise practitioners of CWHM, and which are considered in detail in the remaining chapters. The vulnerabilities of herbal medicine practice arise from the outsider status of its practitioners. The many contradictions of CWHM include the practice of traditional medicine in a society where medicine is determinedly modern, and the attempts of herbal medicine practitioners to professionalise a domain which has been essentially folk medicine. The power of CWHM comes not only from the tenacity of the practitioners who have held on to their craft through decades of persecution but also from the deep reserves of public support which is evident once again. These contradictions introduce an intriguing story of a profession whose very existence continues to incite strong opinions (see for example Guo, Canter, & Ernst, 2007).

2.2 Who are the herbalists? Some demographic detail.

Data from three surveys provides an initial snapshot of Australian practitioners of Western herbal medicine. As outlined in Chapter 1, the identification of herbalists is not straightforward, both due to the unregulated nature of the profession, and the overlap between herbalists and naturopaths. While two of these surveys are workforce surveys which were undertaken in 2002/3, neither was specific to herbalists. In one survey, the respondents were herbalists and naturopaths located via The Grand United Health Fund, which was one of the first health funds to provide rebates for naturopathic consultations (Bensoussan, Myers, Scott, & Cattley, 2005) and in the other, respondents were naturopaths, herbalists and acupuncturists who were members of the Australian Natural Therapists Association and the Australian Traditional Medicine Society (Hale, 2002). The findings of these two surveys are largely similar when common questions are compared, with some disparities particularly on the question of income. The third survey was
smaller, but is more focussed on the work of herbalists. Casey, Adams and Sibritt (2007) surveyed members of the National Herbalists Association of Australia with regard to the treatments they provide and the ways in which they use herbs in clinical practice. Findings from these three surveys have been combined to provide a broad description of the herbal profession in Australia.

2.2.1 Professional identification.
The two workforce surveys demonstrate the lack of clear professional boundaries between naturopathy and herbal medicine which is described in Chapter 1. Further, there are questions as to what constitutes a herbalist. Bensoussan et al (2005) found that 76% of respondents used more than one title with which to identify their practice. Sixty-one percent of those surveyed reported that they use herbal medicine as one of their titles, and 76% used naturopathy as a title. As stated previously (1.5.3), this study indicates that the title used by a practitioner does not fully signify the modalities used: many who call themselves herbalists use homeopathy, nutritional medicine and massage regularly, and those who identify themselves as naturopaths use herbal medicine 44% of the time. Similar overlaps in the use of disciplines were found by Hale (2002), who noted that 63% of naturopaths are also accredited in Western herbal medicine by their professional association.

2.2.2 Gender and clinical experience
Both workforce surveys report that most practitioners are women (seventy-three percent in Hale’s survey, 76% in Bensoussan et al), and while many of those surveyed had been in practice only a relatively short period of time, there were also longstanding practitioners. Hale (2002) found that 40% of respondents had been in practice for less than 5 years. Bensoussan et al (2005) do not provide comparable statistics, but did report that practitioners had on average 6.7 years of equivalent fulltime practice, and this ranged from a few months to 47 years.
2.2.3 Economic viability of practice

The practitioners surveyed by Bensoussan et al (2005) and by Hale (2002) undertake about 20 consultations a week (Hale’s group average 18 consultations a week, Bensoussan et al’s average 22 consultations a week), and most would like to see more patients (Hale, 2002).

Hale (2002) found that the number of consultations increased with the number of years in practice, noting that 63% of those practitioners who average 1-5 consultations per week have been in practice 1-5 years, but only 3% of those who have such a small number of consultations have been in practice over 21 years. It is not clear from this research whether these practices grow over time, or whether a larger number of patients are necessary in order for clinical practice to be viable and therefore those with smaller practices do not survive.

Hale’s study also suggests that while new practitioners supplement their practice income to a larger extent than established practitioners, most herbal practice remains part-time, and one source of income for practitioners rather than the only source of income. Hale found that only 35% of those who have been in practice for 1-5 years derive 80-100% of their income from practice, and even of those who have been in practice for more than 21 years, only 54% of those derive this level of income from practice.

Bensoussan et al (2005) found that consultation fees averaged $62.10 for initial consultations and $42.10 for follow up consultations. Of their respondents, 40% earned under $40,000 p.a., and 27% earned between $40-60,000 p.a. This should be compared with GP earnings averaged $100,000 in 2003-4 (Ford, 2004), and average weekly earnings in Australia of $37,720 (ABS, 2003). Both Bensoussan et al (2005) and Hale’s (2002) findings indicate that this is a poorly-paid profession. Claims that herbal medicine is a billion-dollar business (MacLennan et al., 2006) refer to the industry rather than the
profession, which clearly does not have a financially secure cohort of practitioners.

Despite the lack of a secure financial foundation for its practitioners, herbal medicine education remains big business. While Bensoussan et al. (2005) and Hale (2002) identified Australian practitioners as totalling 1778 and 2134 practitioners respectively (the latter number includes acupuncturists, as previously stated), McCabe (2005) estimates that in 2003 there were 3500 students of naturopathy and Western herbal medicine enrolled in Australia, mostly at private colleges. These figures indicate an apparent discrepancy between the popularity of professional training courses and the likelihood of graduates establishing financially successful practices. Like 19th century doctors, it would appear that naturopaths and herbalists face a crowded marketplace and too few paying patients. If this is indeed the case, few of the students currently training will make a good living from clinical practice. There is currently a lack of graduate destination data which would assist in throwing more light on this issue.

2.2.3.1 Nature of practice – what do herbalists do in practice?

Casey et al. (2007) have provided preliminary information regarding the nature of herbal practice. This research indicates that Australian herbalists undertake lengthy consultations and then prescribe and dispense individual herbal combinations of liquid extracts. These individual combinations are prepared by mixing together a number of single herbs which have each been extracted in alcohol and water. The authors found that while over-the-counter preparations of herbs tend to be in the form of tablets or capsules, the preference by professional herbalists for individualised prescriptions necessitates the use of liquids. Thus herbal practice is carried out on a one-to-one basis, with ‘the mix’ being central to herbal treatment.
2.2.3.2 Diagnosis – how do herbalists interpret symptoms?

Diagnostic methods used by herbalists are drawn from both conventional and non-conventional sources. Bensoussan et al (2005) found that over 90% of practitioners use conventional Western medical diagnoses in all or some of their cases and 62% use conventional Western physical examination. This emphasis using conventional medical diagnosis is counterbalanced by the finding that over 80% of practitioners use iris diagnosis, a diagnostic tool which is seen as unscientific and fraudulent by many scientists (Ernst, 2000b). Research which has been undertaken to test the theory has not supported the claims of iridologists (Knipschild, 1988; Simon, Worthem, & Mitas, 1979).

Iris diagnosis relates the structure of the iris to specific organs and tissues of the body, and practitioners who use it as a diagnostic tool claim that it provides evidence of ‘analysis of biochemistry and of emotional and circumstantial factors…and illnesses past and present’ (Hall, 1980b, p. 3). Such information may include for example structural weaknesses, or overactivity and underactivity of particular organs or tissues. The interesting point here is not only that iris diagnosis is rejected by conventional medicine. It is that the information it provides –which in turn informs treatment –differs from conventional disease analysis and assesses other factors impacting on an individual’s health (see 7.2.2.2).

This indicates that the overwhelming majority of herbalists juxtapose a Western scientific approach to categorisation of disease alongside an approach to diagnosis rejected by conventional medicine. Not only do the treatments herbalists and naturopaths employ (including but not limited to herbal medicines) differ from those of conventional medicine, so do the techniques they use to understand and diagnose the problems faced by their patients.

The research cited shows that herbalists and naturopaths in Australia are generally women, who work part time and earn less than $60,000 per year.
from practice. The treatments they recommend include individually prescribed combinations of liquid herbs which are formulated after a consultation. They use Western medical diagnoses most of the time, and also use iridology as a diagnostic tool.

2.3 Origins: Herbal medicine as a colonial practice

On the 26th of January 1788 eleven ships of the First Fleet arrived at Botany Bay where Sydney now stands, to establish a British penal colony. Among the supplies brought with the new settlers was a broad range of plants. Botanist Sir Joseph Banks, who had accompanied Captain James Cook on his first voyage of exploration to the South Pacific, had been given the task of selecting appropriate seeds and plant cuttings to accompany these first settlers. Malouf (1998, p. 53) describes this task as ‘the equipping of an ark load of plants…the makings of a very practical little Garden of Eden’. Among the plants selected by Joseph Banks to be brought to Australia on the First Fleet were the medicinals sage, chamomile, hyssop, fennel, garlic, thyme and borage (Frost, 1993). An early task for the new settlement was to plant a medicinal herb garden to supply the newly-established Sydney General Hospital (“Celebrations Report,” 1990). This was completed by March 1 1799 – a brief five weeks after their first landing, clearly indicating that the continued supply of native European plants for use in treatment of illness was a priority in the new colony.

Only limited official medical care was available in the early days of British settlement in Australia. Of the nine medical practitioners who arrived at that time ‘very little is known about them and what is known does not inspire confidence, even by late eighteenth century standards’ (Martyr, 2002, p. 27). Thus the earliest European settlers were unable to rely on state-provided medical care to meet their health needs.
Medicine in the country left behind by these settlers - the late 18th century Britain - was a pluralist practice, with many types of practitioners offering diverse approaches to healing. Scientific medicine did not enjoy particular cultural legitimacy and had not yet established a monopoly on medical practice. Thus Martyr is able to claim that Australia was founded in the heyday of unrestricted medical practice in Britain…British healers were a diverse lot – the physician, the surgeon, the barber, the bonesetter, the empiric, the midwife and the apothecary were some of the more common categories (Martyr, 2002, p. 18)

In the Britain these early settlers had left, herbal medicine was a primary medical resource for families and communities (Oakley, 1992). However this resource – utilising herbs found in fields and hedgerows for treatment of illness – was unavailable in the new country as its flora was completely dissimilar to that of Europe.

European medicinal plants were utilised from the earliest days of the colony, but they were cultivated or purchased rather than collected from the local area. An unsourced document within the National Herbalists’ Association of Australia (NHAA) archives lists the herbs and spices which were cultivated or imported into the new colony prior to 1810. These included cinnamon, cloves lavender and sage which were listed specifically ‘for use in the General Hospital’ as well as chamomile, garlic, hyssop, marigold and thyme. (List: Herbs for use in General Hospital 1788-1810. Archives NHAA).

Much of the medical self sufficiency which had been common in England late 18th and early 19th centuries (Cule, 1997) was not transported or applicable in this new locality where familiar medicinal plants were so much more difficult to obtain. In addition, the transportation of individuals (mainly men) rather than established family groups meant that the practices, knowledge and skills of treating illness domestically, within the family unit – so central to the use of medicinal plants at this time – were not available here. Thus from the
beginning of European settlement, the practice of Western herbal medicine in
Australia, necessarily reinterpreted to suit local requirements, was forced to
transform itself.

2.3.1 **Relationship with aboriginal medicine**

Similar to the experience of indigenous communities in other European
colonies, Australian Aborigines experienced appropriation of land,
destruction of culture and genocide. The medical practices of aboriginal
communities in Australia involve the use of medicinal plants (Covacevich,
Irvine, & Davis, 1988), some of which has been recorded (Aboriginal
Significantly, there is little evidence of the details of transfer between
aboriginal and European bodies of knowledge concerning medicinal plants.
From the time of Maiden’s classic text ‘Useful Native Plants of Australia’
(1889), questions arise as to the ways in which, and the extent to which, such
transfer occurred. Maiden’s work, which lists 123 ‘substances reputed
medicinal’, reflects the spirit of the times in stating

> In fairness to ourselves we must confess ourselves very little indebted
to the Australian aboriginal for information as to the medical (or in fact
any other) properties of our plants… (Maiden, 1889 p. 146)

Lassak & McCarthy (1992) echo this view, stating that, while aboriginal
communities held vast and detailed knowledge about the medicinal actions of
plants, there is ‘little evidence that early Australian settlers learned and
adopted aboriginal medicinal knowledge for their own use’, (p.13) but they
add that ‘the question of how much the settlers learned from the native
population is not easy to answer’ (p.15). The absence of evidence of this
interaction is not evidence that it did not occur (absence of evidence is not
evidence of absence).

While of necessity the new settlers self-prescribed and experimented with
local plants (Maiden, 1889 ; Webb, 1948) their use in herbal medicine has not
been popularised or maintained and remains largely of historical rather than contemporary relevance. An examination of the materia medica used by current Australian herbalists reveals that, whatever was learnt during colonial times, only two plants have made it into the herbal pharmacy – the oils of eucalyptus (*Eucalyptus spp*) and tea tree (*Melaleuca alternifolia*). No other indigenous Australian plant has been successfully commercialised for supply to Australian herbalists.

There is very little discussion of the reasons and implications of this within the herbal literature, and few attempts to counter it. Wohlmuth, Oliver & Nathan (2002 p. 35) suggest that this is ‘astonishing’ and that it may reflect, at least in part, ‘conservatism on the part of professional herbalists’. While this may be the case today, Pearn (1987) argues that this was not the case in the early years of settlement when there was significant enthusiasm for the discovery of native medicinal plants.

In contrast to the Australian situation, native plants were incorporated into the European materia medica in the United States. One possible reason for the different experience may relate to economic and professional issues. The 18th and 19th centuries were a vibrant time for herbalists in the United States. Samuel Thompson patented and popularised his system of herbal medicine which used local plants. Subsequently the Physiomedical and Eclectic schools of medicine were established, and their practitioners used herbs extensively and were supported not only by training colleges and journals (Griggs 1997), but also by successful local manufacturers, in particular John Uri Lloyd. These manufacturers produced herbal preparations, many of which were made from locally grown plants (King 1898/1983). Thus in the US there were strong commercial incentives for local plants to enter the materia medica, and this ensured that the medicinal plant knowledge gathered by the early Europeans in the American colonies was maintained and developed. A similar herbal movement did not originate in Australia, and so Australian

2 A significant exception to this is the small volume by Anne Cowper (Cowper, 1990)
remedies were not commercialised and the knowledge of their therapeutic uses was largely lost.

The result of this is, without the incorporation of native medicinals into the materia medica, Australian herbalists remain dependent either on imported supplies, or introduced plants. The plant medicine that was brought with the First Fleeters, European herbal medicine, remains at the heart of contemporary herbal practice for Australian herbalists. Now, after more than 200 years of European settlement, some of these medicinal species have been introduced and thrive in their new location. A few have become pests, competing with or dominating the native species. Other imported species struggle or were unable to survive here. Whatever the fate of these exotic species, their use over and above native plants does put a layer of distance between Australian herbalists and the materia medica they use, their tools of trade.

This level of complexity is not found in traditions where the materia medica is derived from native plants. Practitioners of CWHM in Australia are unable to take a walk in the bush and harvest the plant they pass for medicinal purposes. This sets them apart from indigenous and folk herbalists in most parts of the world.

Despite this, no botany is immune from change, and all systems of herbal medicine modify their materia medica over time, as some plants fall in and out of favour, become more easy or difficult to access, or are replaced by introduced species. At present, the ‘new’ plants which are introduced into the materia medica of Western herbalists in Australia are most often from China or India, rather than plants which are native to Australia. In the future, Australia herbalists may choose to try to find ways to appropriately include local plants into their materia medica.

This could happen in a variety of ways. Links with communities of Indigenous Australians may lead to knowledge-sharing about local plants.
The extant records of native plants used by early colonists may be re-examined. The uses of species of plants, native to Australia and used in the herbal traditions of this region, especially Oceania and South-East Asia, may be explored. Finally, phytochemical analyses of plants may be utilised. All of these sources would provide information about the medicinal uses of Australian native plants. Practical difficulties, not least the requirements of the Therapeutic Goods Administration for the introduction of new herbal remedies, would be obstacles to be overcome if these plants were to be utilised by herbalists.

In summary, European medicinal plants were brought to Australia by the First Fleet, and have been used here since that time. There is little evidence of transfer of knowledge of medicinal plants between indigenous groups and the European settlers, and there is very little utilisation of native Australian medicinal plants by contemporary Australian herbalists. The Australian herbal tradition is based on traditional European plant use, and does not incorporate the Australian flora. While the materia medica does change, there is no evidence of native Australian plants being introduced into herbal practice at this point in time.

It is not only individual medicinal plants that fall in and out of favour, so does the practice of herbal medicine itself. The next section of this chapter documents the process of its re-emergence from the late 20th century.

### 2.4 Herbal Medicine’s Dark Years: the inevitability of marginalisation

The diversity of medical practice described in 2.3 lasted for about a century after the first European settlement, until the end of the 19th century. The period from the early 1900s until the late 1960s is referred to as the ‘Golden Age’ of biomedicine (Friedson, 1988; Willis, 2006) but may be termed a ‘Dark Age’ for non-biomedical practitioners. As biomedicine established a
monopoly on healthcare provision, herbalists felt themselves under continuing threat. They were repeatedly challenged on their right to practice (see for example Guthrie, 1961 also 2.4 and 8.4 below) but never actually lost that right in Australia as did their colleagues in the UK (Griggs, 1997).

The cultural dominance of biomedicine began in the early 20th century and the process and reasons for this have been well canvassed (Friedson, 1988; Porter, 1997; Saks, 2003; Starr, 1982; Willis, 1989). Here I identify three interlinking factors which have played a part in the development of biomedical hegemony and the consequent marginalisation of herbal medicine, and which are particularly relevant to this discussion. These are: firstly, a change of medical perspective in terms of the way in which patients and their diseases were viewed, secondly the involvement of the state in the delivery of medical care, and finally the development of a relationship between capitalism and medicine. From this perspective, science has been an important tool within this process, but the ‘rise of science’ does not fully account for the demise of medical pluralism. Further, I argue that the consequences, conflicts and dialectics set up by these historical processes are embedded in the everyday reality of Australian herbalists.

That is, the dominance of biomedicine and its monopoly over other forms of healthcare did not occur in isolation. It was neither science per se, nor an uncontested idea of ‘progress’ that led to the dominant status which biomedicine enjoyed throughout most of the 20th century, and the marginalisation of other systems of medicine. It was rather the triumvirate of power exercised by the state, industry and the medical profession. Krause’s broader description of professions is relevant to this discussion.

Visualise a triangle with the state, capitalism, and the professions at the corners. The state influences and shapes capitalism and the professions, capitalism influences and shapes both the state and the
professions, and the professions act to influence and confront the power of both capitalism and the state (Krause, 1996 pp. 1-2).

With regards to herbal medicine, overlapping interests between the state, the emerging biomedical profession and industry (i.e. pharmaceutical and medical technology) coalesced in ways which disadvantaged marginalised herbal medicine and herbalists, and ensured their ongoing exclusion from participation in the delivery of mainstream healthcare in Australia.

The ascendency of biomedicine and the development of its monopoly in healthcare is related to the marginalisation of herbalists in the following ways

a. By the application of science to medicine and the development of the medical ‘gaze’, which moved the generation of medical knowledge from home and community to the hospital and laboratory;

b. Through the involvement of the State in the provision of healthcare to its citizens, and the political success of biomedical practitioners in developing a monopoly in terms of state legitimation of their approach to medicine; and

c. By development of an approach to medical education which created a base for a collaboration between science, technology and capitalism.

2.4.1 The Gaze versus Galen – a dialectic?

Pre-Enlightenment European medical philosophy is based on humors, and the popularity of this approach is traced to the Hippocratic writings of classical Greece, via the influential Greek physician, Galen (c 130-c200CE). Within this framework, people saw themselves as part of the environment and subject to laws which affected animals and plants (see Leslie, 1994; Rosenberg, 1977), and thus in what Canguilhem (in Delaporte, 1994) described as a ‘filial relationship with nature’ (see Chapter 4.6.3). Health or
illness was related to ideas of balance and imbalance. Rosenberg (1977) suggests that these ideas remained widespread throughout Europe until the 19th century.

Foucault (1963) suggests that the beginning of the 18th century was a critical juncture in the history of medicine. He describes the change in medical perspective as the development of both a new location of practice, the ‘clinic’, and a new way of looking at the patient and their illness - the ‘clinical gaze’. He describes ‘the gaze’ as a change in the way in which doctors perceived illness. In an attempt to become more precise in understanding the nature of specific diseases and therefore their treatment, the focus of understanding shifted from observing and treating the patient in their own location, and building medical understandings of disease processes within local contexts (as in the example of the old family doctor) to one that favoured a different perspective. Describing clinical observation, Foucault (1963, p. 106) states:

> Not long ago the family still formed the natural locus in which truth resided unaltered... (however) there is a risk that disease may be masked by treatment, by a regime, by various actions tending to disturb it; and it is caught up in the singularity of physical conditions that make it incomparable with others. As soon as medical knowledge is defined in terms of frequency, one no longer needs a natural environment, what one now needs is a neutral domain, one that is homogeneous in all its parts and in which comparison is possible and open to any form of pathological event, with no principle of selection or exclusion. In such a domain everything must be possible, and possible in the same way.

From this time there is a growing emphasis, in medical practice and in medical education, on the hospital and laboratory rather than the family and the community, as the loci of the generation of medical knowledge.

---

3 This discrepancy in dates between Rosenberg (1977) and Foucault (1963) is likely to indicate the development of a new (scientific) approach to medicine was a long process.
2.4.2 Involvement of the state in medicine
A focus on ideas and scientific discovery is insufficient to explain the rise of modern medicine. State involvement in the provision of healthcare – and the extent of this involvement – as well as its economic organisation, are essential components of this discussion. The central role of the state in the provision of healthcare services is long established (Brown, 1979; Illich, 1975; Saks, 2003; Willis, 1989) and discussed in detail in the literature. Foucault (1994) argues that from the 18th century the political power of the state expanded from a limited medieval concern with war and peace, to much broader concerns - economic regulation, public order, and general hygiene, and from this time, the role of the doctor thus became important as ‘the great advisor and expert’ in matters to do with health. The state had a major role in sanctioning the ascendency of biomedicine and in providing massive resources to its implementation (Friedson, 1988; Krause, 1996; Saks, 2003; Willis, 1989).

By the early 20th century, the provision of medical services became a major government expenditure: currently the Commonwealth Department of Health and Ageing accounts for 19.1% of the national budget (Dept. Health and Ageing, 2007) and Australian doctors, like those in other Western countries, have become recognised by the state as the experts in all matters associated with health. This role is jealously guarded by medical practitioners, and attempts by unorthodox practitioners, including herbalists, to gain influence in these areas are not considered trivial. Challenges to the hegemonic status of biomedicine are outlined in 3.1.1.

2.4.3 The state, capitalism, and medical education
Within Australia, the state-supported university medical education has existed since 1862, when Melbourne Medical School enrolled its first students (Willis, 1989). Its establishment was seen by the medical profession as central to their goal of state registration. Medical education here has developed broadly in parallel with that of the UK and the US. In all three countries the first decades of the 20th century saw the adoption of a medical curriculum
based in the biomedical sciences (see Berliner, 1976; Brown, 1979; Griggs, 1997; Saks, 2003; Willis, 1989).

The development of a science-based medical curriculum with an emphasis on hospital and laboratory over clinical empiricism and family practice had profound effects on the development of biomedicine (Brown, 1979). Laboratory sciences became central to the generation of knowledge, and medicine’s research orientation became focussed on the processes of disease rather than those of health, and epidemiology, economics and botany were excluded. As Griggs states in reference to US medical education,

Such an educational curriculum might have been specially devised to turn out enthusiastic clients for the big pharmaceutical companies. It focussed on disease rather than health, on cure rather than prevention ... it eliminated all effective forms of alternative medicine for years, and promoted a monopoly medicine which is heavily drug-orientated. (Griggs, 1997 p. 243)

The relationship of biomedicine with capitalism and its development as a profit making activity are ideas which have been long argued (Berliner, 1976; Brown, 1979). Here Krause’s (1996) triangle of support between the state, the profession (medicine) and capitalism is revisited in order to illustrate their relationship to medical education.

This diagram (below) illustrates the inter-relationship between medicine, the State and industry, which are relationships which continue to determine the structure of Australian healthcare. The regulation of medical practice by the State - statutory regulation - ensures training requirements of all medical practitioners (and other regulated health professions) are fulfilled, and that they continue to abide by its regulations, for example with regard to professional conduct and continuing professional education. In return, these professions have a range of rights within the provision of state-supported provision of healthcare, in particular the access of (primarily) medical
practitioners to the state insurance scheme, Medicare (see 3.3). State regulation of industry with regard to the introduction of medicines onto the market, the quality of those medicines, and the ways in which they may be distributed occurs largely through the implementation of the Therapeutic Goods Act (see 3.4), which places stringent requirements on manufacturers wishing to provide such products. In return, the pharmaceutical industry contributes to the economy, and is supported (for example) by the Pharmaceutical Benefits Scheme, which allows the state subsidy of a range of expensive pharmaceuticals. The medical profession and the pharmaceutical industry are linked by mutual interest: the pharmaceutical industry provides the medicines required (the goods); the medical profession provides the market through treatment recommendations. This relationship was impossible for herbalists to penetrate during most of the 20th century.

Figure 2.1 Krause’s triangle, adapted to the relationship between the state, medicine and the pharmaceutical and medical technology industries (Krause, 1996).
Well funded medical education has developed in line with these considerations for more than a century, while the education of herbalists languished without access to state or industry funding. Herbal education received has received negligible state support and recognition - none at all until a decade ago. The bulk of herbal and naturopathic practitioner education is conducted in private colleges, funded by students themselves, usually on a part time basis, rather than state funded universities. At the time of writing (2008), two state funded universities in Australia (both in New South Wales) offer undergraduate practitioner education for naturopaths: Southern Cross University and University of Western Sydney. These courses have been running since 1995 and 2003 respectively.

While a number of private colleges now offer Bachelor’s degrees, their differences with universities are significant, and McCabe (2005) argues they do not support the development of an academic culture of natural medicine. Private colleges have few full time staff, and 89% staff are employed on a sessional basis, or as guest lecturers (McCabe, 2005). There are very limited career pathways available for these staff, and as teaching-only institutions, they do not engage in research. McCabe (2005) identified 821 teaching staff in naturopathy and Western herbal medicine across Australia. Of these, she found that eight had published in peer-reviewed journals in the previous five years.

---

4 This differential is reflected in the relative university funding, past and present, for medical courses vis-à-vis naturopathic courses. Naturopathy is a recent addition to public universities, the first university Bachelor of Naturopathy being offered in 1995. It is only since this time that state funding has been available for training naturopaths. In contrast, medical education has been part of universities (and therefore has received state funding) since 1863 when the first medical students were admitted to Melbourne University. Thus medical education has a long history of receiving state funding. There is also discrepancy between the level of funding available for naturopathy and medicine. All university places in Australia are funded in part by the Commonwealth Government and in part by a student contribution. In 2008 medical places are funded by the Commonwealth at a rate of $18,227 and by the student at a rate of $8,499, totalling $26,726 per fulltime student place. The comparable figures for naturopathic places are $8,217 from the Commonwealth and $7,260 from the student, equalling $15,477 per fulltime student place. This discrepancy in funding will obviously affect the quality of education which can be provided. Source: DEST Ministerial advice & DEST published 2008 indexed amounts, dated 17.07.07. [http://www.dest.gov.au/portfolio_department/dest_information/publications_resources/resources/budget_information/budget_2007_2008/at_a_glance.htm#Higher_Education](http://www.dest.gov.au/portfolio_department/dest_information/publications_resources/resources/budget_information/budget_2007_2008/at_a_glance.htm#Higher_Education) (accessed 8 September 2008)
years, and all eight were employed in universities (2005). She argues that this indicates a lack of scholarly culture based on research and publication within naturopathy and Western herbal medicine.

In summary, these three factors – the ‘gaze’, State involvement in medicine, and the development of a particular approach to education and the production of knowledge, both reflect and support the development of biomedicine at the expense of its alternatives. In the face of such overwhelming external forces, the problems of herbal medicine during the late 19th century and early 20th century were inevitable.

By the end of World War 2, the practice of herbal medicine was arguably at its lowest ebb, and the dominance of biomedicine seemed complete. The small number of surviving herbal practitioners were marginalised, labelled as ‘quacks’ and seen as eccentrics, as were their patients. They practised outside the regulated and State-supported health care system, unable to participate in it and they were professionally isolated.

2.5 Conclusion.

This chapter has provided an overview of some characteristics of Australian herbalists and the ways in which they practice. In each of the sections in this chapter and the next, I demonstrate that CWHM in Australia is complex, contradictory and paradoxical.

Most herbal practitioners are women who work part time, earning a relatively low income, and consult with patients in a clinical situation and prescribe herbal mixes. They use Western forms of diagnosis as well as iridology – a system which is rejected by biomedicine and which provides information different to that required for a conventional diagnosis. This indicates that not only do the remedies they use (herbs) differ from those used in biomedicine, but the diagnoses they make may also be different in some ways to those of biomedicine.
Western herbal medicine in Australia has its origins in the early years of the British colony, where it was practiced in relative isolation from any influence from the medicine of indigenous Australians and does not incorporate native Australian flora. The herbs of the materia medica are introduced species, either cultivated or imported. Thus Western herbalists in Australia differ from indigenous herbalists and those in many other parts of the world in that they do not utilise the local flora for the medicines they use, and cannot walk out into the Australian bush and recognise the plants they use in clinic. Employing the traditional knowledge of an imported flora – without also using native flora - delivers a layer of complexity to herbal practice found in few other areas.

For most of the 20th century, the lot of herbalists was very difficult after the abolition of ‘free trade in physic’ and the establishing of a state-supported biomedical monopoly. They were professionally marginalised, and excluded from healthcare, yet the practice somehow survived this difficult period. The extent of this marginalisation, and the response of herbal practitioners to it, forms part of the research undertaken in this thesis, and is detailed in Chapter 8.
Ann Doyle is one of my convict ancestors, my great-grandmother’s great-grandmother. Ann was sentenced to death in Maidstone, Kent in 1787, as a 17-year old. She had stolen clothes and linen, to the value of one guinea (Cobley, 1989). Her sentence was converted to seven years transportation, and she was exiled to Botany Bay, arriving in June 1790 on the infamous Lady Juliana, the ‘floating brothel’. Her voyage took ten months. Two months after her arrival in Australia, Ann was sent to Norfolk Island, to join the new settlement there. While on Norfolk, Ann met fellow convict Philip Devine, who had arrived under the alias of Thomas Tennant on the Alexander, part of the First Fleet which arrived on 26 January 1788. Ann and Philip had four children, Sarah, Rebecca, Edward (my great-grandmother’s grandfather) and Thomas. All the children were born on Norfolk Island. The couple separated sometime after Thomas’ birth, and Ann lived with another convict, William Parsons, whom she eventually married in Hobart in 1812. Ann lived on Norfolk Island for 18 years before being forcibly relocated in 1808 when the settlement in Norfolk was abandoned, its inhabitants moved to the nascent settlement of Hobart Town. Ann’s youngest child, Thomas, was 10 years old at that time. Ann Doyle was one of the group exiled three times (Schaffer & McKay, 1992): from England to Botany Bay, from Botany Bay to Norfolk Island, and from Norfolk Island to Van Diemen’s Land (Tasmania).

Ann’s life is emblematic of many undocumented aspects of Australian history as yet untold: stories of women and families and their medical care and the place of herbal medicine in that care. What was Ann’s life like? How did she look after her children on Norfolk Island, and later in Hobart? What medicines did she use for them when they were ill? What were the practices of domestic medicine in those places, at those times? Were medicinal plants cultivated in Sydney, on Norfolk and in Hobart in those early years? Which ones?
CHAPTER 3 THE RE-EMERGENCE OF HERBAL MEDICINE

3.1 Introduction

The practice of herbal medicine remained in the shadows until the late 20th century, when the process of disillusion with some aspects of biomedicine, evident from the 1960s, was accompanied by a renewed interest in other approaches to healthcare, including herbal medicine. The tragedies of thalidomide during the 1960s (Griggs, 1997) had exposed a problematic side to ‘medical miracles’. This was soon followed by a time of questioning of state sanctioned authorities on a range of issues, associated with the unpopular war in Indo-China, the feminist movement and the counterculture.

Concurrent with these events was the growth of the broader self-help movement, including the burgeoning fields of personal growth and physical fitness, in movement therapies (for example yoga and tai chi), as well as in the self-prescription of natural medicines. More informed, confident patients began to demand change in their relationships with their medical practitioners. They were more critical and demanding, and less willing to unquestioningly accept established medical authority. At this time popular interest in home remedies and many forms of alternative medicine became evident, and this interest included both herbal medicine and the broader fields of natural medicine and naturopathy (Baer, 2001; Martyr, 2002; Saks, 2003). This interest was reflected both in increased levels of utilisation of these therapies by the general public, and by an increase in the number of people undertaking its study. Some acquired this knowledge to enhance their own wellbeing, others became practitioners (Evans, 2000).

As the public patronage of herbal medicine increased, it became increasingly difficult for the state to ignore or trivialise it. The effects of popular pressure for the acceptance of herbal medicine and the broader field of natural medicine can be demonstrated by tracking the major government inquiries
into natural medicine during the second half of the 20th century. It should be noted that during the period 1961-1990 herbal medicine was included under the umbrella term ‘naturopathy’ but both the Therapeutic Goods Act (1989) and the La Trobe Report (2005) refer to naturopathy as well as herbal medicine. Table 3.1 has been constructed to summarise the long transition from a period of complete legal-political rejection, to a degree of politico-legal acceptance for both naturopathy and herbal medicine.

Table 3.1 includes reports and legislation that occurred at the level of states and territories as well as at the federal level. Australia’s structure of government involves a federal and six state legislatures, and the Federal Government has oversight of the territories, which include the Australian Capital Territory and the Northern Territory. Registration of health professionals is a state matter under the Australian Constitution, but regulation of medicines - involving trade - is a federal responsibility. This means that regulation of herbal practitioners is the responsibility of the states, but regulation of herbal products comes under federal jurisdiction. Since 1995 the state health ministers have agreed that no statutory registration of unregistered health professionals will occur in any single state without in principle agreement from health ministers in all states (Carlton, 2003).

Early consideration of the need to regulate naturopathy was made alongside calls for the regulation of chiropractic and osteopathy. These professions achieved statutory regulation from the late 1970s (Willis, 1989). The Guthrie Report in Western Australia in 1961 considered that naturopathy should be banned but did not mention herbal medicine (Guthrie, 1961). This recommendation was not adopted. More than a decade later, Victoria’s Joint Select Committee recommended that osteopathy and chiropractic should be legally registered. The Committee considered naturopathy but failed to make a similar recommendation. This report raised serious concerns about the educational standards of naturopathic training courses (Ward, 1975). A short
<table>
<thead>
<tr>
<th>Year</th>
<th>Level of regulation</th>
<th>Title of report</th>
<th>Major recommendations</th>
<th>Comments in relation to the present work</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>State – Western Australia</td>
<td>Report of Honorary Royal Commission into the provisions of the natural therapists bill (Guthrie, 1961)</td>
<td>Naturopathy should be banned (this did not occur).</td>
<td>Herbal medicine is included as a discipline of naturopathy</td>
</tr>
<tr>
<td>1975</td>
<td>State - Victoria</td>
<td>Report of Joint Select Committee into Osteopathy, Chiropractic and Naturopathy Committee (Ward, 1975)</td>
<td>Concern expressed re standard of education for natural therapists</td>
<td>Slightly more positive than the previous WA report</td>
</tr>
<tr>
<td>1985</td>
<td>Territory - Northern Territory</td>
<td>Allied and Professional Health Practitioners Act (1985)</td>
<td>Naturopaths registered in the Northern Territory. Registration was withdrawn in 1991.</td>
<td>Members of the Australian Natural Therapists Association the only naturopaths accepted, members of other professional associations rejected.</td>
</tr>
<tr>
<td>1989</td>
<td>Federal</td>
<td>Therapeutic Goods Act (1989)</td>
<td>Complementary medicines regulated as a therapeutic goods</td>
<td>Fundamental changes to the industry which supplies complementary medicines, increased regulatory demands on manufacturers</td>
</tr>
<tr>
<td>2006</td>
<td>State - Victoria</td>
<td>Latrobe University Report into the Practice and Regulatory Requirements of Naturopathy and Western Herbal Medicine (Lin et al., 2005)</td>
<td>Recommendation that naturopathy and Western herbal medicine be registered</td>
<td>Recommendations still to be acted on.</td>
</tr>
</tbody>
</table>

Table 3.1 Mainstreaming of CWHM via legislation government committees
time later, the Webb Report referred to naturopathy as a ‘minor cult system’, but neither called for its prohibition nor recommended regulation (Webb, 1977).

A change in government attitude was first evident in the mid 1980s. In 1985 the Northern Territory had allowed statutory regulation for naturopaths, but this was later repealed. In 1986 the Victorian State Government’s Social Development Committee found that ‘the reality for many Victorians is that alternative therapists are a primary source of health care’ (Dixon, 1986, p. 365). Soon afterwards, the products used by such practitioners became subject to new federal regulation, although the practitioners themselves remain unregulated. In December 1989 the passage of the Therapeutic Goods Act was a watershed for natural medicine in Australia as it marked formal legislative acceptance of the therapeutic actions of herbs and nutritional supplements (Evans, 1997).

While there was little regulatory activity pertaining to practitioners, during the 1990s, in 2000 the Victorian State Government granted statutory regulation for practitioners of Traditional Chinese Medicine, which includes practitioners of Chinese herbal medicine. This was followed in 2006 by a further report funded by the Victorian State Government which recommends statutory regulation for Western herbal medicine and naturopathy (Lin et al., 2005). This completes the reversal of the 1961 Guthrie report which had recommended its prohibition.

---

5 This legislation limited these rights only to those naturopaths who were members of the Australian Natural Therapists Association (ANTA). Partly in response to complaints of unfair trade from other associations, but also due to a desire by Health Ministers across Australia for consistency regarding statutory regulation of health practitioners across all states and territories, this registration act was repealed in 1991 (Jacka, 1998, pp. 124-126).

6 Consideration of the recommendations of the 2006 report are delayed as a national registration scheme to encompass all health professions is introduced during 2008 (pers. comm. Director, Service and Workforce Planning, Victorian Department of Human Services to Head of Department of Natural and Complementary Medicine, Southern Cross University, 9 October 2007).
Herbal practitioners have been profoundly affected by changes in healthcare which have been driven by popular demand. The legislative changes discussed here can be understood as a response to public popularity rather than as a direct consequence of lobbying by herbalists themselves. To reiterate some statistics already presented in Chapter 1 which illustrate this popularity and the consequent economic power of the herbal medicine manufacturers and education providers: herbal medicine comprises one aspect of the $A1.8b natural products industry. These products are used by 52% of Australians, and 26.5% Australians visit alternative medicine practitioners (MacLennan et al., 2006). Courses in alternative medicine contribute $60 million to the economy nationally in student fees (2003 figures, excluding textbooks and other costs) (McCabe, 2005). Herbal medicine is therefore part of Australian healthcare simply because it is used by so many people: acceptance has been driven by popular demand.

From this description of the changes which have allowed herbal medicine to emerge from the shadows, its position within Australian healthcare is now considered. The relationship between herbalists and other major players, in particular existing healthcare providers, manufacturers of therapeutic goods and the state, are the topics addressed in the following section.

### 3.2 A new context for herbal medicine

Twenty-first century healthcare in Australia is highly regulated, complex, and dynamic. It was a very different situation in the early 1900s when biomedicine established its dominance and then maintained its hegemonic status for more than half a century. However the legacies of the past remains and the relationship between the medical profession (and other healthcare providers), the pharmaceutical industry (and other manufacturers of therapeutic goods) and the state, as well as the roles and interests of these groups and institutions, affect the possibilities for herbal practice. Thus the opportunity for complementary and alternative medicine (CAM) to receive any level of
acceptance is in part as a result of changes which occur in the interests of these other players.

In this section, I outline the influence of each of these groups as the position of CWHM is renegotiated. Today, some sections of the medical profession continue to be unhappy about the use of CAM. As recently as 2002, MacLennan’s report on the extent of CAM use in Australia described parents’ use of complementary medicines with their children as perhaps ‘a form of child abuse albeit with loving intent’, although he failed to produce evidence for harm which resulted from such practices (MacLennan et al., 2002). However this does not reflect the views of all medical practitioners. Some practitioners are eager to include herbal medicine within medical practice (e.g. the Australian Integrative Medical Association) or to collaborate with herbalists in joint clinics or by cross-referral (Barrett 2003; Kotsirilos & Hassed 2004). The focus here is on the changing role of medical practitioners, and their continuing influence in healthcare provision, and the ways in which this influence impacts on herbalists.

Further, I discuss the herbal manufacturing industry which has enthusiastically embraced the increased public interest in medicinal plants. New companies have entered the market and have applied sophisticated manufacturing techniques to herbal products such that many of these products resemble pharmaceuticals. The boom in the herbal market is largely in the consumption of these products rather than the simple medicines used by practitioners. However, questions must be raised about the extent to which information about safety and efficacy of medicinal plants which has been derived from traditional sources can be extrapolated to these new products (Jagtenberg & Evans, 2003).

Such issues of safety are particularly important in terms of the relationship between herbal medicine and the state. While the state is reluctant to take on the responsibility for regulating increasing numbers of professions, it takes
very seriously its responsibilities with regard to public safety. Further, essential grounds for the statutory regulation of unregulated health professions involve public safety. This means that if herbalists want statutory regulation, they need to establish that the continued unregulated status of their profession is a threat to public safety (see 3.5.2). This leads herbalists to a difficult choice: they believe that their practice and medicines are fundamentally safe but statutory regulation requires them to be interpreted as risky.

These three factors - the role of biomedicine, the role of industry, and the importance of issues of safety and risk in Australian healthcare - impact on the acceptance of herbal medicine as a part of the provision of healthcare in Australia. The discussion which follows will allow further understanding of the challenges facing herbal practitioners today.

3.3 The existing Australian healthcare system

As discussed in 2.4, biomedicine had established its ascendency within Australian healthcare by the early 20th century, and the structure which was unchallenged until the 1970s had medical practitioners at its apex. In 1989, Willis used the term ‘medical dominance’ to refer to the supremacy of medical practitioners as the arbiters in all matters related to health.

Medical dominance in the health division of labour is sustained at three different levels: over its own work, over the work of others, and in the wider health field. (Willis, 1989, p. 2)

Nearly twenty years later, the same author acknowledges that medical hegemony has, to some extent, been threatened and its authority, while still evident, is under challenge (Willis, 2006). Changes to the political economy of health have challenged the sovereignty of medical practitioners, and concerns about spiralling costs of healthcare and an ageing population have added urgency to calls to rethink the provision of medicine in Australia (Baer, 2006).
Societal changes which affect healthcare include – patients’ rights, funding issues and professional accountability. These influence all healthcare professionals, including doctors and herbalists. The acceptance of patients’ rights and consumer power has had far-reaching effects. From the influence of self-help groups to the increased utilisation of CAM therapies (see 1.1), the relationship between practitioner and patient has been transformed (Willis, 2006). Patients not only ‘shop around’ for healthcare from different sources, but also access extensive information about their conditions and possible treatments particularly via the Internet. Well-informed patients now play an active role in decision-making regarding the management of their illnesses. Further, the state and health insurers increasingly act as financiers of health services, and as ‘he who pays the piper calls the tune’, their role becomes that of arbiters of treatment (Willis, 2006, p. 423). Thus a medical practitioner’s recommendation regarding patient treatment may now be questioned not only by the patient themselves, but also the funding body. In addition, accountability and transparency are required by all healthcare providers. The effect of these new demands on the nature of the professions is discussed more fully in 5.2.1.

In addition, fundamental changes to Australian healthcare are mooted which Willis (2006, p. 425) describes as a ‘head-on challenge to medical dominance’. The broad-ranging workplace reforms recommended by the Productivity Commission’s (2005) report into health provision amount to a fundamental restructuring of healthcare to increase flexibility of delivery and to better respond to the public needs. These calls for flexibility confront the authority of medical practitioners to determine delivery of medical services, and the report’s focus on the needs of health professions indicates an intention to share responsibility between medical practitioners and other practitioners. Given public demand, such a restructure is likely to include utilization of CAM therapies. The ways in which these therapies are to be utilised – whether by incorporation into the practices of existing healthcare
professionals, or by the inclusion of specialist CAM practitioners into the system, is as yet unclear. The increasing interest in the use of these therapies by mainstream health professionals including GPs (Kotsirilos & Hassad, 2004; Cohen, Penman & Da Costa, 2005), pharmacists (Tiralongo & Wallis 2008) and nurses (Snyder & Lindquist 2006) suggest that CAM practitioners may find their therapies incorporated into these practices rather than their own professions being recognised.

While these changes indicate that medicine is less inviolable than it was half a century ago, the advantages enjoyed by medical practitioners in terms of access to the state’s resources are still substantial. Primary among these is Medicare, a tax-funded health insurance scheme which allows patients to claim rebates for a wide range of medical services. Access to Medicare remains primarily the domain of medicine, but it has recently been expanded to include a limited range of other practitioners (Willis, 2006). Without statutory regulation (see 1.4) the inclusion of herbalists into this scheme is not possible. Even with it, such inclusion is not guaranteed and herbal medicine remains in the private domain, requiring patients to fully fund their treatment.

The cash rebate which the patients of medical practitioners can access makes medical care more affordable than CAM therapies which are fully privatised, and for which there is no state rebate. In addition to this, medical practitioners are also gatekeepers for the state’s health benefits and services. These include access to hospitals, diagnostic facilities, a range of residential care facilities, as well access to State financial support for those with long-term illnesses and disabilities. These are not trivial matters for patients and their practitioners: in many cases they determine the ability of practitioners to offer, and patients to follow, their treatment of choice. For example, a medical certificate by which their illness is ‘legitimised by a medical practitioner in order to get access to sick leave’ (Willis, 2006, p. 424) is required for individuals to take time off work in order to recuperate from an illness.
Without the ability to provide such a certificate, herbalists are constrained in the treatments they can offer, particularly as rest and convalescence often play a substantive part of their recommendations.

Thus while challenges to medical authority have in part allowed herbalists to regain their position as healthcare providers, medical practitioners continue to play a significant role as gatekeepers to state medical resources, in defining the rights and roles of those who fall ill. Future renegotiation of these responsibilities may be instigated by the state in the face of the difficulties they face in the provision of healthcare. Such renegotiations may provide opportunities for herbalists, and other groups of healthcare professionals to take increased responsibility, but are likely to be resisted by the medical profession.

### 3.4 The commodification of medicinal plants

The popularity of herbal medicines has resulted in a dramatic increase in consumption and the development of a myriad of new herbal products by a reinvigorated herbal industry. In this section I turn my attention to the manufacturers of these herbal goods, in particular the effect of regulation on who can manufacture these goods, and the influence of the manufacturers in shaping the herbal market. There are two distinct types of herbal products – the over-the-counter (OTC) retail products which consist mostly of capsules and tablets, and the practitioner products, which consist of single herbs which are mixed together by practitioners to prepare individualised prescription for their patients.

Manufacturers of all CAM products including herbs were largely ignored by authorities until the late 1980s. Herbal manufacture was undertaken in small cottage industries, and products were minimally regulated. The growth in the market led to calls for increased regulation and in turn this led to the passage of the Therapeutic Goods Act in 1989. By including CAM products along with
pharmaceuticals as falling within the definition of ‘therapeutic’, this federal legislation formally recognised for the first time that herbal and nutritional medicines do have medicinal value. Consequently CAM products have been required to comply with manufacturing standards that are comparable to those required for pharmaceuticals. However the requirements for introduction of new CAM products onto the marketplace, and the therapeutic claims which can be made about these products, differ from the requirements for pharmaceuticals.

Unlike pharmaceuticals, herbal products which have a traditional use can be introduced onto the market without extensive trialling which is necessary for the introduction of new drugs. This allows manufacturers to avoid the expensive and extensive research into safety and efficacy usually required by health authorities before a product can be marketed as a medicine or therapeutic good. Herbs have been identified as a new category of therapeutic good, one based on traditional use.

This category is not uncontroversial, and there have been recent calls for its removal, which would force manufacturers to provide evidence of efficacy for all therapeutic goods (Harvey, 2008; Harvey, Korczak, Marron, & Newgreen, 2008). The natural medicine community has been quick to respond. Myers (2008 p. 71) suggests that such a change would signal ‘the decimation of the (complementary medicines) sector in this country and the annihilation of traditional medicine practices’.

Whatever the future holds in this regard, the dual effects of the Therapeutic Goods Act - the introduction of manufacturing standards and the use of traditional claims, have transformed the herbal manufacturing industry. Similar manufacturing standards now apply to all therapeutic goods. Like pharmaceutical companies, herbal manufacturers now must comply with the Code of Good Manufacturing Practice (GMP), which ensure minimisation of such problems as misidentification of raw materials (dried herbs), lack of
standardisation, contamination and substitution. To some small-scale, low-tech cottage manufacturers who operated prior to 1989 the new regulations were prohibitively stringent. For individuals and groups who had been attracted to herbal medicine through a rejection of capitalist values and a desire to construct a more earth-friendly future, they also conflicted with their values and aspirations. For some small, niche companies, the passage of the Therapeutic Goods Act and in particular the requirements of GMP led to their exit from herbal manufacture.

Thus a shake-up within herbal manufacturing occurred post 1989. The exit of the cottage manufacturers was accompanied by the movement of new companies, including pharmaceutical companies, into the herbal products market. This led to the transformation of the herbal manufacturing industry and coincided with huge growth in this market (Jagtenberg & Evans, 2003). To new companies entering the market, the passage of the regulations gave new credibility to the rapidly expanding herbal market. The need for compliance with GMP was accepted with little fuss, and balanced by the introduction of a new class of therapeutic good – CAM products – which attracted less stringent regulations for the introduction of new products than did pharmaceuticals. This expansion occurred particularly within the retail sector.

Herbs used in the retail (OTC) market are commonly marketed in the form of herbal capsules and tablets. In terms of manufacture as well as presentation they increasingly resemble pharmaceuticals and are distanced from traditional herbal products in the form of liquids or herbal teas. In some cases, products are manufactured to contain a specified amount of an identified marker compound, just as a pharmaceutical will contain a specified amount of a particular constituent, in an attempt to overcome the ‘problem’ of the inherent variation between plants. Other products may be concentrated far beyond any previous use of the plant, leading to ingestion of higher quantities of plants than has been used in the past, and also requiring much
greater quantities of herbs as raw materials than have been used previously. Formulated to alleviate specific symptoms or health problems, these preparations are packaged in convenient and familiar forms, yet are promoted as gentler, safer and more ‘natural’ remedies than pharmaceuticals. The name used to refer to these products – phytopharmaceuticals – reflects their similarity to conventional pharmaceuticals.

The data collected on the uses of medicinal plants – the ‘traditional use’, on which safety and medicinal actions are based - refers to their use as teas and simple alcoholic extracts, often as general ‘tonics’ added to the diet, as substances which are ‘good for you’ rather than to counter specific pathologies. The new herbal products are being manufactured in ways which are quite different to traditional preparations, they are employing different doses and they are being used for different ends. The claims made with regard to safety and efficacy are being extrapolated from traditional use, but the question must be raised as to whether such claims are appropriate.

As mentioned in 2.2.3.1, Casey et al’s (2007) survey of Western herbalists in Australia suggests that most prescribe and dispense individualised combinations of herbal extracts for their patients from their own dispensaries. This research suggests that when practitioners use topical applications such as douches, pessaries, gargles, eyebaths and poultices, these are supplementary rather than the primary prescription. Similarly, while tablets and capsules are employed, they are not the central prescription. Herbalists therefore appear to use a range of preparations, but preference traditional preparations. This indicates a difference between herbal practitioners and their patients, and consumers who self-prescribe with herbal medicine, in that the former use less sophisticated preparations.

According to McLennan et al (2006), the CAM market in Australia is worth an estimated $1.8b, $1.3b of which is the herbal and nutritional supplement
market. Of these, 20.6% are herbal medicines (MacLennan et al., 2006). While there has been an expansion of the number of companies entering the herbal retail market since the introduction of the Therapeutic Goods Act, the same cannot be said for the companies who supply herbal practitioners. While some suppliers who were in business at that time have continued, no new companies have successfully entered the field. The most high-profile of those attempting to capture part of this market, Phytomedicine, was bought out by the dominant company in this sector in Australia, Mediherb, in August 2007 (ACCC, 2007). In turn, Mediherb was purchased by New Zealand group Thompsons in 2008 (Logan, 2008).

Thus the mainstreaming of herbal products appears to involve the expansion of the retail market as many consumers are attracted to self-prescription with these products. Such products are more often sophisticated herbal products produced to deal with specific symptoms. These can be contrasted with the liquids preferred by practitioners. Thus practitioners appear to be continuing to use traditional preparations, individually prescribed, as well as the newer products, while the herbal remedies used by general public in Australia are more likely to be pre-formulated tablets designed for conditions rather than individuals (Casey et al, 2007).

3.5 State concerns: safety, risk and herbal medicine

The third external factor identified here as important in the shaping of CWHM is the role of the State in ensuring appropriate risk management and safety considerations. Following Bensoussan (Bensoussan & Myers, 1995; Bensoussan et al., 2005), the discussion of risk associated with herbal medicine is separated into those risks that are related to the clinical judgement of herbal practitioners, and that which is related to the consumption of herbs or herbal products. Ingestion of medicinal herbs is not

---

7 Some of these products are herbal products, some are nutritional supplements, and some are a combination of the two.
proving particularly risky: ‘recorded cases of harm after herb use remain remarkably low, even allowing for obvious under-reporting in this sector’ (Mills & Bone, 2005, p. 4). Paradoxically the idea of risk is used as justification for its mainstreaming via arguments for regulation of practitioners and products. Thus risk assessment is highly political, and used to determine the need for statutory regulation (and therefore occupational closure) of herbal practitioners as well as the extent and type of regulation required for herbal products. The ways in which risk dominates the public debate and has far-reaching effects on the development of CWHM is outlined in this section.

3.5.1 The risk society

Anthony Giddens (Beck, Giddens, & Lash, 1994; Giddens, 1991; Giddens, 1999) is among a group of sociologists who have dubbed contemporary society a ‘risk society’ because of the importance placed on the notion of risk, and the ways in which risk has been institutionalised. He explains that individuals have always faced dangers, such as floods and famines, and the notion of gambling (‘taking risks’) is long established. Risk is differentiated from danger in that risk involves an element of chance, or hazard of loss whereas danger refers to a clear exposure to harm or injury (Giddens, 1991).

In future-oriented societies like ours we accept risk as something to be ‘managed’ whereas past-oriented traditional societies use the concept of fate or destiny to explain experiences of loss. The issue today is that risk has become a fundamental consideration in a range of activity within our daily lives (Giddens, 1991).

Bensoussan et al (2005) emphasise the importance of risk in the context of naturopathy and Western herbal medicine and use it to promote the need for statutory regulation. As stated above, these risks are divided into those associated with the clinical judgement of the practitioner and those associated with the consumption of herbal medicines. They are summarised in Table 3.2, and detailed in the sections that follow.
<table>
<thead>
<tr>
<th>Area of risk</th>
<th>Current management strategy</th>
<th>Future management strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner: risks of omission (failure to act) and commission (inappropriate action)</td>
<td>Professional associations via their requirements for continuing professional education and adherence to codes of ethics.</td>
<td>Should statutory regulation of practitioners occur these requirements would be mandated by law.</td>
</tr>
<tr>
<td>Herbs and herbal products</td>
<td>Predictable risk: Herbs which are dangerous/toxic are included in the Standard for the Scheduling of Drugs and Poisons.</td>
<td>Should statutory regulation of practitioners occur, a specific herbal schedule may be developed to allow for practitioner access to some herbs for which there needs to be a level of public restriction.</td>
</tr>
<tr>
<td></td>
<td>Unpredictable risks: allergic and other idiosyncratic reactions</td>
<td>Need for label warnings</td>
</tr>
<tr>
<td>Herbal products</td>
<td>Failure of GMP: Regulation via the Therapeutic Goods Administration.</td>
<td>Continuing regulation.</td>
</tr>
</tbody>
</table>

Table 3.2 Summary of terms related to risk in herbal medicine
(adapted from Bensoussan, Myers, Scott, & Cattley, 2005)
3.5.2 The politics of practitioner risk
In terms of healthcare, assessment of the likely risk of any intervention – or failure to intervene – is an important consideration in clinical practice, given the emphasis on public safety. Risks of clinical judgement are divided into risks of commission and risks of omission. Risks of commission refer to instances where the practitioner may inappropriately prescribe, i.e. use inappropriate dosage or fail to understand contraindications. Risks of omission may include as misdiagnosis, failure to understand underlying pathology and failure to refer.

State involvement in the regulation of healthcare is largely on the basis of public safety and risk management. While there is overall government reluctance to regulate currently unregulated health professions, it still has a responsibility to protect its citizens from risky practices (O'Sullivan, 2005). The way in which Health Ministers are balancing these two requirements is expressed in the following resolution of the Australian Health Ministers’ Advisory Council (AHMAC) in 1995. The criterion accepted as essential for statutory regulation of unregulated health professions would be that

...the activities of the occupation pose a significant risk of harm to the health and safety of the public (Carlton, 2003).

Thus demonstration of a potential for public risk is a necessary precursor to regulation. This leads to a dilemma for herbalists who want statutory recognition: a major tenet of their rhetoric is that their practice is safe compared to biomedicine, and if their practice is perceived to be safe then politico-legal legitimation in the form of statutory regulation is likely to remain elusive.

Bensoussan and Myers (Bensoussan & Myers, 1995; 2005) have been influential in this discussion. They co-authored ‘Towards a safer choice’, a report commissioned by the Victorian Department of Humans Services, the New South Wales Department of Health and the Queensland Department of
Health which documented risk in relation to Traditional Chinese Medicine (TCM), and more recently in the LaTrobe Report (2005) documented risk in relation to naturopathy and Western herbal medicine. In both cases they have suggested that the risks to public safety of these practices remaining unregulated are sufficiently great to warrant regulation.

Their discussion of risk associated with herbal medicine must be considered in light of their commitment to the professionalisation of TCM as well as naturopathy and Western herbal medicine and its statutory regulation. Indeed their report contributed to TCM being successful in fulfilling the ‘risk’ criterion and gaining statutory regulation in Victoria.

With regard to the risks of naturopathy and WHM, Bensoussan et al (2005) found that risks associated with practitioners’ clinical judgement have been reported, but ‘this does not appear to represent widespread malpractice’. Indeed, it was found that the most common complaints about practitioners (from patients to professional associations) were to do with poor communication rather than poor practice (Bensoussan et al., 2005). Further, in comparison to TCM, Bensoussan et al found that herbs used in Western herbal medicine presented fewer risks of direct poisoning (Bensoussan et al., 2005). Overall, they present very little data regarding the risk to the public of consulting herbal practitioners and naturopaths. The conclusion they draw from their results is not that these practices are safe, but rather that adverse effects of herbal and naturopathic practice are likely to be substantially under-reported, and therefore statutory regulation is necessary in order to ensure public safety. Such a conclusion should be seen in a context of legitimatory discourse, as a rhetorical device influenced by the commitment of the authors to statutory regulation for these professions.

3.5.3 Implications of risk

Further, it should be noted that the debate around the riskiness or otherwise of practitioners, that is the discussion of acts of omission or commission, is almost exclusively framed within the biomedical framework. That is, risks
and benefits are discussed in reference to issues of importance in biomedicine. Biomedical thought and assumptions determine the framework within which non-biomedical practitioners may participate in mainstream healthcare. This is an example of Baer’s (2006, p. 1776) argument that in order to gain legitimation, ‘complementary practitioners are forced to comply with the structures, standards and processes that are dominated by medicine.’

Acts of commission on the part of practitioners may occur not only if an individual inappropriately prescribes herbal medicines but also if they ‘remove the therapies of other practitioners’ (presumably particularly medicines prescribed by medical practitioners). Similarly, the acts of omission include that they may have ‘missed a pathology’ or ‘failed to refer’. Safety and risk is determined within the biomedical paradigm and reflect the values and priorities of that system of medicine. Risks that may reflect the values and priorities from within the philosophy of herbal medicine may include for example that the practitioner ‘failed to ensure adequate rest’ or ‘missed underlying predisposing factor’, but these do not appear.

Thus risk assessment serves as a boundary, the basis on which non-biomedical practitioners will be accepted to participate in mainstream healthcare. Such participation requires these practitioners to understand their work within a biomedical framework, and this becomes one of the drivers within the design of educational curricula.

**3.5.4 Risks associated with herbal ingestion**

The risks associated with the ingestion of herbs have been defined by Bensoussan et al (1995) as arising from three sources: predictable risks, unpredictable risks, and risks associated with failure of good manufacturing practices. A brief discussion of unpredictable risk and risks associated with the failure of good manufacturing practice will precede a more lengthy discussion of predictable risk.
Unpredictable risks include allergic and idiosyncratic reactions, and while these cannot be completely avoided, label warnings are generally recommended where there is appropriate information to be communicated (Bensoussan & Myers, 1995). This might refer to, for example, the allergic reaction that some individuals experience on ingestion of plants from the Asteraceae family. Another category of risk has to do with manufacturing processes. Herbs can impact on public safety due to problems within manufacture, including for example misidentification, contamination or substitution of herbs. Since the passage of the Therapeutic Goods Act the responsibility for risk management in this lies with the Therapeutic Goods Administration (TGA). In 2003 the potential implications of problems with compliance was made evident with the closure of a major manufacturer of CAM products, Pan Pharmaceuticals. The TGA required recall of its 1600 products, which comprised approximately 40% of the CAM market in Australia at that time (MacLennan et al., 2006). The consequences for the CAM industry were devastating particularly to those small businesses affected by the crisis, and also to overseas markets as 76% of Pan’s products were produced for export (Allan Crossthwaite, pers. comm. 11 January 2008). The effect on public confidence in the quality of herbal products is more difficult to quantify, but the negative publicity surrounding the largest drug recall in Australia’s history was substantial and public utilisation of natural medicine products showed a dip in growth as a result (Maclellnan et al., 2006).

With regard to ‘predictable risk’ differentiation between risk and danger is relevant as danger can be associated with ‘predictable risk’. Herbalists have long understood that some plants are dangerous, and should be avoided or handled with extreme care. An examination of the work of 17th century herbalist Nicholas Culpeper reveals concerns with herbal safety, and he particularly addresses misidentification and inappropriate ingestion. In the following example, he cautions against the dangers of misidentification
Have a care you mistake not the deadly Nightshade (*Atropa belladonna*) for this; if you know it not, you may let them both alone, and take no harm... (Culpeper, 1653/1995 p. 181).

In another example, he gives instructions about how to recognise when a person has taken a specific poisonous plant (in this case hemlock) accidentally, and how to deal with the situation. The individual, he states, will show

...a kind of frenzy, or perturbations of the senses, as if they were stupid and drunk, and the remedy is ... to drink of the best and strongest pure wine, before it strides to the heart, or Gentian put in wine, or a draught of vinegar ... (Culpeper, 1653/1995 p. 128).

Thus within the traditional herbal literature the dangers (clear and present, or imminent) of herbal medicine were discussed. These dangers may be compared to the category of ‘predictable risk’ as discussed by Bensoussan and Myers (1995). With regard to such plants, regulation has been established through inclusion of specific plants into the Standard for the Uniform Scheduling for Drugs and Poisons (SUSDP). While this includes all types of poisons, from agricultural poisons to drugs, discussion here will be limited to its consideration of medicinal plants.

SUSDP allows for different levels of access for plants which are identified as having different levels of danger – for example some require specific labelling, or to be sold in particular retail outlets (especially pharmacies) while others are available only from medical practitioners or are not available at all. A continuing source of frustration for herbalists has been that they are restricted from using plants which have safety concerns, yet health practitioners with no training in the use of medicinal plants, in particular pharmacists and medical practitioners, are often able to access them. One of the positive benefits of statutory regulation may be the ability for registered herbalists to access some of these plants.
Not all cases are as clear cut as the distinction in toxicity between hemlock or belladonna, and for example the low risk of toxicity of dandelion root. Decisions regarding the danger of herbs are often political. While herbalists and scientists would agree that hemlock and belladonna are dangerous plants, this is not the case with all plants included in the SUSDP. For example, Comfrey (*Symphytum officinale*) is a highly valued medicinal plant within the Western herbal tradition seen as safe by herbalists, but it is currently banned for internal use in Australia. This is because of concerns regarding potential toxicity of the plant due to the presence of a toxic constituent. There is no traditional concern regarding comfrey: it is widely considered by herbalists to be a safe plant. It is banned because it contains pyrollizidine alkaloids (PAs), substances that, in concentration, have been shown to be hepatotoxic (i.e. to cause severe liver toxicity) (Shaw, 2005). From the point of view of herbalists, valuing tradition of use and clinical experience, the plant is safe and therapeutically effective. Herbalists do not contest the fact that comfrey contains pyrollizidine alkaloids, but they also do not accept that this is sufficient evidence to cease its therapeutic administration. The scientific evidence of the potential toxicity of the plant has been sufficient to have it listed in Appendix C of the Standard for the Scheduling of Drugs and Poisons making it unavailable for sale or supply, or even for research purposes.

Whitelegg (1996) argues that the body of scientific evidence which damns comfrey is seriously flawed within the rules of science, and appears to be biased. The problems identified in this work include the selective reporting of findings, a refusal on the part of the scientists to acknowledge uncertainty, and a lack of precision in the research and its reporting. While a fundamental premise of science is that all science should be able to be challenged, attempts by herbalists to enter into the debate and challenge this evidence have been unsuccessful.

---

8 Restrictions are also in place in Europe and the US.
Whitelegg (1996) also makes a more profound argument, when she details the understanding of herbalists. She suggests the problems are a consequence of …a clash of paradigms in Kuhnian terms, and highlights the incommensurability of one paradigm in terms of the other. In this case, a reductionist yardstick which isolates chemicals from whole plants, tests them on animals and extrapolates to humans, following procedure for orthodox drugs with one basic action for use of a passive patient, proves inadequate and inappropriate...Attention needs to be focused on the plant in context, the synergistic action both of its own constituents and in conjunction with other remedies, and the action in individual patients in a therapeutic context. This then gives a more accurate reflection of the plant as therapeutic agent (1996, pp. 81-82).

It may be possible to develop a genetically modified comfrey in which the problematic PAs are removed. Given PAs have not been identified as having any therapeutic value within the plant, and that they are the reason for the ban on comfrey, a non-PA containing comfrey would be a way of accommodating concerns about its potential hepatotoxicity, and may allow it to be re-introduced for internal use. However, given the controversy regarding the issue of genetic modification and the antagonism it engenders, such a project is highly unlikely to be widely welcomed within the herbal community.

Thus the concepts surrounding the relative ‘safety’ of herbs have changed over the years, from a clear cut state of predictable dangers which were recognised in centuries past, to the more muddy contemporary waters of possible risks, and the balance of risks and benefits. As ‘acceptable risk’ is clearly a subjective judgment (what is acceptable, according to whose judgement?) this is a situation in which herbalists are vulnerable.
3.6 Conclusion

This chapter has described how the biomedical monopoly was challenged towards the end of the 20th century consequent to societal changes. A resurgence of public popularity transformed the place of herbal medicine and brought it into greater contact with the Australian healthcare system, and some aspects of this are detailed above. This resurgence has in turn brought a range of pressures and challenges for herbalists. Three specific challenges are identified - biomedical dominance, capitalism, and safety – which can be understood as factors external to the profession. Herbalists in Australia practice at a time when politically, biomedicine is powerful; when economically, capitalism is dominant; and when the idea of risk cannot be ignored, particularly with regard to healthcare. Each of these factors has helped shape herbal practice, determining to some extent the possibilities of practice.

Biomedicine, which while arguably less dominant than it was in the mid 20th century, remains the major force in Australian healthcare, and to a large extent determines the context within which (and conditions under which) other healthcare professionals, including herbalists, will be accepted. Thus the practical reality for herbal practitioners is that herbal medicine is private medicine, with biomedical practitioners acting as gatekeepers for the health benefits provided by the state.

The demands of industry in a capitalist economy have led to the commodification of herbal medicine, and to the expansion of the market in herbal products, particularly those products which supply the general public. These herbal products increasingly resemble pharmaceuticals and questions can be raised as to whether safety and efficacy data from traditional preparations can be extended to these products.

Issues of safety and risk are important and complex for practitioners. Traditional understandings regarding the safety of individual herbs have not
been widely questioned, and there is no data which indicates that practitioners pose a danger to the public. However such a danger needs to be established in order for statutory regulation to occur – a step understood by many in the profession to be necessary for its long term survival. Thus the very safety of the practitioners and their medicines needs to be denied.

This chapter has given a broad context to the practice of herbal medicine. These ideas will be further developed in Chapters 4 and 5, which provide discussion of the theory that has informed the more general development and analysis of the thesis. In Chapter 4, I address issues related to the development of knowledge in herbal medicine. The concept of tradition is used to establish a framework within which to consider the place of traditional knowledge in contemporary herbal practice. Vitalism and holism, as tenets of the practice of many herbalists, are also discussed. The role of evidence-based medicine (EBM) represents a new direction in the development of medical knowledge, and is considered along with the work of Scheibinger and others on the politics of forgotten knowledge, as this relates to herbal medicine. The theory continues in Chapter 5 which provides a framework in which to understand the issues of marginalisation and professionalization and the challenges they provide to current practitioners.
It is early December 1989 and the Australian Democrats hold the balance of power in the Australian Senate. Our small herbal practitioner support group has just incorporated after meeting together informally for a number of years. We are having our first Christmas party as the Victorian Herbalists’ Association Inc. A fax comes through to the celebration from a favourite manufacturer of herbal tinctures, whose small herb farm we visit often to observe and participate in the harvesting and manufacture of herbal medicines. He informs us that the Therapeutic Goods Bill is about to go before the Senate for its final reading. He believes that this Bill, if passed in its current form, will put him out of business.

Two of us are seconded by the group that evening to ‘do something’ on behalf of our brand new Association. When we contact the major natural therapy associations, the Australian Natural Therapists’ Association and the National Herbalists’ Association of Australia, we find that they are concerned about sections of the Bill but felt nothing can be done, and they have no intention of lobbying any parliamentarians, ‘because it might put the public servants off side’. We have no previous experience of lobbying, but are certain that the democratic process does not necessitate keeping public servants on-side. We call upon more political friends for some pointers and master two essential skills: summarising our argument in no more than an A4 page, and developing a persistent phone technique.

The next weeks are a blur – faxing, phoning, talking, planning – explaining our problems to Democrat senators. We make our points. While the Senators in question do not support our position as much as we would like, and the Bill goes through without major amendment, we find that some compromise is possible. Our concerns (and our Association) are mentioned in the Parliamentary Debates (Parliamentary Debate, 1989), and over the next year, we are included as interested stakeholders in consultations between the TGA and the public regarding the drafting of the Act’s Regulations.
CHAPTER 4 TRADITION AND KNOWLEDGE*

4.1 Introduction

This chapter and the next have been constructed to provide a theoretical context in which to consider the research and its findings. In this chapter I focus on the tension between tradition and modernity within herbal practice particularly as it impacts on ‘what counts as true’ for herbal practitioners: that is, on how they understand their own clinical practice. In the following chapter, the related areas of marginalisation and professionalization are examined, and these concepts are applied to the position of herbal practitioners today. As my interest is in Australian herbal practitioners rather than the manufacturers or consumers of herbal remedies, I am interested in the ways in which the recent public acceptance of herbal medicine is affecting the clinical practice of herbal medicine.

The tension between tradition and modernity is evident in the paradox of herbal practice being described as an emerging and ‘new’ profession while its knowledge base is primarily established out of historical data. As discussed in 3.3 and 3.5.4, ‘traditional use’ is recognised as a valid source of information about herbal remedies within the Therapeutic Goods Act, although there have been recent calls to underpin knowledge about herbal remedies with phytochemistry and clinical trials (Guo et al., 2007; Harvey et al., 2008). It is clear from this debate that the continued use of traditional knowledge as a basis for modern herbal practice is controversial.

*Aspects of this chapter are found in Evans, S ‘The changing knowledge base of Western herbal medicine’, Social Science and Medicine, in press. This article is included as Appendix 8.
This chapter begins with a discussion of the relationship between tradition and progress in light of the work of Raymond Williams (1988) on tradition, as well as Connor (2001), Bauman (1995) and Sheldrake (1990) on progress.

Comparisons between the ‘rules of truth’ which apply to the development of traditional knowledge, in light of work on Traditional Ecological Knowledge (Alexiades & Laird, 2002; Bodeker, Kronenberg, & Burford, 2007; Cotton, 1996; Johnson, 1992; King, 1996; Laird, 2002) and those which apply to scientific knowledge and that of evidence-based medicine (EBM) (Ernst, 2000a; D. Holmes, Murray, Perron, & Rail, 2006; Jagtenberg et al., 2006; Rodwin, 2001; Sackett, Strauss, Rosenberg, Richardson, Gray, 1996; Willis & White, 2004) are made in light of the works of Michel Foucault (1991b) and Jean-Francois Lyotard (1997).

Special emphasis is placed on one characteristics of TK as defined by Johnson (1992) – vitalism. A short history of the concept of vitalism as related to its use within herbal medicine has been constructed (Bergson, 2001; Holmes, 1989; Nutton, 2004; Pitman, 2005; Sheldrake, 1990; Whorton, c2002; Wood, 2000). With regard to the development of the idea of holism, the work of Smuts (1926), Lawrence and Weisz (1998), Pitman (2005), Sheldrake (1990), von Bertalanffy (1975) and Gell-Mann (1994) are considered. I argue that its rejection by science has led to its replacement by the idea of ‘holism’ as an attempt to reinvent it in a way that is acceptable to science. Further, I consider the interpretation of vitalism by French philosopher Georges Canguillelhem (1991; Canguilhem in Delaporte, 1994). Canguilhem (Canghuilhem in Delaporte, 1994) understands vitalism to be a moral position rather than a ‘fact’ and demonstrates how its adoption as a guiding therapeutic principle leads to specific clinical practices.

Following this discussion, the consequences of these challenges brought about by the contemporary reinterpretation of herbal medicine – the modernisation project – are considered in relation to the concept of agnotology, that is, the

I argue that these ideas – tradition, science, vitalism, holism, TEK, EBM and agnotology – contribute to an understanding the complex challenges and opportunities which are facing herbal practitioner in Australia today. The relevance of these concepts to the knowledge base which underpins herbal medicine is illustrated in the final section of this chapter.

Finally, a review of the literature on herbal therapeutics published in the *Australian Journal of Medical Herbalism* (*AJMH*), indicates that the ways in which practitioners describe their treatment of patients during the last twenty years has changed and reflects a change in the knowledge base with an increased reliance on EBM at the expense of TK, and a ‘forgetting’ of traditional philosophy.

### 4.2 Tradition in herbal medicine

The knowledge of a plant’s ‘traditional use’ is fundamental to the practice of herbal medicine. All herbals⁹, even those most firmly supportive of aligning herbal medicine with EBM (Braun & Cohen, 2007), contain references to traditional use. Nevertheless a discussion of the concept of ‘tradition’ is largely absent from herbal literature.

Regulatory definitions, while important, are inadequate for the current purposes. The Therapeutic Goods Act defines ‘traditional use’ in relation to therapeutic products¹⁰. Traditional use, according to the Act, is well documented, or otherwise established, according to the accumulated experience of many traditional health care practitioners.

---

⁹ Herbals are books which contain information about the medicinal actions of specific plants

¹⁰ The importance of this legislation in regard to the economic advantages to manufacturers of having their goods included in this category are outlined in 3.2.2
over an extended period of time; and accords with well-established procedures of preparation, application and dosage ("Therapeutic Goods Act", 1989).

In its definition, the European Union (EU) quantifies tradition. In order for a herb to be granted ‘traditional use’ status in the EU,

it should have documented use for 30 years, 15 of which should be in a member state of the EU (Traditional Herbal Medicinal Products Directive 2004).

In the absence of further discussion, particularly of ‘traditional health care practitioners’ these regulatory definitions are inadequate for the current purposes. The question remains – in what way is CWHM traditional? The discussion here will be limited to ‘traditional knowledge’ as it underpins the use of medicinal plants, and to ‘traditional practice’.

The word ‘tradition’ is derived from the Latin *tradere*, to hand down, or transmit. Gross (1992, p. 9) suggests that *tradere* also refers to ‘giving over something for safekeeping’, and that tradition infers that what is handed down is of value. The ‘value’ of tradition is not commonsense or obvious within mainstream Australian society. Australian herbalists are in an unusual position using traditional knowledge, and calling themselves traditional practitioners\footnote{One of the largest associations of natural therapists is the Australian Traditional-Medicine Society (ATMS)} in a society that valorises modernity and identifies itself as thoroughly modern and part of the developed world.

### 4.3 The question of ‘progress’

As British cultural historian Raymond Williams (1988) states, the term ‘tradition’ is a difficult one. It is used in both a positive and negative way, depending on the point the speaker wishes to make. He says that on one
hand ‘tradition’ can be used to signify a resistance to innovation. On the other, it can also be used to romanticise the past, or to evoke respect. Tradition became problematic when European society began to value modernity.

The Enlightenment, the 17th-18th century European intellectual movement which laid the foundations for modern Western societies, challenged the traditional authority of the ancien régime, and had at its core a commitment to secularism and a belief in human rationality. Tradition, closely associated with religion, was rejected as it was seen to hinder the promise of a new society based in rational science, which, it was believed, could eventually lead to human control of the social and natural worlds (Beck et al., 1994). Thus tradition came to be associated with a dark and primitive past, and was contrasted with science, which held the promise of a bright future. European herbal medicine, as a system of medicine claiming to be based on traditional knowledge and understandings, has been cast as an anachronism by biomedicine which has became ‘a metonym for modernity’ (Connor and Samuel, 2001 p. 7).

A belief in progress as inexorable and linear underpins this rejection of tradition and thereby a commitment to innovation. The widespread acceptance of the importance of progress also explains why the role of tradition in modern societies has been virtually ignored by social commentators until relatively recently, and has supported such constructs as the division of the world into ‘developed’ and ‘developing’ nations, with the implications that ‘developing’, or traditional, usually agrarian societies, would inevitably ‘develop’ into modern, industrial ones (Bauman, 1995; Schech, 2000). However despite massive developments in science and technology, the world is beset with civil unrest, poverty and looming ecological catastrophes. The pendulum has begun to swing in recent decades, as the notion of ‘progress’ has been questioned in the face of massive social and ecological problems which are facing today’s world (Capra, 1982; Gross,
As the assumption that scientific progress leads to social progress and a better world is questioned, negative associations with the word ‘tradition’ have modified.

In this thesis, the question is raised as to the role of traditional knowledge as an appropriate basis for 21st century herbal knowledge. For this reason, an examination of the principles which govern scientific knowledge and traditional knowledge, and the tensions between them, is in order.

4.4 Rules of truth

Michel Foucault follows the philosopher Nietzsche in claiming that knowledge has more to do with power relationships between groups, than with an uncovering of an essential ‘truth’ (Foucault, 1991a). He emphasizes the importance of determining the method, or rules by which knowledge is accepted as true, or legitimate.

There is a battle ‘for truth’ or at least ‘around truth’ – it being understood once again that by truth I do not mean ‘the ensemble of truths which are to be discovered and accepted’ but rather ‘the ensemble of rules according to which the true and the false are separated and specific effects of power attached to the true’, it being understood also that it’s a matter not of a battle ‘on behalf’ of truth but of a battle about the status of truth and the economic and political role it plays (Foucault, 1991b p74).

This perspective is of particular interest to herbalists who have been faced with a change to the ‘rules of truth’ over the last three decades. The specific effects of power have come to be associated with a scientific approach to herbal medicine, and this has led to the weakening of traditional understandings of the therapeutic actions of plants. The differences between these ‘ensembles of rules’ is also reflected in the development of the two poles
of contemporary western herbal medicine - phytotherapy and traditional herbal medicine (see Appendix 1).

4.5 Rules of truth: Science

Consideration of the rules which govern scientific knowledge and traditional knowledge reveal divergences which assist in the analysis being undertaken here. Science is said to be the rational, disinterested study of the real world: it attempts to characterise the structure of reality. While the universalising claims of science have been challenged (Jagtenberg, 1983; Kuhn, 1962; Lyotard, 1997), for the current purposes it is sufficient to outline the aims and principles of scientific endeavour. Scientists base their research on observable facts, i.e. facts that transcend nations and cultures. These facts are formalised as scientific statements which are clear, concise statements about the world. Methodologically, science proceeds by ‘inventing hypotheses and systematically testing them against observation and experiment’ (Dunbar, 1995, p. 32).

Scientific proof involves persuading others who are expert in the field of the rigor of the work undertaken, and scientific discourse involves developing an argument as to why a particular proof should be accepted, and dealing with counter arguments. Further, any acceptance of the truth of the statements a scientist makes is conditional and not finally established. Science focuses on phenomena which occur in the ‘real’ or physical world. It involves a specific methodology; it involves notions of proof, and of argument. Science is always tentative, its results open to falsification (Dunbar, 1995).

Biomedical knowledge, based in science, is comprised of two arms: laboratory research and clinical knowledge. Nearly three decades ago, Friedson (1988) distinguished between clinical rationality (what happens in practice – empirical understanding) and scientific rationality (scientific explanations of disease characteristics and therapeutic interventions), and argued that
clinicians preferred the former over the latter. At that time, the medical profession was at the peak of its power and influence. It was the ‘Golden Age of medicine’ (Friedson, 1988, p. 384) and was able to easily repel any questioning of the authority and clinical decision-making of its members. Today the nature and extent of the power of the medical professions has changed and the ‘rules of truth’ regarding the development of medical knowledge have also changed. No longer do the clinical judgements of medical practitioners go unchallenged. Patients have come to expect to participate in the decision making regarding their treatment and funding bodies – generally the State and insurance companies - expect some control over the costs incurred by medical treatments (Rodwin, 2001).

4.5.1 Evidence-based Medicine (EBM)

The vehicle for this new approach to medical knowledge is evidence-based medicine (EBM). It was introduced in the 1990s to encourage medical personnel to critically evaluate their clinical decision-making (Rodwin, 2001). It also gives non-medical practitioners more information about appropriate interventions in medicine and thereby challenges the right of doctors to be in complete control of clinical decision making. It is used to relate evidence to clinical decision-making, and aims to bring clinical practice more in line with ‘best evidence’.

The classic, often repeated definition of Evidence-based medicine is the following:

> Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research (Sackett et al., 1996, p. 71).
In practice, EBM uses hierarchies of evidence which are understood to best assess the efficacy of specific medical interventions. This hierarchy of evidence is illustrated in Table 4.1.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Systematic review of all relevant randomised controlled trials (RCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>At least one relevant randomised controlled trial</td>
</tr>
<tr>
<td>Level 3.1</td>
<td>Controlled trials without randomisation</td>
</tr>
<tr>
<td>Level 3.2</td>
<td>Case control or cohort studies involving more than one centre or research group</td>
</tr>
<tr>
<td>Level 3.3</td>
<td>Multiple time series with or without intervention</td>
</tr>
<tr>
<td>Level 4</td>
<td>Clinical opinions of respected authorities, descriptive studies or reports of expert committees</td>
</tr>
</tbody>
</table>

Table 4.1 Hierarchies of evidence in Evidence-based medicine (adapted from Willis & White, 2004, p. 50)

Within EBM, certain types of evidence are given preference over other types of evidence. Clinical trials are seen as the most reliable source of knowledge, and the ‘gold standard’ of clinical trials is randomised controlled trials (RCTs). The highest level of evidence, level 1, is a systematic review of all relevant randomised controlled trials (RCTs). Level 2 evidence is at least one relevant RCT. Level 3.1 refers to controlled trial(s) without randomisation, and level 3.2, to cohort or case-control studies involving more than one centre or research group. Level 3.3 is a multiple time series, with or without intervention. Level 4 is clinical opinions of respected authorities or descriptive studies, or expert reports.

Apart from its importance within biomedicine, EBM has two particular consequences for the broad CAM disciplinary group. Firstly, the rhetoric of EBM is that the clinical effect of an intervention should supersede any criticism of its use. Thus, the carrot for CAM (including herbal medicine) is that when an intervention, or a specific herb, is proven useful in a specific situation, it should be accepted, no matter the theory behind it.
If a treatment works … then the explanation for its effectiveness is less important. If a treatment works and is safe, it deserves a place in the pantheon of accepted treatments and should be a part at least of a range of care options available to patients…So what matters in EBM terms is not why CAM treatments work but whether they do (Willis & White, 2004, pp. 54-55).

Thus while the opportunity for acceptance is given, the caveat is that evidence acceptable within this hierarchy must be found. These are the ‘rules of truth’ which form the boundaries of knowledge. Edzard Ernst, Professor of Complementary Medicine at Peninsula Medical School, UK, is one of the strongest proponents for the use of EBM in CAM, and states

To answer the question of the specific effectiveness of CAM (i.e. effectiveness over and above placebo or sham treatment), we ought to consult the evidence from controlled, preferably randomised clinical trials (RCTs). This research strategy allows us to establish whether or not an observed effect can be linked causally to a specific intervention, with the highest degree of probability (Ernst, 2000a p.166).

While it is said that EBM includes a range of evidence, not only RCTs, in practice the ‘gold standard’ of RCTs is the preferred evidence, and lower levels of evidence - particularly level 4 evidence, that based in ‘expert opinion’, is rarely considered appropriate. Ernst himself is part of a group now calling for the rejection of clinical herbal practice on the basis of an absence of RCTs investigating the efficacy of individually prescribed herbal mixes (Guo et al., 2007).

The methodological implications of assessing CAM disciplines (including herbal medicine) in this context have raised concerns with regard to the application of EBM as a treatment rationale for herbal medicine. Some authors suggest that EBM is paradigmatically incongruent with core natural medicine principles including vitalism and holism (Coulter & Willis, 2004; Jagtenberg et
al., 2006; Kerridge & McPhee, 2004), and that RCTs are inappropriate tools with which to assess herbal medicine (Baer 2004). RCTs work best when examining a single intervention. Clinical herbal practice rarely involves single interventions, but rather is characterised by its use of individual and complex interventions. Because it is tailored to treatment of an individual rather than of a condition, individuals with the same condition are likely to receive different treatments. Such an approach is complex not only because individual herbs are complex substances containing a range of constituents, but also because herbalists individually formulate combinations of herbal extracts (Casey, Adams, & Sibbritt, 2007). Such treatment is routinely complemented by individualised therapeutic advice, for example involving changes to diet and lifestyle (Green, Denham, Ingram, Sawkey, & Greenwood, 2007; Jagtenberg et al., 2006) and the resulting complexity of herbal practice cannot be reflected if reduced to single-interventions required by conventional RCTs. Either RCTs must be modified to allow for the complexity of herbal treatment (Tilburt & Kaptchuk 2007) or methodologies are required to allow for assessment of those highly complex interventions.

An increasing number of herbal products have been subject to RCTs, and this move facilitates their public acceptance and their incorporation into mainstream healthcare. However this approach to herbal treatment does not reflect a philosophy of herbal practice which stimulates the body’s self-healing mechanisms, but rather the application of herbal remedies as treatments which fit in with a biomedical approach to treatment which aims to alleviate symptoms or counter pathological change.

### 4.6 Rules of truth: traditional knowledge

Traditional knowledge employs very different rules of truth to that of science according to Lyotard (1997, p. 19) who explains that ‘narration is the
quintessential form of customary knowledge’ which is handed down through stories.

Narrative forms of discourse are highly complex. The aims of narrative are to transmit a broad range of information, not only facts that pertain to the ‘real’ world. Lyotard states that the majority of statements found within scientific discourse are denotive (descriptive) statements. When the types of statements which occur in narrative accounts are analysed, a wide range of different types are found, including evaluative (judgemental) statements; deontic (involving moral obligation) statements, and historical statements (Lyotard, 1997). Herbal texts which are based on traditional knowledge contain such a range of statements (Evans, 2004).

Problems arise with regard to the use of traditional knowledge about plants because

Science has always been in conflict with narratives. Judged by the yardstick of science, the majority of them prove to be fables (Lyotard, 1997, p. xxiii).

Thus within non-traditional cultures, claims to authority with regard to the ‘truth’ about the level of therapeutic efficacy of plants are understood to be necessarily based in science rather than tradition. It is an acceptance of this political reality which led herbal leaders to understand that in order for public acceptance to occur, herbal medicine needed to be redefined as scientific herbal medicine and distanced from folk medicine and witchcraft (Griggs, 1997; Zeylstra, 1992). From this perspective, the appropriate modernisation of the knowledge base, the way to ‘bring herbal medicine into the 21st century’, involves employing the discourse of science to explain the medicinal actions of plants (Mills & Bone, 2000).

However within other contexts, traditional knowledge is receiving renewed attention and appreciation. Since the passage of the International Convention
on Biological Diversity (CBD) at the Rio Earth Summit in 1992, traditional knowledge has been recognised for its role in informing ecological issues and particularly the preservation of biodiversity (Bodeker, 1995; Laird, 2002). Terms such as traditional knowledge (TK), indigenous knowledge (IK), and traditional ecological knowledge (TEK) have arisen within the fields of ecology and conservation (Cotton, 1996).

Bourque, Inglis and LeBlanc (1993, p. iv) define TK within this context as …the knowledge base developed by indigenous and local peoples over many hundreds of years through direct contact with the environment. It includes a detailed knowledge of plants, animals and natural phenomena the use of appropriate technologies for hunting, fishing, trapping, agriculture and forestry, and a holistic knowledge or ‘world view’ which parallels the scientific discipline of ecology.

As these terms generally refer to the knowledge of the environment developed and maintained by indigenous people, it would be easy to dismiss TK as having little relevance to CWHM. However Johnson claims that what is ‘traditional’ about TK is not its antiquity, but the ways in which it has been acquired and is used. Further, Ellen and Harris (1999) suggest that in practice there are no clear distinctions between TK, IK and TEK, and more established terms including tacit knowledge and folk knowledge. They characterise folk knowledge as the indigenous knowledge of European cultures, and claim that it is alive and well (Ellen & Harris, 1999). Given that much of the knowledge base of herbal medicine is derived from folklore, it is worth considering the extent to which CWHM can be understood as part of the traditional knowledge base of the West. It is argued here that there is overlap between many of the characteristics of CWHM, particularly where it retains strong links to its folk origins, and TK.

Table 4.2 has been constructed in order to demonstrate the extent to which TK (as described by Johnson) overlaps with folklore and CWHM.
<table>
<thead>
<tr>
<th>Characteristic of TK (after Johnson (1992))</th>
<th>Whether found in folklore/CWHM</th>
</tr>
</thead>
<tbody>
<tr>
<td>An oral culture: information is transmitted orally</td>
<td>Evidence of this in CWHM remains, see Appendix 2</td>
</tr>
<tr>
<td>Learning occurs through practical experience and observation.</td>
<td>Characteristic of folklore (Clarke &amp; Clarke, 1963; Georges &amp; Jones, 1995)</td>
</tr>
<tr>
<td>Data is generated by resource users, not by specialists</td>
<td>Characteristic of folklore (Clarke &amp; Clarke, 1963; Georges &amp; Jones, 1995)</td>
</tr>
<tr>
<td>Data is diachronic rather than synchronic.</td>
<td>Characteristic of folklore (Clarke &amp; Clarke, 1963; Georges &amp; Jones, 1995)</td>
</tr>
<tr>
<td>Explanations of environmental phenomena are derived from cumulative, collective, often spiritual experiences. These experiences are checked, validated, and revised regularly.</td>
<td>Not characteristic of CWHM</td>
</tr>
<tr>
<td>Matter has a life force</td>
<td>Characteristic of CWHM</td>
</tr>
<tr>
<td>Human life is not superior to other life. Information is derived from a social context that sees world in terms of social &amp; spiritual relations between all life forms</td>
<td>Not characteristic of CWHM</td>
</tr>
<tr>
<td>Holistic, not reductionist</td>
<td>Characteristic of CWHM</td>
</tr>
</tbody>
</table>

Table 4.2 Comparison of TEK and folklore (adapted from Johnson, 1992)
As indicated in this table, TK is transmitted orally, and is associated with practical experience and observation. This is also characteristic of folklore, which is expressed and transmitted ‘during face-to-face interaction’ (Georges & Jones, 1995, p. 1). An example of the problems facing CWHM as a result of the move away from a dependence on level of orality and practicality to a more print-based discipline is outlined in Appendix 2. In TK, as well as folklore, data is collected by the users of the knowledge, the ‘folk’, not by specialists, and this acquisition continues over time (Clarke & Clarke, 1963; Georges & Jones, 1995). This also describes the collected knowledge of the ‘traditional uses’ of plants (see for example Grieve, 1931/1980 who documents uses amassed over a long period of time), and is cumulative, rather than relying on snapshots of information, for example as would be the case in testing a herb within a clinical trial of necessarily limited duration and population.

Johnson’s (1992) description of TK as the collection and revision of information by a group of people, often involving spiritual experiences, is not easily associated with CWHM or folklore. However both vitalism and holism are characteristic of CWHM and are discussed below. Conversely, the understanding that human life is not superior to other life is not an issue discussed in the literature around CWHM.

4.6.1 Vitalism

It is argued here that vitalism is the most controversial of the characteristics of CWHM from the point of view of science, although similar concepts are accepted within traditional cultures. This discussion is limited to the role of vitalism in Western herbal medicine, and does not extend to the related concepts of for example prana in Ayurvedic medicine or chi in Traditional Chinese medicine. It is important to understand the role of vitalism in herbal medicine as it
... leads to a different philosophy about health, healthcare and the role of the healthcare provider. It is the basis of the claim that biomedicine and CAM are distinct paradigms (Coulter & Willis, 2004, p. 584).

Such an philosophy, emphasising the centrality of health and vitality, is consistent with Antonovsky’s (1987) description of approaches to healthcare which he terms *salutogenic*, or health promoting, and which he contrasts with *pathogenic* approaches which focus on disease management.

Vitalism can be linked to a commonsense understanding of the world as being interconnected and alive, an idea which was widespread in Europe prior to the scientific revolution of the 17th century (Larner, 1992; Sheldrake, 1990; Thomas, 1971). Since the early twentieth century, it has been soundly rejected in scientific circles, with scientists arguing that all biological processes can be explained by the laws of physics and chemistry. Consequently, well-respected chemistry texts suggest that the discrediting of vitalism was necessary to allow for the development of modern organic chemistry (Hart, Craine, Hart, & Hadad, 2007, p. 2), and Greco (2004, p. 680) states ‘Many biologists today tend to use “vitalism” as a derogatory term associated with lack of intellectual rigor, anti-scientific attitudes, and superstition.’

Within the discipline of herbal medicine, a pre-modern understanding of the world as alive causes discomfort to those who feel it is important for herbalists to adopt the discourse and rhetoric of science. Mills, a leading British herbalist over the last twenty-five years, rejects its religious overtones, stating that ‘the lack of any criterion even to define a vital causal force has meant that vitalism itself has taken retreat into the bunker of modern religion’ (Mills, 1991, p. 120).

Wohlmut draws attention to the divide between traditional herbalists and those who see herbal medicine as a science.
Many proponents of traditional herbal medicine argue that vitalism and its concept of a ‘vital force’ are fundamental parts of the theoretical and philosophical framework of herbal practice. In contrast, many others, who view herbal medicine as an essentially scientific practice employing medicinal plants as pharmacologically active therapeutic agents, see vitalistic concepts as irrelevant, antiquated and unhelpful to the promotion of herbal medicine as a valuable part of healthcare (Wohlmuth, 2003, pp. 198-199).

However, this emphasis on the science of herbal medicine and rejection of vitalism is not universally accepted. Baer (2004), VanMarie (2002) and Singer and Fisher (2007) draw attention to a developing rift, termed an ‘epistemological bifurcation’ by Singer and Fisher (2007), between those herbal practitioners who consciously support traditional herbal medicine and give centrality to the idea of vitalism, and those, like Mills (1991) and Wohlmuth (2003) above, who reject it.

<table>
<thead>
<tr>
<th>Concept</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitalism</td>
<td>life cannot be understood just through principles of physics and chemistry (Sheldrake, 1990 p79)</td>
</tr>
<tr>
<td><em>Vis medixatrix naturae</em> (healing power of nature)</td>
<td>An understanding, originating with Hippocrates, that the body has a natural tendency to recover from disease (Pitman, 2005; Whorton, c2002)</td>
</tr>
<tr>
<td><em>Vital force/life force</em></td>
<td>Self-regulating and self-healing, creative, directive intelligence; the Archeus of Paracelsus(Wood, 2000); of early naturopath Lindlahr (1919), also of Thompson and the Eclectics (Wood, 2000)</td>
</tr>
<tr>
<td><em>Elan vital</em></td>
<td>Philosopher Henri Bergson credited evolution and progress to the <em>elan vital</em> (Bergson, 2001)</td>
</tr>
<tr>
<td>Entelechies</td>
<td>Biologist Hans Driech used this term to refer to a ‘purposive vital factor’ (Sheldrake, 1990)</td>
</tr>
</tbody>
</table>

Table 4.3: Concepts related to Vitalism in European herbal medicine
Within the herbal literature, a number of terms have been used to describe the vitalistic impulse in European herbal medicine. The table above has been developed to present a summary of these terms.

The terms listed in this table are often used interchangeably within herbal medicine, but they have arisen in different contexts, in different historical periods, and are not identical. Vitalism refers to a quality which animates all biological entities (McCabe, 2000; Sheldrake, 1990) whereas *vis mediatrix naturae* is a description originating in the Hippocratic writings, of a principle by which the body recovers from disease (Pitman, 2005). The Roman physician Galen used the term *pneuma* to refer to a vital spirit (Holmes, 1989 p. 18; Nutton, 2004, p. 234) whereas later writers from the 19th and early 20th century, including the American herbalist Samuel Thompson (Lloyd, 1900), understood ‘*vital force*’ to be a more concrete, robust force (Wood, 2000 p. 106), and one which moves the body towards healing. Wood suggests that, as a basis for medical practice, ‘*vital force*’ has been perceived differently by Paracelsus, Thompson and the Eclectics (among others), and that these differences are evident through the differing styles of therapeutic intervention (Wood, 2000). The terms *élan vital* which Bergsen (2001) used to describe an evolutionary impulse, and *entelechy*, used originally by Aristotle but reintroduced by Driech to refer to a more individual organising impulse, are not used in normal herbal discourse. Thus the terms listed above indicate a rich tradition of vitalistic thought within Western philosophy, which, with careful re-examination, may contribute to an understanding of its persistence within herbal practice.

**4.6.2 Holism**

The term ‘holism’ is used in a variety of ways by different authors within natural medicine, and there does not appear to be an easy and well-accepted definition. Coulter and Willis (2004) suggest that vitalism and holism are distinct ideas, listing both as characteristic of natural medicine. Other writers interpret holism as a contemporary re-interpretation of vitalism. Pitman
(2005), for example, uses references to vitalism as part of her evidence for the presence of holism in the Hippocratic Corpus. Tobyn (1997) characterises the practice of 17th century herbalist Nicholas Culpeper as a ‘holistic practice of medicine’ although ‘holism’ is not used by Culpeper himself. Lawrence and Weisz (1998, p. 5) argue that holism is an ancient therapeutic paradigm, associated with the need of humans to ‘adapt themselves to – rather than master – natural forces and rhythms’.

The origin of the term ‘holism’ is less than a century old. Smuts, a South African philosopher - general-politician, first introduced it in the 1926, in an attempt to find a way to move beyond the limitations of mechanism while still rejecting vitalism, Smuts states:

> I suggest that the substitution, for scientific and philosophic purposes, of the concept of the **whole** for **life** would give far more precision to the underlying idea. Thus a definite concept, whole properties would be investigated and defined, would take the place of a vague expression, already ruined by popular use and abuse. A living organism is not an organism plus life, as if life were something different and additional to it; it is just the organism in its unique character as a whole, which can be closely defined (Smuts, 1926, pp. 109-110 my emphasis).

Since Smuts’ time, holism has been developed and applied to a broad range of fields by scientists concerned with the limitations of reductionist science to explain the behaviour of complex wholes.

Thus the ‘science of the whole’ is used as a replacement for the idea of vitalism. Some of the major developments of holism as illustrated in the broader scientific community are summarised in Table 4.4 below. Smuts’ work predates that of Von Bertalanffy and later of Gell-Mann.
From the 1930s until his death in 1972, von Bertalanffy (1975) demonstrated that when complex systems interact with their environment, characteristics that were additional to the constituents were evident. His General System Theory was applied to biology, psychology and history. Like Smuts, von Bertalanffy attempted to bridge the limitations of mechanism without resorting to ‘a vitalistic demonology’ (von Bertalanffy, 1975 p. 152). He described his work as a ‘scientific exploration of ‘wholes’ and ‘wholeness’, which not so long ago, were considered to be metaphysical notions transcending the boundaries of science’ (von Bertalanffy, 1975 p. 157-8).

<table>
<thead>
<tr>
<th>Theory</th>
<th>Holism</th>
<th>General Systems theory</th>
<th>Complex adaptive systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decade</td>
<td>1920s</td>
<td>1940s</td>
<td>1970s</td>
</tr>
<tr>
<td>Major authors, disciplines</td>
<td>Smuts politics, philosophy</td>
<td>Von Bertalanffy, biology</td>
<td>Murray Gell-Mann, physics</td>
</tr>
<tr>
<td>Major premises</td>
<td>Wholes are more than a sum of their parts; properties of whole cannot be understood by properties of parts</td>
<td>Complex systems interact with environment, &amp; exhibit additional characteristics to those of parts.</td>
<td>Simple and complex systems are linked, and develop in patterns as these systems co-evolve with the environment</td>
</tr>
</tbody>
</table>

Table 4.4: Comparison of systems related to holism (adapted from Capra, 1982; Mills, 1991; Sheldrake, 1990)

More recently, Murray Gell-Mann (1994) and his colleagues at the Santa Fe Institute have pioneered the development of the field of holistic science. They have explored the development of complex adaptive systems, researching the ways in which systems adapt and change in relationship to the environment within which they exist. Gell-Mann has particularly focussed on the importance of patterns, and delicate balance between order and chaos which appears to be necessary for these systems to function and adapt (Gell-Mann, 1994). The interconnectedness of life and the study of the whole is being explored in this case via physics and mathematics.
Thus the principle of holism, while accepted within natural medicine, is treated in quite distinct, even contradictory, ways. Some use the term as consistent with vitalism, (‘herbal medicine is holistic and vitalistic’) while others use the term to allow for the rejection of vitalism. For them, the complexity of holism provides sufficient explanation that phenomena may be explained without ‘resorting’ to vitalism. Sheldrake (1990) for example takes holism to be, in effect, a modern-day version of vitalism, as it allows its proponents to

   …agree with the mechanists in affirming the unity of nature, seeing the life of organisms as different in degree from the rest of the physical world, but not different in kind. And it agrees with the vitalists in stressing that organisms are organic wholes, and cannot be reduced to the physics and chemistry of simpler systems. The holistic theory in effect treats all nature as alive, and in this respect represents an updated version of pre-mechanistic animism (Sheldrake, 1990, p. 80).

Thus holism applies the principles of science to explain the behaviour of complex wholes, while vitalism requires ‘something beyond’ science in order to explain life processes.

4.6.3 Vitalism as morality
A potentially fruitful approach to the ‘problem’ of reconciling vitalism with science is provided by Georges Canguilhem (1904-1995). Canguilhem suggests that vitalism is not a ‘truth’ to be proven, but a perspective from which to develop an attitude concerning health and disease. Describing himself as a ‘rational vitalist’, he understands vitalism as a ‘categorical imperative’, a Kantian moral obligation, which provides a framework for the ways in which life should be lived. He does not claim that vitalism is true, and rejects calls to provide ‘proof’ of vitalism. He recognises it as ‘an imperative rather than a method and more of an ethical system, perhaps, than a theory’ (Canguilhem in Delaporte, 1994, p. 288).
He claims that vitalists are people who see themselves ‘in a filial relationship with nature’, that is, as part of nature, in which they find ‘life, soul and meaning’ (Canguilhem in Delaporte, 1994, p. 288). Canguilhem differentiates these individuals from those who stand separate and apart from nature, observing it from a distance (Canguilhem in Delaporte, 1994). If vitalism is understood as an ethical position, questions of ‘veracity’ as understood by natural science do not need to be addressed. From this perspective, vitalism does not need to be a clearly articulated doctrine, and not consistent with the principles of rational thought as required by contemporary science (Canguilhem in Delaporte, 1994 p. 288).

Canguilhem is concerned with what vitalism does and what its adoption leads to in terms of medical practice, more than in what it is. He is a philosopher and a medical practitioner, not a herbalist or naturopath, but his approach is consistent with the philosophy of natural medicine when he describes a concern with vitalism in medicine as:

> a biology for physicians sceptical of the healing powers of medication… Because nature is the first physician, therapy is as much a matter of prudence as of boldness. Vitalism and naturalism were thus inextricably associated. Medical vitalism reflected an almost instinctive wariness of the healing art’s power over life (Canguilhem in Delaporte, 1994 p. 287-8) (my emphasis).

Canguilhem’s focus on consequences rather than ‘truth’ may not endear him to scientists, but is likely to be sympathetically received by those who are concerned with the failure of science to lead to social progress, as discussed in 4.3. His emphases on utilising nature as healer, and on minimum intervention rather than dramatic, heroic attempts by the practitioner to ‘heal’, are characteristic of natural medicine (Coulter, 2004). These principles are consistent with the emphasis in CWHM on the body’s ability to heal itself (*vis mediatrix naturae*), on the role of practitioner as facilitator in this process, and
the individuality of treatment. Patients are understood as unique individuals rather than as carriers of specific pathologies.

Canguilhem further asserts that health is defined by adaptability. This is consistent with the idea of a ‘vital response’, so important to herbalists. For Canguilhem, health is not a steady state. He claims that for a person’s health to be maintained in narrow boundaries is the opposite of health, as ‘what characterises health is the possibility of transcending the norm’ (Canguilhem, 1991, pp. 196-197). This association of health and activity with life is consistent with the association of acute symptoms with vitality and chronic symptoms with a lack of vitality which is a fundamental principle in both herbal medicine and naturopathy (Bradley, 2006; Griggs, 1997). Canguilhem understands that

To be in good health means being able to fall sick and recover, it is a biological luxury. Inversely, disease is characterised by the fact that a reduction in the margin of tolerance for the environment’s inconstancies (Canguilhem, 1991, p. 199).

In summary, Canguilhem avoids the need to prove the existence of vitalism by removing it from the phenomena appropriate for scientific inquiry, re-interpreting it as a ‘morality’ rather than a ‘fact’, and concentrating on its implications for medical practice. He demonstrates how vitalism leads to tenets of natural medicine including naturalism and therapeutic conservatism. His perspective on the relationship between humans and nature is reminiscent of rural and pre-Enlightenment life where humans are responsive to nature and see themselves as part of the natural world, rather than the rulers of it, and is consistent with contemporary herbal philosophy.

4.7 Remembering and forgetting

The repositioning and restructuring of the knowledge base of herbal medicine involves the inclusion of new (usually scientific) material and the excision of
some (usually traditional) material which is seen to be outdated. Some authors suggest that traditional herbal knowledge should eventually be completely replaced by scientific understandings, with traditional knowledge not supported by science being discarded (Guo et al., 2007). However this is not a view which is held universally.

However there is an absence of discussion of what is lost in this process of modernising the knowledge base of herbal medicine. The study of agnotology, or a ‘theory of forgetting’ has not previously been applied to herbal knowledge. There two schools of thought regarding the appropriate use of the term ‘agnotology’. Proctor (1995) and Schiebinger (2004) use the term ‘agnotology’ to refer to ‘cultural forgetting’. Tuana (2004) rejects this interpretation, and prefers the term ‘epistemology of ignorance’. She suggests that ‘agnotology’ was used in the mid-19th century as well as more recently to refer to knowledge that was unknowable, and the term therefore refers to something different to the construction of ignorance. She wishes to counter a perception that ignorance is the background against which knowledge is developed, but rather sees it having an important role in the understanding of power relationships.

Just as we have epistemology/ies of science, of religion, and so on, I wish to argue for an epistemology of the complex phenomenon of ignorance as well as to suggest that no theory of knowledge is complete that ignores ignorance (Tuana, 2004, p. 227).

Proctor suggests ignorance is a complex concept, not just ‘an ever-expanding vacuum into which knowledge is sucked’, but can be an intentional product. His example of this type of ignorance is the longstanding ‘doubt’ on the part of many tobacco companies as to the hazards of smoking. (Proctor, 1995, p. 8).

Schiebinger develops Proctor’s work, and demonstrates the politics of forgetting information about plants in her book Plants and Empire, Colonial Bioprospecting in the Atlantic World, where she explores the possible reasons for
the loss of knowledge about the abortifacient actions of *Poinciana pulcherrima*, peacock flower. This plant was introduced from the West Indies into Europe in the 1700s as an ornamental plant. However in the West Indies it was known as an abortifacient, and it seems to have been widely used, particularly among slave women. The knowledge about this use did not accompany *Poinciana's* journey to Europe, presumably due to anti-abortion attitudes at that time (Schiebinger, 2004).

She contrasts this type of ignorance from that associated with knowledge produced in secret (*Poinciana's* abortifacient action was well known in the West Indies at the time), or the active suppression of knowledge, or even misconceptions that, once discovered, are corrected. Rather, she is interested in ‘the cultivation of certain types of knowledge over others’ (Schiebinger, 2004, p. 126).

As herbal medicine is modernized and new herbals are written, decisions regarding the inclusion of some material and the exclusion of other material are not publicly analysed. An examination of herbals - particularly those written for health professionals and an educated public - reveals changes in emphasis from recipes and general information to clinical trials and plant constituents.

If the herbals indicate ‘what counts as true’ in herbal medicine, or at least what is considered important information, then clearly what counts as important to know today is more phytochemistry and fewer recipes and gardening tips than for example Grieve included 35 years ago when she wrote her popular herbal (Grieve, 1931/1980).

Assumptions of vitalism and holism, essential characteristics of herbal medicine (Coulter, 2004; Kerridge & McPhee, 2004), are increasingly replaced by documentation of clinical trials and connections between phytochemistry and the actions of plants (Braun & Cohen, 2007). As the knowledge base is
documented increasingly in this way, such characteristics are backgrounded. It remains to be seen whether they will disappear.

4.8 An illustration: The Australian Journal of Medical Herbalism (AJMH)

In order to explore the extent to which the tensions discussed here are to be found within the contemporary herbal literature, a review was carried out of articles on herbal therapeutics in the Australian Journal of Herbal Medicine. This review was undertaken as an exploration of the ways in which herbalists describe their treatment of patients. The AJMH has been published by the National Herbalists Association of Australia since 1989 and a statement in each issue describes it as including ‘material on all aspects of medical herbalism, including philosophy, phytochemistry, pharmacology and clinical application of medicinal plants’. A review of original articles published between the Vol 1:1 in 1989 (month not stated) and Vol 19:2 in June 2008 located a total of 285 articles. In order to explore the ways in which herbalists describe their treatment of patients, articles written by clinical herbalists on herbal therapeutics, i.e. the herbal treatment of specific conditions, were identified. In total, 31 articles on herbal therapeutics were found.

Articles excluded from the review included those which dealt with the actions of individual herbs or groups of herbs; those which dealt with specific conditions and not their herbal treatment; articles on therapeutics which were not written by practising herbalists and those which dealt with individual case histories without including discussion of the specifics of the condition and broad therapeutic approaches to its management.

While the total number of articles is small, further analysis of their content is justified because of the unique place this journal has within Australian herbal practice. It is the sole Australian journal which deals specifically with the
clinical practice of herbal medicine. A broad analysis is presented in Table 4.5 below, with the articles collated in five-year periods.

Two initial points are made in relation to this table. Firstly the number of articles on herbal therapeutics published in the Journal has decreased during the last decade. 22 articles were published on therapeutics out of a total of 149 (14.76%) articles in the first ten years whereas 9 articles were published on therapeutics out of a total of 136 (6.6%) articles in the next decade. Secondly, it is of note that herbalists publishing in this journal overwhelmingly use the language and concepts of biomedicine: almost every article in this review includes biomedical concepts, most commonly in the description of condition treated. This indicates that herbalists’ understanding of illness is congruent with that of biomedicine.

<table>
<thead>
<tr>
<th>Volume, date</th>
<th>Original articles</th>
<th>Articles on herbal therapeutics</th>
<th>Refer to biomedical concepts</th>
<th>Evidence base for practice</th>
<th>Refer to herbal philosophy</th>
<th>Refer to Vitalism</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989-1993 Vol 1-5</td>
<td>78</td>
<td>12</td>
<td>11</td>
<td>2</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>1994-1998 Vol 6-10</td>
<td>71</td>
<td>10</td>
<td>10</td>
<td>7</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>1999-2003 Vol 11-15</td>
<td>72</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2004-2008 (to June) Vol 16-20(2)</td>
<td>64</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 4.5: Therapeutics articles in the AJMH

The review also demonstrates an evidence-base for clinical practice through references both to clinical research into herbal interventions and phytochemical research with regard individual plants and their constituents. While such references were largely absent prior to 1992, almost three quarters (14 of 19) of the articles published since then refer to literature in these fields.

Under half of the articles (15 of 31) refer to concepts which can be seen as part of traditional herbal philosophy, a philosophy which is essentially vitalistic. These concepts include references to humoral medicine based on the four-
element theory, to physiomedicalism which arose in the 18th century US, and include functional diagnostic categories used by herbalists including lymphatic congestion, enervation and organ dysfunction. It is of particular note that while during the first five years of the Journal’s publication specific references to vitalism almost equalled those of herbal philosophy (9 references to vitalism, 11 to herbal philosophy), this is no longer the case and there have been no references to vitalism in the last five years.

The review shows that an evidence-base for practice is increasingly apparent in descriptions of therapeutic interventions, and references to herbal philosophy and to vitalism are decreasing. Discussions with the editor of the Journal indicate that an emphasis on science within the Journal’s focus has meant that articles on herbal therapeutics are now expected to be more research-based than they were in the early years of the Journal (pers.comm. Anne Cowper 3 June 2008). No claims are made here as to the extent to which these articles reflect the actuality of clinical herbal practice.

4.9 Conclusion

This chapter begins a discussion of the theoretical perspectives which can assist in developing an understanding of the complex position of Australian herbalists. In this chapter I focussed on the paradox of herbalists attempting to keep alive a traditional craft in a non-traditional society – and attempting to participate within the thoroughly modern healthcare sector. I have contrasted attitudes to knowledge generation favoured by traditional practitioners whose information has involved the use of narrative, and practitioners of scientific medicine, who demand adherence to the specific methodological requirements of the scientific method. These two approaches are not easily reconciled. Of particular interest is the controversial notion of vitalism – central to traditional herbal practice, but rejected by science.
Contemporary applications of these two approaches which are relevant to herbal medicines are found in Traditional Knowledge (TK), and evidence-based medicine (EBM). TK is of particular importance within the ecological movement as it emphasises the relationship between humans and their environment and is accepting of the idea of vitalism. EBM follows scientific methodology to provide very specific information about the therapeutic application of certain herbal preparations – and does not accept vitalism.

Knowledge in 21st century Australia is dynamic, and rapidly changing. Herbal medicine is re-emerging as a popular choice for healthcare after a century where it was largely ignored. Part of the process of this re-emergence involves a revision and updating of its knowledge base. Herbs are reinterpreted in ways that are appropriate for 21st century consumers and practitioners (both herbal and the broader healthcare community). Choices are made as to which information – about herbs and about herbal practice - is included in books and curricula and which is considered archaic.

Disagreements develop between groups of practitioners as to appropriate emphases within herbal knowledge. Is traditional knowledge, based on a vitalistic philosophy, appropriate in 21st century Australia? Or should all healthcare interventions, including herbal medicine, be justified in terms of EBM or laboratory-based phytochemical research? A consideration of the literature concerning agnotology and the epistemology of ignorance contributes to the development of discussion regarding the basis on which these decisions are made.

In this section, I have considered the problems of combining two quite antithetical approaches to knowledge, in order to allow retention of aspects of traditional practice in a modern context, as reflected in TK and EBM. I will now turn to the issues of marginalisation and professionalisation, which reflect where herbalists have come from and where they appear to be heading.
It is November 2005 and a conversation about elderberries and their possible link with avian flu is occurring between a number of herbalists on the UK Herbal List. It began with the mention of research showing that a constituent of elderberries had been found to be potentially useful against avian flu. A number of herbalists have responded, noting that the previous autumn the elder trees were picked clean of berries before they (the herbalists) were able to harvest them. One herbalist notes that an elderly pigeon fancier has visited her clinic for a supply of elderberries, which he used each year to protect his pigeons from the flu. This man usually picks his own elderberries, but has found them unavailable this year, so has turned to the herbalist for an alternative source of supply. The discussion continues over a number of days, with some herbalists sceptical of these observations and others quite convinced that these observations indicate the wisdom of the animals.

The important point here is not whether or not the birds ‘know to eat more elderberries’, or the observations of the pigeon-fanciers which had been borne out with the phytochemical research. Rather it is that these herbalists are continuing to observe nature, utilise science, and incorporate scepticism – they observe, observe, observe. This is folk knowledge combined with scientific knowledge – living traditions, contributing to contemporary herbal knowledge.
5.1 Introduction

In this chapter, the twin issues of professionalisation and marginalisation are addressed. Professionalisation is part of a broad legitimatory process and related to statutory regulation, and has been well canvassed with regard to Australian herbal practitioners ((Carlton, 2003; Hunter, 2000; Pearson, 2004). Legitimatory activity has become a major part of the work of professional associations, for example in responding to government proposals and reviews, establishing educational criteria for potential members and introducing requirements for continuing professional education for established members. Thus while issues of legitimation are evident in the working lives of herbal practitioners, the discussion of its converse – marginalisation – appears to be absent. Marginalisation is not a term which herbalists apply to themselves, although they are well aware of the imbalance of resources available to themselves and their profession vis-à-vis other healthcare professionals and professions. A consideration of the idea of marginalisation in relation to CWHM provides insights useful to an analysis of the position of Australian herbalists.

Gross (1992) maps the place of traditions which have survived into modernity and his work is used here to help understand the issues confronting Australian herbalists. He suggests that surviving traditions may be found in four (metaphoric) ‘locations’, each of which is associated with particular difficulties. He illustrates the inherent problems faced by traditions – whether they become completely accepted and legitimated, or whether there is some level of rejection and consequent marginalisation. This analysis provides a link between the discussion of tradition in the previous chapter, and the discussion of professionalisation and marginalisation which are the focus of this chapter. In mapping the cultural location of surviving traditions,
Gross (1992) argues that traditions either face the difficulty of being close to power, or they are marginalised in some way. The locations are illustrated in Table 5.1

<table>
<thead>
<tr>
<th>Gross’ location of surviving traditions</th>
<th>Distinguishing features</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the centre of society</td>
<td>Difficulty maintaining own integrity</td>
</tr>
<tr>
<td>At the margins of society</td>
<td>Small, without power; localised clientele.</td>
</tr>
<tr>
<td>In the cracks and interstices of social existence</td>
<td>Unrecognised, or perceived as inconsequential</td>
</tr>
<tr>
<td>Underground</td>
<td>Perceived as dangerous</td>
</tr>
</tbody>
</table>

Table 5.1 Cultural location of surviving traditions (adapted from Gross, 1992)

Thus all these locations are identified by Gross (1992) as problematic. Traditions located at the centre, firmly within modern society, face the challenge of maintaining their identity and without excessive and inappropriate compromise ‘so close to power and money’ (Gross 1992, p. 122). For Australian herbalists, acceptance and inclusion within the healthcare sector is a longstanding goal, and the pathway to that acceptance is professionalisation. In their view, professionalisation will bring economic benefits and social status, as well as the ability to participate fully in the delivery of healthcare (McIntyre, 2005). In the first part of this chapter, I explore the challenges herbalists face in their quest to achieve political legitimation via professionalisation. The complexity of this struggle is described in relation to three factors. These are - the changing nature of professions; the internal conflicts which arise from being part of the elite; and the problems of maintaining intellectual autonomy. It is the third of these factors that is consistent with Gross’ (1992) analysis of centrally-located traditions.

The second part of the chapter develops Gross’ (1992) remaining three locations of surviving traditions – all of which can be seen as marginalised in some way, and I interpret these possible ‘locations’ as othering, invisibility
and political resistance. In the model presented, Gross (1992) places surviving
ethnic traditions at the margins of society, tolerated as long as they do not
become too powerful and present a threat to state stability. This can be linked
to Said’s (1995) concept of the ‘other’, which results from the domination and
labelling of one group over another, in this case the domination of herbal
considering the complex processes and expressions of power the process of
‘othering’ involves, and this contributes to an understanding of the difficult
situation in which herbalists have found themselves.

Gross (1992, p.123) suggests that traditions may also survive due to their
relative invisibility to the state, for example within the family or home, having
‘secured a foothold in the free spaces within modern society… In the small
nooks and crannies inside the social whole… ’ This is expanded and related to
herbal medicine by reference to the work of a range of authors, particularly
Thiele (1986) who originally referred to the invisibility of women. Her ideas
were extended by Jagtenberg and McKie (1997) to apply to the exclusion of
nature from academic discourse within their own field of cultural studies, and
both of these approaches parallel that of Waring (1988). Finally, Gross (1992)
suggests that traditions may ‘go underground’, and continue their practice
even if they are entirely unobserved, or legislated out of existence. The term
‘underground’ has associations with a range of fields including the arts
(particularly music and cinema), organised crime, persecuted minorities and
political dissidence. Discussion in this chapter will focus on persecution, and
political dissidence, in particular civil disobedience.

To some extent the first three of these divisions parallel Kleinman’s analysis
of healthcare structures involving three levels - professional, folk and
popular medical care (Kleinman, 1980), however the model presented here
allows for an explanation of the range of difficulties faced by herbalists in
each location.
5.2 Professionalisation

Friedson calls professions ‘special types of occupations’ in that they are

…deliberately granted autonomy including the exclusive right to determine who can legitimately do its work and how the work should be done. Virtually all occupations struggle to obtain both rights, and some manage to seize them, but only the profession is granted the right to exercise them legitimately. And while no occupation can prevent employers, customers, clients, and other workers from evaluating its work, only the profession has the recognized right to declare such ‘outside’ evaluation illegitimate and intolerable (Friedson, 1988, p. 72).

Medicine has been studied as an exemplary profession, in that it transformed itself from a poorly paid occupational group at the end of the 19th century to one that, by the middle of the 20th century, had successfully crippled its opponents, and had established a monopoly on medical practice (Friedson, 1988; Saks, 1996; Starr, 1982; Willis, 1989). However by the late 20th century, this monopoly on deciding ‘who should do its work and how it should be done’ was being shaken, or at least with regard to the scope of the ‘work’ which belongs to biomedicine. This ongoing process was described in 3.3 and involved the increased demands of groups outside medicine to influence its practice. These groups include the state, health insurers and consumer groups.

Habermas’ discussion of political legitimacy helps to make sense of these contests and changes and explain the acceptance of herbal medicine despite its longstanding rejection by biomedicine. He defines political legitimacy as ‘a political order’s worthiness to be recognized’ (Habermas in Outhwaite, 1996, p. 248), and asserts that legitimation is not fixed, but is a continuing process (Giddens, 1989; Outhwaite, 1996). Further, he argues that since the state has a range of responsibilities, some of which are contradictory, clashes between demands are inevitable, for example between the ‘health’ of the
economy (and therefore the interests of the owners of capital) and the social welfare needs of the greater society – or the demand of a powerful lobby. Where there is a clash between such demands, Habermas claims that a capitalist state will always choose to side with the economy (Habermas in van Krieken et al., 2000). In this case, once the market value of herbal products reached a particular point, herbal medicine could no longer be rejected by government. The power of the medical profession in the late 20th century was not sufficient to over-ride the power of the market.

Notwithstanding the removal of these barriers to acceptance, the external realities governing herbalists’ attempts to professionalise in the early 21st century are very different to the context in which they were marginalised a hundred years ago. The social and economic advantages of professionalising in the early 21st century may not be as great as they were in the 19th and early 20th centuries. The healthcare field is now highly regulated and many professions – not just medical practitioners – have obtained statutory regulation. These groups include nurses, osteopaths and, in the state of Victoria, practitioners of Traditional Chinese Medicine. Herbalists are attempting to carve out a niche in which to practice in a highly competitive world where many other groups of healthcare practitioners are now well established, some of whom offer similar services to those of herbalists.

Furthermore, I argue that the advantages of professionalisation for herbalists today are limited by the following three factors.

a. Changes in the nature of professions today means that professional autonomy is constrained and professional accountability is great;

b. The elitism which remains implicit in the process of professionalisation contradicts principles of equality and patient empowerment which are core to the practice of many herbalists;
c. The loss of autonomy and need for intellectual conformity associated with professionalisation is of particular importance as fundamental principles of natural medicine are ‘out of line’ with mainstream values. Each of these factors will be discussed in the following section.

5.2.1 Changing nature of professions

The first limiting factor relates to changes in the possibilities for professional behaviour. Eraut (1994) argues that the nature of professions is changing. While he is in accord with Friedson’s (1988) comment above insofar as autonomy and the public acknowledgement of expertise are important, he argues that these aspects of professionalism are being transformed in three ways. Firstly, an ever-more specialised knowledge base has led to an increased number of professional specialisations, and a new level of complexity to inter-professional relationships and boundaries. Thus an individual may now require a team of specialist professionals, each with an in-depth but narrow knowledge base to complete a task that was once completed by one person – be that in the field of medicine or architecture. Secondly, calls for increased accountability, particularly regarding the competence of professionals, and public scepticism with regard to the practice of professions disciplining their own, means that professional autonomy is being challenged. Increasingly, checks are now placed on the work of professionals. Finally, there is now not only an emphasis of the rights and choices of clients, but the notion of service is made more complex by the relative responsibilities of the professional to a range of parties. A professional’s clients are not only individuals, but the bureaucracy in which they may work – and the demands of both may conflict. Mendel (2007) has recently detailed this complexity of the responsibilities of herbalists and naturopaths working in retail pharmacies and she discusses the difficulties which can arise in this setting as they juggle their relative responsibilities to the client/customer, to their professional philosophy and to their pharmacist employer.
5.2.2 The question of elites – sisterhood vs professionalisation

The second constraint concerns elitism and here the problems experienced by lay midwives in the US (Reid, 1989) are relevant to Australian herbalists. A resurgence of lay midwifery occurred in the US in the counterculture of the 1960s and 1970s - at approximately the same time, and in similar communities, as the initial resurgence of interest in herbal medicine. Like herbal medicine, the lay midwifery movement was, in part, an attempt to challenge biomedical dominance and reclaim women’s control of their bodies. However over time, tensions began to develop among the midwives with regard to internal and external pressures to formalise training, decisions about the appropriate level of biomedicine within that training, and the problems of financial recompense for individuals who were dedicating large amounts of time to developing these skills. In particular, Reid (1989, p. 258) contrasts the early emphasis on sisterhood in lay midwifery with the later moves to professionalism and states these are ‘very different doctrines, stemming from different worlds and relating symbolically to different genders’. Sisterhood, a term which refers to a close tie of kinship, is egalitarian and minimises the boundaries and interpersonal distance between practitioners and clients. It emphasises their similarities rather than their differences. In contrast, professionalism is essentially about boundary making, which involves both inclusion and exclusion. Professionalism involves the formation of an elite group of practitioners with special rights and responsibilities and forces a division between those practitioners who fulfil the requirements to be ‘professional’ and those who do not. Saks (2003, p. 8) notes

…the irony posed by the desire of many alternative therapy organizations to professionalise when this has historically been the vehicle through which their members have been marginalised…
Both lay midwifery and herbal medicine are women-centred. Most herbal practitioners (Bensoussan et al., 2003; MacLennan et al., 2006) and most patients of herbalists (Hill, Bensoussan, Myers, Condron, & Song, 2005; Sherwood, 2001) are women. Both lay midwifery and herbal medicine favour minimum intervention (therapeutic conservatism) and both confront difficulties of working in a healthcare system dominated by biomedicine. Reid’s (1989, p. 238) questions about lay midwives are easily transposed to reflect ones facing Australian herbalists.

Can midwives set up and achieve an alternative …occupation that lies outside the traditional sphere of professional groups but is accepted by them, and has access to professional resources and rewards? Or, in order to achieve those rewards, do midwives have to conform to the demands of (and be dominated by) professional authorities? The future of lay midwifery is not yet clear, although the continued pressure for licensure…suggests that they may well have accepted integration and domination as the viable option.

A final similarity between lay midwives and herbalists involves the level of their commitment to their practice. Reid notes that lay midwives accept that their practices may at times conflict with the law, and that they may choose to break the law in order to fulfil what they perceive as their obligations to their patients. This attitude has been expressed to me in private by some herbalists in Australia, and is more openly expressed in the US (Dougherty, 2005) and the UK (VanMarie, 2002). This indicates that, perhaps due to their history of marginalisation, at least a subset of herbalists do not discount the possibility of breaking the law if they believe the law conflicts with the interests of their patients. This is discussed further in 5.3.3.

5.2.3 Loss of intellectual autonomy
The third constraint on the advantages of professionalisation is the potential for limitation of intellectual autonomy. Said (1994) comments on the ways in which professionalisation limits the expression of ideas. According to Said,
this happens in two ways. Firstly, a role of professionals is as the publicly identified expert: specialisation and concern with inter-professional boundaries constrain who is seen to have the right to speak on a particular topic. Professionals’ opinions are called upon for comment, both publicly and privately. Secondly, power brokers (and financial backers) within each profession influence the development of particular directions of thought within that field (Said, 1994). The issues of who gets to represent the field, and the pressure for thought to be developed in specific directions has particular relevance for herbal medicine, given that its knowledge base is transforming not only in content and philosophical basis but with regard to the disciplinary ‘rules of truth’ which are becoming more consistent with those of the dominant paradigm.

This is not just a question of ‘who gets to speak’ on behalf of herbal medicine and of the ability of herbalists to maintain a unique approach, distinct from biomedicine. It is also a question of whether there is value in having multiple perspectives on health and disease. Vananda Shiva (1993) is adamant in her support of such multiplicities. She questions the appropriateness of the loss of diversity of knowledge systems, and the development of what she terms ‘monocultures of the mind’ and likens the pervasive nature of rational Western thought to the invasion of eucalypts in developing countries. She warns that only having one way to understand the world is comparable to the dangers posed by the loss of plant diversity and increased dependency on monocultures within agriculture.

Said (1994, p. 61) suggests that since professionalisation ‘rewards intellectual conformity’ we should rethink its importance, and he recommends

… amateurism, literally, an activity that is fuelled by care and affection rather than by profit, and selfish, narrow specialisation.

Amateurism has other implications, i.e. it can also refer to activity that is poor in quality, or not worthwhile without a ‘dollar value’ attached. Within herbal
medicine, it also is associated with ‘old wives tales’, a term used to denigrate such knowledge. However this argument does highlight the problems of maintaining a range of intellectual approaches within a professional framework.

5.3 Marginalisation.

Tucker (1994 p. 7) defines marginalisation as ‘the process by which any group can be ignored, trivialised, rendered invisible and unheard, perceived as inconsequential, de-authorised, ‘other’ or threatening, while others are valorised’. This is consistent with the application of the term by social and political commentators to social groups to explain disadvantage due to such factors as class, gender, race, sexual orientation or disability and parallels discussion of social exclusion.

The marginalisation of herbal medicine is not on the above grounds, which are arguably fixed, but is consequent to occupation, which is something associated with choice. Other forms of marginalisation are often related to race or gender, where choice is not a factor. For Australian herbalists, their occupation is marginalised, but other parts of their lives do not appear to be although it is true that herbalists are predominantly women, as discussed in 2.2.2. My observation of both students of herbal medicine and my colleagues is that herbalists are largely of European descent, culturally quite homogeneous.

The fact that marginalisation occurs with regard to work but not according to other indicators may explain why herbalists do not appear to identify themselves as a marginalised group. In addition, the changes required to enable participation in mainstream healthcare in Australia appear to practitioners as political and therefore possible, dependent on the passage of relevant Acts of Parliament.
5.3.1 Othering
The construction of the ‘other’, as originally discussed by Edward Said is central to the idea of marginalisation developed in this thesis. ‘Orientalism’ (Said, 1995), was originally a critique of a discourse around geopolitics, but has been extrapolated to many other situations which involve the interrelationship of groups of unequal power. The notion of ‘other’ originates from this influential work. Said uses the term ‘other’ in his description of Western conceptions of the orient and the term has subsequently been adapted to many other situations where a dominant group analyses and describes a subordinate group, in their absence. Within this thesis it has been applied to help explain the relationship between herbalists and medical practitioners and concerns the ways in which herbal medicine has been constructed as ‘other’ by biomedicine.

The mechanisms by which the dominance of one group over another is established, are not straightforward. Said (1995, p. 12) describes this in relation to the expression of power of the Occident over the Orient.

..it is, above all, a discourse that is by no means in direct corresponding relationship with political power in the raw, but rather is produced and exists in an uneven exchange with various kinds of power, shaped to a degree by the exchange with power political (as with a colonial or imperial establishment), power intellectual (as with reigning sciences like comparative linguistics or anatomy, or any of the modern policy sciences), power cultural (as with orthodoxies and canons of taste, texts, values) and power moral (as with ideas about what “we” do and what “they” cannot do or understand as “we” do).

These different types of power – political, intellectual, cultural and moral – are illustrated in Table 5.2. This table applies Said’s power differentials to the relationship between biomedicine and herbal medicine and shows that there is unequal power in the relationship between herbal medicine and biomedicine. That is, there is an unequal struggle between the two groups in
their efforts to provide healthcare, generate income for their practitioners, and
to be providers of medical reason and ethics. The two occupational groups are
in competition if they are attempting to fulfil a similar role within the same
society.

<table>
<thead>
<tr>
<th>Type of power</th>
<th>Biomedicine</th>
<th>Herbal medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political</td>
<td>Statutory regulation, and accepted as the state authority on all matters to do with health and disease</td>
<td>No protection in law, no authority even re own practice</td>
</tr>
<tr>
<td>Intellectual</td>
<td>Based in science, firmly based in well-funded high status universities</td>
<td>Partly based in tradition, which is poorly articulated; partly based in science, whose research is recent and poorly funded.</td>
</tr>
<tr>
<td>Cultural</td>
<td>Traditional support bases arguably weakening</td>
<td>Power based in current popular support</td>
</tr>
<tr>
<td>Moral</td>
<td>In the absence of religion, arguably one source of ethical decisions, although this is weakening</td>
<td>Does not carry significant moral authority in the broader society</td>
</tr>
</tbody>
</table>

Table 5.2 Power differentials (adapted from Said, 1995).

On a political level, biomedical practitioners are highly regulated via Acts of Parliament, while herbal practitioners have no such requirements or protection. In terms of the development of the intellectual basis, biomedicine has been strongly supported by the state and by the pharmaceutical industry over the best part of the last century and has been able to establish a solid research foundation and well funded education and training institutions. Herbal medicine has not received similar support, which leaves its knowledge base poorly articulated, and its new science base poorly funded, as described in 2.4.3. The cultural dominance of medicine is weaker than it was half a century ago and part of the evidence for this weakening is the public acceptance and utilisation of natural medicine against the strong advice of practitioners of biomedicine (Willis, 2006). The moral ascendency of biomedicine, while perhaps weakening in association with the decline in its
cultural dominance, has not clearly been replaced by any group. While it remains common to seek the public opinion of biomedical spokespeople in ethical matters, this is not the case with regard to herbalists.

Saks (2003) discusses the activities of biomedical practitioners in their attempts to establish and maintain their dominance over their rivals, including herbalists. These activities include using their influence to deny other groups (specifically herbalists) who wanted to gain state recognition. They used medical journals, such as the British Medical Journal and the Lancet to ‘define the normative boundaries of the medical community’ (Saks, 2003, p. 69), and to criticise unorthodox practitioners and those who consulted them. They engaged in violent verbal attacks against their opponents, and kept a close eye on their own. They maintained a check on those entering the medical profession, ostracising and striking off medical practitioners who used unorthodox practices, as well as limiting cooperation of medical practitioners with ‘outsiders’. These examples demonstrate the ways in which biomedical practitioners have used their power in order to dominate their rivals, including herbal practitioners.

### 5.3.2 Invisibility

A second way in which herbal medicine has been marginalised is by being made invisible. Invisibility is arguably a more problematic form of marginalisation than ‘othering’, as it involves a denial of identity. Knowledge of herbs has not been considered of high status but rather associated with folk knowledge which is generally under-valued (Ellen & Harris, 1999). Thiele (1986) discussed invisibility in relation to women. Her focus is of those who are marginalised but their marginalisation goes unrecognised as their difference is unacknowledged. She suggests this is more likely to happen when the ‘other’ is closer at hand. It is relatively easy for the dominant class (classically rich white men) to ‘other’ people of a different class or race, where the distance between them is prescribed by physical or social distance. When ‘othering’ refers to gender, such distancing is more problematic, as it occurs...
within the family, the closest relationships we engage in. Women are mothers, daughters, sisters, and wives; men are fathers, sons, brothers and husbands.

Jagtenberg and McKie (1997) have extended and applied the analysis of the invisibility of women to apply to the exclusion of values and ecological issues from academic discussion. They use the concept of ‘silence’ with regard to the common exclusion of nature from the discourse of the social sciences and the humanities during the 1990s, and parallel the invisibility of ecological issues with the invisibility of women’s issues. Waring (1988) makes a similar point concerning the ways in which much of women’s work is made invisible by its exclusion from the national accounts (such work being either labelled as voluntary, or as housework), just as clean air and water are not given dollar value in these same accounts. The use of herbal medicines, particularly when they are wildcrafted or cultivated for domestic use, can be understood as an economically ‘invisible’ form of medical care if the money (for purchase of the herbs, or consultation) either does not change hands or is not documented e.g. for tax purposes. This continues a tradition in Western thought in which women and nature are similarly marginalised (Thiele, 1986). This link from Thiele to Jagtenberg, McKie and Waring can be further applied to the experience of herbalists, as a female group of practitioners who utilise remedies which are sourced directly from nature, and whose practice was largely ‘disappeared’ from healthcare with the advent of biomedicine.

5.3.3 Civil disobedience

Following Gross (1992), a third form of marginalisation may be that the practice, or tradition, moves underground. To be underground is to be hidden, and in herbal medicine, this may be related to persecution and to political dissidence. While not fitting the description of a persecuted minority in Australia today, CWHM has an historical association with witches, an emblematic persecuted group. Herbal medicine has an historical association with the range of stigmatised practices, including abortion, magic and sorcery, practices which are also associated with witchcraft. There are
conscious efforts on the part of many herbalists to distance themselves from such associations, for example by changing the name of the profession from herbal medicine to phytotherapy (VanMarie, 2002). This association with witchcraft may be understood as a dark side of herbal medicine, and one rarely discussed in the literature around CWHM.

Another association with the ‘underground’ is political dissidence, for example in reference to the ‘underground railroad’ which was an expression of resistance to the slave trade in the US in the 18th century (Taylor, 2004). Herbalists appear to be more likely to engage in civil disobedience than in revolution. They are not concerned to overthrow entire governments; however they object to specific laws which disadvantage them in the practice of their craft (Murphy, 1971). Civil disobedience has long been accepted by philosophers as a right within Western culture when individuals choose their own conscience over the rule of law, often by reference to a higher authority. Two examples will suffice. An early example of a philosopher choosing his conscience over the rule of law was Socrates. At the trial which led to his death, at which he was accused of corrupting the youth of Athens, Socrates asserted ‘Men of Athens, I honor and love you; but I shall obey God rather than you’ (Socrates, 428-348 BCE, p. 11). Similarly, 18th century American philosopher Thoreau asserted that

> It is not desirable to cultivate a respect for the law, so much as for the right. The only obligation which I have a right to assume is to do at any time what I think right. (Thoreau, 1849, p. 20).

The lack of clarity regarding their legal position, both in terms of the legality of clinical practice and changing circumstances regarding the legal availability of individual herbs, means that legal concerns are part of professional life for herbalists. While Australian herbalists have not experienced their practice being outlawed, they have experienced laws being passed which they consider unfair and discriminatory, and against their interests and the
interests of their patients. This is particularly the case with regard to the scheduling of specific medicinal plants viewed as valuable by practitioners (3.4.4)\(^\text{12}\). There is no documented evidence that Australian herbalists are following the lead of Socrates and Thoreau, ignoring the laws with which they disagree. Bensoussan et al (2003, p. 18) found that some herbal practitioners use herbs that are listed on SUSDP and suggest that such use indicates ‘either a lack of awareness of the legal restrictions that apply or a lack of willingness to comply with the law’. It would appear that these herbalists do not recognise the primacy of legislation with regard to the safety of medicinal plants.

### 5.3.4 Marginalisation as process

It is noted, however, that in the discussions above, of ‘othering’, of invisibility, and of civil disobedience, the term marginalisation is used as a descriptor of the experience of specific groups, in this case herbalists. Varas (2005) argues further that it is also useful to understand marginalisation as a process, not fixed but ‘a concept that is amenable to change’. That is, groups who were once marginalised become more or less so, as public attitudes and laws change – indeed this is the question explored by this thesis. The change of names locating the position of herbal medicine within Australian healthcare over the last twenty-five years – from quackery, to fringe medicine, to alternative medicine, then ‘complementary’ medicine and most recently ‘integrated’ medicine illustrates this point. These changes do not reflect any simple policy alteration of any particular group of decision makers. Rather, they reflect a range of factors which combine to simultaneously promote and limit, to determine and reflect, the practice of CWHM. These changes in descriptors indicate a movement from marginalisation to a level of

\(^\text{12}\) Plants included in the Standard for Uniform Scheduling of Drugs and Poisons (SUSDP) are largely unavailable to herbalists. These include most of the plants used in the treatment of acute respiratory diseases, such as *Lobelia inflata*, *Ephedra sinica* and *Tussilago farfara*; herbs useful for internal lesions, specifically *Symphytum officinale*, although this herb is available as an ointment, for external use. This point is also discussed in relation to statutory regulation of herbalists in 1.2
recognition, or acceptance. However, herbalists do not appear to initiate such changes but rather to swim with or resist prevailing tides.

5.4 Conclusion

In this chapter I have addressed the issues of professionalisation and marginalisation, and relate them to Gross’s (1992) framework for the cultural locations of traditions. Recent changes to the nature of professions have been discussed and related to herbal medicine in order to develop a contemporary understanding of the implications of professionalisation for herbalists. For example, moves towards increased specialisation of knowledge and therefore of practice may lie uncomfortably with practitioners who hold holism as a central tenet of therapeutics. Moves towards increased accountability may affect independence of clinical decision-making. Further it is not only likely that there will be challenges to the maintenance of their intellectual autonomy, but also professionalising herbalists must establish boundaries within their own ranks – occupational exclusion - the process of which goes against cultures of inclusion and support.

In relation to marginalisation, Gross’ analysis suggests that the cultural location of all traditions is problematic within contemporary societies. His work contributes to an understanding of the difficulties faced by Australian herbalists by providing a framework within which their choices may be understood. In this context, the move toward professionalisation can be viewed as their attempt to culturally locate themselves close to power, and to move from previous positions where they have been identified as ‘other’, as invisible, or as an ‘underground’ practice. This discussion of marginalisation allows for the development of a more nuanced approach both to the political history of herbalists, as well as to the likely outcomes of their current choices.

The theoretical perspective provided in this chapter highlights possible consequences of professionalisation. It also allows the profession to
understand and participate in the changes it faces, and to develop language and concepts with which to understand these changes, rather than ‘letting them happen’ or worse, becoming disempowered in regard to their professional futures.

Having considered a range of theoretical issues of relevance to Australian herbal practice, it is now time to move to a consideration of a key subject in this study – researching.

**Tale 5. Victorian Herbalists Association**

*From about 1987 a small group of herbalists began to meet in my living room on the first Friday of the month. Over time, this group grew into the Victorian Herbalists Association (VicHerbalists). In retrospect it is clear that at that time, VicHerbalists took responsibility for herbal medicine within Victoria. We organised practitioner support, lobbied politicians, supported small herbal growers, published a newsletter, fund raised, ran a book supply, and organised visiting speakers. Some participated only in a few activities, but other of us used the group as a community, supporting each other as individuals and families: sharing meals and the cycle of celebrations throughout the year, as well as a love of plants and concern with patients. 20 years later VicHerbalists still continues, as the Victorian branch of the National Herbalists Association of Australia. Many of the early functions have been subsumed by other organizations, but it still holds monthly meetings. It has long grown out of anyone’s living room, but continues to support herbalists in Melbourne.*
CHAPTER 6 RESEARCHING

6.1 Introduction

My aim in this research has been to explore the question – How is the practice of contemporary western herbal medicine adapting to contemporary Australian society, particularly given its increasing popularity and widespread acceptance? The project aimed to provide a perspective on herbal medicine which has, at centre stage, the herbalists themselves. While research into various aspects of complementary and alternative medicine (CAM), including herbal medicine, has burgeoned over the last three decades, this research has largely excluded herbal practitioners and their practice. The current research project was designed to look ‘in the box’ of CWHM, to consider the attitudes of practitioners, rather than for example patterns of use of herbal medicines, or the reasons for the uptake of herbal medicines by specific populations.

This chapter will provide an outline of my approach to methodology, its specific application in this work and a description of the research design of this project. Methodological issues of the project that did not exist at its outset have gained poignancy during its course, as the question of ‘what counts as true’ within herbal medicine emerged. Clearly, this question cannot be divorced from issues of ‘what counts as true’ within this thesis.

My interest in contributing to the knowledge base of CWHM and describing its complexity is influenced by two statements, made decades ago, which have had a profound effect on my thinking. The first of these was a claim by one of my herbal teachers, Hein Zeylstra\(^{13}\), that herbs have been used as medicines in all cultures at all times. This seemed then, and continues to seem to me a symbol of commonality between cultures. Secondly, I was influenced

\(^{13}\) Zeylstra taught at the National Institute of Medical Herbalists’ (UK) School of Herbal Medicine, later renamed the College of Phytotherapy, between the mid 1970s and the late 1990s.
by Sigerist’s (1951) claim that systems of medicine reflect the cultures from which they arise.

Medical theories always represent one aspect of the general civilization of a period, and in order to understand them fully we must be familiar with the other manifestations of that civilization (p. 11).

That is, the ways in which the herbs are understood, their place in any system of medicine, reflects the culture within which they are used. That statement has continued to affect the way I attempt to understand herbs both historically and cross-culturally, both in clinical practice and in teaching. That is, when I read herbal monographs and attempt to understand the actions claimed for a particular herb by a herbalist in a particular culture or era, I attempt to foreground the context in which the herbs were used. I attempt to stand in that herbalist’s shoes and think – what did they mean by this statement? In what way does this statement reflect a truth for this herbalist? These two insights – that herbs have been used in all cultures at all times, and that systems of medicine reflect their cultures of origin, taken together and applied to the understanding of specific herbs, have highlighted for me the importance of context with regard to the actions of individual plants.

6.2 Methodological discussion

I have favoured a methods-based approach over a paradigmatic approach to methodology (Grbich, 1999). My professional experience grappling with questions concerning ‘what herbs do’ has led me to accept that there are some relatively simple actions of medicinal plants, e.g. that the ingestion of a tea of the fruit of *Cassia angustifolis* (senna pods) is likely to cause bowel evacuations in most people, and the explanation of this action has remained constant over centuries (Gerard, 1633/1975, p. 1297; Mills & Bone, 2005, p. 566) However explanations of the activity of other medicinal plants has changed as cultural understandings of health and disease change. This
accords with a more postmodernist position that knowledge ‘is always partial and perspectival’ (Usher, 1997, p. 31) and is due, in part, to the fact that knowledge is limited by language, as Usher (1997) explains:

The structures, conceptuality and conventions of language, embodied in discourses and texts – language as a meaning-constituting system – govern what can be known and what can be communicated (p. 31).

An example of this is that the herb *Echinacea* which is currently primarily understood as a herb which modulates and enhances the immune system. (Mills & Bone, 2005) However it was described in the early years of the 20th century as an antiseptic (Grieve, 1931/1980) and depurative (blood cleanser) (Felter, 1922). Its effects on the immune system necessarily post-date the conceptualisation of the immune system, and Illich suggests that ‘the term ‘immune system’ does not appear in the index of a single biological textbook before 1972’ (Illich, 1996, p. 31). Thus, it is not only that knowledge is incomplete, but the type of knowledge generated is determined by its connection to existing knowledge.

Knowledge generation is also influenced by underlying values, given the relationship between power and knowledge (Foucault, 1994). Thus the task of research – of generating knowledge – is also political, in the sense that the findings and conclusions necessarily reflect the values underlying and the choices made during the process of the research project. At the same time, the researcher plays a role in uncovering and constructing a story as part of the process of ‘generating knowledge’ (Usher, 1997). It is therefore necessary for the researcher to be aware of their position and the likely influence of the research undertaken, and claims for research findings will be constrained by these considerations. Perhaps an appropriate metaphor is that of a kaleidoscope, with each piece of research contributing to one piece of glass, or one mirror, within that kaleidoscope. A single researcher, or team of researchers, can ensure that this piece of glass or mirror is clear, accurately
reflecting one ‘take’ on the project under research. However this is only one of many ‘takes’ possible.

This thesis was necessarily exploratory, given the absence of comparable research in this area which focuses on the activities of herbal practitioners. In keeping with this exploratory nature, it was decided to undertake an iterative approach, in which findings were analysed and theory considered, followed by more fieldwork and more theoretical consideration. This process allowed the role of theory in informing research to become clear, and has allowed the development of a framework within which (it is hoped) practitioners will be able to explore the complex position in which they find themselves, the paradoxes they face, and hopefully the changes and options open to them.

At the outset of the project, my aim was to develop an account of the ways in which herbalists understood their clinical practice. My aim was that this project would act as an introduction to a second phase of the project which would examine what actually goes on within a herbal consultation. However the issues which arose in the initial phase led me to understand that I needed to focus more on the context within which herbalists practice in Australia.

As stated above, my initial concern was to explore the ways in which herbalists understand aspects of their clinical practice. The ways in which researchers can come to understand the reality of another’s experience has been described in social science literature as verstehn. Verstehen may be translated as ‘meaningful understanding’ and is the process by which one person can understand another’s reality. Verstehen is associated with naturalist enquiry and qualitative methodology, and according to Meyer is ‘an attempt to ‘crack the code’ of the culture, that is, detect the categories into which a culture codes actions and thoughts’ (Meyer in Patton, 2001 p. 53). While many disciplines, including sociology, cultural studies and psychology focus on ‘understanding’, in this thesis, the idea of understanding (verstehen) is also central to the therapeutic moment which is the basis of herbal practice,
where the practitioner attempts to understand the patient’s reality. Thus *verstehn* is integral both in providing an account of the actual practices/beliefs of professional healers, and in a central aspect of their practices.

Mannheim (in Coser, 1977) was of the view that groups were influenced by a collective mind-set, which reflected their socio-cultural background, termed *Weltanschauung*, or world view. This, he felt, was as important as objective data and the subjective meanings (*verstehn*) which contribute to the understanding of any phenomena. This project explores the issues facing CWHM which at this historical juncture has its share of paradoxes and tensions. These include: herbal practitioners who live in a non-traditional society claiming legitimacy for their knowledge based (at least in part) on tradition; herbal practitioners who use traditional information at a time when science remains the legitimatory discourse; active lobbying by practitioners to be included as part of mainstream healthcare after many decades of exclusion. The ways in which these paradoxes and tensions influence the world view of the Australian herbal practitioners are central to this work.

### 6.2.1 Narrative

The role of narrative in this project requires special consideration. Narrative was not considered as a methodology at the outset of this project: this was because the project is not an account of the lived experience(s) of herbalists, nor is it an auto ethnography. However as the work developed, the role of narrative was revised as I came to understand its central meaning in the transmission of traditional knowledge. The difficulties of reconciling scientific ways of knowing with traditional knowledge are discussed in Chapter 4. As discussed there, traditional knowledge is based in narrative and narrative, with its focus on context, is anathema to positivism (Lawler, 2002; Lyotard, 1997).

The link between narrative as a form of transmission of traditional knowledge, and narrative as a methodology within the social sciences has not been widely commented upon. Lawler argues that narrative links the
individual with the collective, and that stories of individuals make no sense unless they are connected to broader social narratives (Lawler, 2002). Social science refers to issues of humans, and narrative within the social sciences focuses on the role of stories for humans, particularly as they construct their identity. In contrast, within herbal medicine, an implicit focus is on the relationship between plants and people. Thus just as narratives link individuals and the collective, so, in herbal medicine, narratives - stories about plants and stories which involve the use of the plants for individuals - provide a link between humans and the natural world.

The case history, central to herbal practice, is itself a specialised narrative, and the process of a practitioner ‘taking the case’ allows for examination of the experience of individuals who present for treatment. The form of case taking and the aspects it encompasses (i.e. whether it includes consideration of psyco-social aspects of the patient’s life, or is focussed on the physical manifestation of the presenting problems) may vary significantly between practitioners. The point is that a case history is, in some sense, always a story.

The specific forms of narrative found here include interviews, which can be understood as accessing the stories of respondents about particular issues (see 6.4.1) and historical research based on documentary evidence (see 6.4.2) which was used to construct a history of Australian herbalists. In addition, my personal narrative has been threaded through the thesis in the form of a series of ‘tales from the field’. These tales are used as a way of both acknowledging the influence of my professional history on the writing of this thesis, and of contributing these experiences to the work. Each tale is illustrative of particular issues raised in the thesis and connects my professional experience with the present project. This format also allows for continuing reflection with regards to my personal position, considered necessary given my longstanding participation in the field.
6.3 Research design

As stated in 6.1, the design of this project evolved in an iterative fashion rather than being laid out in the beginning. This section outlines the story of the research project and data collection: section 6.4 will provide further detail about the components of each of the major aspects of the research.

Interviews with practitioners were undertaken at an early stage in the research and were designed to describe aspects of current herbal practice from the perspective of herbalists. On analysis of the interview transcripts, there appeared to be an underlying assumption on the part of respondents that herbal practice was moving from a place of exclusion from the provision of healthcare in Australia to one of inclusion or mainstreaming. While the term ‘marginalised’ was not used by respondents or the interviewer, the idea of movement was a recurrent theme. The question then arose - movement from where and to where? If herbal medicine was becoming mainstream, where had it been previously?

This led to an inspection of the archives of the National Herbalists Association of Australia (NHAA). These archives were held in two locations: at the Association’s office (at that time in Annandale, Sydney) and at the State Library of New South Wales. The archives contain documents relating to the business of the Association since its incorporation in New South Wales in 1920\textsuperscript{14}. It was clear from these documents that in 1920, the Association was continuing the work of previous herbalists and previous herbal associations; however information about these previous groups was scanty. From this archival material, and from conversations with herbalists in the Association who have taken an interest in its history (some of this history remains oral, and documents are scanty or absent), it was clear that prior to 1920

\textsuperscript{14} In 1920 the Association was called the National Herbalists Association of New South Wales, it was registered in NSW in 1924 under the then Companies Act 1899. Its was changed to the National Herbalists Association of Australia in 1953 (Howard, 1982)
considerable political activity was carried out in Melbourne, although that activity appeared to be almost non-existent from the late 1920s.

Because of the Victorian connection, I began to search public records in that state for evidence of herbal associations prior to 1920. While there were many dead-ends, in the State Library of Victoria I found 14 issues of a journal, The Australian Botanic Practitioner and Journal of Botanic Medical Practitioners of Australasia. These issues were published in Melbourne and dated between March 1889 and January 1892. This was clear evidence that herbalists were organised and active well prior to 1920. In addition, there is reference, in each issue of the journal, to legislative and political threats facing herbal practitioners. Herbalists appeared to believe they were under siege from orthodox medicine, and that political activity was necessary to continue their right to practice. It appears that this journal was one vehicle for such political activity.

I therefore turned to the legislative history of medical registration in Victoria provided in Evan Willis’ classic text Medical Dominance (Willis, 1989) to identify the important pieces of medical legislation that came before Victorian State Parliament from its inception in 1856 until the establishing of the NHAA in New South Wales in 1920. By examining the debates which accompanied the introduction of these pieces of legislation, and by accessing documents from the Public Records Office of Victoria (PROV), I was able to triangulate the evidence of political concern which I had found in the Journal, and which had been referred to in the archives of the NHAA. These aspects of the history of herbal medicine in Australia have not previously been documented, and I consider this work to be a significant contribution to Australian herbal medicine.

Lastly, a review of selected articles published in the Australian Journal of Herbal Medicine, from its inception in 1989 to the present, was undertaken. The review examined the language and content of articles on herbal therapeutics
published in the *Journal*, and the results of the review have been described in 4.8.

### 6.4 Sources of data

In this section I describe the major sources of data, the interviews, documentary evidence and observation through professional experience. Each of the following sections will be introduced by general theoretical discussion, followed by the specifics of how this source was used in the context of the present research.

#### 6.4.1 The interviews

Interviews are commonly used as a primary means to gain access to the perspective or private world of the group who are being researched. In this case, interviews were the most appropriate way to develop a description of herbal practice from the practitioners’ perspective. An issue inherent in data collection using interviews concerns reliability – the way in which the responses reflect a situation. Silverman (2000) questions this in relation to the extent to which interviews reflect the narrative constructed by the respondents, and the extent to which they can be seen as any external reality of the ‘experience’ of the respondents. This is particularly problematic in this research, which in part aims to elucidate herbalists’ processes of clinical thought. The only information available will be the respondents’ constructed narrative: thought processes are not accessible to anyone else. That is, interviewing practitioners about their clinical thought provides their descriptions of these processes: the processes themselves are not able to be examined. Thus this research documents the stories that the practitioners tell themselves – and me – about these processes. Silverman (2000) suggests researchers should make a conscious attempt to ‘see the world from the perspective of our subjects’, rather than taking their words (and narrative) at face value. Such an ability to see the world from the subject’s perspective is one of the advantages of ‘insider research’ as discussed in 6.4.3.
Direct observation of clinical practice (not undertaken in this research) of the respondents would give further information and may allow statements to be made regarding the levels of apparent consistency between theory and practice. However this still would not elucidate the thought-processes of practitioners.

6.4.1.1 Selection of participants

Sixteen herbalists were interviewed, all of whom were in clinical practice, and members of the National Herbalists Association of Australia (NHAA) (Brisbane practitioners) or the Victorian Herbalists Association (VHA) (Melbourne practitioners). These associations were chosen as the professional associations that specifically represent herbalists. While many professional associations represent the interests of a range of natural therapists which include herbalists, both NHAA’s and VHA’s focus has been primarily on herbal medicine. The VHA was incorporated into the NHAA subsequent to the interviews in Melbourne being completed. However at the time the interviews took place it was a separate organisation, although many members held dual membership of both associations. There was no local Queensland herbalist organisation at the time the interviews were undertaken.

Given the highly urbanised nature of Australia, cities rather than regional or rural areas were chosen. Melbourne and Brisbane were the most convenient cities available to the researcher.

The NHAA and VHA provided a list of practitioners in the Brisbane and Melbourne areas, and indicated the approximate length of time these members had been practising. Of the sixteen practitioners, eleven were women (68%) and five were men (31%). While there was no conscious effort on the part of the researcher to achieve a particular gender balance, this does generally accord with Hale’s (Hale, 2002) and Bensoussan’s (Bensoussan et al., 2003) findings of 73% and 76% women practitioners and 27% and 24% male practitioners respectively. The one variable which was considered in choosing
the respondents was the length of time practitioners had been in clinical practice. This was not to discover the ways in which length of time in practice specifically affects views and perceptions but rather to ensure a range of views which included both new or experienced practitioners (Gerson & Horowitz, 2002).

Thus the respondents were herbal practitioners currently in clinical practice, who practise in urban areas, and have a range of length of experience in herbal practice. In terms of gender balance, the group reflects Australian practitioners, but no attempt was made for this small group to be representative on such criteria as age, education, income or experience.

6.4.1.2 Ethics and Confidentiality

Ethics approval was received from Southern Cross University Human Research Ethics Committee, approval no ECN-01-58. All participants were invited to participate via telephone. Letters of consent and information sheets were taken to the interviews, and given to the respondents prior to the commencement of the interviews. These information sheets gave details of the project and information about records, opportunities to retract, and measures for anonymity. A sample copy can be found in Appendix 3. The tapes were stored securely, apart from the transcripts of interview and personal information of the participants. The interviewees are identified in this text by using a psuedonym.

6.4.1.3 Conduct of interviews

The interviews took place at the participant’s clinic, which was on occasion part of their home or on other occasions in separate premises. The interviews were taped, and each interview took about an hour to complete. All participants were aware of the status of the researcher as an ‘insider’, that is, with an understanding of the field and its conflicts, and assumptions underpinning it. However care was taken not to influence and interpret the questions within the interview.
Questions were used as a guide to the interviews, and while the sequencing of the questions remained the same with each participant, some flexibility was included to allow a more natural conversational exchange to develop.

In addition to collecting basic biographical information, the questions which were put to each informant were:

What terms do you use to describe your occupation?

In your clinical practice, do you use pathology, or naturopathic/ herbal philosophy to inform your diagnosis and treatment?

In what way does pathology, or pathophysiology inform your practice?

In what way does naturopathic or herbal philosophy inform your practice?

Do ideas regarding pathophysiology and philosophy complement each other, or do you have to choose between the two in clinical practice?

If you use them both, how does this happen?

Is there an articulated philosophy of Western herbal medicine or naturopathy?

Who are its exponents, what are its sources?

How did you learn about it? Was this learning formal or informal?

What do you understand by the term vital force? What synonyms do you give to vital force?

Is the concept of vital force useful to you as a practitioner?

How do you use it?

Do you ever talk about it to patients? How would you explain it to a patient?
Do you experience conflict between scientific understanding of your craft and your understanding of its traditions?

How do you resolve it?

Would you describe yourself as a spiritual or religious person?

6.4.1.4 Analysis and Coding

The tape recordings of the interviews were subsequently transcribed by the researcher. The excerpts of interview included in Chapter 7 are verbatim except for the omission of vocal segregates, such as ‘um’, ‘like’, ‘ok’, ‘you know’.

An open coding method was used for the ‘first run’ of the interviews. The first interview was coded phrase-by-phrase for information that related to the research project (Miles & Huberman, 1994). Each phrase was given a number code, which corresponded to a concept code. Subsequent interviews were coded using these codes, with additional codes developed for material that was not in the previous interview(s) (Miles & Huberman, 1994). Notes on the codes were kept, and used to inform further literature searches and to connect the codes with other data.

Further levels of coding involved identifying similarities between these codes and categorising them into categories of codes. A similar process was undertaken in order to allow for further consideration of these categories and to development broad propositions (Miles & Huberman, 1994). The codes were discussed with my supervisor who served as a peer debriefer.

6.4.1.5 Confirmability and Member checking.

Records of interviews, coding data and lists, as well of records of consent, were kept. The initial findings from the interview material were presented at NHAA conferences of herbalists in Melbourne, Sydney, Brisbane, Adelaide and Perth during 2003, and feedback from the participants was incorporated into the results.
6.4.1.6 Profiles of respondents

The following profiles have been constructed to give some information about each respondent. Pseudonyms have been used to assist confidentiality.

Kylie is in her forties, and has been in practice for seven years. She holds a Diploma of Herbal Medicine, and works in a suburban multi-disciplinary clinic which focuses on fertility treatments. She also consults with patients at home. She describes herself as a herbalist, prescribing herbs and a small number of nutritional supplements. She also works as a consultant to companies which manufacture naturopathic and herbal supplies.

Jolene is in her forties, and has been in practice for seven years. She has an Advanced Diploma in Naturopathy and is completing further study which will upgrade this qualification to a degree. She works as a sole practitioner in a home-based practice. She describes herself as a herbalist and naturopath, and uses herbs, nutritional supplements and flower essences. She has recently begun to specialise in working with patients who wish to use herbal products in order to lose weight, and finds this work very satisfying. She prefers this work, using clear treatment aims and educating patients about improving their health, to her previous work which focussed on specific health problems.

Flynn is in his late twenties, and has been in practice for two years. He holds an Advanced Diploma in Naturopathy and works from his home, where he manufactures most of the medicines he uses in his practice. He describes himself as a naturopath, and uses herbs and tissue salts, and puts great emphasis on dietary change. He is extremely passionate about his work, and has just begun to be involved in some lecturing at a local private college.

Betty is 50 and has been in practice for seven years. She has a Diploma of Naturopathy and previous training in another health profession, in which she holds a postgraduate qualification. She works in a multi-disciplinary clinic with mainstream health practitioners, and this clinic focuses on women’s
health issues. She describes herself as a naturopath, and uses herbs and
dietary and lifestyle advice as her major tools. She also sees patients at home.

Michael is in his late forties and has been in practice for over 20 years. At one
stage in his life he lived in a spiritual community for several years before
becoming disenchanted with the community and the lifestyle. He is qualified
in acupuncture, and holds a Diploma in Naturopathy. He has his own busy,
inner-city clinic, where he works with other practitioners of natural medicine.
He describes himself as a herbalist and acupuncturist, and uses herbs,
homeopathy, nutritional supplements as well as acupuncture. He specialises
in the treatment of patients with cancer.

Phoebe is in her mid thirties and has been in practice for eight years. She
works in a clinic with two other practitioners, and has a Bachelor of Health
Science (Naturopathy). She also has additional qualifications in counselling,
and in her practice she focuses on emotional and psychological issues as well
as physical problems. She describes herself as a herbalist, naturopath,
homeopath and counsellor. She uses diet, supplements, herbs and
homeopathy.

Christine is in her fifties, and has been in practice for twelve years. She works
in her own clinic at home, and is about to establish a new clinic in a
neighbouring suburb with a colleague who is also a herbalist. She holds a
Bachelor of Applied Science (Naturopathy), and describes herself as a medical
herbalist and naturopath. She uses herbs, tactile therapies and nutritional
supplements in her practice. She has worked as a consultant to a natural
products company, giving advice to practitioners on a ‘help line’ for the past
five years.

Anna is in her fifties and has been in practice for twenty-three years, being
one of the long-standing naturopathic practitioners in her city. She has a
Bachelor of Health Science (Naturopathy), and she has worked for many
years in a clinic with other practitioners of natural medicine. She describes
herself as a naturopath and acupuncturist. She uses herbs, supplements, flower essences, massage and acupuncture, and treats a wide range of conditions. She has recently become interested in a specialist form of Japanese massage.

Greg is in his early thirties and has been in practice for five years. He has been involved with a range of meditational groups at different times in his life, and has a focus on nutrition and meditation, as well as herbal medicine, within his home practice. He has a Bachelor of Health Science (Naturopathy), and teaches at a local private naturopathic college. He describes himself as a naturopath. He uses herbs and nutritional supplements, as well as dietary modification, and is keen to emphasise the latter.

Daniel is in his fifties and has been in practice for twenty years. He has a Diploma in Naturopathy. He works in his own clinic with two other practitioners, and describes himself as a naturopath, employing herbal medicine, homeopathy, nutritional supplements and massage. He learnt natural medicine through becoming an apprentice to a naturopath after this practitioner had inspired him to change his life and health. A practical, no-nonsense type of person, he has little time for students who ‘choose this as a living’ – for him it is a passion, and a way of life.

Gemma is in her mid thirties and has been in practice for two years. She has an Advanced Diploma in Naturopathy and works in a clinic with other natural therapists. She describes herself as a naturopath and masseur, and is finding the path of making a living as a naturopath very difficult. She gave up a well-paid job in the public sector to undertake her naturopathic training, and feels she has made many sacrifices to enter a profession which so far is not satisfying for her.

Grace is in her late thirties and has been in practice for 13 years. She has a Diploma in Naturopathy and practices at home, describing herself as a naturopath. She used herbal medicine, minerals including celloids, dietary
supplements, flower essences and homeopathy. She is strongly connected through her family (she has school-aged children and her husband is a teacher) to a local community for whom she acts as a health practitioner, both on a formal and informal level. Many of her patients come from this group.

Debbie is in her late twenties and has been in practice for three years. She has a Bachelor of Applied Science (Naturopathy) and works in a clinic with other natural health practitioners. She finds it important to pay attention to what she calls her ‘own inner world’, and studied naturopathy because her previous employment left her feeling ‘dead inside’. She practices in a multi-modality clinic with other natural health practitioners, but is not completely happy with this setup, as she sees herself as more conventional than her colleagues, who are more interested in the esoteric aspects of healing. She describes herself as a naturopath, and uses herbs, celloids, Bach flowers and nutritional supplements.

Charles is in his fifties and has been in practice for more than 20 years. He works in two practices, one in his house and another in another suburb, some 30 minutes away, where he rents practice rooms from another health practitioner. He is a herbalist with postgraduate qualifications in another health discipline. He uses herbal medicines and nutritional supplements. He comes from a family where his family have been using herbs as medicines for generations.

Sarah is in her early thirties and has been in practice for two years. She works in a state-funded women’s residential facility three days a week, and also has her own practice. She has a Bachelor of Health Science (Naturopathy), and uses herbs, nutrition, tissue salts and flower essences. She still feels like she is ‘working her way through’ all the information she received in college, which she found overwhelming.

Hannah is in her forties and has been practising for twenty years. She has previous training in another healthcare discipline, a Diploma in Naturopathy,
and runs a busy clinic where she works with a number of other practitioners. She uses herbs, dietary advice and some nutritional supplements, and has a particular, but not exclusive, focus on women’s health. She is often called upon by practitioners in her own clinic as well as outside her clinic for advice on difficult cases.

6.4.2 Documentary evidence

The use of documentary evidence in this research allowed for an exploration of the broader context of herbal practice, in particular its political history. As stated previously, the references of interview respondents to the ‘move’ of herbal medicine into mainstream healthcare raised questions about its history. It is emphasised that these questions were not raised by the respondents, but came about as a result of my consideration of their statements about their hopes and concerns regarding the future of the profession. No participant reflected overtly on the origins of their outsider status. The questions which arose for me as a researcher concerned the ways in which this exclusion developed. Revisiting the literature did not provide answers to my questions: the political history of Australian herbalists has not previously been documented. I therefore turned to historical documents, as I understand that

Originality is not simply about new data; rather it is about new insights (Daly, Kellehear & Gliksman, 1997 p.123).

These documents were predominantly archives and parliamentary records, but they were also newspaper reports and journals. This secondary analysis allowed me to further explore a question which arose out of the interviews – What has been the professional experience of Australian herbalists?

6.4.2.1 Archives

The archives of the NHAA contain a range of written materials, as well as photographs and objects. The written materials are predominantly minutes of meetings, and letters, and fall somewhere between the ‘personal’ and ‘official’ categories of documentation (Grbich, 1999). The material found in all archives
is necessarily selective and partial, as only certain information is ever recorded or material collected. Choices must be made all along the way, in this case by officials of the NHAA, from the documenting of certain debates and not others in minutes of meetings, to the retention of some letters and not others. Some debates, some letters, some objects are deemed to be more ‘important’ or ‘interesting’ and are therefore retained. Over time, not all of that collected or recorded continues to be retained. These decisions about conservation of materials and objects may or may not accord with the interests of subsequent researchers, but they certainly affect the history that is able to be written, given the gaps that are inevitable.

A selection of archives of the National Herbalists Association of Australia is held at the Mitchell Library, Sydney and was accessed there. Further records were made available to me by the NHAA Sydney office, which at the time was located at 8 Breillart St, Annandale. I also accessed Victorian Government archives stored within the Public Records Office of Victoria (PROV).

These archives contain incomplete records of minutes, as well as correspondence and memorabilia of the NHAA. The records are striking in their documentation of the political concerns of herbalists particularly concerning their continuing practice rights. Conferences, correspondence to and from members, and other herbal organisations in Australia and overseas centred on the apparently continuing political threats and the efforts of a small association, with few financial resources, engaged in what seemed to them to be a battle similar to that between David and Goliath.

These sources were rich with regard to documenting the marginalisation experienced by herbalists in the early to middle decades of the 20th century. However they did not fully answer my questions regarding the experience of the reality of the disenfranchisement which, from these findings, was so clearly of concern to practitioners from the inception of the NHAA.
Ms Robyn Kirby, a past president of the NHAA with an interest in its history, had informed me that she understood that herbalists, and herbal associations, existed in Victoria prior to the records of the NHAA, but she had been unable to find any records of their activities (Robyn Kirby, pers. comm). In addition, a speech given by the late Paul Wheeler in 1982 refers to an organisation of herbalists in Melbourne in 1852. I have not been able to confirm its existence. However these pieces of information encouraged me to follow up a statement in Willis’ *Medical Dominance* (1989), referring to a piece of medical legislation introduced into Victorian State Parliament in 1905.

Herbalists also objected to the bill in libertarian ideological terms, arguing that the ban on unqualified practice ‘interferes with the liberties of the public in requiring attendance with a doctor and a certain theory of medicine thereby entailed’ (CSO, 05/W6529 15.11.1905, cited in Willis, 1989, pp. 73-74).

I followed up this lead, and attempted to locate the letter referred to, through the Public Records Office of Victoria (PROV). While the document CSO, 05/W6529 15.11.1905 had gone missing from PROV, the ledger of correspondence for 1905 for the Chief Secretary of Victoria shows that it was sent by the Secretary of the Australian Union of Herbalists (AUH).

This alerted me to the existence of an organisation of herbalists in 1905. Searches of the records of the Trades Hall were unsuccessful in finding any mention of this association. A search for records within the State Library of Victoria was also unsuccessful with regard to locating information about the AUH. However by locating issues of *The Australian Botanic Practitioner and Journal of Botanic Medical Practitioners of Australasia* dated between March 1889...

---

15 Ms Kirby archived the materials which are now located in the Mitchell Library. She came into possession of these archives when, on her election as President of the NHAA, a longstanding member delivered her ‘the boxes of NHAA papers which had been in the garage for years’.

16 Paul Wheeler was another past President of the NHAA, and his father and grandfather were also active members of the Association.
and January 1892, evidence was established of another association of herbalists 15 years before the AUH contested the 1905 legislation (see 8.4.1.1).

6.4.2.2 Parliamentary records

Excerpts of the official record of parliamentary debates (Hansard) were accessed in the Victorian Parliamentary Library, Spring Street, Melbourne. As Hansard documents the debates which occur in parliament, it is a particular ‘end point’ in discussion which leads to legislation. It does not provide a broad picture as to the instigators and influences brought to the drafting and introduction of a particular bill. This record indicates the major issues regarding the legislation as perceived by the parliamentarians. Accounts of the factors that led to the passage of the bill must be found elsewhere e.g. in journals and press reports of the day, and in correspondence in various archives which outline concerns and attitudes.

My searching of Hansard was informed by the work of Willis (1989) who documented the long battle by medical practitioners to establish their professional dominance and put an end to ‘free trade in physic’. Willis uses the period of almost 80 years between 1856 and 1933 (Willis, 1989) as that required for legislation allowing for the medical practitioners to establish professional dominance.

My interest was to explore some of these early battles, where there were records of herbalists’ involvement in the political process, and I therefore focussed my attention on the bills introduced into Victorian State Parliament between 1856 and 1908. My selection of debates was derived initially from Willis’ work, and this was developed through cross-checking with dates which arose in the herbal literature and correspondence. The list of debates inspected is found in Table 8.1.

This interest arose in part from personal experience. In 1989, representing the Victorian Herbalists Association (VHA), I had lobbied federal parliamentarians for changes to the Therapeutic Goods Bill (see Tale 3:}
Lobbying), and had later been surprised to find our association mentioned in the parliamentary debates (Parliamentary Debates, 1989 p. 4289). This experience caused me to wonder whether I could locate evidence of similar activity by previous herbalists. I wondered whether a search of the Hansard debates of previous bills which may have been of concern to herbalists would provide information, or whether parliamentary papers associated with their lobbying may be available. Willis (1989) had mentioned an 1892 petition which was presented to State Parliament in support of the maintenance of ‘free trade in physic’. Calls for the public to support this petition were also found in issues of The Australian Botanic Practitioner and Journal of the Botanic Medical Practitioners of Australasia.

6.4.2.3 Press reports

Press reports are a valuable source of information about broader community attitudes to herbal medicine, and they record events which may be omitted from archives. In this project they were used to provide details of a 1956 court-case involving Charles Noakes, a president of the NHAA. The story of the case and the events leading up to it has existed in the oral history of the National Herbalists’ Association of Australia, but they have not previously been documented.

6.4.2.4 The Australian Journal of Medical Herbalism

The Australian Journal of Medical Herbalism (AJMH) is the journal of the National Herbalists Association of Australia, and has been published four times a year since 1989. It is the only journal in Australia specialising in the practice of herbal medicine.

A review of articles on therapeutics in the AJMH between 1989 and 2008 was undertaken and the articles were analysed for the following references: biomedical concepts, evidence-base for practice, herbal philosophy and vitalism. The results of this review have been discussed in 4.8.
The articles examined were limited to discussion by practitioners of the treatment of specific conditions by Western herbal medicine. Categories of articles excluded were single case studies without discussion of the condition; articles on particular diseases without references to herbal therapeutics (i.e., herbal treatment), articles dealing with the actions and/or uses of particular plants or groups of plants; articles dealing with other approaches to herbal medicine, e.g., Traditional Chinese Medicine, and articles on treatment by non-herbal practitioners.

6.4.3 Personal professional experience

As previously mentioned, this project arises from, and is informed by my personal background in herbal medicine. My experiences in herbal medicine are documented in Chapter 1, and demonstrate that I have actively participated in the Australian herbal community for more than 25 years. This means that the project was not designed or carried out by a stranger to the profession: I was a participant in the profession long before I decided to study it.

My insider status brings with it advantages and challenges. The issues of the researcher with insider status compared to an outsider, one who has no prior relationship with the group or community being studied has been broadly explored (Coghlan & Brannick, 2005; Edwards, 2002; Hewitt-Taylor, 2002; Kanuha, 2000), and the major considerations are discussed below. Advantages include pre-understanding and ease of access (6.4.3.2 and 6.4.3.3 below), and challenges occur particularly in terms of maintaining objectivity (6.4.3.4) and role conflict (6.4.3.5). I argue that some of these problems are addressed if the researcher is able to develop ‘anthropological strangeness’ (6.4.3.1).

Some researchers argue that insider status is an advantage. Grbich (2004, p. 92) suggests that
The best data, which include an accurate interpretation of the cultural clues embedded in both verbal and non-verbal interaction, are gathered by researchers of the same culture.

6.4.3.1 Pre-understanding and ‘anthropological strangeness’.

An understanding of the perspectives which are used by clinical herbalists – the ways in which phenomena are understood and interpreted, and the professionally appropriate activity that relates to this – influences the understanding I bring to the research, both in data collection and analysis. My experiences within herbal medicine, both as a practitioners and educator, have allowed me to develop an understanding of the processes involved in the development of a ‘professional vision’. However while this rich familiarity with the culture of herbal medicine, and the information of practice and networks which is available to me as an insider, means that I understand the references made in documents and by respondents, this familiarity may also have its downside. Because of this very familiarity, there may be unwarranted assumptions of understanding – on my own part and that of my respondents. We both may assume an understanding rather than engaging in a full exploration. A stranger to the profession, by needing more information in order to understand, may actually gain more clarity about the phenomena under investigation (Kanuha, 2000). Further, aspects of the culture may be ‘missed’ as they may appear normal to both researcher and respondent. Latour and Woolgar (1986, p. 254) suggest the development of an attitude of ‘anthropological strangeness’ in such situations, particularly if previous research, and therefore literature, is scant.

In this case I was able to establish the ‘anthropological strangeness’ of my professional group through interaction with a very different culture of medicinal plant use. This allowed me to see my profession with new eyes. As outlined in the Prologue to this thesis, during the course of this research I had an opportunity to participate in an educational project in Chile aimed at facilitating interaction between the medicine of a large indigenous group, the
Mapuche, and biomedicine (Evans, 2002). I was able to observe some aspects of herbal medicine, both its practice and the position of its practitioners within a very different culture to my own in Australia. The juxtaposition of the familiarity of aspects of herbal practice – in particular the use of the plants themselves – with the strangeness of Chile and in particular the Mapuche culture itself, had the effect of challenging some assumptions about the fundamentals of herbal practice, and affirming others. In particular, it highlighted the connection between culture and medicine – my understanding of the therapeutic activity of medicinal plants is related to my views about the reasons for illness and recovery. In Mapuche culture disease causation and medicinal plant activity are described in ways that are very different to my understandings (Citarella, 2000; Evans, 2002).

6.4.3.2 Access

My involvement in the profession affects my access to people and information. Networks developed during my professional life were utilised during the execution of this project, and I found a high level of cooperation among the individuals and organisations I approached regarding this research. Assistance was forthcoming in a range of areas, including providing contact information for potential respondents, participating in the interviews, allowing access to documents, and providing introductions to individuals who might be able to provide me with further information. This was due not only to my relationships with individuals in the profession, but also to the view of those I contacted that this work was likely to be worthwhile.

Being known does not always ensure access. This has also been my experience and these considerations influenced my choice of project. Prior to this project being undertaken, I attempted to undertake research which focussed on graduate destinations of naturopaths. In order to undertake that project I would have required the cooperation of stakeholders within the natural medicine community. While the individuals I approached were known to me over many years, they were unwilling to allow me access to the
information I needed to undertake the project. In due course, the failure of that project led to the commencement of this one.

6.4.3.3 Interpretation of data

How does one deal with the effect that previous knowledge and experience has on the interpretation of data? The questions of objectivity and bias are contextualised in a project such as this, which emphasise the social construction and partiality of truth. It is accepted here that all facts, stories and research necessarily reflect one perspective and neglect others. This means that while the view of an ‘outsider’ is different to that of an ‘insider’, it is not more ‘true’ or necessarily more or less complete. This approach to research does require a process of continuous reflection and the inclusion of contradictory data and critical comments.

In addition, my work as an academic within a department of natural and complementary medicine has meant that many of the ideas worked on during the course of this thesis have been well discussed with colleagues, friends and students – many of them herbalists - as the ideas were worked upon and digested. Weil (1987) discussed the role of the unacknowledged ‘Others’ - friends, family and colleagues, who influence the interpretation, the ‘making sense’ of her fieldwork as an anthropologist. In the case of this thesis, many of the individual influences are no longer identifiable, but there is a sense in which many herbalists have contributed to this work. The final choices and interpretations are mine, but they have not been established in isolation. There are many levels to the cultural construction of knowledge (Jackson, 1987), and the point made here is that it is not only the persons whose names appear as authors who contribute.

6.4.3.4 Role conflict

While I am professionally an ‘insider’, none of the participants in this project were work colleagues; I did not have ‘deep insider’ status (Coghlan & Brannick, 2005; Edwards, 2002). Given the dispersed nature of professional
contact among herbalists – herbalists do not usually practice in large organisations - my dual roles as researcher and colleague have been minimised.

Nonetheless there is a sense that by walking the ‘margin’ between researcher and researched (Kanuha, 2000), my professional role has changed from a participant to a participant who also observes. This has put a subtle distance between me and my colleagues, setting me apart from them. During the course of undertaking this project, there have been many comments from colleagues about the fact that ‘we are waiting to see what you say in your thesis about Australian herbal medicine’. I have taken such comments to indicate interest rather than concern. I have also been regularly questioned about the access of the herbal profession to this work when it is completed. (‘Can we read it? Will you give a copy to the NHAA library? Is it going to be published as a book?’ – to which I answer ‘Yes, yes and don’t know’). While I have not consciously made decisions regarding material for inclusion or exclusion on these grounds, this is still the background to this work: I expect this work to be read by herbalists. This is being written for the profession as well as for an academic audience.

Further, my involvement in herbal medicine is such that it is not only that my relationships with the field of my research will not end with the completion of this research. It is not only that I take on an additional role as researcher by undertaking this research, but it is also that my involvement with the community under consideration here will not end with the completion of this project; like Mascarenhas-Keyes (1987) my relationship with the group I am studying is a ‘lifelong engagement’, and for that reason there is a level of emotional involvement with the research. While this cannot be excised, its recognition can mitigate the extent to which it influences the work.
6.5 Conclusion

The research set out to explore the ways in which herbal medicine is changing, influenced by its recent popularity and the demands of 21st century health practice. Initially sixteen herbal practitioners were interviewed, and these interviews were analysed and coded. These findings from the interviews were integrated with findings from literature, and follow up interviews and my own professional experience. Further exploration has led to the investigation of the political history of Australian herbalists, largely relying on official records and archival material from the NHAA. The findings from the interviews are reported in Chapters 7 and 8, and some aspects of its political history are documented in Chapter 8. In addition, a review was undertaken of selected articles published in the AJMH, and this has been discussed in 4.8.
It is January 2005. I have spent the last couple of weeks at the NHAA office in Sydney, immersing myself in archives and piecing together some of the political history of the association. I am fascinated by a story written by herbalist Robyn Kirby about the Wheeler family of Hill End, a family which included 5 generations of Australian herbalists. So I drive the 80k on the unmade road between Utopia and Hill End, west of Sydney, mildly concerned that my lovely new car was designed for German autobahns rather than Australian dirt roads. Once a gold-mining town, Hill End is now quite isolated.

When a town is deserted and the buildings decay or are removed, the introduced plants remain. Some flourish and others disappear. The plant populations in Hill End have outlasted the human population. I wonder whether any record of medicinal plants that the Wheelers might have used will be inscribed upon the landscape.

I am not disappointed. What beautiful, huge hawthorn trees greeted me there! I have never seen such a collection of old established, healthy hawthorn trees scattered throughout a town – or rather where a town used to be. Other medicinal plants included elder trees, centaury and St John’s wort, as well as the more expected dandelion and plantain: all are exotic to the area. But it is the hawthorn which is the most stunning.

A visit to the local museum which is housed in the old Hill End Hospital reveals another treasure. An old tincture press made by the Enterprise Manufacturing Company is on display. It is labelled ‘for crushing herbs’ and is clearly an early model of the tincture presses still used by herbalists today who prepare their own medicines from fresh or dried herbs. The existence of the press as part of the display on medicine in the town in the late 19th century indicates that this practice existed in Hill End at that time. Were hawthorn berries collected from those wonderful trees and used to make medicines for the heart and circulatory problems of the town, in this very tincture press?
CHAPTER 7 REFLECTIONS ON PRACTICE

7.1 Introduction

Herbal practice – as any medical practice – can be divided into diagnosis (what is wrong?) and treatment (how can it be fixed?). Diagnosis determines treatment – that is, the conclusions made by the practitioner as to what is wrong determine what should be done. The diagnosis determines the rationale behind the appropriate choice of treatment, whether this be the choice of particular herbs for a herbalist, or particular pharmaceuticals (or surgical interventions) for a biomedical practitioner, or particular acupuncture points for an acupuncturist. There will be a ‘right fit’ between the diagnosis and the treatment.

However within herbal medicine, there is an additional layer of complexity in that there can be many approaches to diagnosis. Unlike pharmaceuticals, which were developed to be administered within a biomedical framework, or acupuncture, which was developed within Traditional Chinese Medicine, medicinal plants themselves (distinct from products) are naturally occurring (i.e. not developed/invented/engineered by humans) and they have been applied within multiple medical systems across cultures and throughout history. This diversity of use is a consequence of their being employed in all cultures at all times. Each herb can be used in different ways, depending on cultural context and/or the philosophy of the practitioner. Thus within the Western tradition of herbal medicine, *Echinacea spp*, as an example, may be used as an immune stimulant or a blood cleanser depending on whether the patient’s symptoms are considered by the practitioner to be a result of depleted immunity or accumulated wastes. These two approaches may be compatible, but they arise from different medical traditions and are not identical. ‘Immunity’ is a biomedical concept whereas ‘toxicity’ arises from European medical systems which precede biomedicine. Respondents in the
interviews which form the basis of this chapter demonstrate the use of a number of diagnostic and treatment frameworks which they use in clinical practice.

This chapter is divided into three sections. The first is related to diagnostic considerations in clinical practice; the second to treatment considerations in clinical practice; and the third to perspectives on the underlying philosophy of clinical practice.

When asked, all respondents claim their practice is informed both by traditional herbal medicine and by biomedical science. No respondent denies the influence of traditional understanding, or denies the influence of biomedicine. However the ways in which such integration is managed and the relative importance of each approach appears to be an individual matter: not all respondents place similar emphasis on traditional and biomedical knowledge. Some respondents describe consciously moving between paradigms during consultation, as if they are bilingual and moving from one language to another, while others describe interlinking differing concepts in a complex and indivisible whole. However such integration is not straightforward, or reported by all respondents.

Respondents describe herbal diagnosis and treatment as not simply based on biomedical understandings of disease processes, but something different. While details of specific biomedical pathology are important to many (but not all) practitioners, physiological function is also emphasised. Some respondents state the aim of their treatment is as much to stimulate health as to treat disease, and wherever possible, they locate and treat the cause of that disease or dysfunction. They describe their practice as ‘more than’ simply using herbs to treat specific symptoms or pathologies.

Respondents also emphasise the importance of treating each patient’s individual circumstances and their unique response to, and experience of, their disease. This integration of the various sources of information and
perspectives is highly complex. The philosophy of CWHM practice is poorly articulated and relatively uncodified, with each practitioner develops their own approach. In spite of this, a consensus around a number of thematics including the categorisation of disease, diagnosis, and the actions of herbal medicines is identified in the interviews.

This chapter has been constructed to give a clear voice to the practitioners. Their words have been retained as far as possible in order to allow them to describe their understanding of clinical practice. While there are differences between practitioners, there is considerable agreement on such factors as the importance of treating the patient as an individual; considering a wide range of factors, both physiological and psychological, in the consultation; and attempting to find the root cause of the illness.

7.2 Diagnostic considerations

All respondents acknowledge that diagnosis in their clinical practice incorporates an understanding of a conventional (biomedical) approach based in pathology. Each respondent has some level of training in biomedicine, either from their initial training or included in the CPE (continuing professional education) requirements of their professional association; none uses purely traditional or intuitive approaches, although the importance of intuition is emphasised by some respondents. Referral of patients to medical practitioners for pathology tests or treatment is not unusual, and where patients have been medically diagnosed prior to the initial consultation, respondents state that they take account of the pathology with which a patient presents. Some respondents place a great deal of emphasis on biomedical understandings, while others find it less important, emphasising traditional or intuitive approaches to diagnosis and treatment.
Hannah’s approach is emphatic: she understands that Western diagnosis is a necessary part of her duty of care towards her patients. For her, a correct biomedical diagnosis is an ethical responsibility.

*From the point of view of Western pathophysiology I’d be thinking in terms of safety and making sure that I’d had all the pathology covered and that I had a good differential diagnosis and an understanding of what was going on.*

While this is not the sum total of Hannah’s approach to practice, it is a primary consideration in her patient assessment. She is trained as an ancillary health professional and as a practitioner of Traditional Chinese Medicine in addition to her training in naturopathy, and her practice reflects this broad range of skills and interests. Her bias towards having a clear biomedical understanding of each patient has facilitated – and is reinforced by – the high level of cross-referral with biomedical practitioners. She has spearheaded the development of this professional interaction between her clinic and the local biomedical community, and considers this to be an important part of her success as a practitioner.

At the other end of the spectrum in terms of emphasis on biomedical understandings is Grace, who does not regard biomedical diagnoses as central to her practice.

*In terms of diagnosis, philosophy is much more important than pathology… I like to have a pathological diagnosis but only if it sort of helps to clarify things, it’s not that important really.*

In this statement, Grace does not reject biomedical understandings, but preferences those based in traditional herbal (and in her case traditional naturopathic) philosophy. Such diagnoses include ‘toxicity’; ‘lymphatic congestion’; ‘acidity’; ‘stress’; ‘adrenal exhaustion’ as well as organ and system dysfunction. In addition, digestive dysfunction, including liver and bowel underactivity and overactivity, is of particular importance. Grace uses these concepts as central to her understanding of ‘what is going on’ with her
patients. Grace is well-respected within a small community which shares a common spiritual understanding, and where she is raising her children. She provides many of the primary healthcare needs of that group. This focus allows her to practice while being highly involved in her children’s lives, and those of the families in the community.

Greg has developed a different focus in his practice. He emphasises biomedical understanding – but for him physiology takes precedence over pathology in underpinning his clinical understanding.

*My thinking is very much based in physiology…not so much how the body works but where systems are going wrong. And that really ties in very beautifully with all the old channels of elimination and nutrition and drainage – you can explain all of that in physiology.*

Greg has a previous degree in exercise science, and his home practice complements his teaching which is increasingly in the area of nutrition.

These examples indicate that respondents combine biomedical understandings of disease processes with a range of diagnoses, which in turn reflect the contexts in which they practice, and their interests. Some emphasise physiological disturbance as a cause of disease, and understand this as characteristic of herbal practice. The phrase ‘physiological enhancement’ reflects an emphasis on stimulating health as well as treating disease. In complex cases, respondents indicate an intricate ‘knitting together’ of physiological inter-relationships. This is one of the ways in which they differentiate themselves from healthcare based in biomedicine.

### 7.2.2 Diagnostic tools

The major diagnostic tool used by practitioners is ‘taking the case’, which involves listening to a patient’s account of the problems they are experiencing. While this account is guided by the practitioner, respondents

---

17 This is not characteristic of all medical systems which use herbs: for example in the case of Mapuche people in Chile, the practitioner (machi) is expected to inform the patient of their
emphasise the importance of allowing the patient the time and space to tell
the story of their illness, or problem. In addition, physical examination and
iridology (see 2.2.3.2) are common tools used by practitioners to supplement
the information gained through case taking.

7.2.2.1 Case taking

Practitioners report that they encourage their patients to ‘tell their story’.
Grace describes what this involves, and her thought processes in ‘making
sense’ of the process. She attempts to relate symptoms to the patient’s
individual and family history, and to their current circumstances.

You’ve got their symptoms. If they have a number I say ‘Well what one prompted you
to come here today?’ When you do the case history then you find out all the other
things like medications they’ve taken, all past illness and disease and family weakness
and problems like that, and you have talked to them about their digestion, and then
when you’ve got all that information you can sit back and say to yourself ‘Alright,
what’s going on here?’ Do I think it’s related to some gastric infection and they’ve
had antibiotics that didn’t suit them? Or was there a big stress element here?

Thus for Grace, taking a case is comparable to solving a puzzle, to finding a
missing piece that makes the other parts of the story comprehensible. In order
to do this, she takes account of the range of factors that may impact on a
person’s life and health. Symptoms are seen as one aspect of a picture, which
is multi-factorial. Emphasis is put on narrative and the personal meaning
which these factors have for the patient. While the story is guided by
practitioner questioning, the patient’s experience of the disease is emphasised.

7.2.2.2 Other diagnostic procedures

Some respondents use physical examination as part of their diagnostic
procedure. Others use iridology which is used by the great majority of
Australian naturopaths and herbalists (Bensoussan et al., 2003). While there

problem without verbal input from the patient, and it would be a sign of extreme
incompetence for a machi to ask a patient to report their symptoms.
are different systems which are used to diagnose via the iris (Hall, 1980b; Jensen, 1989) within each the information allows an assessment of the condition of specific organs and tissues and their level of function or dysfunction. It is also understood to give information about inherited strengths and weaknesses. It is not necessarily used to make a diagnosis in biomedical terms.

7.2.3 Integrating the information

The process of combining biomedical and herbal diagnoses is not straightforward. In the following examples, practitioners discuss their individual approach to integration of the information they gather. Michael refers to the range of contributing factors to complex diseases, in this case cancer and asthma. Such involved diagnoses are common within herbal practice, where the emphasis can be upon the state of tissues, organs and systems which has allowed the symptoms to manifest.

Someone has a cancer and these are the considerations you know like detoxification, antioxidant, and liver status, digestive (function). You’ve got to reduce inflammation, you’ve got to improve detoxification, you’ve got to stimulate immunity you know so it is very much boom boom boom boom boom, these are major considerations. For asthma you might say well OK you’ve got a lung deficiency asthma, you’ve got a stress related asthma which may be more adrenal related, you know so you’ve got all these different syndromes that are part of one disease condition so it’s not just about lung tonics and bronchodilators.

The initial part of this example, concerning cancer, can be related to ‘terrain’ medicine by Bechamp, who considered that microbes would only flourish in unhealthy tissue and therefore it was the tissue, rather than the microbe, that should be treated when a person was ill (Duraffourd, 1995/6). Similar ideas were developed by 18th and 19th century herbalists, who considered the condition of the body more important than any disease (Haller, 1993). In this view, disease is an indication that the body, or ‘terrain’ requires treatment.
Restoring the body to good health will ensure that conditions are inappropriate for the continued presence of the disease, and it will disappear.

Phoebe described a process of intertwining aspects of natural medicine philosophy with a biomedical understanding, and moving between both forms of thought in her work with patients.

*I think about pathology, and looking at it from that Western perspective, with regard to inflammatory factors and the inflammatory cascade and all those sorts of things. But I think then once I have evaluated it that way I’ll switch over…to putting it into the natural medicine philosophy thinking that ok well there’s inflammation occurring here, how do we deal with that… I use the Western diagnosis model as a backup, as a bit of a, almost like a structure, but then overlaid that is the holistic structure.*

In this way Phoebe appears to be interpreting the patient’s symptoms in terms of processes of pathology and then re-interpreting the actions of plants, or dietary interventions, to counter those processes. For Hannah, who also trained in Traditional Chinese Medicine (TCM), the process is even more complex.

*I would run two sorts of diagnoses in my head at the same time, if not three or four. If I have a student sitting and I want to teach them the philosophy of Western herbal medicine then I will talk to them in terms of the humors and the temperaments and those sorts of things and what that means and how you select herbs on that basis and how you put a formula together on that basis. If I’m doing a Chinese diagnosis and using Chinese herbs then obviously I’ll do it along Chinese lines.*

This appears to be similar to a person being fluent in more than one language, and moving between them as appropriate. Hannah stated that she made decisions about which diagnosis to use on the grounds of ‘best fit’ for a particular patient at a particular time.
7.2.4 Finding the cause
Respondents differentiated between focussing on the alleviation of a patient’s symptoms, and using a more indirect approach, involving locating a deeper cause. Some practitioners call this treating what is ‘underneath’, and relate it to the ‘coming together’ of information which for many is the aim of the consultation. Greg discusses locating the ‘root cause’.

*I can apply herbal medicine symptomatically, that is someone may have say arthritis and I give them devil’s claw or whatever, celery seed, or whatever. I mean it’s not going to cure it… Or I could approach root cause and I’d say for instance that might be a dysbiosis, immune hypersensitivities, etc.*

This ‘root cause’ is understood in the context of assumptions about system or organ dysfunction, and it is often related to non-biomedical diagnostic categories. It is considered not only that the diagnosis and treatment of the ‘root cause’ will result in longer lasting success, but also that it may result in the disappearance of unrelated symptoms. To some practitioners, the discovery of the root cause is a distinctive feature of herbal practice.

*The beauty of it to me is when you can get a range of apparently disparate symptoms or signs or manifestations and look beyond all them and find the crux of it and one thing that you can treat or adjust that will flow on and effect all the others, that is what I love. (Grace)*

While treating the underlying physiological disturbance is seen as more likely to bring long-term benefits, than treating the pathology directly, it may not always be appropriate to treat patients in this way. Some respondents state that a more direct approach, for example the use of antibiotics, is an appropriate intervention on some occasions as it will achieve a more speedy result than a herbal treatment, as Charles explains.
If somebody comes with pneumonia I simply prefer antibiotics as the primary choice of treatment for a couple of days instead of treating them with myrrh\textsuperscript{18} for a week and their body will be so weak they will have to recover for 6 to 9 months\textsuperscript{19}.

From the material presented above, it is reasonable to generalise that Australian herbal practitioners do not exclude biomedicine, whether in terms of diagnosis or treatment. This finding is consistent with that of Bensoussan and Myers who questioned practitioners on their theoretical training in medical sciences and Western diagnosis. They found that the majority of practitioners felt they had been adequately prepared or well prepared in these aspects of practice. This indicates that practitioners are confident in these aspects of practice, and they are well integrated into naturopathic practice (Bensoussan et al., 2003). It is also consistent with the findings of the review of therapeutic articles in the Australian Journal of Medical Herbalism, described in 4.8.

### 7.3 Treatment considerations.

Respondents emphasised the individual nature of prescribing, and the importance of taking a broad range of factors into account in deciding on treatment. This general orientation in traditional health systems can be contrasted with biomedicine where statistics tend to prevail over individual differences.

#### 7.3.1 Individuality: The patient’s response to the illness

Respondents attach significance to the fact that patients with similar pathology may react to the disease process in quite different ways, demonstrating different symptoms as well as different severity of symptoms. For Flynn, this understanding is in the form of ‘guidelines that we are taught,’

\textsuperscript{18} Myrrh, \textit{Commiphora molmol}, is a herb used by herbalists for upper respiratory tract infections.

\textsuperscript{19} Here Charles reflects the view that antibiotics work more quickly than herbs in acute situations.
like how to recognise lymphatic congestion or how to decide on dose, that are passed on but made specific to individual patients’.

Hannah, on the other hand, understands these differences as indications of specific information about the patient’s health. She makes sense of them through recourse to ‘traditional’ interpretations of disease, and used them to suggest the need for differing interventions. Such assessments are incorporated alongside pathological understanding.

In the following example, she uses the diagnosis of hepatitis, but finds it inadequate to fully inform her treatment interventions. She uses ‘something more’, which in this case is an analysis of the symptoms in terms of hot and cold and wet and dry. This analysis was popularised by the work of the Roman physician Galen, and can be related to the ‘temperament’ of the herb. This analysis determines her choice of herbs.

You look at groups of symptoms and that gives you an understanding of hot cold moist dry those types of things and then that gives you an understanding of what to prescribe. The pathology is the pathology, but we all know those examples where you could have someone with hepatitis and they might be hot and wet, or hot and dry, or whatever.

In this example, Hannah has diagnosed the patient with hepatitis. Her treatment advice is influenced by this knowledge (‘the pathology is the pathology’) but it is not limited to this. She not only interprets hepatitis as a ‘hot’ disease (acute inflammatory diseases are seen as ‘hot’ in this system) but she also takes account of a range other symptoms which indicate to her that the disease in this individual can be described as ‘wet’ (for example characterised by excessive secretions) or ‘dry’ (characterised by a lack of secretions). Thus between the many possible combinations of herbs that may be appropriate for a patient with hepatitis, Hannah chooses specific herbs and other therapeutic interventions for a specific patient by including such considerations as whether the disease is ‘hot’ or ‘cold’ or ‘wet’ or ‘dry’.
7.3.2 Holism beyond physical considerations.
Phoebe, like other respondents, takes her analysis beyond a contrast between pathology and physiology. She is interested in more than the physical aspects of the individual’s health problems. She places importance on the physical, emotional, social and cultural aspects of life, which she synthesises. She collects a range of information about her patients, including social and cultural information. She feels that this is necessary in order to treat them effectively. She described her attempts in understanding the patient’s story

*I strive to have an understanding of the person on an emotional level, physical level, I need to know about their environment, what their current situation is, I like to know a lot about their family, their siblings, parents, because it’s all very important, all of it makes up the story of where they are, who they are.*

This indicates that to Phoebe, the patient’s personal life, the context in which they live, and in which they are experiencing sufficient dis-ease to visit a practitioner, are of clinical importance. Similarly, Christine develops a broad picture of her patients, and then uses this information to understand how their environment and attitudes impact on their physical health.

*I’m trying to get a picture of the person and the way they feel about their life, and how they approach their life and how all that is impacting on their health.*

Debbie takes this even further, and attempts to relate aspects of the individual’s life to their disease. She indicates that it is not only the patient’s disease which is important, but she looks for further connections between their individual circumstances and the specific manifestation of the disease. In this way, the holistic approach and the individual approach come together.

*...but very much trying to see why this person has got it (the complaint) as opposed to the other person, who may get a cold and it goes to their throat, well why has this gone to their chest.*
All of the respondents expressed the need to integrate a wide range of information in diagnosis. While overt references to holism were scarce, no practitioner resorted to reductive strategies or said that single causes of disease were ever adequate.

### 7.4 The place of philosophy

All accounts of clinical practice either explicitly or implicitly refer to philosophical discourses, as ‘medical epistemology cannot be separated from medical metaphysics’ (Tonelli and Callahan, quoted in Coulter, 2004, p. 109). Philosophical and cosmological beliefs provide meaning and explanation, and are generally part of the herbal discourse. Respondents are clear that herbal practice involves ‘something more’ than biomedicine and they state that the difference between herbal practice and biomedical practice is not fully explained by a difference in choice of therapy, i.e. herbs rather than pharmaceuticals. There is also concern at the poor articulation of an underlying philosophy of practice within the profession. Respondents characterise herbal approaches to underlying philosophy as individualistic and grounded in personal experience. Thus while respondents identify their practice as contributing a unique perspective, they have difficulty in articulating the ideas which inform this perspective. Thus there does not appear to be a formalised philosophical or theoretical framework for herbal practice. Further, a number of respondents recognise this absence of a clearly formulated philosophy as a problem.

In the absence of a well-articulated philosophy, each practitioner develops their own approach in clinical practice. Christine reflects that instruction in herbal philosophy is typically placed early in the curriculum of herbal training courses, and that for her, it became ‘lost’ within the subsequent focus on biomedical sciences. However this changed when she started clinical practice.
To be quite honest, by the time I had finished my training I think I had lost some of the philosophy, a little bit because you do that first...then you are just so overloaded with sciences. It was really just from the experience of being a practitioner that the philosophy came back to me more strongly over a period of time...and I think it influences me most, and influences my practice most...And you know I can use the science, and I really like all the scientific aspects but that’s not what people are.

However Betty remains unsatisfied with this aspect of her education. She was looking for a consideration of philosophy within her naturopathic training, but found instead a ‘lack of serious depth in philosophical inquiry’. She had previously trained in another branch of health sciences, and states

I actually went to study naturopathy because I was hoping to be shown how to comprehend the world differently from the purely rational thing and I think that is exactly what didn’t happen because I found there was fuzzy thinking which threw me back into the biomedical model which I would have liked to avoid. I found the fuzziness of it all really frustrating.

She too has developed her own approach to philosophy. She uses the idea of health being equated with balance, and relates it to the importance of homeostasis, or the maintenance of a ‘dynamic equilibrium’ in clinical practice. She also believes her exposure to Chinese and Indian philosophies of medicine ‘help me understand what Western herbal medicine had been saying in a very fuzzy sort of way’. This exposure has not been formal instruction in these systems of medicine, but has arisen from her use of a number of herbs from China and India which have been introduced onto the Australian market by herbal manufacturers over the last 20 years. Much of Betty’s understanding is based on information developed and provided by manufacturers in the promotion of these products. Based in phytochemical research and clinical trials, the information does not aim to foreground traditional Chinese or

---

20 As explained in Chapter 1, in Australia, the boundaries between naturopathy and herbal medicine are indistinct, and in terms of philosophy practitioners often did not differentiate between the two.
Indian philosophy. While on the one hand these manufacturers can be seen to be interpreting the uses of these remedies in a manner comprehensible to Western practitioners and patients, on the other there is an appearance of a lack of information from independent, non-commercial sources, about these introductions to the Western materia medica.

While some literature concerning Western herbal philosophy has recently been developed (Di Stefano, 2006; McCabe, 2000; Wood, 2000, 2004) the articulation of the philosophy of herbal medicine is not an area of extensive academic activity, particularly in comparison to developments in phytochemistry and the clinical applications of specific herbs for specific diseases. There is little focus on philosophical matters in journal articles or conference presentations, and no evidence of serious discussion of ways in which practitioners might integrate different approaches to treatment, the practicalities of holistic practice, or attempts to resolve the problems of issues of apparent inconsistency between vitalistic and biomedical approaches to treatment. More popular topics in conferences and journals are specific treatments of particular disorders, and model prescriptions for ‘what works’ in a particular disorder maintain their popularity.

In addition there does not seem to be a core canon of philosophical knowledge. There is little agreement among respondents as to the names of the significant authors or texts that contribute to their understanding of these aspects of herbal practice, and respondents with long experience as practitioners in particular found it difficult to name specific authors or books that were important influences on their work. This may indicate a level of integration and comfort with the ideas on the part of these practitioners, such that recourse to external authorities is unnecessary, however the fact remains that practitioners are not aware of the ways in which the philosophies which underpin their practices have been articulated. In a society as determinedly literate as our own, the absence of such established texts – or familiarity with
them – was of concern to some respondents, and consequently the rhetoric of the profession seems empty.

If I give a talk I always very busily tell people that “herbal medicine is holistic” and “herbal medicine is not just about using herbs to treat symptoms”. But in fact if I reflect where exactly my sources are then honestly, I wonder where they are. (Betty)

However for others, the core of herbal medicine can be expressed succinctly.

So it’s pretty basic, the philosophy of herbal medicine, you can sum it up in three sentences, you know, vital force, treat the whole person, use the whole herb. (Kylie)

This discussion has demonstrated that a range of positions are articulated by the respondents with regard to their understanding of their philosophy of practice. Some emphasise physiological processes, others use terms such as ‘imbalance’, which may be related to the maintenance of homeostasis. While some practitioners are influenced by specific systems of medicine others do not appear to formalise their philosophy into a specific system.

It is to be expected that concepts should be rearticulated as part of the continual reinterpretation of tradition, as the past is made relevant to the present. However clearly this articulation of basic concepts had not occurred to the satisfaction of these respondents, and in their view the philosophy underpinning their craft lacks substance. It was therefore of interest to explore basic ideas about this philosophy, fuzzy and inadequately expressed as it may be.

7.4.1 The role of vitalism

Vitalism is commonly listed among the characteristics of herbal medicine, either on its own or as part of the wider field of complementary and alternative medicine (CAM) (Coulter & Willis, 2004; Kerridge & McPhee, 2004; McCabe, 2000; Mills, 1991; Pitman, 2005; Saks, 1996; Wood, 2000). It is rejected by biomedicine, and understood as incompatible with it, as discussed in 4.6.1.
Respondents were questioned regarding their use of the concept of ‘vital force’ and the ways in which this was articulated and communicated within their profession, both during their training and during ongoing professional education. It is necessary to emphasise that this was not a discussion as to whether vital force ‘exists’, but rather refers to their opinion of its utility and applicability in a therapeutic context, i.e. the therapeutic application of the concept.

All respondents are familiar with the term. While for some, there appears to be reticence and discomfort in discussing it, for others it is central to their clinical practice, as Daniel who states that ‘The whole of naturopathic medicine revolves around vital force.’ He goes on to explain the direct clinical implications of vital force within his practice.

*You deplete your vital forces and if you don’t replenish it, if you don’t take time out to revitalise that well, you’ll get sick. There’s not enough energy, not enough chi to maintain the day-to-day running of each individual cell. When a cell gets sick, the first thing that gets sick is the vital force, the vital energy, and the resonance of that particular molecule.*

In this excerpt, Daniel equates chi, energy and ‘resonance’ with vital force. Other practitioners apply the concept of vital force to include the plants themselves, and understood plants to be imbued with or share a vital force. For these practitioners the growing and harvesting of medicinal plants, and the manufacturing processes used, are of concern.

*You start off with this plant that has a vital force, but how much does it have by the time you end up with this liquid in a bottle or these tablets in a jar? I don’t know how much vital force is still there.* (Christine)

Practitioners used the terms ‘vitality’, ‘vitalism’ and ‘vital force’ interchangeably. While this may lack a certain precision (see 4.6.1) it allows a flexibility which can be useful in practice. Phoebe uses the concept in her clinical practice, and tailors her description of it to the specific patient.
I describe it in many different ways, depending on the condition I am treating. If you are talking to someone about pregnancy you talk about the vitality of the egg and the sperm coming together and the DNA and all of that...but if you are talking to someone who has say, cancer, then you’re talking about rejuvenation of that vitality, building that, especially after they have had chemotherapy or radiation.

For these practitioners, the term has a range of meanings related to life and to energy. In order to further understand their use of this concept, they were asked for synonyms for the term ‘vital force’. They were not limited in the number of synonyms they could use.

The terms ‘energy’ and ‘vitality’ were the most commonly used among a wide range of words suggested by the respondents. Most of the other terms were used only once, i.e. by only one respondent. This indicates a low level of codification of the concept, and supports the assertion of respondents that this idea has been poorly articulated and remains, as it appears to have been in the past, a commonsense assumption, expressed in terms which are individual to each practitioner (Kaptchuk, 1996). I categorised the terms as indicated in the Table 7.1.

<table>
<thead>
<tr>
<th>Synonyms of vital force given by respondents</th>
<th>Categories (as developed by researcher)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy, vitality, chi, prana, resonance, brightness, fullness, viriditas, joie de vivre, potential</td>
<td>Vital force as energy and/or as an energy-giving force.</td>
</tr>
<tr>
<td>Reserve, physical &amp; mental strength, glue, threshold, capacity to react, susceptibility, immunity</td>
<td>Vital force as strength, and/or as a protective, defensive force</td>
</tr>
<tr>
<td>Unity, harmony, synergy of body mind and spirit</td>
<td>Vital force as an integrating, combining or coordinating impulse.</td>
</tr>
</tbody>
</table>

Table 7.1 Categories of synonyms for vital force used by practitioners.

There appeared to be three groups of words used to describe vital force. One group referred to vital force as energy, or an energy-giving force; a second group related to vital force as strength, or protection, and a third group...
related it to an integrating or coordinating facility. Respondents used synonyms from more than one category, so these are not ‘either/or’ categories, i.e. practitioners may understand vital force as both a source of energy and an integrating force. The categories of ideas are presented as an initial analysis of the way in which practitioners use this term.

After developing the categories in 7.1, the literature was again reviewed and it was found that terms used by practitioners can be related, to some extent, to different strands of traditional understanding of this concept, as expressed by herbalists in the past, and these are expressed in Table 7.2.

<table>
<thead>
<tr>
<th>Category</th>
<th>Association in literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital force as energy and/or as an energy-giving force.</td>
<td>To the animistic understanding of the world common in Europe prior to the scientific revolution (Sheldrake, 1990; Thomas, 1971), comparable to Galen’s pneuma, and Culpeper’s interpretation as related to the astrological significance of the Sun.</td>
</tr>
<tr>
<td>Vital force as strength, and/or as a protective, defensive force</td>
<td>Develops the understanding that vital force is located in the heart, to include the heart is strong ‘coer de Lion’ (Hillman, 1981; Tobyn, 1997)</td>
</tr>
<tr>
<td>Vital force as an integrating, combining or coordinating impulse</td>
<td>(Eclectics) see diseases as dis-regulation of the vital force, diagnosis as understanding these patterns: (Wood, 2000)</td>
</tr>
</tbody>
</table>

Table 7.2 Categories of synonyms for vital force, associated with historical periods.

The conception of vital force as energy, or an energy-giving force, is associated with an animistic understanding of the world, that is, an understanding of the world as if it is alive. Sheldrake (1990) argues for the centrality of such an understanding in pre-18th century Europe, as well as its more recent revival in the concept for example of Gaia. Culpeper, a notable 17th century herbalist who underpins much of his understanding of herbs

21 Culpeper says “The Vital spirit hath its residence in the heart, and is dispersed from it by the arteries, and is governed by the influence of the Sun...for as the Sun gives life, light, and motion to the Creation, so doth the heart to the body...’ (Culpeper, 1653/1995 p. 300).
and herbal treatment within the framework of medieval astrology, reflects a similar idea when he associates vitalism with the astrological symbolism of the Sun (Tobyn, 1997).

The overlap between these categories is demonstrated in the literature as well as in the synonyms suggested by the respondents. Culpeper expresses the ancient understanding that the vital force is located in the heart (Tobyn, 1997) and Hillman (1981) associates this idea with strength – a strong heart is a Lion’s heart. The use of the term ‘immunity’ as related to vitalism conveys the resilience with which practitioners associate vitality.

The idea of vital force as an integrating force is reflected in the Eclectic literature, in which disease is understood as the dysregulation of vital force. In this school of thought, vital force is seen as an integrating or coordinating impulse, and the aim of treatment is to return the vital force to normality, or health (Wood, 2000).

When questioned, respondents described themselves as ‘spiritual’, but not religious. This spiritual orientation provides an important context for understanding the nuances and meanings herbalists use of the word ‘vital force’. Individuals may not enter into in-depth discussions, and some may show reticence to discuss it at all, but the assumption is that vital force is real, universal and part of the naturopathic world of clinical experience. Vital force may take on other shades of meaning, but there is a strong consensual understanding of this idea that is clinically and practically based.

### 7.5 Conclusion

This chapter has outlined diagnostic and other considerations in clinical practice as well as perspectives on the underlying philosophy of this practice. The focus of the interview questions is to enquire into the extent to which, and the ways in which, Australian herbalists are able to combine traditional understandings and philosophies with those of biomedicine. Of particular
interest are the ways in which practitioners viewed their own practice, and the extent to which they understand practice as being informed by both biomedicine and tradition, and the ways in which integration of the two approaches might be achieved. That is, the interviews set out to explore some assumptions of Australian herbal practice.

With regard to their approach to clinical diagnosis, practitioners state that they use biomedical concepts, and they also use other perspectives alongside this. In some cases their understanding of disease is based in biomedicine, but in others practitioners emphasise diagnosis in terms of ‘physiological disturbance’, and this may involve consideration of the inter-relationships between organs, systems and symptoms. In other cases, diagnosis may be associated with the location of a ‘root cause’ of the disease or problem. In yet other situations, practitioners may use humoral philosophy or physiomedicalism, or be influenced by Traditional Chinese Medicine. Practitioners agree that a major diagnostic tool is the taking of the case, and considerable emphasis is placed on allowing a detailed account, or story, to be given by the patient.

In treatment, practitioners emphasise the differences between patients rather than their similarities, in order to take account of each person’s individuality. Some practitioners emphasise the importance of tailoring treatment to the individual by acknowledging differences in response to a similar disease, while other practitioners emphasise the importance of gathering a wide range of information about their patients and integrating this into their assessment and advice. This data relates to both physical and non-physical aspects of disease.

No respondents describe the philosophical underpinnings of herbal practice as well-articulated, and instead it was indicated that herbal and naturopathic approaches appear to be individually reinterpreted by practitioners rather than being shared and clearly articulated philosophical ideals. However in
questioning practitioners regarding the idea of vitalism, a concept found in herbal and naturopathic philosophy but discounted in biomedicine, all practitioners were familiar with it and many of them claimed to use it in practice. Practitioners provided a wide range of synonyms for this term. These were grouped in categories which were in turn associated with perspectives on vitalism well developed in the literature. This indicates that while practitioners may be unaware of a literature which formalises a philosophical basis to practice, its practical application, at least in this study, has not disappeared from practice.

Overall, respondents found traditional principles of disease categorisation largely compatible with their understanding of physiology. Although these principles are defined and discussed here, it is emphasised that clinical practice and cosmology – philosophy and practice - can only be separated analytically and do not reflect the everyday thought processes of practitioners. Further, the practical application of this philosophy appears to be highly context-dependent and patient specific.

While there is evidence here that herbal practice is informed by a philosophical/spiritual perspective, this appears to be largely private to the practitioner rather than one which is overtly shared with the patient. In addition, there were no identified forums for where these topics were discussed with peers.

In the next chapter, I move away from the reflections of practitioners on their work to an examination of their position within Australian society. These findings deal broadly with political and economic realities and their attempts to move towards legitimation, after a history of harassment and marginalisation.
It is April 1982 and I am attending the National Institute of Medical Herbalists annual conference in Buxton, Derbyshire. I have travelled by train with another student herbalist. In a plenary session, in a small hall, with rows of chairs facing the front, discussion centres on the role of science in the education of herbalists. An older herbalist makes an impassioned speech. He reminds us that the essence of herbal medicine is that as herbalists we use plants which are alive to treat people who are alive, and it is the life force of the plants which supports the life force of our patients.

This is the first time I have heard a practitioner speak of the importance of vitalism to clinical practice. There is something riveting about his conviction regarding the interconnection between people and plants. Vitalism is not theoretical to him, it is real. His practice involves treating life with life.
CHAPTER 8 THE PROCESS OF TRANSITION

8.1 Introduction

The material presented in Chapter 7 focused on practitioner reflections on herbal practice, and demonstrates that while respondents are able to identify characteristics of their practice, the contemporary application of its underlying philosophy appears to be largely uncodified. That is, there is little evidence of a common philosophical basis underpinning the approach of herbalists to their clinical practice. The current chapter moves from practitioner reflections on clinical practice to consider their perspectives with regard to the broader environment within which they practice. Respondents indicate that herbal medicine is changing and developing, and they express attitudes to these changes and developments which range from enthusiasm to concern and resignation. It is not only that there are differences between respondents with regard to the changes occurring, but also some respondents report that they experience conflicting emotions: both positivity about the changes occurring and concern at the implications of these changes.

Two inter-related influences are identified here as affecting the direction of herbal medicine. The first is the development of a scientific and biomedical approach to practice as a basis for legitimation, including the gains and losses, advantages and disadvantages, of this move. The second is the influence of herbal manufacturing companies on CWHM which is demonstrated in the following three ways: a) the availability of specific herbs to practitioners and the public, b) the types of preparations of herbal products which are available, and c) the information which is used to promote the use of those products, particularly through practitioner education seminars. These two broad influences form the discussion in the first part of the chapter.

The identification of these influences is accompanied by practitioner references to a profession ‘on the move’. Images of movement, of progress, of
moving forward, are part of the respondents’ discourse. Issues of legitimacy and credibility are embedded in discourses around the need for a scientific basis for herbal practice. Along with valuing science for its own sake and responding to patient demands, the need for increased communication with medical practitioners is identified as influential in the move towards a scientific basis for herbal medicine. This leads to a number of questions – where are herbalists moving from? How have issues of legitimation and the relationship with biomedicine arisen? Why are they problematic? In order to answer these questions, aspects of the history of CWHM will be explored, and documentation of this history forms the second part of the chapter.

8.2 The role of science in herbal medicine

Respondents are clear that herbal practice should encompass biomedical sciences, but also reflect that inclusion of scientific rationale for herbal practice is necessary for herbal medicine to be accepted within contemporary Australian healthcare. Pressure ‘to make herbal medicine credible’ is not associated with biomedicine or the scientific community per se, but rather is described as coming from themselves, their patients, and from their professional community. A scientific basis to herbal medicine is seen by respondents as beneficial to their practice and deepening their understanding of patients and plants, and by being necessary for herbal medicine to become part of mainstream healthcare.

This emphasis on science is grounded in and reinforced by the emphasis on biomedical sciences and chemistry within training courses in herbal medicine, in line with the education of other health practitioners (McCabe, 2005). The inclusion of these subjects is accepted by respondents, and they expressed a range of views on its appropriate emphasis: the fact that herbal medicine is becoming more scientific is described as ‘brilliant’ by Flynn, and Christine says she ‘can use the science, and I really like all the scientific aspects’. However Anna is concerned about an over-emphasis on its importance: ‘it is science,
science, science for credibility all the time, you know we have to make it credible, we have to make it OK’. Sarah, a new practitioner, is satisfied with the balance of information presented in her training course, and says ‘you get the science; you get the philosophy you get all of it put together as a well-rounded package’.

8.2.1 Advantages
The importance of a scientific emphasis is described in both personal and professional terms. Debbie wants personally ‘to feel validated in the world of science’. However the need for a strong scientific basis for herbal practice is also explained in terms of patient expectations. Respondents are well aware that their clinical practice is dependent on a high level of patient satisfaction both with the treatment they offer, and with practitioner-patient interaction, as Kylie indicates.

If I see someone who’s been on IVF for seven years and they’ve spend $20,000 and they’re familiar with all the pathology, I’ve got to know what they know otherwise they think, I’m dealing with a witchdoctor.22

Such comments should be seen in the context that consultations with herbal practitioners are private medicine, and do not receive state support in the form of state funded rebates, as are available for biomedical treatments. Limited rebates for herbal and naturopathic consultations are available from some private health insurance schemes as part of a more expensive ‘extras’ cover. In addition, herbal products do not receive government subsidies comparable to those available in respect of many pharmaceuticals23. Thus herbal treatment, both in terms of the cost of the herbal consultation and the cost of the herbal medicine prescribed, involves considerable out-of-pocket expenses for patients, and therefore restricted to those with a relatively high disposable income (MacLennan et al., 2006).

22 Assistance with fertility for couples having difficulty conceiving or carrying a baby to full term is a relatively common area of herbal treatment. The reference to ‘$20,000’ refers to the hefty out-of-pocket expenses incurred for patients who seek biomedical treatments for these problems.

23 The Pharmaceutical Benefits Scheme (PBS) provides Commonwealth funding to make a range of pharmaceuticals more affordable for individual patients.
8.2.2 Disadvantages
Some respondents acknowledge pressure from the other parts of the herbal community to be increasingly science based, as reflected in Daniel’s experience of continuing professional education (CPE) seminars.

Practitioner (seminars) are all integrated pharmacology, advanced nutrition, advanced herbs, those sort of thing, and they are really research based... Energy isn’t acknowledged.

Here, he refers to the topics and style of presentations at practitioner seminars. In his view, these seminars introduce new knowledge such as a more developed understanding of the connection between plant constituents and their actions, as provided to some extent by phytochemistry, and the relationship between the administration of plant extracts and clinical outcomes, as provided to some extent by EBM. However, other ways of knowing – such as employing the notion of ‘energy’ are not discussed.

Gemma would like a more holistic view of disease expressed, including a greater emphasis on the use of a range of interventions in the treatment of disease.

Practitioner seminars seem to focus exclusively on the physicality of illness and how do we use specific herbs to treat specific illnesses...(rather than) more of the holistic approach and what other practitioners are doing and how they’re using the various modalities in combination.

Phoebe would also prefer to ‘get back to basics’, and to re-assess the principles of treatment, as ‘we need practitioners and people who still come back to those basic principles and remind us again and again that nothing’s changed’. In a similar vein, Anna would like to ‘let the body heal and you know just to leave it at that but...we’re not allowed to do that’.

This indicates that the development of the new knowledge base also involves ‘loss’ of some types of knowledge as others are given preference (see 3.5),
although this has attracted little discussion within the literature (Singer & Fisher, 2007). Perhaps this is an assumption that ‘progress’ is a linear voyage towards better times. However some practitioners express concern that the reinterpretation of herbal medicine as a science may lead to a loss of the unique contribution of herbal medicine to healthcare. Betty is concerned that developing an understanding of herbs as being similar to drugs is problematic.

*I think it means we are becoming far too close to the pharmaceutical model and we’re going to lose ourselves because they do those things much better than we do. We have to produce complements of care or alternates of care but we must not become the same as them. We are different from that model and we have to strengthen that difference, otherwise we are lost.*

Debbie worries about the consequences to the profession of an over-emphasis on science, which she sees as possibly including a loss of professional identity.

*The science is brilliant, it really is, but I think that a lot of the essence of being a good herbalist is knowing about vitality how to use that and it’s that the herb is greater than the sum total of its constituents. I worry that if we’re just learning the chemistry of herbs and we’re teaching it to doctors in weekend courses, where are we? I think that we’ve got to come back to our philosophy and know that really well, to be able to put that forward. Whereas at the moment I think we’ve got a foot in both camps, and not necessarily doing either of them very well.*

Any reservations to the introduction of biomedical sciences and chemistry as the basis for herbal practice appear to be not so much that practitioners want to turn back the clock, but rather they express that there may be ‘more to the story’ than can be expressed from a scientific perspective. Flynn, while enthusiastic about using science as part of his understanding of his craft, is also concerned about the consequences of ‘being scientific’.

*Now it is all lost on one level, you look (at) Kerry Bone’s book Principles and Practice (of Phytotherapy) - it (herbal medicine) has just become science unfortunately. That’s*
the nature of where it’s going because people want that validation of what our medicines do but they (the herbs) do more than that.

Flynn goes on to discuss the ways in which herbs ‘do more’ and indicates a perspective that while herbal medicine may be used to alleviate a symptom, it may also be used to address a problem which is understood to come from an organ or system dysfunction, something ‘deeper’.

It (practice) is about the herb rather than the science, because we know one herb will work on three different systems. So when we pop in a herb for this particular symptom of the body, it may not be a causative factor or it may be the exacerbating factor that is aggravating it. So I like to move a bit deeper in the body if I can, without pushing it all through that little scientific notch.

In this comment, Flynn expresses concern that ‘the science’ excludes important information required for herbal practice, and he resists ‘pushing’ his understanding about the herb ‘through that little scientific notch’.

In summary, respondents are welcoming of the fact that the knowledge base of herbal medicine is being reconstructed, ‘becoming more scientific’. They appreciate this expansion of the knowledge base for its own sake, and for the ability it gives them to explain their work to their patients. They indicate that an emphasis on science is evident both in their initial training courses and also in seminars they attend as part of continuing professional education. They understand this emphasis as allowing for a closer relationship with mainstream healthcare, particularly medical practitioners. However some practitioners express concern regarding an over-emphasis on science at the expense of other aspects of herbal practice. These practitioners want to employ science and utilise its contribution and perspective for its own sake, but they do not want to be constrained by limiting their understanding to only those aspects of herbal practice which are scientifically verified. They want to retain the ‘something more’, contributed by herbal practice and by each herb individually.
8.3 The role of herbal manufacturers

As discussed in 2.3, the medicinal plants used by Australian herbalists are botanically ‘exotic’, i.e. not native to Australia. Practitioners do not use local plants in their clinical practice. Given this, and in the absence of an Australian herb growing industry able to supply the local market at competitive prices, the overwhelming majority of medicinal plants used here are imported either as raw materials or as finished products. This means that Australian practitioners are fully dependent on herbal importers and herbal manufacturers for access to their remedies. This emphasises the influence of herbal manufacturers in directing market demand, particularly through their educational programs, as the distinction between practitioner education and product promotion is not always clear.

In the interviews carried out for this project, respondents were not asked about the influence of manufacturer, but they themselves initiated concern on two counts. The first relates to the influence of the manufacturers in determining the type and quality of herbal medicines available to practitioners and to the public, and secondly their influence on the knowledge base of herbal medicine via the development of ‘industry seminars’ as the major source of continuing education for practitioners.

8.3.1 Herbal products today

As discussed in 3.4, a range of commercial interests have contributed to a move away from simple herbal extracts to more sophisticated herbal formulations. The type of herbal medicines available from manufacturers, both for practitioners to use and for the general public to buy over-the-counter (OTC), has developed from simple herbal teas and low-technology macerations of herbs in a mixture of alcohol and water, to sophisticated manufacture of highly complex herbal preparations which are more concentrated than any herbal medicines have been in the past.
In the following quotes Charles and Greg highlight the potential of side-effects for these new products, and raise the issue that traditional literature is being used to support the claims for the safety and efficacy of these products.

Charles suggests that

*The interactions between herbs and drugs will become important in the future not because of the herbalists but because of the availability of the herbal substances over the counter are in much higher doses. You never heard about the side-effects of St Johns Wort until we got the Hypericum 7000 in one tablet.*

Greg is also concerned regarding the concentration of herbal products

*There are many different forms (of herbal medicines) coming on the market as in concentrated extracts, which have been never really taken in that sort of concentration, spray dried extracts – extremely concentrated… they are being flogged over the counter and the traditional literature is being cited (with regard to safety and efficacy) and it just doesn’t apply. I think that is pretty scary. It is inevitable that there will be adverse reactions and drug interactions, and of course we could end up losing them.*

Greg’s concern relates to the development of side-effects and symptoms of toxicity as well as interactions with pharmaceuticals, consequent to ingestion of concentrated extracts. Such concentrated extracts are not discussed in the traditional literature as they are only recently developed, and are not traditional forms of preparation. This is clearly of concern with regard to patient safety. However Greg’s comment that ‘we could end up losing them’ is related to the regulation of herbal products through the Standard for the Uniform Scheduling of Drugs and Poisons (SUSDP).

The regulation of ‘risk’ in relation to herbal products via their inclusion in SUSDP is discussed in 3.5.4. Problems associated with one herbal product, not
associated with processes of manufacture\textsuperscript{24}, are usually extrapolated to include concern with all products containing that herb, rather than that specific product or range of products\textsuperscript{25}. Thus if a particular product including herb X is shown to cause problems in a particular patient, or group of patients, it is that herb in all its forms which is likely to be targeted in terms of negative publicity and possible inclusion in the SUSDP\textsuperscript{26}. Thus Greg refers to the fact that herbs can be prepared by manufacturers in higher concentration than they have used traditionally, sold to the general public and any negative consequences related to that product puts at risk all supplies of that herb to herbalists. Ironically, in such a situation the availability of a herb may well be restricted to, for example, pharmacists or medical practitioners – who are rarely trained in its use.

Daniel makes a slightly different point with regard to OTC preparations. He suggests that the actual products used today are newly introduced.

\textit{A lot of what we used to practice was historical. Whereas a lot of stuff now isn’t historical. We have never heard of these products before. We don’t know where the information comes from, apart from the manufacturers.}

A final concern with regard to the use of OTC medications is raised by Charles. He has noticed people who ‘get colds 25 times a year’, self-prescribe Echinacea because, as he says, tongue in cheek ‘everybody knows that Echinacea is good for you’. If this is not the appropriate treatment, it is the system of medicine, not the individual instance, which is considered a failure. As

\textsuperscript{24} That is, as long as the problem of the product is seen to be a problem associated with the herb, and not a problem of misidentification, or associated with problems in the manufacturing processes of the product.

\textsuperscript{25} In Australia, these exceptions are the use of comfrey (\textit{Symphytum officinale}) for external use when internal use of the plant is prohibited, and the use of kava (\textit{Piper methysticum}) in the form of water-based extracts when other forms of use are prohibited. In the case of both of these herbs, the problems (in the former extrapolated from laboratory findings on rats) occurred using concentrations of the herb which are of a magnitude far in excess of those ever used by practitioners.

\textsuperscript{26} In Australia, herbalists are not legally differentiated from the general public. Therefore if a herb is considered inappropriate for over the counter (OTC) sales, it is unavailable to herbalists. See Chapter 1 for further discussion of statutory regulation.
Charles says, a poor result from an inappropriate herb leads to the individual thinking ‘herbal medicine is ineffective’. In his experience only ‘some (people) are wise enough to come and see a herbalist’ to ensure individualised treatment which he believes is more successful: ‘when they see it is working they stick to it’.

### 8.3.2 Manufacturing knowledge

Continuing professional education is part of the professional life of herbal practitioners, and one of the common ways for practitioners to fulfil these hours is through attendance at seminars (Bensoussan et al., 2003). When manufacturers are also the source of information about therapeutic products, conflicts of interest are at least apparent, if not real. Respondents view the line between product promotion and patient education as often blurred, and also crossed. Daniel says

*Seminars are predominantly product related. The (professional) associations don’t put on a lot of seminars. The herbal association (NHAA) puts on good seminars, the rest of them are put on by companies and they’re really shocking seminars. … Everything’s ‘let’s get something that absorbs better faster’ and ‘look this is the one component and let’s highly concentrate it and forget all the other synergistic factors’ within the whole herb or mineral or whatever it may be. And it is all to sell more product.*

Apart from the association of product with the information presented, Daniel expresses another concern here. The influence of manufacturers on the development of knowledge of plants appears to be largely through the domination of herbal manufacturers as providers of continuing professional education (CPE). Practitioners are required by their professional associations to accrue a certain number of CPE points each year in order to maintain their professional membership. While there are a variety of ways to accrue these points, many practitioners utilise industry-sponsored practitioner seminars.

---

27 See for example [http://www.nhaa.org.au](http://www.nhaa.org.au) for the requirements of the National Herbalists Association of Australia in this regard. CPE points may be accrued by undertaking not only by conference attendance but also by undertaking further formal study, research,
as a time-effective and cost-effective way to fulfil this obligation. While this can be seen as a service by the industry to the profession, concern was raised that educational seminars should not be closely aligned with purely product promotion. Flynn suggests there is a further agenda with regard to the information provided by manufacturers, and this relates to herbal dosage.

You know there is this attitude - give 'em herbs. You know, bump em up. 60 (mls) in 100 (ml weekly dose), that is really a lot of herb. And the cynical part of me says – well is that the herbal company and their presentations in all those seminars? Sorry. Yeah but it’s true – they tell us to use 40ml of Withania in a bottle and show us research which is always based on high doses – now I have had great results on drop doses of Withania. It’s a powerful herb, a powerful medicine. If it’s indicated, why do you need so much?

8.4 Legitimacy lost: a retrospective

A recurring theme among respondents is that of movement: they state they are moving towards a more mainstream and legitimate position within Australian healthcare, associated with increased communication with medical practitioners. This gives rise to a further series of questions – if herbal medicine is on the move, where is it moving from? What has the position of herbalists been in the past? Why is ‘going forward’ associated with a stronger relationship with medical practitioners, and how does this effect herbal practice?

In their discussion of herbal practice, none of the respondents use the term ‘marginalised’, or express the view that they are engaged in a process of ‘legitimation’, although Grace refers to the disparities between the two systems in that

---

28. 40 mls a week would equate to almost 6 mls a day. Flynn’s reference to ‘drop doses’ indicates that he has used doses of under 20 drops (about 1ml), which, if taken three times daily, would equate to less than 3 mls daily, less than half the dose recommended by the manufacturers.
herbal medicine is not sort of given the same opportunities and chance and support as orthodox medicine in terms of access to things like Medicare, hospitals, education.

In addition there is a strong sense of change and movement within the interviews. For example Debbie talked about the need to use a biomedical framework

...out of respect for the industry and going forward...we have to learn all the science

Christine agrees, and associates this with medical practitioners.

I think the reason we have to have a better understanding of the pathology is because more and more we are working with medical practitioners and that’s the level you relate to them on...and that’s fantastic, that’s where we want to be heading, that’s where the future is, but it means we have to be able to talk to them in their terms.

Daniel associates the focus on scientific research in seminars with the move in the profession for mainstreaming, as ‘they are wanting to get us to be able to talk on terms with doctors’.

Respondents reflect a range of views regarding the attitude of medical practitioners towards their work. Phoebe speaks of those patients who have ‘gone to their GP (to discuss their herbal treatment) and they’ve said ‘oh that’s rubbish, you might as well just throw your money down the toilet’. However Charles sees the medical interest in herbal medicine as stimulating phytochemical research because as ‘the doctors (are) starting to be interested in herbal medicine they ask what is in there? and why is it active?’

At the very least, as Debbie says, ‘when I have to talk to doctors it is good to be able to speak on that level’.

Anna states that ‘we have to make it (naturopathy) credible’, and while she would often prefer to ‘let the body heal and to leave it at that’ she feels this is not an option because ‘we have a responsibility now, we can’t’. It is unclear from this
whether this is a reference to the way in which she practices or the way she describes her practice.

These statements indicate that respondents understand herbal medicine to be changing, and that this movement makes new demands on practitioners. As stated previously, the practitioners do not overtly talk about legitimation, but this imagery is of movement, particularly in reference to the relationship between herbal medicine and biomedicine. As described in 6.3, this observation led to further research in an attempt to understand the significance for practitioners of this movement towards legitimacy.

The absence of secondary literature regarding the position of Australian herbalists prior to the 1970s led to an exploration of the ways in which biomedicine in Australia established its dominance, in particular the role of legislation in establishing a medical monopoly. This exploration revealed the contested nature of this legislation and the attempts by herbalists and their supporters to maintain the viability of herbal practice. In this section I describe the process by which Australian herbal medicine lost its legitimacy as an accepted approach to healing and became an increasingly marginalised practice from the mid 19th century, a process which was reversed in the latter years of the 20th century. Far from herbal practice appearing fully formed, Athena-like, in the late 20th century as part of a ‘New Age’ or countercultural impulse, this account demonstrates that herbalists have been actively attempting to protect and promote herbal medicine for at least a century.

The systematic exclusion of herbalists from legislation that affected their practice parallels a systematic privileging of biomedicine. Here, a history of the political activity of herbalists at the time of the introduction of statutory regulation of biomedicine in Victoria is constructed. In addition, a high-profile example of the harassment directed towards herbalists in NSW in the 1950s is documented, and it is compared to an account of workplace harassment given by one of the respondents in the interviews. These are
examples of the ways in which legislative marginalisation of practitioners are reinforced by social means.

This is a discussion of the move from medical pluralism in 19th century Australia to a medical monopoly in 20th century Australia, and a demonstration of the ways in which the marginalisation of herbalists was maintained. This history is indicative rather than comprehensive, and has been constructed in the absence of other accounts which focus on the experience of Australian herbalists. It serves as a demonstration of the legal basis for the marginalisation of herbalists and the relationship between this process and biomedical dominance. This history has contemporary application. Today (2008), statutory recognition of Western herbalists is again mooted subsequent to the release of the LaTrobe Report in 2005 (Chapter 1) and I argue that an understanding of the struggles for recognition during the last 150 years gives new poignancy and meaning to the current debate.

**8.4.1 Initiating marginalisation**

Registration of health practitioners is a responsibility of individual states under the Australian Constitution, so historical accounts of legislation affecting herbalists must take into account the complexity introduced by state differences. In this account, the legislative fate of herbal medicine vis-a-vis biomedicine is documented during the period 1862-1910 in Victoria, and substantiates the claim that herbal medicine moved to a position of professional marginalisation during that period. This is not an account of the ways in which previous generations of herbalists practiced or the ‘success’ or otherwise of herbal practice. Rather, it provides evidence that Australian herbalists and their supporters attempted to maintain herbal medicine as an independent approach to medical practice by organised political activity over many decades. For this reason, the historical account of legislation presented here is not only concerned with bills passed, but also with bills withdrawn in apparent response to outside pressures, including that of herbalists. It is not the intention in this research to reconstruct all pressures brought to bear on
the introduction or withdrawal of particular medical legislation: merely to
demonstrate that herbalists were among those who frequently supported or
objected to the passage of specific pieces of legislation which they perceived
as advantageous or detrimental to their interests.

An examination of the debates around the introduction of medical legislation
(as recorded in Hansard and by herbalists of that time) in the state of Victoria
between 1856 and 1920 shows that practitioner groups of herbalists were
highly organised, and actively resisted legislative changes which they
considered would negatively impact on their ability to provide a herbal
medicine to their patients. It also begins to account for their political
vicissitudes during the first half of the 20th century.

8.4.1.1 The implications of a biomedical monopoly

Until the mid 19th century medical practice in Australia can be described as
pluralistic (see 2.3). The transformation from medical pluralism to the
monopoly of one approach to medicine (biomedicine) was a gradual process
which occurred over many years. Battles over the legitimacy of particular
groups and practices of medicine increased in intensity as practitioners
attempted to define and organise themselves, and to gain advantages vis-à-vis
other groups (Willis, 1989).

All regulation establishes boundaries, with an ‘in-group’ who receive certain
advantages in exchange for their compliance with requirements including
educational standards, and an ‘out-group’ which is not so bound, but also
does not receive advantages. The number of ‘non-scientific’ or ‘irregular’
practitioners had increased between 1830 and 1890 29. In discussing Ludwig
Bruck’s 1886 Australasian Medical Directory and Handbook, and its
appendix, the List of Unregistered Practitioners, Martyr emphasises that
many of the 257 people included in the list (242 men and 15 women) were
clearly well respected members of society – some were clergymen or had

29 Irregular practitioners included herbalists, homeopaths, hydropaths, phrenologists and
magnetists (Martyr, 1998).
worked for the government, others were Justices of the Peace, and one had been Mayor of Wood’s Point, Victoria (Martyr, 1998). While ‘regular’ medicine was striving for exclusive rights to practice medicine, this had not yet occurred, and neither were irregular practitioners marginalised as they would be in later years.

The image of the quack in nineteenth century writing is of the fly-by-night practitioner, who slips out of town in the dead of night, having defrauded dozens of their money, or one who, in a city, would leave an office suddenly deserted and boarded up. Yet from Bruck’s own List, it can be seen that in fact a great many of these practitioners had long careers, which presupposes satisfied customers, or a lack of registered competition (Martyr, 1998).

Many of these practitioners appear to have enjoyed the respect of their community and their popularity was sufficient to allow some initial success in defending their practice rights during the late 19th century (Martyr, 1998). At this time, herbalists appear to be maintaining their position within healthcare. Far from being absent in the debate about medical registration, they were consistent in attempting to maintain their practice rights. However they were unable to challenge the ascent of biomedicine after the early years of the 20th century, and the tide turned to the benefit of the regulars (Willis, 1989)

The systematic awarding of privileges to biomedical practitioners meant that, over time, herbalists became disadvantaged relative to those practitioners. For example, early advantages granted registered medical practitioners but not shared by unregistered practitioners were the right to sign death certificates, and the right to sue for recovery of fees. An examination of parliamentary and other records with the state of Victoria reveal that the process of biomedicine claiming ascendency over other medical disciplines was contested particularly by herbalists and homeopaths and their supporters. The process of statutory regulation of medicine, and the privileging of the group that has
come to be known as ‘medical practitioners’ was achieved over many years via the piecemeal introduction of privileges and responsibilities. In a number of instances, legislators were insufficiently convinced of the public benefit that would result from the mooted changes, and the bills which would have given advantages to medical practitioners were rejected or withdrawn.

A summary of the bills affecting herbalists which were introduced into Victorian State Parliament between 1856-1905 is shown in Table 8.1. This was the period of greatest legislative activity establishing the practice of registered medicine, allowing specific rights to registered practitioners (Willis, 1989).

This table shows that the move from medical pluralism to biomedical dominance: that is, to restrict medical practice to registered medical doctors, which began in the mid 19th century, was gradual and contested. The first bills gave minimal (from today’s standpoint) advantages to doctors. The introduction of medical registration was initially controversial, with some groups wanting to restrict medical practice to registered practitioners, and others wanting to retain different approaches to medical practice. Herbalists vigorously contested the developing discrimination against their practice at this time.

In 1856, the year that the Victorian Parliament was established, a bill was introduced which required registration of all medical practitioners. It lapsed after concerns were raised as to its effect on ‘free trade in physic’ (Parliamentary Debates, 1858 Mr Greeve p. 424), and it was replaced in 1862 by the Medical Practitioners Act. Significantly, this bill did not ban unregistered practitioners, but instead it gave advantages to registered practitioners (Parliamentary Debates, 1862). Some members of Victorian state parliament did not agree with advantaging one group of medical practitioners over another,
<table>
<thead>
<tr>
<th>Date and Name</th>
<th>Aim</th>
<th>Comments on parliamentary debate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1856 Medical Practitioners' Bill</td>
<td>To require registration of medical practitioners</td>
<td>Bill lapsed after vigorous debate on the effect this would have on ‘free trade in physic’ (<em>Parliamentary Debates</em>, 1858 Mr Greeves p. 434)</td>
</tr>
<tr>
<td>1862 Medical Practitioners Act</td>
<td>Protection of title: uncertified practitioners unable to use medical titles. No ban on unregistered practice.</td>
<td>Concern expressed re discrimination against herbalists &amp; homeopaths (<em>Parliamentary Debates</em>, 1862 Mr Berry p. 1271)</td>
</tr>
<tr>
<td>1878 Medical Practitioners Statute Amendment Bill</td>
<td>Private Member’s bill introduced to extend medical registration to practitioners without formal qualifications but with 15 years experience.</td>
<td>lapsed: Medical Board retained authority to register practitioners. (<em>Parliamentary Debates</em>, 1878 p. 1383-1385)</td>
</tr>
<tr>
<td>1905 (August) A Bill to Amend Part 1 of the Medical Act 1890; 1905 (December) (No 2) A Bill to amend the law relating to Medical Practitioners.</td>
<td>Attempt to ban unregistered practitioners from ‘rendering to any other person any surgical or medical aid whatsoever’ (Clause 6:1 (b)</td>
<td>Correspondence between Secretary, Australian Union of Herbalists to Chief Secretary of Victoria asking for removal of specific clause (Secretary &amp; Herbalists, 1905). Clause was removed in the second iteration of the legislation, but the entire Bill was subsequently withdrawn.</td>
</tr>
</tbody>
</table>

Table 8.1 Victorian medical legislation effecting herbal practice: 1856-1905
although in the comment below the speaker clearly did not have a great deal of respect for any group of medical practitioners, suggesting that this bill was intended

..to give the exclusive privilege of quartering and killing to a class who were at least equalled by others whom it was endeavoured to prevent from practising (Parliamentary Debates, 1862 Mr Woods p. 1339).

Peter Lalor echoed these sentiments; questioning whose interests the bill served.

Mr Lalor remarked that the hon. member who had introduced the bill had said that it would be beneficial to surgeons and physicians but he had not proved that it would be beneficial to the public (Parliamentary Debates, 1862 Mr Lalor p. 608).

Over the next 50 years, the registration of medical practitioners was the subject of competing pressures: in 1878 there was an unsuccessful attempt, through a private members bill, to deregulate medical practice to some extent by allowing practitioners who had no qualifications but at least fifteen years of practice, to be registered. Among the arguments against the bill was the statement that if this had passed 'It would enable even a Chinese doctor to be registered' (Parliamentary Debates, 1878 Mr LL Smith p. 1385). Whether the concern expressed here was an expression of racism against the Chinese, or of a concern about the system of medicine they used, is unclear\textsuperscript{30}.

Fourteen years later, in 1892, a bill was introduced which again attempted to ban unregistered practice (Parliamentary Debates, 1892). This was vigorously opposed, with a number of parliamentarians speaking in defence of the rights of herbalists to continue to practice, and giving examples of the benefit they brought the community. Herbalists continued to lobby to defend their

\textsuperscript{30} Pensabene (1980, p. 17) suggests that in 1873 European mistrust of Chinese medicine prevented the registration of the first Chinese-trained doctor to apply, and that no Chinese-trained doctor was registered in Victoria until 1970.
practice, and for example were active in collecting signatures for petitions. The *Australasian Journal of Botanic Medicine Practitioners and Journal of Botanic Medicine Practitioners of Australasia* outlined the importance of defeating this legislation in its first issue.

We are happy to say that the petition against the proposed new Medical Act is being numerously signed. We are not surprised at this when we consider the thousands of men, women and children who have benefitted by the herbal system in the colonies ("Medical Act," 1889).

The petition was presented to Victorian State Parliament with 4-5,000 signatures (*Parliamentary Debates*, 1892 Hon JA Wallace p, 1398). It calls for an end to the ‘medical monopoly’ and requests a royal commission into the efficacy of various types of medicines (*Covering Letter, Petition re Medical Practitioners Bill* 1892). A copy of this covering letter has been accessed through the Public Records Office of Victoria (PROV), and is included in Appendix 4.

The requests contained in this petition are as follows

1. that there be an end of the ‘legalised monopoly’ and ‘State patronage’ of one system of medicine over other systems, and that all systems be awarded the same recognition and privileges by the State

2. that the petitioners be allowed to continue their ‘rights as British subjects’ to choose whatever system of medicine they wish

3. that the Medical Council be reconstituted as a popularly elected body

4. that a Royal Commission be held into ‘these matters’.
While the requests contained in this petition were not granted, herbalists and other non-registered practitioners retained the right to practice. The issue of unregistered medical practice was revisited in August 1905, when a further bill ("A Bill to amend Part 1 of the Medical Act 1890," 1905) was introduced which included a clause to remove the right of unregistered practitioners to prescribe or dispense medicines, or to ‘render to any other person any surgical or medical aid whatsoever’. That is, it aimed to ban unregistered medical practice. The records of PROV show that the Secretary of the Australian Union of Herbalists (AUH) wrote to the Chief Secretary of Victoria in November of 1905 to ask for the withdrawal of Clause 6, a clause problematic to herbalists (Secretary & Herbalists, 1905). An amended bill, excluding these clauses ("(No 2) A Bill to amend the law relating to Medical Practitioners," 1905), was introduced in December 1905, but it was withdrawn before it was considered by Parliament. While other influences may well have been brought to bear on the drafting of this bill, the fact remains that the request of the AUH’s secretary was granted.

In summary, parliamentarians clearly saw herbal medicine as legitimate in its own right, and supported the maintenance of ‘free trade in physic’. Parliamentary discussions, as reported in Hansard in Victoria at least, consistently indicated that legislators were consistently concerned for the rights of the minority medical professions, in particular herbalists and homeopaths, and for the right of the public to have access to their services. The petition of 1892 echoes these sentiments, asking Parliament to ‘abolish State patronage to any one system of medicine’ and to ‘emancipate the public from the medical monopoly’ (Covering Letter, Petition re Medical Practitioners Bill 1892).

In this initial phase, from the mid 19th century until the early 20th century, the rights of herbalists were repeatedly discussed in Parliament and widely supported, as attested by the 1892 petition. The process of marginalisation, and loss of power, appears to have been well remarked upon. However
during the early decades of the 20th century, the tide turned and the medical monopoly became more of a reality, and the influence of the alternative practitioners waned.

Brown (1979) and Pensabene (1980) suggest that the eventual ascendency of biomedicine over its alternatives involve more than simply the acceptance of science as the basis for medical practice. Brown’s (1979) analysis of the rise of biomedicine in the US includes consideration of the relationship between capitalism and biomedicine, and he argues that a congruence of class interests was beneficial in the development of a biomedical monopoly. Pensabene’s (1980) interest focuses on the detail of the ways in which biomedical practitioners managed their public relations in Victoria in the early 20th century, as part of a program which successfully engaged public sympathy. This program included doctors becoming involved in issues around public sanitation; the introduction of a school-based medical inspection system which gave children from low-income families access to medical care; and the introduction of baby health clinics (infant welfare centres). These authors indicate that while developments in biomedical science may have played a significant part in public acceptance of the biomedical monopoly, other influences also played their part.

8.4.1.2 Struggles for survival: 1920s-1960s

By the 1920s biomedicine had made significant progress in its attempts to establish its privileged position with regard to provision of healthcare (Pensabene, 1980; Willis, 1989). Herbalists had lost the popularity and influence they had enjoyed in the late 19th and early 20th centuries. Public support in the form of petitions, and parliamentary support as found in the Parliamentary Debates, was no longer evident by the end of the 1920s. This indicates that their exclusion had by this stage became more entrenched, the debate about it silenced.
The archives of the National Herbalists Association of New South Wales indicate that during the 1920s political activity continued, with correspondence between itself and groups of herbalists in all states, mostly regarding legislative concerns. Items of correspondence refer to defensive activity on the part of the herbalists, opposing legislation, or putting their case to various Ministers where they understand that proposed legislation may negatively impact on their work (see Appendix 5). National conferences of herbalists were also held at this time, and while details of these are sketchy, archival correspondence indicates that one focus of discussion was on common political concerns.

Two major campaigns were carried out during the 1920s, one of which was successful and one unsuccessful. Firstly, in Victoria, an attack on practice rights of herbalists was successfully defended in 1925. In that year, a bill to amend the Pharmaceutical Chemists’ Act was introduced into the Victorian Parliament and, if passed, it would have restricted the dispensing of herbs to pharmacists only. The bill was defeated, after intensive lobbying by a combined group of Western and Chinese herbalists (Bentley, 2005; Loh, 1998). Bentley (2005) suggests that at this time there was not only public support but ‘support and quite possibly patronage from a higher level of society than is generally considered to be the preserve of herbalism.’ In particular he suggests that Louisa Eggleston, wife of the then Attorney General, Frederick Eggleston, and friend of the Prime Minister, Alfred Deakin, was a prominent supporter, along with church leaders, activists and lawyers who were interested in a range of social reforms. However subsequent to this campaign archival material regarding the political organised activity of herbalists is largely absent.

In 1929, herbalists in New South Wales were able to persuade a member of state parliament, RJ Stuart Robinson, to move to introduce a private member’s bill to allow for statutory registration of herbalists. Robinson was unable to instigate debate on the bill, or to marshal the required support from his
parliamentary colleagues, and it lapsed (Parliamentary Debates, Questions and Answers, 1929 Mr Stuart-Robinson p. 3225).

Apart from these examples, there is little evidence of political campaigns involving herbalists in the ensuing decades, but there is evidence of their continued existence as practitioners. Martyr (2002) has collated Post Office records between 1924 and 1940 for Queensland, Western Australia, New South Wales (NSW) and Victoria to establish the numbers of practitioners during that period. In NSW the number of herbalists ranged from a high of 89 in 1925 to a low of 57 in 1940. In Victoria, the numbers were lower: the greatest number of herbalists listed was 61 in 1925 and the lowest was 37 in 1935. Martyr suggests that herbalists may have a diversity of cultural backgrounds, most often Chinese and Anglo-Celtic. For example, of the 61 herbalists in Victoria in 1925, 12 had Asian surnames, and all of these practiced in Melbourne (Martyr, 2002).

Correspondence in the NHAA archives indicates continuing concern with the legality of herbal practice during this time. The legality of practice appears to have been of continuing concern to Australian herbalists. Since its inception in 1920, the NHAA has sought opinions from Queen’s Counsel on four occasions – in 1927, 1930, 1932 and 1982, regarding the legality of the practice of its members. These requests indicate that there have been serious concerns on the part of the Association as to whether or not the practice of herbal medicine, or specific activities of practitioners, were legal, and whether practitioners may be inadvertently acting in ways that could make them liable for prosecution for their professional activities. Most recently in 1982 an opinion was sought as to whether practitioners may be guilty of practising as unregistered medical practitioners. Mr Cassidy, QC (1982), was of the opinion that a herbal practitioner (as practiced in 1982) ‘is not acting as a medical practitioner and does not commit an offence by not being registered as such’. A copy of the solicitor’s questions and barrister’s opinion are included as Appendices 6 and 7.
Whatever their concerns about their precarious position, herbal practitioners not only maintained their own businesses, but they also performed community service and were concerned to ensure the continuation of the profession by training students. For example, during the 1950s the National Herbalists Association of New South Wales ran a free herbal clinic and hospital in the Sydney CBD near Hyde Park for the ‘poor and indigent sick’. It was registered under the Charitable Institutions Act of NSW, and also was used as a training facility for students of herbal medicine, where they could learn not only to diagnose and treat but also ‘to process and dispense herbal medicines’ (Wheeler, 1982). While little details are available regarding this Clinic, the fact is that it was established during these difficult years.

8.4.2 Sustaining marginalisation
A range of techniques of harassment employed by British medical practitioners towards non-orthodox practitioners are outlined by Saks (2003) in Chapter 3. These include engaging in violent verbal attacks, using their influence to deny state recognition for herbalists, and criticising unorthodox practitioners in their journals. While it is not the intention here to outline the extent or range of incidents of harassment experienced by Australian herbalists, two examples are presented here to demonstrate the ways in which herbalists continue to be challenged in their attempts to practice their craft. These examples are separated by fifty years. One was very public, and ended up in the Supreme Court of NSW in 1956, and the other was a more private and recent experience of a practitioner in clinical practice.

8.4.2.2 Harassment then: Truth newspaper’s campaign
A high profile case of harassment of NSW herbalists occurred during the 1950s, when an unsuccessful campaign was run by the sensationalist Truth newspaper to outlaw non-biomedical practice. Charles Noakes was President of the NHAA in November 1954 when he was one of seven non-registered

31 In 1952 the National Herbalists Associations of New South Wales changed its name to the National Herbalists Association of Australia.
practitioners to be the subjects of an expose in the *Truth*. Noakes subsequently successfully sued *Truth and Sportsman* Ltd for defamation.

From 1947-1956 the *Truth* weekly newspaper carried out a campaign that attempted to persuade the NSW State Government to ban unregistered medical practice. The *Truth* published a series of newspaper articles and editorials to this end, a number of which were carried in November 1954. On the 7th November, under the banner ‘Quacks must be quelled’, the *Truth* stated

> At long last, the State Government looks like it might yet act to put out of business the many heartless medical quacks who are battening in on the sick and gullible.

On November 21 1954. the *Truth* called on the State Government to close down a ‘scheming impostor…quack charlatan and fraud’ who was practising in Macquarie Street. A week later, it did a more full-blown expose, entitled ‘It’s time the Government quelled the greedy quacks’. The journalist Frank Broome (1954) stated

> The Government has at last turned its attention to the medical quacks and charlatans *Truth* has been exposing since 1947 – greedy ghouls, who batten on the sick and in the most callous and unscrupulous of all rackets.

Among the ‘ghouls’ it went on to detail were the then President of the National Herbalists Association of Australia, Charles Noakes, and its Secretary, Gilbert Wheeler. Noakes was described as a ‘psychic who ‘diagnoses’ his patients without asking a question or making an examination’. It was said of Wheeler that he was a ‘self-styled magician, spiritualist and bone specialist’. Both were accused of having ‘phoney medical degrees’.
This was not the first time *Truth* had exposed them, the article reported. Wheeler had been ‘exposed’ in March 1947 and Noakes in February 1949. Despite this, said the *Truth*, ‘they are still there’ (Broome, 1954).

After the publication of this article, Noakes sued the Truth and Sportsman for defamation, a case which he won after an eleven-day trial in the Supreme Court of New South Wales. The *Daily Telegraph* and *Sydney Morning Herald* of November 7 1956 carried stories of the case, which referred to the financial hardship this had caused Noakes, and the detrimental effect the article had had on his business. Expert witnesses were called for the defence, and the *Sydney Morning Herald* reports that

Medical evidence was given that the herbs Noakes prescribed had no medicinal value (SMH 7.11.1956).

Whether the individual supplying the medical expertise had any specific knowledge or experience with the use of medicinal plants is unknown, but unlikely given the attitudes of medical practitioners towards herbal medicine at that time (see 2.4.3).

The court found for the plaintiff, Noakes, and while this may seem a victory for the herbalists, the story, as communicated within the NHAA is related as a cautionary tale. Lindsey Shume, at that time a young herbalist who had just joined the NHAA, remembers this as a scandal, spoken of in whispers among the older members (pers. comm. 18-5-06). Charles Noakes had taken *Truth* to court on behalf of his fellow herbalists, and as a consequence he suffered great personal and professional hardship. If the press would attack the most successful and influential herbalists in Sydney, Charles Noakes, President and Gilbert Wheeler, Secretary of the herbalists’ association, no-one was safe; this was encouragement for others to keep a low profile (pers. comm. Robyn Kirby, past President NHAA, 8-1-05).
No papers or press clippings concerning the Noakes case were found in the NHAA archives. However within a document written 25 years later, a solicitor’s brief to a barrister requesting an opinion regarding the legality of herbal practice, reference is made to it. This solicitor’s brief also included a newspaper article about it in its background papers (Appendix 6). In addition, the response from the barrister makes brief reference to the case (Appendix 7). The absence of details provided in these documents further indicates a level of assumed knowledge, and that the audience for whom this document was written – the office-bearers of the NHAA – were still aware of the case. While Noakes’ trial occurred in 1956, it had not been forgotten by 1982. No other herbalist or case is mentioned by name in these documents.

The Noakes case is an example of serious and ongoing harassment, and also indicates that the history of herbal medicine in Australia – particularly its painful history – is poorly recorded, and the archives are incomplete. Correspondence in the NHAA archives at the time indicates the ongoing concerns of herbalists about the vulnerability of their professional position, but the Truth’s campaign, and the Noakes case, are conspicuously absent.

8.4.2.1 Harassment now: getting in the way of practice

For one respondent in this study, the issue of acceptance and legitimation was of immediate importance. Sarah was working in a state-funded women’s residential facility, where she works with a range of health professionals.

_The manager of the whole unit is very supportive of what we’re doing. Their pharmacy bill is huge, absolutely phenomenal…since the advent of naturopathy women are starting to request to come off their pain medication, for some of them their symptoms are like 20% of what they were._

However a resident doctor is unhappy at her participation, which she believes is associated with a fear _‘that if the pharmacy bill comes down his position might be in doubt’_. She goes on to describe his attitude towards her.
He doesn’t talk to me, he tried to turn the nurses against me. He spent a weekend gathering information from websites sponsored by (pharmaceutical companies) Fauldings and Roche saying that herbal medicine doesn’t work and what’s more causes hypoglycaemia in patients. He called a meeting with the nurses and said that we were going to have an epidemic on our hands in the centre.

Sarah has been in practice only a couple of years, and had been very excited to become part of this project, with the opportunities it offered to work as part of a team to provide a range of healthcare choices for patients. While she believes that there may be big problems ahead, her approach is to ‘lay low’.

*I suspect it will be quite an explosive thing but I am just sort of laying low and burrowing away.*

The mechanisms of harassment by medical practitioners towards non-medical practitioners have been described in Chapter 3 and above. In this case, the medical practitioner is using information to ‘define normative boundaries’, and is clearly attempting to limit the extent to which the other health professionals in the clinic interact with the respondent.

**8.6 Conclusion**

Respondents see herbal practice as changing, mainstreaming, and that the development of a scientific base for practice is part of that process. However they also recognise that these changes involve loss: and some practitioners worry that the aspects which are being lost are important, even fundamental, to practice. Practitioners want to maintain a scientific basis to their craft but they want to maintain their difference: they raise a concern that mainstreaming involves a loss of identity. Further concern was raised about the role of manufacturers in these developments, both in terms of their influence within the continuing professional development of practitioners, and in the type of products being brought on to the market.

Given the changes that practitioners discussed, questions arose as to the previous state of the profession. It was found that while the history of
medicine is well documented, very little has been written about the history of herbal medicine. As ‘privilege nurtures blindness toward those without the same privilege’ (Varas, 2005, p. 196) conventional histories of medicine do not include the experience of those professional groups disempowered by the activities of the medical professions. The work involved in this thesis has been to begin a process of establishing a history of herbal medicine as part of the broader field of the history of medicine in Australia.

It is not an aim of this research to provide a comprehensive account of the steps which led to the dominance of biomedicine, but rather to document the resistance of herbalists to aspects of that process, and to show the process by which herbal medicine became marginalised. As described in Chapters 2 and 3, biomedicine was not easily established over its competitors, and took more than 50 years and multiple pieces of legislation for ‘free trade in physic’ to disappear, and for biomedicine’s monopoly on medical practices to become a reality. The current research suggests that its most active competitors were herbalists and homeopaths and demonstrates that the herbalists vigorously defended their approaches to practice. It also suggests that the legislative marginalisation was followed by incidents of harassment which have not disappeared today.
It is 1977 and I have begun studying herbal medicine in the UK. The spectre of the EU looms over British herbalists. Professional ‘harmonisation’ between the countries of the European community is mooted. This will involve the introduction of legislation to allow free movement of professionals to work in any member country. This is of grave concern for British herbalists as in most European countries the practice of herbal medicine is severely restricted, if allowed at all, only to those with medical qualifications. In the face of possible loss of livelihood, British herbalists decide to undertake a major overhaul of herbal education, and put it on a scientific footing. This decision is being implemented at the same time that a tremendous upsurge in public interest in herbal medicine has begun – the herbal ‘boom’. During my third year, a prominent English herbalist, Simon Mills, puts together the first subject in herbal pharmacology, and it is received with great enthusiasm as we glimpse for the first time the possibilities of explaining our remedies in ways that will be accepted by sceptics. We are also required to complete a difficult and outdated subject in the Philosophy and Practice of Herbal Medicine. Unpopular with all, it becomes increasingly irrelevant, is not rewritten or updated, and is dropped from the curriculum a few years later. The energy and enthusiasm surrounding the new pharmacology course is in stark contrast to the neglect of the philosophy course. Are there no herbal philosophers?
CHAPTER 9 DIRECTIONS IN CWHM

9.1 Introduction

Herbal medicine is adapting to take advantage of the opportunities provided by its resurgent popularity and in this way it is an example of a living tradition growing and adapting. Ossified traditions do not change. The reinterpretation of herbal medicine to both serve and reflect the health needs of 21st century Australia is an involved process, which changes and develops both the knowledge base and clinical practice. The decisions taken by herbalists in respect to the way these changes occur will effect the future of CWHM.

Two historical factors are of relevance. Firstly Western herbal medicine in Australia originated as an imported tradition, a colonial practice. Herbalists are culturally connected to, but ecologically disconnected from, the plants they use. Knowledge regarding the habitat and use of individual plants, and their appropriate application in specific conditions was developed in the context of another country on the other side of the world. Secondly there is a long history of marginalisation of Western herbal medicine in Australia. This is associated with professional harassment and exclusion, and has contributed to poor economic returns for herbalists. These factors have led to a low level of development of the institutions and culture of Australian herbalists, and a consequent lack of professional confidence. These factors effect the ability of herbalists to articulate and therefore defend their contribution to healthcare and to respond appropriately to the opportunities and demands brought about by the sudden increase in public popularity of their medicines.

In this chapter, the work of Gross (1992) on the cultural location of traditions has been used as framework within which to understand the position and pressures effecting CWHM. In Chapter 5, the ideas of professionalisation and the various forms of marginalisation were discussed. There, Gross’ (1992)
model of the cultural locations of existing traditions (Table 5.1) was considered along with issues of professionalisation and marginalisation. When this discussion is combined with the findings outlined in Chapters 7 and 8, a framework is created within which to analyse the challenges faced by herbalists, and to speculate on the possible consequences of their choices.

9.2 Legacies of history

9.2.1 Colonisation
Western herbal medicine in Australia originated in Europe. It is a cultural practice which developed in relation to one continent and climate and was exported to another continent and climate. One consequence of this is that Australian practitioners are dependent on cultivated or imported plants for their materia medica, rather than depending on local plants for their supplies. These factors mean that CWHM does not have a strong connection with the Australian landscape.

As a result, much of the knowledge of appropriate cultivation, habitat and patterns of growth of medicinal plants which was developed in Europe does not fit the Australian situation. The varying ways in which imported (‘exotic’) medicinal plants have adapted to the new environment demonstrates this point. Some plants which are medicinal weeds in Europe struggle to survive here, for example coltsfoot *Tussilago farfara*32, a lung tonic; while other medicinal plants, cultivated in Europe, become noxious weeds here, for example St John’s Wort *Hypericum perforatum*33 and white horehound *Marrubrium vulgare*. This ‘lack of fit’ between imported (European) traditional knowledge regarding medicinal plants and local (Australian) experience was

---

32 Colt’sfoot also happens to be a scheduled poison here, due to its pyrrolizidine alkaloid content. It is generally known among herbalists as a remarkably safe plant when used in traditional doses.

33 The issue regarding difference in medicinal activity of plants grown in different locations, which may be linked to different concentrations of active constituents, is also acknowledged but beyond the scope of this thesis.
not commented upon by the herbalists interviewed for this project, and is not discussed in any depth or detail in the herbal literature.

Traditional knowledge of medicinal plants does not occur in isolation. In the case of Western herbal medicine, it has developed over centuries through its contribution to health restoration and maintenance. It is culturally embedded in foods, festivals and daily life – the festivals and daily life of Europe.

An example may illustrate this point. The reversal of seasons from the northern hemisphere to the southern hemisphere means that the (European) midwinter festival of Christmas is held in midsummer in Australia. The warming foods, drinks and activities (e.g. the use of spices such as ginger and cinnamon in food for internal warmth and the centrality of the yule log to provide external warmth) can be understood as broadly therapeutic practices to assist individuals to maintain their health through a cold winter. In Australia, such practices are unnecessary in December, in the middle of an often scorching summer, and their emulation can be uncomfortable if not detrimental to health. “A Christmas roast with all the trimmings” is inappropriate in searing summer temperatures, not to mention the problems of lighting fires in a bushfire-prone environment and season. Christmas in Australia, after more than 200 years of European settlement, is still celebrated close to the summer solstice and to some extent the rituals of the festival itself have been changed to suit this climate. It is a cultural practice which serves as an example of the disjunction which occurs when European customs are imported into a completely different climate and land.

While issues of ‘lack of fit’ were not discussed in the interviews, they underpin CWHM in Australia, and are raised here as a factors intrinsic to the experience of Australian herbalists.
9.2.2 Marginalisation and low level of professional resources

CWHM is not only a colonial practice; it is also a practice which became marginalised in Australian society in the early years of the 20th century. The reality for herbal practitioners in Australia today is that their acceptance as full partners in the provisions of Australian healthcare remains a dream. While the effect of colonisation is not commented upon by respondents, issues around marginalisation are much closer to the surface. As discussed in Chapter 8, Grace discussed the imbalance in opportunities available to herbalists in comparison to those available to other healthcare practitioners. Phoebe expressed concern that medical practitioners tell her patients that their herbal treatments are ‘rubbish’. However the picture is complex and many factors are likely to have contributed to the current state.

The marginalisation experienced by herbalists for most of the 20th century meant that their professional resources were severely limited. In addition, practitioners were involved in longstanding fights for their professional survival, due to the regularity of the appearance of legislation which appeared to threaten their legal right to practice. Thus energy and resources to establish and maintain fundamental professional infrastructure of, for example, educational courses, conferences and journals, were diverted to issues of professional survival. With perhaps the exception of the establishing of the Free Clinic in Sydney in the 1950s, there appears to have been neither time nor resources available for professional activity, let alone reflection and the development of a scholarly culture during this time.

Consequently, the demands in recent decades to underpin the knowledge base with science, to go ‘head to head’ and prove the efficacy of herbal medicine to the scientific community, was undertaken from a low base, with little professional support or infrastructure. Today, there are very few practitioners acting as spokespeople for the profession, or presenting a public face for herbal medicine: it is ‘holistic doctors’ who are usually consulted on matters which concern herbal medicine (McCabe, 2005). Practitioners struggle
to maintain their minimal representation on government committees such as the Complementary Medicines Evaluation Committee, and at mainstream conferences where again, complementary medicine is often represented by holistic doctors. Research agendas reflect the interests and needs of manufacturers rather than those of practitioners as evidenced by the paucity of non-product herbal research, such as research into non-commercial therapeutic interventions and whole practice research. In combination, these factors meant that there is little development and articulation of a unique identity for CWHM.

The legacy of a professional history of exclusion and harassment, as well as a lack of confidence associated with a lack of robust professional culture and strong academic tradition within herbal medicine, has thus left its mark on the herbal profession today.

9.3 Opportunities and choices for herbalists.

Opportunities arose for herbalists in the closing years of the 20th century and the early years of the 21st century with the dramatic increase in popular uptake of herbal medicine, and this has been described in Chapter 3. These opportunities have required practitioners to make choices with regard to the future directions of the profession. In this thesis, Gross’ (1992) analysis of the location of traditions in modern (non-traditional) societies has been used to contribute to an understanding of the types of choices available, and their costs and benefits. This is summarised in Table 9.1.

In this table, each of these categories is related to an aspect of CWHM. The first two locations – close to the centre and at the margins – are most reflective of the position of Australian herbalists. The difficulties associated with the first location (at the centre) being the ability of the group to maintain its own identity and integrity. Those associated with the second (at the margins)
<table>
<thead>
<tr>
<th>Gross’ location of surviving traditions</th>
<th>Nomenclature associated with herbal practice in this location</th>
<th>Challenges for herbalists in this location</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the centre (professional)</td>
<td>Integrated medicine, complementary medicine</td>
<td>Maintaining integrity close to power, especially maintaining control over knowledge base.</td>
</tr>
<tr>
<td>At the margins ('other')</td>
<td>Alternative medicine</td>
<td>Small, localised clientele who share similar world view with regard to health.</td>
</tr>
<tr>
<td>In the cracks and interstices of social existence (invisible)</td>
<td>Domestic medicine. Arguably being replaced by commodified, over-the-counter (OTC) preparations</td>
<td>Home treatments do not contribute to GDP, so are not ‘seen’ in the national accounts. OTC herbal products highly profitable and highly regulated.</td>
</tr>
<tr>
<td>Underground: persecution, civil disobedience. (The political history of CWHM includes threats to ban practice. To be a practitioner or patient in these circumstances is to engage in acts of civil disobedience).</td>
<td>Quackery.</td>
<td>Difficulties with authorities and the State. Practice becomes illegal.</td>
</tr>
</tbody>
</table>

Table 9.1 Gross’ (1992) locations of traditions applied to herbal medicine. See also 4.2 and 4.3.
include the limitation of the group’s relevance to a localised clientele which shares its world view. Respondents indicate their desire to establish a place ‘close to power’ and to provide services to a broad community, although their professional rivals resist this. The interviews revealed that herbalists see themselves as moving from the margins (‘alternative medicine’) to a more mainstream (central) location.

The third cultural locations of traditions in contemporary society discussed by Gross (1992) - the ‘cracks and interstices’ is not developed from consideration of the position of domestic medicine and the rise of commodified self-care is undertaken. The transformation of self-care and home care by the rise of the OTC market in herbal medicine is related to the rise of a powerful natural medicines industry, and is of concern to respondents. Discussion of this point was oblique, as the focus of the interviews was issues around clinical practice.

The fourth and final of Gross’ (1992) categories, arises from an examination of the historical record and represents the great fear of herbalists. It was fought against during much of the 20th century. Being forced underground is an extreme form of marginalisation, and connections are made with the 20th century experiences of herbalists of harassment and persecution. Recent suggestions that the use of complementary medicine in children can be understood as a form of child abuse (MacLennan et al., 2002) and that herbal practice should be banned unless it is supported by a strong body of clinical evidence, as from RCTs (Guo et al., 2007), indicate that this threat has not completely disappeared.

**9.3.1 At the centre: professionalisation and integration**

Respondents in this project, all of whom are in clinical practice – from which they derive part, if not all, of their income - do not talk about overthrowing or transforming biomedicine, but rather of finding ways to practice alongside it. They aim to place themselves in Gross’ (1992) terms, close to the ‘centre’ of medical power in Australian society. Gross (1992) suggests the problems
associated with this cultural location for a tradition are likely to centre on the maintenance of the integrity of the tradition. In this instance some respondents are ambivalent regarding the changes required of them, and the challenges to maintain their distinctive approach to clinical practice. Anna regrets not being able to use herbs to ‘let the body heal and leave it at that’, and Betty is concerned that by ‘becoming too close to the pharmaceutical model’ she and her colleagues will ‘lose ourselves.’

Respondents acknowledge that herbal practice is becoming increasingly product and symptom focussed, with practitioners moving away from a reliance on interventions which aimed at restoring health to one where the focus is on alleviating symptoms. This change can be related to the fact that Australian herbal medicine has become increasingly aligned with medical science. The medical perception characteristic to biomedicine, the ‘gaze’ described by Foucault (1963), focuses on the commonalities between cases of physical symptoms and allows for the development of a particular perception of disease within which pathology plays a dominant role.

The decision to locate ‘close to power’ effects many aspects of CWHM, including education, philosophy and the manufacture of herbal products, as well as the relationship of herbal medicine to the idea of risk. These aspects are discussed below.

9.3.1.1 Education

Most respondents have attained awards in health science, either as their initial practitioner qualification, or in the case of some of the more experienced practitioners whose initial training was completed as long as decades ago, as an upgrade qualification. This disciplinary placement reflects a political decision to join with existing health providers, rather than attempting to establish a new model of health delivery.

The location of herbal medicine within health science, rather than for example in social science, potentially alongside counsellors, psychologists and social
workers, means that the content and methodologies of science, rather than the content and methodologies of social sciences, are seen to provide appropriate training for modern Australian herbalists. High status herbal courses argue their academic rigour by a reference to a strong focus on medical science, and all training courses exclude subjects which address the social context of disease (McCabe, 2005). Respondents in this study all accepted the importance of science to the practice of herbal medicine although some felt its influence was excessive.

However they continue to insist that they do ‘more than’ biomedicine, and this difference is a source of pride and identity. In the descriptions of practice provided within this project, practitioners put great emphasis on the influence of social context on the health of their patients, and they also claimed to ‘think differently’ about the causes of health and disease. However the future of both of these aspects of practice must be questioned given that neither is currently formally taught. The more that the education of herbalists mirrors that of other healthcare professionals, the less possible it will become for herbalists to develop an individual approach or philosophy of healing, or to maintain a sense of ‘thinking differently’.

### 9.1.1.2 Philosophy

A well articulated philosophy would appear to be central to ‘thinking differently’. However respondents had difficulty in articulating the philosophical basis of their practice, and claimed that this area of study is de-emphasised within both undergraduate education and continuing professional education. Despite this, a number of practitioners indicate that philosophy underpins the difference between herbal medicine and biomedicine.

As mentioned above, herbalists are located within the broad discipline are of health sciences. Undergraduate instruction in biomedical sciences for herbalists and naturopaths appears to be well-developed and well-resourced,
while instruction in philosophy and social sciences appears to be scant or absent. While respondents make reference to some philosophy being taught in the early part of their training, development of the ideas presented there ‘gets lost’ during the later years, according to Christine. This is despite the fact that, as she says, philosophy allows an understanding of ‘what people are’. Nor is philosophy discussed in seminars associated with continuing professional education. Thus the process of applying philosophical principles to clinical practice appears to rely on personal and individual efforts, rather than being shared with other practitioners.

Of further concern is the fact that the concept of vitalism, which is understood by many respondents to be a central tenet of herbal practice, is rejected by science. Comments indicating that it is no longer an accepted idea can be found in, for example, chemistry textbooks used by herbal and naturopathic students (see Hart, Craine, Hart & Hadad, 2007). This is not a disagreement regarding a minor theoretical point. As has been discussed in 4.6.3, the application of the principle of vitalism to clinical practice leads to specific understandings of the therapeutic encounter as well as a therapeutically conservative approach to practice. Therefore its rejection within one part of the discipline is not only problematic due to inconsistencies which arise between areas of study, but it has implications for clinical practice.

Further, respondents indicate that the connection between vitalism and contemporary herbal practice is poorly articulated. They are unable to identify a developed academic discourse which describes the philosophy of herbal practice and the practical application of its principles. This absence combined with the problems of rejection by science outlined above, means that there is currently no robust philosophy underpinning Western herbal medicine. This is a problem for practitioners because as Betty says, while she believes that her practice is different to biomedicine, with regard to locating the sources of these ideas ‘I wonder where they are’.
The perspective is reinforced by the review of selected literature from the *Australian Journal of Medical Herbalism (AJMH)* which was described in 4.8. The finding there was that references within articles on herbal therapeutics (i.e. how herbs can be used in the treatment of specific disorders) to concepts related to philosophy and particularly to the discussion of vitalism, has decreased over the 20 years of the *AJMH*’s existence. During this period articles on herbal therapeutics have decreased in number and have become increasingly science-based.

Thus while practitioners claim that they do ‘more than’ apply scientific understandings of herbs and diseases and to their diagnosis and treatment, this ‘more than’ is not reflected in their professional journal. Without such discussion in journals, at conferences and within educational courses, the maintenance of a uniquely herbal perspective on clinical practice is unlikely to be maintained.

**9.3.1.3 Herbal products**

Respondents’ concerns about the use of the new forms and doses of herbal preparations relate both to the potential for side-effects of these herbs individually and in combination, and for herb-drug interactions. When herbal medicine is practised according to the principles of pharmaceutical science, herbal medicines – the preparations of herbs which are dispensed – change accordingly. For example, the inherent variation between plants, perfectly acceptable in traditional systems, becomes problematic within a scientific framework. To address the issue of variation, herbal products may be standardised during manufacture to a specific constituent. While standardisation and concentration are not necessarily linked, in practice, products which are standardised are also likely to be concentrated.

Respondents emphasise that the focus of practitioner seminars (which they regularly attend as part of the Continuing Professional Education (CPE) requirements of their professional associations) emphasise the use of
standardised and concentrated herbal products rather than more simple preparations of herbal remedies.

9.3.1.4 Statutory regulation and the advantages of risky products

While the question of statutory regulation did not arise within the interviews, it has been a focus of professional activity of the NHAA since its inception in 1920. While the desire for legitimation may be one driver of the desire of herbalists for statutory regulation, another is the need for occupational closure. Given the involvement of the state in the provision of healthcare, the current political reality is that regulation of practitioners is a necessary precursor to substantive participation in mainstream healthcare, including participation in inter-professional activities and potential broadening of employment opportunities, such as in hospitals and community health projects and centres.

Unless and until occupational closure occurs, herbalists are vulnerable to the appropriation of their practice by other health professionals, and concerns regarding ‘doctors doing short courses in herbs’ were raised in the interviews. While there is undoubtedly an aspect of self-interest here, respondents clearly believe that the approach to treatment which they offer is of value. However while some herbalists continue to demand occupational closure this not a sufficient justification for the Australian Health Ministers Advisory Council (AHMAC) to act to allow such regulation. As discussed in 3.5.2, statutory regulation of unregulated health professions will only be enacted if it is shown to be in the public interest.

One of the ways that statutory regulation can be shown to be in the public interest is if issues of public safety are involved. It is here that ‘risky’ herbal products may play an important role. It is the inherent safety of herbal medicine which is understood by herbalists to be preventing them achieving their aim of statutory regulation. The potential dangers associated with phytopharmaceuticals can be seen as advantageous for those herbalists to
wish to achieve statutory regulation. The introduction of increased risk into
the practice of CWHM may assist in the achievement of this aim. However
this in itself can be seen as a high-risk strategy, which may backfire.

9.3.2 At the margins: alternative medicine.
The application of the term ‘alternative’ to herbal practitioners places those
practitioners as the ‘other’ to the current dominant system of medicine in
Australia, biomedicine. Gross (1992) suggests that traditions found at the
margins of society are supported by a small group with similar views. The
resurgence of popularity of herbal medicine can be linked to the
counterculture of the 1960s and 1970s (Baer, 2001; Saks, 2003). The values
promoted there, including self-sufficiency, return to nature and anti-
materialism are congruent with the use of simple herbal extracts for health
maintenance and treatment of disease. The countercultural movement
managed to re-invigorate the CWHM and assisted its re-emergence from its
long period of exclusion and harassment.

Respondents in these interviews are not obviously part of any particular
subculture, and there are few references in the interviews to the
counterculture. While practitioners may describe themselves as spiritual or
religious, indicating that non-material values are part of their identity, there is
no evidence of a broad common spiritual or religious philosophy which may
provide a cosmology within which to explain their approach to healing. The
description of the typical Australian herbalist extrapolated from Bensoussan’s
(Bensoussan et al., 2003) and Hart’s (Hale, 2002) research as a middle-aged
woman who works part time and earns less than $60,000 per year (2.2) does
not include reference to her belonging to any particular cultural subgroup.
While Beck (1999) suggests that herbal practitioners and users in the US may
be described as ‘cultural creatives’, no similar suggestions have been made in
relation to Australian herbalists.

Thus it appears that Australia herbalists by and large are members of
mainstream Australian society and enjoy full access to the privileges that such
membership grants. They do not belong to a marginalised cultural group: it is their profession which is marginalised. This means that in most aspects of their lives an individual herbalist may identify with mainstream Australian society, and be treated as such. It is their work where they occupy a different cultural place. This disconnect, that their profession is marginalised but they are not, is problematic for them as in most aspects of life they share the worldview and values of the dominant Australian society – yet with regard to medicine, they take a different perspective. The worldview and values which underpin their approach to medicine appear to be personal, not attached to a broader cultural expression. It is therefore to be expected that as they move closer to their goal of ‘becoming mainstream’ that not only will the pressures to adapt to the dominant paradigm become greater, but also there will be difficulty in maintaining a different way of thinking, as such a difference has no broader context.

An illustration may assist in clarifying this point. In the prologue to this thesis, I described the influence on this work of my time in Chile, and my observations of some aspects of traditional medical practices of the Mapuche an indigenous people. In Chile, while the Mapuche are marginalised as a group, Mapuche medicine is consistent within Mapuche culture, which both supports and is supported by it. Mapuche conceptions of the nature of the universe, including ideas of health and the origin of disease, and appropriate interventions, differ from the ideas of science, biomedicine, and of mainstream Chilean society. The ideas, and terminology, of Mapuche medicine are consistent with Mapuche philosophy and world view. Mapuche medicine is consistent within a cosmology which supports and reinforces it (Citarella, 2000).

For example, should a machi (shaman) diagnose that a person’s illness originated in that person’s behaviour which involved ‘cutting down trees without respect’, this diagnosis is congruent with Mapuche society, where strong links exist between the understanding of health and disease and an
individual and the health and wellbeing of the land. Further, this philosophy can be understood as broadly vitalistic, and the term ‘newen’ is broadly akin to life force, although it is somewhat more complex and differentiated (pers.com. Dr Teresa Duran 15 November 2003).

Mapuche medicine has an uneasy relationship with biomedicine and the strength of its practice of medicine is because it is part of Mapuche culture. There is no similar common ‘cultural ground’ for Australian herbalists.

9.3.3 The cracks and interstices: OTC and domestic medicine
The use of herbs for self-care and as domestic medicine as associated with the privacy of the home was described as ‘invisible’ and discussed in 5.3.2. This is related here to Gross’ (1992) description of traditions found in the ‘cracks and interstices’ of cultural existence. While the domestic use of herbal medicine, that is the use of household commodities for the treatment of illness, has not been investigated here, it is argued that the use of herbs as domestic medicine has been transformed by the rise in influence and popularity of the over-the-counter (OTC) herbal industry. The dramatic growth in the OTC herbal medicine market is such that the rituals of for example chicken soup and a day in bed as a treatment for ill-health may well be being replaced in many Australian households with the dispensing of Echinacea capsules.

It is not argued here that the professional practice of CWHM is, or was, appropriately described as being found in the ‘cracks and interstices’. However, the boundary between the domestic use of herbs and the use of herbs by herbal practitioners is not completely fixed particularly because of the absence of regulation regarding the practice of CWHM, and the domestic use of herbs – as CWHM itself – has been transformed within the last quarter of a century with the rise of the OTC market in herbal medicine.

OTC herbal products are intended for use as self-care, i.e. for self treatment of disease without the need to involve a medical or herbal practitioner. In this way it is similar to domestic medicine. However the ‘invisibility’ of domestic
medicine can be related to its absence from the national accounts. For example, the use of fresh garlic for the home treatment of colds and flu, or the use of fresh ginger for the home treatment of indigestion or menstrual cramps, is ‘invisible’ because it is impossible to track the purpose of its purchase and its eventual use. Was the garlic or ginger in question bought for culinary or medicinal use? The boundary between food and medicine is blurred, but this is less the case with regard to OTC preparations, which are much easier to track in terms of production and sales.

Respondents expressed mixed opinions regarding the OTC market. While it was accepted that its dramatic growth is one of the ways in which the public support of herbal medicine is demonstrated, the type and potency of medicine being produced and marketed is of concern to respondents. The point was made by Charles and Greg (8.3.1) that problems associated with side-effects and herb-drug interactions have occurred in relation to self-prescription or prescription of potent, standardised herbal extracts, rather than being associated with the doses and preparations prescribed by herbalists in clinical practice.

These adverse events with regard to herbal medicine are unfortunate and, in the opinions of these respondents, avoidable. They argue that the safety data which is being used to justify their use is flawed as it is based on traditional information – which relates to herbs in different concentrations and dosage. Further, the consequences of these adverse effects can mean that, in Greg’s words, the herbs will be ‘lost’ to practitioners if adverse effects lead to restrictions in supply as herbalists and the general public have the same access to herbs, again due to the absence of regulatory status of herbal practitioners.

This is not only of concern to respondents in relation to safety, as discussed in 8.3.1. The use of herbs in this way emphasises their similarities with drugs, and their use to counter symptoms and/or disease states. This is counter to
the approach to herbal practice described by respondents which is individualised and may emphasises the stimulation of health rather than the treatment of disease. As Charles emphasised in relation to the use of Echinacea to treat colds, the use of a herbal product to counter symptoms is considered by herbalists to be less reliable than individual prescription according to these principles.

The differences between the uses of herbal medicine in these different locations is illustrated in Table 9.2

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Professional herbal medicine</th>
<th>OTC market</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form of preparation</td>
<td>Herbal products prescribed in combinations for individual patients from stock bottles of liquid herbal extracts</td>
<td>Usually combinations of herbs, concentrated, standardised. Often in tablet form.</td>
</tr>
<tr>
<td>How are herbal uses described?</td>
<td>Practitioners diagnose and prescribe</td>
<td>Self diagnosis and self prescription informed by manufacturers instructions and retailers.</td>
</tr>
<tr>
<td>What are the sources of knowledge?</td>
<td>Increasingly accepted that herbal practice requires tertiary training. Herbal training uses both traditional and scientific information</td>
<td>Information provided by manufacturer. Increased use of evidence from clinical trials.</td>
</tr>
<tr>
<td>What payment is involved?</td>
<td>Payment for consultation and herbal medicines.</td>
<td>Payment for products only.</td>
</tr>
<tr>
<td>How is risk managed?</td>
<td>Professional associations require practitioners to hold Professional Indemnity Insurance.</td>
<td>Manufacturer bears risk.</td>
</tr>
</tbody>
</table>

Table 9.2 Comparison of professional and OTC herbal use.

These differences include the individual prescription of herbal combinations which is characteristic of herbal practice as compared to the sale of generic products for symptoms or conditions. Professional practitioners diagnose and prescribe on the basis of their training, whereas self-prescription depends on the individual’s personal knowledge, informed by the manufacturer’s
instructions and often by the retailers selling the products. Professionals are paid for the herbal consultation and bear the risk associated with that (therefore Professional Indemnity Insurance is widely used) whereas manufacturers bear risks associated with their products.

The move from herbs being used in the ‘cracks and interstices’ to being a multimillion dollar industry has fuelled the movement of herbal medicine (and other forms of natural medicine) from the margins into the mainstream, and been the cause and result of the attention of regulators, industry and biomedicine. The increase in over-the-counter (OTC) medications may indicate that the public is interested in taking increased responsibility for their healthcare, via pills to ingest in convenient blister-packs backed by evidence of efficacy from clinical trials. There is little evidence to suggest that there is also a return to the application of grandmother’s domestic remedies.

9.3.4 Underground: herbal medicine as dissent

Gross’ (1992) final location of existing traditions is that they can be pushed ‘underground’. A consideration of the history and renaissance of herbal medicine reveals an enduring and complex relationship with the underground if that term is understood to refer to practices which fall between legal and illegal. These are not criminal activities in the sense that they involve theft, or physical violence, but they are activities which have been, and in some cases continue to be, criminalised.

The characterisation of herbal medicine as an underground activity did not arise in the interviews, but the archival research uncovered repeated threats to the professional survival of herbal practice. This resulted in ongoing battles by practitioners to protect their practice rights. During the latter part of the 19th century and the early 20th century these battles were largely legislative, but threats also came from other quarters, as the 10 year campaign which was (unsuccessfully) waged by a tabloid newspaper, the Truth and Sportsman, to persuade the New South Wales state government to ban herbal practice (and all non-registered medical practice). As late as 1982 the National Herbalists
Association of Australia was sufficiently concerned about the legal status of its members that it sought a legal opinion from a Queen’s Counsel regarding this matter (see Appendices 6 and 7).

By the late 20th century, after a century of professional disenfranchisement and harassment, herbalists had few links with mainstream healthcare. By the 1970s they were small in number (there were 68 full members of the NHAA in 1982) and professionally isolated but they had resisted annihilation. The practitioners were clearly resilient.

The burst of energy and new practitioners from the counterculture which revitalised the profession from the 1980s was a group from a very different background, which had demonstrated a very different attitude to the law. Influenced by their own challenges with authority, including their vocal opposition to the unpopular Vietnam War and their experimentation with recreational drugs, this group had a history of civil disobedience. They also demonstrated an interest in developing values which were different to those of the dominant culture. These individuals were not threatened by the fact that herbal medicine was not accepted by mainstream society. While the counterculture movement no longer holds the influence it did thirty years ago, the origins of the herbal renaissance can be traced to this period and struggles for professional survival continue to be largely legal in nature.

9.4 Conclusion

Challenges arise from CWHM’s specific history as a colonial practice and a marginalised profession. In this chapter, the challenges and choices for CWHM have been discussed in relation to Gross’ (1992) model for the location of traditions in non-traditional societies. The interviews carried out in this project suggest that Australian herbalists see themselves as moving from a position on the margins of society and consequent limited ability to provide healthcare, to one that is more mainstream. In contrast, historical research
suggests that this move follows a long struggle for the maintenance of practice rights. For many decades, herbalists have defended their right to provide herbal medicine against legislation, or the threat of legislation, to ban it.

Current moves to ensure the continuation and growth of the profession by placing themselves ‘close to power’ may better ensure the legality of practice but it is proving problematic in other ways. The mainstreaming of herbal medicine is conditional on herbalists reinterpreting their knowledge base to suit the dominant culture. The cost of mainstream acceptance appears to be not merely the ‘modernisation’ of herbal medicine, but its complete reinvention.

The consequences of the extent to which this reinvention is occurring go beyond questions of whether there is likely to be a place for an independent profession of herbal practitioners into the future. The implications of a herbal medicine based on the logic of clinical trials and phytochemistry is leading to a practice which brings new problems in terms of sustainability of supply (by using large amounts of imported raw materials) and safety (by using herbs prepared in new ways, using new extraction methods). Further the unique perspective on healthcare offered by herbal practitioners, offering therapeutically conservative and individualised treatments is in danger of being lost if herbal medicine is reduced to the activity of individual plants rather than an overall approach to healthcare.

It is the mid-1980s and Twin Creeks is a property in northeastern Victoria. It is home to both a medicinal herb-growing business, Southern Light Herbs, and a herbal medicine manufacturing business, Green Pharm. Greg Whitten grows medicinal herbs and Michael Gardiner makes simple herbal extracts for herbalists there on the farm. Twin Creeks is the place where I get to know the plants I use in practice - how they look and how they grow. It has also become an important resource for the nascent herbal community in Melbourne. Greg and Michael become our herb suppliers of choice, and Twin Creeks is a place where we could meet and learn and connect with the plants. We visit the farm regularly, often with our families. We cultivate. We harvest. We make medicines. We run ‘growers days’ which are introductory seminars for people to learn about the world of herb growing: we want more people to grow medicinal plants. We are idealistic and think there is a rosy future for growing medicinal herbs in Australia. We also run students’ days for herbal students and herbalists’ retreats for practitioners. A lot of people come to the farm. The herb gardens cover perhaps an acre, and there are 55-60 species of medicinal plants grown there. Most are European plants, and a few are North American, often more difficult to grow. Greg has a shed where he dries and packs the herbs. It has a wonderful distinctive smell. We help harvest medicinals on the farm and at nearby herb farms, and we wildcraft Hypericum and Drosera. Greg is brilliant with the sickle and scythe, but I have never mastered either. There is always plenty to talk about, wonder about, and worry about. Is this skullcap the right species, is this liquorice the right species? How can we support the herbalists, the herb growers? Where is herbal medicine heading?
CHAPTER 10 CONCLUSIONS

10.1 Introduction

There is something almost primal and certainly universal about using plants as medicines. The stories associated with them, the pleasures of their cultivation, especially within a home garden, their physical beauty, and the simplicity and efficacy of making herbal preparations ensure their continuing popularity for many people. On this level, there is a lightness and romance about herbal medicine.

In contrast, the preceding chapters have considered another side of herbal medicine, altogether more complex and challenging, which is that of professional herbal practice. These chapters demonstrate the difficult history of herbalists, and the ways in which herbal medicine is now being re-interpreted to take advantage of its current popularity in Australian society. In this final chapter I argue that this process of reinterpretation needs careful management, as herbal medicine’s most significant contribution to healthcare may be by providing a different way of thinking about health and disease to that of biomedicine, and this contribution can only be made if herbalists find ways to maintain their core philosophical tenets.

My research began with questions regarding the practice of European herbal medicine in 21st century Australia and the ways in which practitioners are adapting to its resurgence in popularity and consequent modernisation. Two inter-related issues were considered - the professional identity of clinical herbalists and the relative place of traditional and scientific knowledge within contemporary Western herbal medicine (CWHM).

The story of CWHM was analysed using Gross’ (1992) analysis of the cultural locations of traditions in contemporary society. It was argued that during most of the 20th century, CWHM was preoccupied with maintaining the
legality of its practice, but that the final years of that century saw an increase in public support, initially from the counterculture movement. The early years of the 21st century have seen a continuation of this popularity, now broadly based, and many herbalists believe that the future of the profession lies in its integration into mainstream healthcare. They want to participate in its provision and this puts them, in Gross’ terms, ‘close to power’. The challenges for a traditional practice which locates itself ‘close to power’, according to Gross (1992), centre on the difficulty of maintaining its own integrity and identity.

10.2 Primary findings

The themes which arose in the course of the project can be divided into two categories. One group relates to issues internal to the profession, including the way in which herbalists understand their practice – the role of tradition, of herbal philosophy including vitalism, and the way in which practitioners understand their place in Australian healthcare. The other deals with the relationship of herbal medicine to the outside world and includes issues of professional legitimation and marginalisation. While my initial interest was in exploring the first group of issues, in particular the relative place of traditional and scientific knowledge within contemporary Western herbal medicine, it became clear during the course of the research that the professional identity of herbalists and their concerns about the future were inexorably entwined with the questions which interested me. It also became evident that internal and external issues affect each other, inform each other and mould each other.

The respondents in this project assert that their contribution to healthcare is different to that of biomedicine. In their words, they see their practice as being ‘more than’ biomedicine: thus they do not see themselves as being ‘green doctors’, i.e. working as medical practitioners, using herbs instead of pharmaceuticals, but rather they understand that they are providing a distinct
approach to healthcare. They emphasise the complexity of interrelationships between body systems, the significance of a range of influences on an individual’s life, and the importance of locating the ‘root cause’ of a patient’s disease.

Further, they accept and largely welcome the changes which are occurring in herbal medicine, in particular the underpinning of its knowledge base in science. However some respondents also express concern that the ‘scientization’ of herbal medicine is occurring at the expense of traditional ways of understanding and treating patients, and that it is also effecting the types of herbal preparations being manufactured. These concerns are supported by a review of articles on therapeutics in the *Australian Journal of Medical Herbalism*, which demonstrates a growing influence of phytochemistry and evidence-based medicine and the loss of traditional herbal philosophy. Rather than combining the best of science and tradition, the review indicates that the latter is being replaced by the former.

The incorporation of a scientific basis into herbal medicine ensures a consistency of approach and understanding between herbalists and other medically-trained healthcare practitioners. The integration of herbal medicine into state-supported healthcare provision is facilitated by practitioners adopting the logic and perspective of biomedicine.

The understanding of herbal medicine which is provided by science is clearly valuable to herbalists in its own right as well as facilitating this communication. The difficulty which arises is that this is at the expense of traditional ways of understanding which do not conform to ideas of scientific rigor. It is the implication of the concurrent loss of traditional herbal philosophy which is questioned here.

The concerns of practitioners regarding their craft are made more poignant by the fact that they have recently emerged from a period of marginalisation as a stigmatised healthcare profession. For almost a century, as biomedicine
became the State-endorsed approach to medicine, the developing monopoly of biomedical practice meant an end to medical pluralism (‘free trade in physic’) as herbal medicine, along with other non-biomedical approaches, was marginalized and practitioners were harassed in their attempts to continue practice. These difficult events in relation to the history of CWHM are documented for the first time in this thesis.

While there is no indication from the interviews that practitioners are aware of the specifics of their history, they are sensitive to the resultant disparity in power, social standing and income between herbalists and doctors. This does not seem to discourage them. While the motivation of practitioners to enter and remain in herbal practice was not part of this study, many respondents were enthusiastic and appeared to view herbal practice as more of a vocation than ‘just a job’. Grace, in practice for over a decade, says she ‘loves every moment of the work I do’; Flynn talks about the ‘magic’ of herbal medicine, and Sarah ‘really loves’ her work although, after five years, she still finds the reality of making a living daunting. Daniel says that ‘if I won Lotto I would still be in my clinic’. For these herbalists, there is something very special about their practice which helps sustain them through the vicissitudes of their professional lives.

10.3 Research implications: challenges and tensions

The challenge identified in Chapter 9 is for herbalists to stand ‘close to power’ while maintaining their identity. This is not proving an easy task. The continuing public demand for their therapies is accompanied by an ongoing struggle for inclusion in the state provision of healthcare. Saks (2002) argues that given the imbalance of power, status and resources between biomedicine and natural medicine, aspects of natural medicine (including herbal medicine) are more likely to be incorporated into biomedicine than to continue as discrete practices. The popularity of natural medicine has not so far resulted
in the development of a new medical pluralism, and according to Saks, this is unlikely.

However the health system itself may be forced into fundamental change in the near future. It is not only that it is under great stress because of an ever-increasing health budget and an ageing population. Ecological and financial global crises as well as problems with the supply of oil demand that we engage in new ways of thinking about how we use the earth’s resources. The demands of these crises are likely to profoundly affect every aspect of our lives, including healthcare.

In order to think differently about health and disease I argue that we need to move beyond our dependence on the biomedical model to consider different paradigms. As mentioned in 5.2.3, Shiva (1993) has argued against ‘monocultures of the mind’ and suggests that the loss of alternative ways of thinking about the world, and the dominance of Western perspectives, should be viewed with the same concern as the loss of plant diversity. To continue her analogy, just as seed banks are gaining new importance in recent years as the dependence of the world on monocultures for their foodstuffs begins to appear foolhardy and dangerous, so we may begin to question the appropriateness of dependence on one way of understanding health and disease.

One of the issues here concerns the values which underpin systems of medicine. The values underpinning biomedicine prioritise the mitigation of the human experience of disease, and the extension of human life without consideration of the cost of these interventions to the environment. That is, consideration of the effects of human activity on the environment is not central to biomedicine but it is central to the values and assumptions which underpin traditional systems of medicine. A simple example may clarify the implications of taking the environment into account. If remedy A is 20% more effective than remedy B, but 90% more demanding on the environment in
terms of energy used or waste produced, perhaps B should be chosen over A (Jagtenberg 2006). A consideration of costs to the environment would change the medicines we use and the medical interventions considered appropriate.

Alternative systems of medicine provide perspectives which are different to those of biomedicine, and may reflect different values. The terms ‘complementary’ and ‘integrated’ have largely replaced ‘alternative’ as descriptors of herbal medicine, such language being criticised as reflecting an outdated, adversarial approach. However this move in language also indicates a coming-together of perspectives and a loss of potentially important differences. The costs of integration and complementarity may be not only problematic for the maintenance of herbalists’ identity, but this may be a short-sighted approach in terms of constraining herbal medicine’s potential contribution public healthcare.

**10.4 Research implications: possibilities**

As stated, herbal medicine not only provides new remedies with which to counter or alleviate specific disorders or diseases, but it can potentially provide different ways to think about health and disease, ways that are more environmentally friendly and more cost effective than biomedicine. However for such a contribution to be made, the concept of vitalism needs to be restored to its central place as a guiding principle of herbal practice.

As has been argued in Chapter 4, a major sticking point for vitalism has been the difficulty in establishing its existence in scientific terms. However Canguilhem’s (Delaporte 1994) suggestion circumvents this problem by understanding vital force as a moral position and emphasising the consequences of its adoption in medical practice. Its precise nature and indeed, its existence become less important than its implications for practice. When practitioners act *as if* they are treating the vital force, other principles, including minimal intervention and an emphasis on self-healing follow.
The ‘suspension of belief’ with regard to vitalism which Canguilhem suggests is not the only problem for adopting it as a central principle within medicine in the West. Therapeutic minimalism challenges a commodity-driven market economy. The relationship between industry and medicine and the role of medicine as a profit-making activity, means that the adoption of these ideas will not fit current business models, and will be attractive to the commercial instincts of neither pharmaceutical manufacturers nor herbal manufacturers.

However given the wild ride which is the current world economy, and the high cost of providing many aspects of biomedical care, it may be prudent to be turning our minds to alternative economic models, and thinking of cheap, environmentally-friendly ways in which at least some aspects of healthcare may be delivered. Ideas such as the ones proposed here, which may have been dismissed out-of-hand a short while ago may develop new appeal.

The problems facing healthcare include the need to supply medicine which is affordable to individuals, as well as affordable on community, national and global levels. Further, because of the range of ecological crises which will affect all aspects of life, there is urgent need to take account of the costs to the environment of all human activity. Thus it is both the economic and environmental costs of healthcare that are coming under scrutiny. As if this were not enough, the dependence of modern medicine on petrochemicals means that the looming oil crisis is likely to threaten the availability of many conventional medical supplies. ‘Medicines security’ (cf ‘food security’) may require that we re-think the sourcing of medicines and re-evaluate the usefulness of medicinal plants.

A further contribution of Canguilhem’s (1991) perspective is of interest here. He suggests that health is not a steady state, but rather should be measured by how far a person can move from the ‘norm’ and return. This idea can be contrasted with the trend towards the identification of behaviour and symptoms, once seen within the range of normal, which have become defined
as pathological. Some have dubbed this trend the ‘medicalisation of life’ (Illich, 1975; Moynihan & Cassels, 2005) where disturbances of function, previously accepted as an appropriate fluctuations within healthy boundaries, are narrowed, and those conditions outside these narrowing bands are seen as disease. The commercial implications of this are clear. If a condition is pathological, it needs intervention – which includes not only advice from health professionals, but usually the use of a drug or other intervention which will assist in a return to a state of ‘normal’. Should, post-oil, less medicine and fewer remedies be available, the definitions of what constitutes ‘disease’ may need to change, and ideas of normality consistent with those of Canguilhem may gain increased support.

It is not suggested here that herbal medicine replace biomedicine. Rather it is argued that an independent profession of herbal medicine, with the authority to determine its own philosophy and ways of understanding, is necessary in order for it to make its most valuable contribution – a different way of thinking about health and disease. It is the importance of diversity of thought which is once again emphasised here.

10.5 Limitations of the research

While this study may contribute to a range of fields of study, it is limited by a number of factors. Given the paucity of research in the area, this study should be understood as aiming to provide future researchers a ‘place to start’ with regard to future research on CWHM in Australia.

This research has considered the issues facing Australian practitioners of Western herbal medicine. It has not considered the use of other traditions of herbal medicine practiced in Australia, such as Traditional Chinese Medicine or Ayurveda, nor the medical traditions of Indigenous Australians.

The interviews were carried out with a small number of respondents; all based in urban environments, who were recommended by one particular
professional association, the NHAA. The extent to which the views of this group are congruent with the broader group of Australian herbalists, including those from other associations, and from other parts of the country, is not established. In particular there may be differences between the attitudes and practices of these respondents who by and large desire participation within the broader healthcare community and the attitudes and practices of herbalists who belong to associations less enthusiastic than the NHAA in the promotion of statutory regulation.

With regards to the historical analysis undertaken here, the work must be seen as exploratory, indicative and introductory rather than comprehensive. The focus in this thesis is on Victorian legislation in 1850-1920 and may not be indicative of the activity of herbalists in all Australian states. The anxiety and harassment evident in the NHAA archives largely refers to the experience of herbalists in New South Wales from the 1920s: evidence of similar activity in other states has not been considered. Further research is needed to establish the activity of herbalists in other Australian states.

My own involvement in Australian herbal medicine, a relatively small field, means that it was impossible to ensure my personal anonymity during the course of the research. While there are advantages to researching a field about which one is knowledgeable and passionate, this involvement does influence the course of the research, as described in 6.4.3.

10.6 Contributions of the research and suggestions for further research

This work contributes to four areas of activity – contemporary herbal practice, the history of medicine, social science and public health.

10.6.1 Contribution to contemporary herbal practice

This thesis contributes to the development of professional identity among Australian herbalists by documenting the practice of contemporary Western
herbal medicine in Australia. It builds on the work of Lin et al (2005) and Casey (2007) in Australia, VanMarie (2002) and Nissen (forthcoming) on herbal practice in the UK, and Dougherty (2005) with regard to US herbalists. It identifies and describes aspects of practice as well as central challenges and concerns faced by practitioners, in particular the maintenance of a distinct approach to patient care and the activity of medicinal plants. Further investigation is required in order to establish a more complete understanding of herbal practice. In particular further research into issues of herbal practice should include:

- Ethnographic studies to elucidate the nature of herbal practice. The observation of practitioners in consultation, with particular attention to the ways in which herbal philosophy is translated into practice;

- Interviews with patients to document the experience of patients of herbalists;

- Further interviews with practitioners to discover the extent to which the current findings are representative of herbalists across Australia;

- Interviews with individuals suggested by respondents as significant influences in the development of their clinical practice may provide useful information.

10.6.2 Contribution to the history of medicine
This research establishes not only the existence of herbalists a century ago, but also provides evidence of their political activity and public support during the late 19th and early 20th centuries. It builds on previous work by Martyr (2002) on the place of herbal medicine within the broader history of medicine in Australia, as well as that of Willis (1989) with regard to the history of the relationship between biomedicine and other health professions in Australia. It also develops Saks’ (2003) work on the historical relationship between
biomedicine and alternative medicine in the United Kingdom and the United States, by considering the Australian experience.

Further areas for historical research which have been uncovered during the course of this project, and which are likely to be of particular interest to the herbal medicine community, include

- The Free Herbal Clinic which ran in Sydney in the 1950s. How did it begin? Who patronised it? How was it funded? Why was it established and by whom? Why was it closed?

- The Noakes trial. Who instigated the Truth’s campaign against unregistered medical practitioners? What records remain of the trial, and the judgement? What was the effect of the trial on Noakes and other practitioners?

- The early practice of Western herbal medicine in Australia. To what extent were medicinal plants grown and used in the early years of the colony? What information can be located about the trade and early manufacture of herbal products? What further information can be collated about the ways in which indigenous plants were used by the early settlers?

10.6.3 Contribution to social science

The interface between tradition and modernity is of concern to many disciplines within the social sciences and humanities, including but not limited to history, cultural studies, medical anthropology, politics, philosophy, sociology, healthcare and human rights. This work provides a contemporary example of the issues involved in knowledge transfer and the challenges of maintaining traditional knowledge while incorporating scientific knowledge. This is a problem faced by many communities around the world, not least in relation to the practice of medicine, as attempts are made to find a place for the practice of traditional medicine alongside
biomedicine. Consideration of the reinterpretation of Western herbal medicine to suit 21st century Australian healthcare, and the discussion of the issues of knowledge transfer between traditional and contemporary knowledge contributes an understanding of the ways in which traditions change and adapt, and the political nature of not only knowledge construction but of the ways in which knowledge is de-emphasised and eventually forgotten. These issues have implications for the maintenance of cultural heritage and identity.

10.6.4 Contribution to public health
As the previous section has indicated, this research has the potential to contribute to new ways of thinking about healthcare in Australia. There is clearly overlap between the approach suggested here and the emerging ‘wellness’ industry, however the focus here is on minimal economic and environmental impact, and is therefore neither commercial nor commodity-driven. The potential of such approaches have yet to be demonstrated, and a range of research initiatives are required. Such research initiatives may include:

- Longitudinal studies which assess the economic impact of herbal practice, for example the impact of herbal and naturopathic training on family health expenditure. An assessment of the relative health status of the families of naturopaths, and the level at which they utilise the healthcare system, would provide information regarding the economic benefits of using this approach to healthcare;

- Pilot programs in for example aged care facilities and chronic care facilities where practitioners advise on the ways in which herbal and nutritional modification could be employed to improve healthcare while reducing both the expenditure and environmental impact of healthcare;
• Community gardens could be an environmentally friendly way to access and self-prescribe cost effective medicines, especially for basic diseases\(^{34}\).

Were such therapeutically conservative approaches introduced, their advantages may contribute to reductions in spiralling state health budgets. However such a change would not be successful in isolation, but would require a context in which individuals were encouraged to take increased responsibility for their own health, including care for the environment.

10.7 Finally

The ubiquity and resilience of herbalists is at once depressing and inspiring. Depressing because the same stories keep being told and inspiring because whatever is hurled at them, whatever happens, herbalists do not lie down and die but like some persistent weed (dandelion? plantain?) they keep coming back, returning to practice this ancient craft. Perhaps like chickweed (and many Australian wildflowers) they just disappear for a while, until the rains come...

The herbal renaissance of the late 20th century occurred in the context of concern for a gentler, greener medicine (Baer, 2004; Griggs, 1997; McKee, 1988; Saks, 2003; Sharma, 1992) but the combination of legitimatory demands and massive market forces have meant that both the profession and industry of herbal medicine are becoming aligned with mainstream medicine. By reinventing itself, arguably ‘joining the 21st century’, herbal medicine is more easily used alongside, or incorporated into, conventional healthcare. The supporters of this move suggest that it is therefore more accessible for patients, and is taking its rightful place as part of the healthcare system.

\(^{34}\) Programs such as the Farmacias Vivas (living pharmacies) project, established by Prof. A Matos at Universidad do Pernambuco in Fortaleza, Brazil (Griggs 1997), and the Home Herbal Gardens project in southern India (Hariramamurthi, Venkatasubramanian, Unnikrishnan, & Shankar, 2007) follow these principles.
If this were the only story, it would be tempting to conclude from this that the cost of mainstream acceptance is the dissociation of herbal medicine from traditional ways of understanding herbal practice. However mainstream medicine is itself facing major challenges, in particular economic and environmental ones, which are outlined above.

There is an apparent disjunction in using an approach to medicine, in a 21st century post industrialised post modern society, which is based on knowledge that was largely developed many years ago in agricultural communities on the other side of the world. This knowledge base originated before European settlement of Australia, and so for Western herbalists in Australia, its origins are imported rather than home-grown. Very few Australian herbalists harvest and prepare their own medicines, and it is difficult to argue a strong link between the individual practitioner and the plants they use.

It is clear that we are all required to learn how to live more gently on the planet, consuming fewer resources and living more sustainably. Reassessments of traditional knowledge and traditional philosophies which have underpinned the practice of European herbal medicine have the potential to contribute to a new approach to healthcare which puts such principles into practice. This is not a question of the ‘survival’ of herbal medicine. Humans have used plants as medicine throughout their existence, and there is no indication that this is going to stop. Rather the question is whether the CWHM will reinvent itself as a branch of biomedicine, or whether ideas embedded in the traditional philosophy of Western herbal medicine can usefully contribute to our finding gentler, more careful ways to care for and heal ourselves and our planet.
It is a sunny Sunday morning in late March 2008. I go to the local market to shop for food and to meet friends for coffee. When I return home, I feel vaguely unwell, and by nightfall I am clearly ill. The next day my appendix is removed. This procedure, simple and straightforward here in Australia, probably saves my life.

The following week spent in hospital is salutary as I experience first-hand some of the strengths and limitations of the local health system. The hospital staff is cheerful but overworked and however sick I feel, the level of chronic ill-health of other patients in my ward, and the discomfort and pain they endure, is humbling and leaves me grateful for my own overall good health.

The procedures and treatment I receive during my stay include heavy-duty painkillers, diagnosis confirmed by high-tech imaging, surgery, broad-spectrum antibiotics to counter a suspected bowel infection, further painkillers to counter the effects of the surgery and anti-emetics to counter the effects of the antibiotics. All these interventions are standard, all are best-practice and all are aimed at removal of my disease and the prevention of complications, and at making me feel comfortable during my recovery. The focus of the medical treatment is on the removal of problems: my pain is removed, my appendix is removed, my bowel bacteria, both beneficial and problematic, are removed – and painkillers and anti-emetics, are administered in attempts to remove the side effects of these interventions. The cause of my problem is treated surgically, and the remaining symptoms are treated with pharmaceuticals.

Attempts to restore my health receive scant attention apart from medication to ‘make me comfortable’ by removing symptoms of discomfort. Hospital food is neither appealing nor nutritious, being largely either pre-cooked or out of a can, and on one occasion it makes me physically ill. My surroundings on the ward are far from peaceful, with hospital routines taking precedence over the needs of patients for rest and quiet.
My friends and well-wishers, many of whom are herbalists and naturopaths, bring me gifts aimed at restoring my health. As well as flowers and books to cheer me, they bring me yoghurt and probiotics to restore beneficial gut bacteria, nourishing soups and fresh fruits to provide good nutrition, as well as more specialised medicinal foods such as herbal teas, ginger cordial35 and Manuka honey36.

During my hospital stay, reports regarding the adverse effects of hospital food in NSW on patient care appear in the media (Wallace, 2008), and the imbalance of expenditure on medical technology and the provision of good-quality food in hospitals is highlighted.

Looking back, I am grateful not only for the medical care which I received, but also for the practical support of my friends. While the anti-emetics failed to take effect, the probiotics alleviated my nausea. While the hospital food was unappealing, I could taste the simple goodness in the nutritious soups and fruits brought in from the outside. The medicinal foods not only contributed to my wellbeing, but tasted delicious.

This recent personal experience has reaffirmed for me the complementary nature of the two health paradigms. Our current health system does a good job of fighting disease: enormous resources have been poured into strengthening this part of the health equation for the last century. The other half of the health equation, neglected during this time, is a focus on strategies to restore and promote health. It is time to restore the balance.

35 Ginger alleviates nausea
36 A New Zealand honey which is a potent antibiotic.
As this work draws to completion, two events are unfolding which will affect the next chapter of Australian herbal medicine. Firstly, the saga of Pan Pharmaceuticals which was described in 3.5.4, has taken a new turn. Pan was the major supplier of the complementary medicines industry when its manufacturing license was withdrawn and its products recalled by the Therapeutic Goods Administration in April 2003. This destroyed the company and devastated many smaller manufacturers and businesses. The incident rocked public confidence in the quality of natural medicine products. Since that time, Jim Selim, the former boss of Pan, has been involved in litigation with the TGA, claiming that the regulator abused its power by cancelling Pan’s license and withdrawing its products from sale. In August 2008, the TGA agreed to pay him $A55m in an out-of-court settlement.

This settlement is unheard of in Australian history and its implications are profound in respect to the accountability of the regulator. It opens the way for others who were adversely affected by the Pan recall to sue, and a class action is to be mounted (The Australian 16/8/2008). Given the market share held by Pan at the time, and the number of people involved, such an action is likely to be very costly to the government.

However in comparison with the media frenzy and outpouring of negativity regarding natural medicine which occurred subsequent to the Pan recall in 2003 and given the possible implications of the payout, press coverage of the issue has been minimal. Perhaps the fact that the regulator may have been over-zealous and made some mistakes is less newsworthy than the view, now

---

37 It is worth noting that the product which precipitated the withdrawal was one of a small range of pharmaceuticals produced by the company – it was not a complementary medicine.
questioned, that people’s lives were being put at risk by dangerous herbal (and other natural medicine) products.

The second series of events which are unfolding concerns naturopathic training within the public university system. At present limited to two universities, the University of Western Sydney (UWS) and Southern Cross University (SCU), its position appears more tenuous than ever. Subsequent to an internal review of Health Sciences, UWS’s naturopathy program is to be suspended in 2009, pending development of a ‘contemporary programme in Complementary Medicine for 2010’ which will contain ‘elements of naturopathy but provide a broader training opportunity’ (UWS 2008). In a similar but slightly less dramatic move, academic staff in the Department of Natural and Complementary Medicine at SCU have been put on notice that they need to make ‘significant changes in order for this provision (the Bachelor of Naturopathy) to be sustainable’ (School of Health and Human Sciences, HOS School Bulletin no 8, 5th September 2008). The reason for the problems for the programs at both universities is, in part, falling student numbers, as university education becomes increasingly expensive and there continue to be too few well paying jobs for naturopathic graduates.

The staff group at SCU, of which I am a part, is formulating its suggestions for these changes, and in the months after this thesis is submitted this task will be my major focus. It is clear that the changes necessary for the survival of naturopathy at SCU will include a decreased focus on the teaching of future naturopaths and an increased focus on teaching other groups (including but not limited to healthcare professionals) as we are encouraged to ‘broaden our offerings’. The changes mooted may reinvigorate the program but this is by no means certain.

It is too early to predict the consequences to herbalists of either the Pan saga or the changes facing naturopathic education. Public demand for access to
herbal medicine remains high, but its provision – by whom, in what form, funded by whom, and under what type of regulation, remains unclear.


A Bill to amend Part 1 of the Medical Act 1890, Victoria. Legislative Assembly (1905).

A Bill to amend the law relating to Medical Practitioners (No 2) (1905).


*Parliamentary Debates*, Victoria. Legislative Assembly (1858).

*Parliamentary Debates*, Victoria. Legislative Assembly (1862).

*Parliamentary Debates*, Victoria. Legislative Assembly (1878).

*Parliamentary Debates*, Victoria. Legislative Council (1892).

*Parliamentary Debates*, Questions and Answers, New South Wales. Legislative Assembly (1929).


Secretary, Union of Australian Herbalists (1905). *Letter to Chief Secretary of Victoria*. Unpublished manuscript, Melbourne.


Wallace, N. (2008, April 3). The food is so bad that patients are starving. *Sydney Morning Herald.*


List of Appendices

Appendix 1
Phytotherapy and Traditional Herbal Medicine.

Appendix 2
On the oral transmission of information.

Appendix 3
Participants’ information sheet.

Appendix 4
Covering Letter, Petition re Medical Practitioners Bill 1892.

Appendix 5
List of correspondence regarding legislative concerns, NHAA archives.

Appendix 6

Appendix 7

Appendix 8
Articles arising from the thesis.

Appendix 9
List of presentations arising from the thesis.
Appendix 1
Phytotherapy and Traditional Herbal Medicine
Phytotherapy and Traditional Herbal Medicine

Phytotherapy

The term ‘phytotherapy’ was first used in France, and was introduced into herbal medicine in England from the 1980s to refer to a modern and scientific herbal medicine, and to distance this from the associations of herbal medicine with folk medicine and with witchcraft. (Bone, 2002). It has increasingly been adopted in Australian herbal medicine, particularly in the last decade, usually to refer to ‘scientific’ herbal medicine. VanMarie (2002) suggests that its adoption is an attempt to re-formulate herbal medicine as ‘scientific’ as a strategy for professionalisation.

As scientific medicine phytotherapy becomes acceptable to an orthodoxy of medical science and as a re-formulated knowledge within a scientific paradigm it distances its history of irrational mythology and folk-lore…The empirical and clinical knowledge of herbal medicine is re-formulated through the more socioculturally recognisable quantitative science of pharmacology. (p. 105)

‘Phytotherapy’ is also used in connection with products described as ‘phytopharmaceuticals’ – that is, herbal products produced in ways which counter the more common criticisms of herbal medicine from a scientific perspective. These products are designed to counter specific conditions, and are usually standardised to a particular constituent or marker compound. They are usually single-herb products, and usually produced as tablets capsules. The rationale for their use is based in clinical trials and laboratory evidence (Heinrich, Barnes, Gibbons, & Williamson, 2004, p. 186).

Bone’s definition of phytotherapy as arising from ‘the successful blending of tradition with research science’ is not supported by his description of a phytotherapist as

‘…a multidisciplinary practitioner, with training in botany, phytochemistry (plant chemistry), pharmacognosy (plants studied as medicines),
While there is no doubt such a practitioner would be well-trained, the clear emphasis of this training is on the science, not the tradition, of herbal medicine. With background studies in the sciences as listed above, but without a background in those subjects which proved a background to ethnopharmacology, subjects which may appropriately include history, cultural studies, medical anthropology, politics, philosophy and sociology, it is difficult to understand, let alone critically evaluate, the contribution of traditional knowledge to herbal medicine. That is, with training only in the science of herbal medicine, and minimal emphasis on its tradition, the ‘blending’ of tradition and science would be difficult to achieve, and assertions regarding the maintenance of tradition appear to be tokenistic.

**Traditional herbal medicine**

Phytotherapy was developed as a term to differentiate a modern, scientific herbal medicine from an old-fashioned and ill-informed approach to using medicinal plants. However the voices of those practitioners who perceive this to be problematic are becoming stronger. These herbalists have begun to use the epithet ‘traditional herbal medicine’ to distinguish their approach from phytotherapy. Traditional herbal medicine is the term which is coming into use to indicate a practice of herbal medicine where emphasis is placed on the the maintenance of a the centrality of vitalism and holism to their practice (Baer, 2004; Dougherty, 2005; Singer & Fisher, 2007). Some of these practitioners argue that there is a basic dissonance, and essential paradigmatic conflict, between biomedicine and the vitalistic philosophy of traditional herbal medicine (Coulter & Willis, 2004). As Singer and Fischer (2007) note

A decade ago, herbalists did not feel compelled to use the label ‘traditional’ in order to clarify their philosophical orientation. However, in recent years as herbal medicine is increasingly popularised by biomedicine and practised within a reductionist framework, some more established
traditional herbalists are compelled to make this distinction explicit as they reclaim and reassert their traditional values (p. 24).

Bone contrasts the phytotherapist with the traditional Western herbalist who uses simple preparations of herbs, individually formulated for each patient, but ‘many of whom do not acknowledge the value of scientific investigations into their remedies’ (Bone, 2002). Further research is required in order to understand the extent, and the ways in which, these practitioners combine vitalism and science.
Appendix 2
On the oral transmission of information
The oral transmission of information

Although western herbalists have long used books to record and transmit information about their practice, there remain details which are not written down, but rather passed from practitioner to practitioner. Thus understand a herbal text requires a comprehensive knowledge of the assumptions and context in which the book is written. Misunderstandings occur when non-herbalists, ignorant of the perspectives and assumptions of herbalists, (and often ignorant of their own ignorance in this matter) make statements about specific herbs or the practice of herbal medicine.

A contemporary example will clarify this point. A number of books designed to inform medical practitioners about herbal medicines and their potential dangers have appeared in recent years, written by ‘experts’ with qualifications in medicine, pharmacy or pharmacology and presumably well-trained in those fields, but untrained and inexperienced in the practice of traditional herbal medicine. Two books which fall into this category The Professional’s Handbook of Complementary and Alternative Medicines (Fetrow & Avila, 2001) and Mosby’s Dictionary of Complementary and Alternative Medicine (Jonas, 2005), have been written to inform professionals in the broader healthcare community regarding alternative medicines, including herbal medicine. In reference to the herb Ulmus fulva (slippery elm), a plant considered remarkably safe by herbal practitioners, both books state that it is contraindicated in pregnancy as it will cause miscarriage (Fetrow & Avila, 2001, p. 724; Jonas, 2005, p. 373). In fact the only way in which this plant causes a miscarriage is if a piece of the whole bark is inserted into the cervix, which causes the bark to swell in the moist environment of the vagina, the cervix to become dilated, and the foetus to be dislodged. The distinction between oral ingestion and cervical insertion is, inexplicably, not made in these texts. One of the texts specifies that it is ‘whole bark preparations’ which can cause abortions, but does not specify that the whole bark must be inserted in the cervix (Fetrow & Avila, 2001, p. 291). Such misinformation, in a supposedly ‘authoritative’ text, about an overwhelmingly safe herb may be due to ignorance or carelessness rather than mischievousness. It also demonstrates the
detailed knowledge about medicinal plants which is necessary in order to be able to give sensible and accurate advice, and the mistakes which can occur when healthcare professionals who are untrained in herbal medicine assume that their medical or pharmaceutical expertise is sufficient to provide advice in herbal medicine.

The problems in recording all aspects of the craft are not unique to herbal medicine. Traditional knowledge overlaps with practical or technical knowledge, which has been differentiated from theoretical knowledge from the time of Aristotle. The works of Polanyi and Wittgenstein have contributed to what is termed ‘tacit knowledge’ which encompasses the practicality of knowledge from doing (Gustavsson, 2004 p 37). Once again, boundaries between practical and theoretical knowledge are a conceptual guide, and can be problematic in their implementation. Notwithstanding the lack of clear delineation between these concepts, the practical nature of herbal medicine indicates an ongoing difficulty in comprehensively transferring an oral tradition to the written word.

Traditional knowledge is said to be transmitted orally (Johnson, 1992), thus involving memory (Giddens, 1994; Lyotard, 1997 pp 19-22). While the knowledge base of herbal medicine has become more institutionalised within western society, and the knowledge base becomes less reliant on oral transmission, the authority of the practitioner has not yet been completely replaced with the authority of the text.

As stated in Chapter 1, the characteristics of complementary and alternative medicine (CAM) include the ideas of vitalism, holism and individualism. That is, practitioners of CAM therapies including herbalists understand that the world is animated by a ‘life force’, that therapy should be informed by an appreciation of the importance of more than the physical nature of disease (i.e. the emotional, spiritual and environmental aspects) and that patients should be seen as individuals (Coulter, 2004; Willis & White, 2004).
Appendix 3

Participants’ information sheet
Who are the herbalists? Some aspects of identity formation.

You are invited to participate in a study concerning the nature of herbal practice, in which we require your honest thoughts and reflections on your work. Your name has been selected from a list which we have compiled of those people involved in the community of professional herbal practitioners, who we feel may be able to assist in this research.

By doing this research we hope to establish some of the characteristics of current Australian herbal practice, in particular the place of philosophical considerations in diagnosis. This information is needed in order to understand the professional and political changes currently occurring in the field, and to inform the development of directions in education.

This research is being undertaken by Sue Evans of the School of Natural and Complementary Medicine. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time. However, we would appreciate you telling us your decision. Should you decide to withdraw then all data that you have provided will be destroyed.

If you agree to participate, I will interview you for about 45 minutes. The interview will be tape recorded. If you agree, some photographs will be taken of yourself in your clinic, as documentary evidence of the daily life of herbalists. If we wish to use a photo of you or your clinic in a publication, we will contact you for permission before doing so.

Interviews will be guided by a number of key issues, in particular the role of traditional perspectives in herbal medicine today and the place of science in contemporary herbal practice. On completion they will be analysed using qualitative and quantitative methods.

The tapes will be transcribed, and their purpose is to inform this research.

You will be asked questions which relate to the culture of your herbal practice. In particular the place of philosophy in contemporary herbal practice and its role, if any, in considerations of diagnosis and treatment, will be explored. This will include questions relating to the place of traditional herbal and naturopathic ideas such as ‘vital force’, ‘toxicity’, and ‘weakness’ or ‘strength’ of such organs as the liver and the digestive system.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. Any reports or publications written will not lead to the identification of a specific individual. If we wish to use material which may lead to your identification we will obtain your permission in advance. All data will be maintained in a secure and safe location for a period of 5 (five) years, after which time it will be destroyed.

Inquiries
If you have any questions, we expect you to ask us. If you have any additional questions at any time please contact me –

Sue Evans: School of Natural and Complementary Medicine, Southern Cross University
Phone 02 66203854 email sevans2@scu.edu.au

Or for further enquiries
Mr John Russell, Graduate Research College, Southern Cross University.
Phone 02 66203705; email jrussell@scu.edu.au who will be happy to answer them.
I have read the information above, or contained in a separate information sheet entitled 'Who are the herbalists, some aspects of identity formation' and agree to participate in this study. I am over the age of 18 years.

Name of Subject: ............................................................................................................

Signature of Subject: ...........................................................................

Date: .....................................................................................................................

I certify that the terms of the form have been verbally explained to the subject, that the subject appears to understand the terms prior to signing the form, and that proper arrangements have been made for an interpreter where English is not the subject's first language. I asked the subject if she/he needed to discuss the project with an independent person before signing and she/he declined (or has done so).

Signature of the researcher: .............................................. Date:
.......................................................................................................................
Appendix 4

Covering Letter, Petition re Medical Practitioners Bill 1892
To the Right Honourable
The President, and other Right Honourable Members of the Legislative Council, in Parliament assembled.

The petition of the undersigned, Thomas Brown, that your petitioners humbly shew, that your petitioners believe, that a state of destitution of Medical and surgical knowledge and skill amongst the people of Nova Scotia is of the highest importance to that community. That we are prepared to furnish abundant proof of the advantage of medical and surgical knowledge and skill amongst the people as British Subjects to have full liberty of choice in all cases of disease, to select the practising surgeon and the element of that element in the development of our sciences. And we are convinced that the practising surgeons upon whom we enoble will enjoy the same privileges which the legalised practitioners now enjoy. And we order that medical practice of properly licensed and safe surgeons and the public thus protected are considered that the Medical Council should be composed of a chief officer (or other) nominated by the people.

Therefore we pray that you will enable of grant commission to inquire into the opinion of the people as to the best method to proceed to the object we have in view to the end that a medical system, which is no monopoly, shall be encouraged and fixed by the people.

Robert L. Gregory, et al.

William Montgomerie, J.P.

Dundas, 1831
Appendix 5

List of correspondence regarding legislative concerns, NHAA archives
<table>
<thead>
<tr>
<th>Date</th>
<th>Correspondence from</th>
<th>Correspondence to</th>
<th>Regarding</th>
<th>Summary of content</th>
</tr>
</thead>
<tbody>
<tr>
<td>31.3.1925</td>
<td>EB Harkness, Chief Sec Office and Office of the Minister of Public Health, NSW</td>
<td>Sec and Registrar NHA</td>
<td>Request by members of NHA for meeting with the Minister re proposed legislation</td>
<td>Refusal of meeting – ‘no hope of any legislation on the line suggested being passed during the life of this Parliament’ (Bill for registration of Herbal and Eclectic Practitioners)</td>
</tr>
<tr>
<td>10.12.1926</td>
<td>HR Judge</td>
<td>LH Cross</td>
<td>Bill</td>
<td>‘...your success thus far, in that you have prevailed in getting our Hon member Mr Stuart Robinson MLA to bring forward the proposed Bill of registration for Herbulists (sic) and Eclectics’</td>
</tr>
<tr>
<td>18.1.1928</td>
<td>WJ Broadbent, Melb (AUH)</td>
<td>LH Cross, Sydney (NHA)</td>
<td>Resolution, conference of Australian herbalists</td>
<td>‘Each state should get a legal opinion regarding the exact legal position regards the practice of herbalism’</td>
</tr>
<tr>
<td>13 1 1934</td>
<td>HR Judge</td>
<td>LHCross, Sec, NHA</td>
<td>Bill before NSW Parliament</td>
<td>Ref to Dr Northey du Maurie – Bill looks to prosecute those who have certificates by correspondence</td>
</tr>
<tr>
<td>6.8.1940</td>
<td>Minutes, Sec NHA</td>
<td>members</td>
<td>Legal position</td>
<td>Suggest members consider obtaining legal advice re professional standing</td>
</tr>
<tr>
<td>27.9.1955</td>
<td>Charles Noakes, Sec NHAA</td>
<td>Minister for Health, NSW</td>
<td>Bill</td>
<td>‘It is with deep regret that we … notice that you are bringing down a Bill for the suppression of our work’</td>
</tr>
<tr>
<td>7.10.1955</td>
<td>Paul Wheeler, Sec NHAA</td>
<td>Members</td>
<td>Bill and Clinic</td>
<td>(Bill)’is the most sincerest attempt that has been made upon our liberty...(also) the Clinic has been registered as a charity’</td>
</tr>
<tr>
<td>31.10.1982</td>
<td>Minutes, Sec NHAA AGM</td>
<td>Members</td>
<td>Opinion</td>
<td>Opinion from D Cassidy, QC available to members for $2</td>
</tr>
</tbody>
</table>

Correspondence about legislative concerns, NHAA archives 1925-1982
Appendix 6

RE: General Advice

Mr. D. Cassidy,
Barrister,
DX 372,
SYDNEY

DERHALL, DAWSON & HOWARD
Solicitors,
1st Floor, Potts House,
Burns Crescent,
GosFORD 2250
DX 7204 Gosford
Telephone: (043) 24 7711
Counsel will find briefed herewith copies of the following:


4. The Memorandum and Articles of Association of the National Herbalists Association of Australia.

5. Brief historical outline of the Association dated 12th October, 1921 prepared by Mr. Wheeler.


7. Opinion prepared by Frank Kitto on 24th June, 1930.

8. Further opinion prepared by Frank Kitto on 12th May, 1932.


11. Letter from the Secretary National Institute of Medical Herbalists (of England) to the National Herbalists Association of New South Wales dated 30th November, 1951 extending affiliation.

12. Copy of the Munley's Insurance Policy under which some members of the National Herbalists Association of Australia are insured.

Observations

Your instructing solicitors act for the National Herbalists Association of Australia. The current President of the Association is Mr. Paul Wheeler and we are instructed that the Association has at present sixty eight (68) full members and ninety three (93) associate members.
We have been instructed to seek your opinion generally as to the position of persons practicing as herbalists in Australia and in particular in New South Wales. We are instructed that the Association is only registered in New South Wales. Although the Association was in existence for some time, it was not registered until 1924 when it was registered in New South Wales as the National Herbalists Association of New South Wales, a Company Limited by guarantee under the then Companies Act, 1899. In 1953, that name was changed to the present name, The National Herbalists Association of Australia.

Without limiting your advice, our clients would specifically request your opinion on the following points:-

1. What legal right do members of the Association (for sake of convenience we will call them "Herbalists") have to practice herbal medicine in Australia and New South Wales? What legislation, if any, extends to their activities or purports to regulate them in any way?

2. Does the practice of Herbalism fall within the definition of "medicine" and to what extent, if any, is this practice regulated by the Medical Practitioners Act? Are herbalists in danger of any prosecution or other action against them if they are not registered under that Act?

3. Does the Therapeutic Goods and Cosmetics Act, 1972 and the regulations and orders made thereunder (note in particular the order of 21st August, 1973 a copy of which is briefed herewith) purport to regulate the practice of herbalism and in what way does it regulate or limit the practice of herbalism?

4. How can herbalists best protect themselves from claims against them? In particular, how can they adapt the manner in which they practice, either by obtaining
releases from clients, displaying signs, or taking other precautionary measures, so as best to protect themselves from liability under any statute law or at common law, including claims for negligence?

5. What steps would be proper for the Association to take in order to achieve recognition and the passing of legislation to more clearly and specifically define their rights to practice?

6. Are there any pitfalls to a Herbalist in an existing insurance policy such as the Lumley’s Policy briefed herewith?

It would seem that the members of the Association have every reason to be baffled as to their existing legal standing. They are naturally anxious to clarify their position and to take whatever steps are advisable to strengthen their own protection from liability and also to take whatever steps are appropriate to bring about the introduction of clearer legislations specifically dealing with their art. In this regard, our clients have asked us to point out that they would wish to use your opinion as a basis from which to make whatever approaches are appropriate to bring about the passage of new legislation in the field.

The briefed documents we trust will give you a reasonable introduction to the history of herbal medicine and, although they are old, the earlier opinions of Frank Hatto briefed herewith should assist you. It seems that perhaps the most interesting development that we are able to ascertain at this stage in the legislation in this field, is the order under Section 6 (1) of the Therapeutic Goods and Cosmetics Act, 1972 which was gazetted by the

We appreciate that the advice requested is of a very searching and, in many ways, of necessity, of a very generalised nature. However, it would seem that the legal status and position of practicing herbalists is very unclear to those practicing herbalism, and a start must be made somewhere.

We are pleased to see that, in the past, the Association has been successfully and victoriously represented by your late father Sir Jack.

Our clients are naturally anxious to have an opinion as soon as possible and if we may be of any assistance to you in your research of the matter, please do not hesitate to contact the writer.

Yours,

With compliments,

[Signature]

Per:

Daniel Howard.
Appendix 7

RE: NATIONAL HERBALISTS ASSOCIATION OF
AUSTRALIA

ADVICE

It is possible to encapsulate many of the principles of the criminal and civil law in the Laissez Faire philosophy of John Stuart Mill: "The only purpose for which power can be rightly exercised over any member of a civilised community is to prevent harm to others". (On Liberty). Prima facie, anyone is entitled to earn his livelihood by whatever means he chooses: Ex parte Watson (1920) 20 S.R. 1361 at 1362, 1364. The limit is the need which others in the community perceive for his goods and services and their willingness to pay for these goods and services. Any interference with liberty can be imposed only in accordance with positive rules of law, established by parliament or judicial precedent.

I will deal later with three cases of such statutory interference, the Medical Practitioners Act, the Pharmacy Act and the Therapeutic Goods & Services Act.

I am told that an Act of the Imperial Parliament dealt with the practice of herbalism. There seems to be some confusion as to the precise identity of this statute, Mr. Johnstone speaks of it as 3 Hen. VIII c.8 and Sir Frank Kitto as 34 and 35 Hen. VIII c.8. I have not bothered to search for and read the statute. I have little doubt that originally it was in force in New South Wales pursuant to 9 Geo. IV c.83 except to the extent it had been repealed by subsequent Imperial
Legislation though it was not included in Bignold’s Statutes in Force. However, all Imperial statutes with certain express exceptions, of which this was not one, were repealed for New South Wales in 1969 by the Imperial Acts Application Act of that year.

Some such positive interferences which may apply to the practice of his profession by a herbalist are general in that they apply to all members of the community. A herbalist, the same as any other diagnostician or supplier of goods, must not positively misrepresent the nature or use of his produce (a matter to which I will return later). If he diagnoses that cannabis sativa is what is needed he will be guilty of an offence if he prescribes or supplies it. His belief of its efficacy will afford him no defence. I propose to deal primarily with laws which may interfere with freedom of conduct and may have particular relevance to the profession and not with such general laws which, only incidentally, may affect the herbalist.

I propose only to deal with the statute law of the State of New South Wales. Apart from my lack of knowledge of the law of States in which I am not admitted to practice a general advice of this nature would become too cumbersome if it developed into a study in comparative jurisprudence. However, I suspect that most other States have statute laws which will be more or less similar to that considered in this advice.

The first of these laws of direct relevance to herbalists are the laws governing the conduct of the medical profession. Some of these matters were discussed at length by Sir Frank Kitto, as he now is, in his 1930 opinion and though he was dealing with an earlier Act they remain of considerable significance. The leading
provisions of the Medical Practitioners Act, 1938, compel any medical practitioner to be registered and imposes conditions for registration which a herbalist would not normally be in a position to comply with. The first question then that arises is whether a herbalist is a medical practitioner so that the Medical Practitioners Act applies to him and the practice of his profession is illegal unless he is registered under that Act.

The definition section in the Medical Practitioners Act is conspicuous for the absence of any definition of the phrase "medical practitioner" or any of its constituent concepts. In its widest sense medicine is "the healing art" (Concise Oxford Dictionary) and a medical practitioner is one who practices that art. The art of the physician is to diagnose the patient's ailment and, by prescribing medicines without surgery, to cure or alleviate it or its symptoms. The art of the herbalist as I understand it, is to diagnose his patient's illness and by prescribing and manufacturing medicines derived from natural substances to cure or alleviate the illness or its symptoms. The similarity of the purposes and methods of the two professions must suggest that a herbalist practices medicine. In the absence of a definition in the Medical Practitioners Act many trades or professions must also appear, at least at times, to be within the prohibition. The pharmacist, in addition to dispensing, often prescribes in simple cases. The manipulations of a chiropractor or osteopath may be hard to distinguish from those of an orthopaedic surgeon. The St. John's Ambulanceman at the school football match and even more the paramedic in the intensive care ambulance give medical care. Where do the ministrations of a dental surgeon and those of an ear, nose and throat
specialist begin? And what is the difference between a psychologist and a psychiatrist? Yet, is it to be held that all these personnel are acting illegally because they are not registered as medical practitioners? If it were, the health care system would be unworkable. Are each of these medical practitioners and, if not, why not? In most cases these para-medical occupations (pharmacists, dentists, nurses, optometrists, veterinary surgeons, physiotherapists, chiropractors) are expressly exempted from the Medical Practitioners Act by S.49(1). But in some cases, for example, osteopaths, psychologists and ambulancemen, they are not. Are these persons unregistered medical practitioners? I do not think they are for the reason that each of them has an established and understandable meaning which depends upon the area and method of treatment. Sometimes it may be difficult to distinguish the precise method of treatment - between an osteopath and a chiropractor for instance. As I see the distinction between the herbalist and the physician it is twofold. The herbalist -

(a) makes use of remedies occurring naturally;

and

(b) dispenses his own prescriptions.

At times the distinction may be blurred and it will be necessary to look in detail at the facts of each particular case, something that cannot be done in a general opinion of this nature.

I see the authorities referred to by Sir Frank Kitto, as he now is, at pp.2 to 4 of his advice on the question of advertising as having vital importance on this aspect. It seems to me to follow from Watson's Case that the giving of eye tests, and from Alohaoh v. Drew that the curing of nerves, kidney troubles and rheumatism
on the sale of rheumatic tablets by an unregistered person do not constitute medical practice. I emphasise what I, and Mr. Johnstone before me, perceive to be the two vital distinctions between the practice of medicine and the practice of herbalism. The first distinction is that the herbalist makes use of substances, taken by mouth or applied externally, derived directly and without chemical change from vegetable sources (I do not apprehend that his armory is limited to herbs strictly so called). The physician uses a wider range of substances applied by a wider range of means. He may use vegetable remedies (e.g. castor oil) but also uses animal, mineral and synthetic substances. He may apply those substances by injection (intravenous or intra muscular), aspiration or per rectum. There may be a grey area. Is penicillin a vegetable for example? But by and large the pharmacopoeia of the physician should be fairly easy to distinguish from that of the herbalist.

The second distinction is that the herbalist fills his own prescriptions while normally the physician leaves it to a third party, the pharmacist, to do so. Even in cases where the physician gives an urgent injection from his black bag he will have obtained it from a third party. Again, of course, there may be exceptions, a doctor in a small country town for example.

It follows that in my view, provided the herbalist carries on his profession along the lines I have suggested above, he is not acting as a medical practitioner and does not commit an offence by not being registered as such.

It follows that a herbalist would not be disqualified by S.41B of the Medical Practitioners Act from suing for his fees or the price of a herbal mixture.
provided by him by his lack of registration as a medical practitioner. His services are, as I have said, not medical or surgical ones.

Even with the consent of a legally qualified medical practitioner to the use of his name, a herbalist may not use a medical practitioner's name in an advertisement for one of his remedies: S.45(1). There would, however, seem to be no reason why a herbalist should not use a testimonial from a medical practitioner to advertise himself as distinct from his medicines.

One particular offence under the Medical Practitioners Act it is necessary to deal with in some more detail. Section 41A applies to certain named diseases and others which may be prescribed (for the general prescribing power see S.53(1)). These diseases are cancer, polio, tuberculosis, epilepsy and diabetes. No other diseases have yet been prescribed. It prohibits any person other than a registered practitioner from giving any medical or surgical advice or performing any medical or surgical service or operation in relation to the particular disease. It does not seem to me that this provision gets over the basic problem that a herbalist does not give medical treatment.

Section 41A(4) however prohibits any person from supplying a substance with a representation that it cures or prevents carcinoma unless with the authority of a medical practitioner. This sub section would extend to herbalists because unlike the provisions dealt with earlier it extends to all persons not only medical practitioners. The supply need not be by way of sale so that by charging for a consultation and supplying the substance free the herbalist would not avoid it. The representation may be express or implied. It may
be given by the supplier or the manufacturer or any person in the distribution chain. It may be made at the time or point of sale or earlier.

Section 42(2) also deals with the S.41A diseases but goes somewhat further. It makes it an offence for an unregistered person to hold himself out as treating these particular diseases. It does not limit the proscribed treatment to medical treatment so that the defence that I have suggested above would not be available. The offence would not be committed merely by treatment of one of these diseases in a patient who came to the herbalist but it would be committed the moment the herbalist actively moved to get patients to be treated for these diseases. In practice it would therefore seem almost impossible for a herbalist to treat the diseases of cancer, polio, tuberculosis, epilepsy and diabetes.

Sir Frank Kitto has dealt at considerable length with the provisions of the 1912 Act that make it an offence for an unqualified and unregistered person to pass himself off as a medical practitioner. Those provisions are re-enacted in the 1938 Act with some changes, as Ss.42. The prohibition is against the use of a title or letters which suggest that the user is -

(a) a registered medical practitioner; or

(b) would be entitled to be registered.

It follows from what I have said above that to describe oneself as a herbalist would not be to pretend to be a medical practitioner. Ex parte Watson shows that the use of the word "doctor" or an abbreviation of this does not constitute the offence. I think Watson's Case would be followed today despite the minor differences between the Act construed in it and the 1938 Act. Although I think certain of the examples given in the judgment may not
be accurate under the altered provisions. It would
depend on the precise evidence called but I would think
that for an unregistered practitioner to describe himself
as a Fellow of the Royal College of Surgeons or Physicians
(in full or by the use of the abbreviations F.R.C.S. or
F.R.C.P.) would constitute the adopting of a qualification
likely to be understood as entitling registration. There
is no doubt that under the present section it is proper
to regard the circumstances of the representation. For
example, it could well be that the display of a red
light with the word "surgery" or "consulting room" on
it in association with the prefix "Dr." could constitute
the forbidden representation. Of course, the use of the
phrase "Doctor of Medicine" or the abbreviations M.B. or
M.D. would constitute the offence. And independently of
this Act a person who obtained patients and payment from
them by pretending that he holds some degree or post
that he does not may be liable criminally and civilly
for false pretenses or fraudulent misrepresentation:
Similarly I take the same general view in relation to
the Pharmacy Act.

A pharmacist is a person who sells drugs (using
that word in a very wide sense) normally sold by pharmacists;
a herbalist generally supplies different substances. A
pharmacist generally makes up or supplies medicines to the
prescription of a third party; a herbalist both prescribes
and supplies.

Section 28(1) of that Act makes it an offence
for any person other than a pharmacist, a person acting
under his personal superintendence or a medical
practitioner to dispense or compound any medicine on
the prescription of a medical practitioner. Irrespective
of the nature of the substance supplied this section obviously has no application to a person who dispenses a medicine which he himself has prescribed. It would not prevent a herbalist dispensing his own prescriptions.

Section 25(1) of that Act in substance provides that only a pharmacist can lawfully carry on the business of a pharmacist in open shop. Obviously manufacturers, hospitals, mail order houses and wholesalers are excluded or they do not operate from an open shop. Less obviously, a medical practitioner who charges one combined fee for diagnosing and supplying the prescribed medicines would not be conducting a shop; a surgery is not a shop. A herbalist would not offend against this section for three reasons:-

(a) If he restricted himself to dispensing herbal remedies not normally stocked by pharmacists, he would not be a pharmacist.

(b) If he prescribed and supplied from his consulting room only patients of his own for a fee which covered the diagnosis and treatment, his place of business would not be a shop.

(c) If he did not have his premises open to the public so that either the outer door was opened to admit each patient, patients were seen by appointment or a receptionist was employed by whom patients had to be passed in to see the herbalist, the premises would not be an open shop.

These principles may be deduced from the decision in *Shillington v. Hewer* 15 A.L.T. 253, referred to by Mr. Johnstone. Although that case is only persuasive authority
in New South Wales, I have no doubt it would be followed here. It should be possible for a herbalist to tailor his business along lines that will satisfy these rules.

Section 25(1) is circular. "Business of a pharmacist" is defined to mean the business of a chemist, pharmacist, druggist, homeopathic chemist, dispensing chemist or dispensing druggist. Of these words and phrases the only one which is defined is "pharmacist" which means, unless the context otherwise requires, a person registered under the Pharmacy Act. What the section appears to be saying is that no one shall carry on the business of a registered pharmacist other than a registered pharmacist. This is obviously not what is intended. Nonetheless in my view a person who supplies natural remedies which are not such as would ordinarily be stocked in a chemist's shop would not offend against this section.

By S.12 of the Therapeutic Goods & Cosmetics Act, 1972, it is an offence to conduct or control premises on which a therapeutic substance is manufactured for sale without a licence. Manufacture would include the mixing, separating and packaging of herbal remedies which would constitute therapeutic substances. On its face this section interferes very greatly with the freedom of practice of a herbalist.

The Minister has a power by proclamation in the Gazette to exempt particular goods, or a class of goods, from all or any of the provisions of the Act. He has exercised that power by exempting from S.12(1) any herbalist who, in premises of which he is either the owner or a tenant and which are capable of being closed so as to exclude the public, he sells to a particular patient for administration to that patient in the exercise
of his professional judgment.

The effect of this exemption would be to excuse from this Act a herbalist who carries on his profession in what I would imagine is the usual and natural form. The herbalist, himself or by a servant, should compound his medicines on his own premises. He could not act as a wholesaler or a manufacturer selling to other herbalists. He should examine and assess each patient. He could not diagnose by mail (as I recall was one of Mr. Noake's practices) though, provided he has first diagnosed personally, he could fill repeat orders by mail, phone or telegram. The herbal preparation must be delivered for administration to the particular patient whom the herbalist has seen and diagnosed - not for some relative or principal of the patient. Wisdom would dictate sticking a label on the bottle or container with the patient's name on it, as does a pharmacist. The herbalist would not lose his protection if the patient, unknown to him, gave the preparation to someone else.

The order can, naturally enough, not override the provisions of the Poisons Act. If the herbal preparation happens to be scheduled under that Act then the provisions of that Act must be complied with. The phrase "Herbal Preparation" used in the Order is defined. It seems to be a fairly wide definition though I do not know enough of the details of herbalism to judge whether it is wide enough for all the Association's purposes. It contemplates preparation from plants not animals nor minerals although it would not prevent the addition of small quantities of such substances to a vegetable extract. It would not prevent the solution of the vegetable substance in a liquid vehicle which did not have a vegetable origin. It appears to allow only physical changes
in the vegetable matter rather than chemical changes. The plant can be dried, crushed, broken up, infused in alcohol (not necessarily ethylalcohol) or water or distilled. Fractional distillation would be possible. But, as I say, chemical changes would not be permitted, for example fermentation of sugars to alcohol.

By S.22(2) the Minister for Health is given power by regulation to prescribe standards for therapeutic goods. These include composition, potency, purity, manufacture and storage and include a power to prohibit named substances. Some standards have been laid down. Section 24 makes it an offence to sell therapeutic goods that do not conform with the standard. The exemption from S.12 does not exempt from the obligation to comply with this provision. It is beyond my knowledge and the scope of a general advice to discuss the detail of these standards. One example can be given, however, and this is the prohibition of the use of methylated spirits as a vehicle in herbal preparations to be swallowed. (Incidentally, methyl alcohol, provided it has not been treated and is pure, can lawfully be used, a lamentable gap in the draftsmanship of regulation 30). Incidentally, that it probably is a breach of that section which caused damages (for example, selling a medicine the vehicle in which was methylated spirits and thereby causing blindness), would create civil liability under the rule in O'Connor v. Bray 56 C.L.R. 484.

Part V relates to advertising and under it the Minister has power to proscribe particular therapeutic goods and particular representations. Advertising of prescribed goods or of prescribed representations is forbidden.

It may be seen that this Act in theory interferes most minutely with the practice by a herbalist
of his profession. Whether in practice he has anything to fear from it is another matter. A herbalist who practices quietly in a small way in his own premises, treating patients who come to him individually for help, and carefully compounding his remedies in accordance with the standards prescribed has ample protection from the order of 21st August 1973.

Although I said that I would not deal with matters that only incidentally touch herbalists there are some matters of that kind without some mention of which this advice would be incomplete.

Where any person unlawfully administers to or causes to be taken by a woman any drug or noxious thing with intent to procure her miscarriage, he commits a felony for which the maximum penalty is 7 years gaol. It is not necessary that the woman be pregnant, only that the defendant intend her to abort if she is. A drug, for the purposes of this section, would include any substance which was a known aborticaciant or which the defendant believed to be so even if it were in fact useless for this purpose. The defendant does not have to administer the drug himself, it would be sufficient that he provided it and left the woman to take it in her own time. The word "unlawfully" has been the subject of many decisions, *R. v Bourne* (1933) 1 K.B. 687, *R. v. Davidson* (1969) V.R. 687, *R. v. Wald* (unrep.), and it can fairly be said that nowadays a legally qualified medical practitioner working under proper conditions is pretty well immune from conviction. I doubt, however, that this word would protect a herbalist, chemist or nurse acting other than in the course of treatment by a medical practitioner.

Manslaughter is an offence the maximum penalty
for which is life imprisonment. It consists of two kinds, voluntary and involuntary. The first occurs where the defendant does some act which causes death and the second when he fails to do some act as a result of which death occurs. In the case of a herbalist the first would be exemplified by the prescription of a substance which happened to be poisonous to the deceased. The latter would be exemplified by a herbalist who continued to treat an illness upon a wrong diagnosis or with useless substances thereby discouraging the patient from obtaining effective treatment elsewhere. In neither case, however, is the offence absolute — a mental element — what in law is called mens rea — must be established. To establish voluntary manslaughter the prosecution would have to prove that the deceased ought to have recognised that the substance was harmful. It would probably suffice to prove that he did not make reasonable tests of it before administering it to a human being. To establish involuntary manslaughter it would have to be established that he knew or ought to have known that his treatment was ineffective and that alternative treatment would probably assist.

One of the means by which to avoid the provisions of the Pharmacy Act which has been discussed above is for the herbalist to charge one fee which covers both the diagnosis and the treatment including any herbal remedy which is supplied. If this is done genuinely and not as a mere sham it would be hoped that the transaction by which the medicine was supplied would not constitute a contract for the sale of goods. In any case in which this cannot be done and the herbalist in the course of his profession sells the remedies which he compounds the provisions of the Sale of Goods Act will apply to the transaction.
Although that Act generally recognises the principle "caveat emptor" - let the buyer beware - it does imply terms into the contract of sale in three circumstances which may have some relevance. First, where goods are sold by description they must comply with the description (S.18). If a herbalist sells a substance labelled as "powdered mandrake root" it must be the root of that plant reduced to powder. If he supplies something else which is ineffective against the patient's ailment and the patient is able to prove that mandrake root would have cured it he will be liable for damages. Second, where goods are sold by description it will be implied that they will be of merchantable quality (S.19(2)). This means that they must be fit for the purpose for which, or any one of several purposes for which, they are normally used. If Banjo Patterson's hero Johnson had sold his snake bite antidote and the dead dog had been owned by the buyer he would have been liable in damages for its value. However, I doubt whether many transactions would fall within the definition of a sale by description. The usual form of the transaction would be that the patient described his symptoms, the herbalist selected the nostrum and compounded and delivered it. The presence of a label on the bottle would not constitute this a sale by description. Thus the implied conditions under Ss.18 and 19(2) that the remedy comply with a description and that they be of merchantable quality would not apply. Seldom, I imagine, would there be a sale by sample so that the provisions of S.20 would not apply either. Of more importance to the herbalist will be S.19(1). This section implies a term in the contract where the goods are of a description which it is in the course of the seller's business to supply and the buyer requires
them for a particular purpose and makes that purpose known to the seller so as to show that he relies on the seller's skill or judgment to supply goods reasonably fit for that purpose. In the normal case where a herbalist diagnoses an illness and supplies a remedy, all the elements of this section will be established and under it there will be implied a term that the remedy is reasonably fit for the disclosed purpose.

To take an example, a patient comes in complaining of a pain originating in the back and radiating down one leg in the distribution of the sciatic nerve following on a lifting incident at work. The herbalist prescribes and supplies an embrocation to be rubbed on the skin at the sites of the pain. The patient honestly perseveres with this treatment for three months but his pain gradually gets worse. The patient consults a doctor, has a myelogram and a C.A.T. scan and there is diagnosed a prolapsed disc between the 4th and 5th lumbar vertebrae. The disc is removed at laminectomy and the two vertebrae fused and the patient's pain is reduced and he is able to return to work. In these circumstances it may well be that the herbalist would be liable for damages for breach of the term implied by S.19(1) or for breach of the general duty of careful diagnosis flowing from the contract between him and his patient. In the above scenario these damages may be limited to loss of earnings, pain and suffering during the three months of ineffective treatment. There is excluded from S.19(1) goods bought under a patent or trade name.

Where a customer goes into a chemist's shop and asks for something for a bad cough he is entitled to complain if the medicine given him is useless against his cough though it soothes his sore throat. The fact that it is put up in a bottle by "Nyal" or some other manufacturer
of patent medicines does not bring the proviso into operation unless it was the customer who asked for "Nyal Cough Mixture". If he did there will have been absent the necessary reliance of the chemist's skill to raise the implied term. Again, if the customer could show that another substance would have cured his cold he would be entitled to damages.

Independently of the Sale of Goods Act any person who carries on a profession for reward undertakes to bring to that profession reasonable skill. In the case of a herbalist he undertakes to apply the ordinary and usual skills of his profession both in diagnosing and dispensing. He does not guarantee a cure but will be liable for damages if he falls short of the accepted standards. Other practitioners' evidence will be admissible to identify those standards. Such evidence would be admissible from herbalists practicing in other States or countries: Albrighton v. R.P.A. Hospital (1980) 2 N.S.W.L.R. 542. Evidence of chemists, biochemists, pathologists and other specialist medical practitioners would be admissible to define the standards generally recognised by herbalists.

The liability of a herbalist, whether in contract or for negligence, can however be altered by contract. Many statutes, of which the Trade Practices Act is an example, contain provisions against contracting out. The Sale of Goods Act is not one of these and it is quite possible for a vendor in a contract for the sale of goods to insist that no implied terms are to be included. So too where the duty of care arises under contract it is possible for the parties in the same contract to specify that the one is not to be liable for negligence. Examples of cases where this is done are
parking and dry cleaning tickets. For preference this should be done by having each patient or purchaser enter into a signed contract but this is probably impracticable except where business is done by mail and the necessary words can be included in the printed order form. A warning on the package or invoice may be all that can be expected. Two things should be borne in mind. It is necessary that the exclusion be part of the contract; for example, it is useless to include it in a receipt given for the purchase price after the contract has been made.

The display of signs in a waiting room is hardly likely to be effective. The benefit of a written agreement signed by the patient is that by it the patient is fixed with knowledge of all its terms. He cannot be heard to say that he did not read them. No matter how prominently it is displayed after he has become sick and decided to sue, the patient is likely to forget, genuinely or fraudulently, that he saw it. The contract must, however, be very carefully drawn as the courts lean against such clauses and read down their effect where possible. It is necessary to consider each case separately in drafting such a clause but the clause following might form the basis. I have included in it a provision for arbitration in the event of a dispute about fees.

"The herbalist undertakes to treat the patient who agrees to pay reasonable fees for such treatment. Any dispute as to the reasonableness of such fees shall be determined by arbitration by the Committee of the National Herbalists Association of Australia at the time the dispute arises or some person nominated by it. The making of an award in arbitration shall be a condition precedent to any right of the herbalist to recover his fees. The herbalist and the patient agree that the herbalist shall not owe to the patient any duty of care and that the herbalist shall not be liable for damages or otherwise to the patient,"
whether for negligence, breach of contract or otherwise. The supply of any herb, potion, medicine, preparation, remedy or thing by the herbalist to the patient shall not constitute a sale of goods and no condition, warranty or term that any herb, etc., should have any particular quality, be of merchantable quality or be fit for any purpose whether implied or express shall form part of any contract between the herbalist and the patient."

Frankly I think it quite impracticable to contract out of liability. I would have thought that any serious attempt to do so would result in such loss of business as to be impossible. Rather I would suggest protection by professional indemnity insurance. I have been briefed with a form of policy which I understand is in use and have been asked whether it has any pitfalls. It does not contain any particularly unusual provisions but the following things should be observed about it:

(a) It does contemplate a claim limit. It is for the individual insured to decide, bearing in mind the nature of his particular practice, the income bracket of his patients, their age and other personal factors, just what is an appropriate limit. Usually the premium for the first few thousand dollars cover is much greater than for an extension.

(b) It will be important to comply strictly with the notice provisions of condition 4 in the event of a patient making a claim.

(c) The policy recites the making of a proposal and contains a "basis of contract clause". The insured should realise that any mis- or non-disclosure
will avoid the policy. These remarks apply particularly to prior insurance and claims history. If a broker is employed to fill in the proposal he will be the agent of the insured who will be responsible for any inaccurate answers the broker gives.

(d) Note should also be taken of the prohibition against admissions in Condition 5.

I have not been briefed with the schedule to the policy so I cannot advise upon it.

It is unlikely that the Commonwealth Trade Practices Act would apply to a transaction between a herbalist and his patient because it only applies where one party to the transaction is a corporation. That Act contains a part dealing with consumer transactions - many provisions of which could be of importance if it applies. Similar conditions to those implied under the Sale of Goods Act are implied under this Act and this Act does forbid contracting out. The patient will necessarily be a natural person and provided the herbalist is either a sole trader or a member of a firm or partnership the Trade Practices Act will not apply.

I am asked what the Association should do to define herbalists' rights of practice and achieve recognition. My answer would be to let sleeping dogs lie. I suspect that most professional people, doctors, lawyers, accountants, architects and others hanker for a return to the days before they received parliamentary recognition, government financial assistance and control. It is a matter for individual philosophy but I am a firm believer in the view that peer group control gave us
better professions – from the point of view of the professional and the consumer – at far less cost than control by bureaucrats and consumers. I am interested to note that this is the same advice that was tendered by Mr. Johnstone over 50 years ago.

My brief poses a series of numbered questions. All have been answered in the course of the discourse above. I repeat those answers in summary below.

1. Herbalists have in general a legal right to practice their profession. However each case – each practitioner – would need to be considered in relation to its own facts and his particular mode of practice. The Therapeutic Goods & Cosmetics Act, 1972, extends to many of their activities but by proclamation a fairly wide exception is created. Certain particular diseases of which cancer is the most important cannot, for practical purposes, be treated by herbalists.

2. Herbalism is not medicine and its practitioners are not required to be registered under the Medical Practitioners Act as a general rule.

3. The Act does regulate the practice of herbalism in the manner described above.

4. By insisting that every patient enter into a written agreement containing the appropriate term, if this is practicable.

5. None.

6. Covered above.

Chalfont Chambers, 28th June 1982.

D. I. CASSIDY, Q.C.
Appendix 8

Articles arising from the thesis

Published articles


Conference proceedings:


Evans, S. Contemporary western herbal medicine: the interplay of tradition and of science (Poster, Abstract). Revista de Fitoterapia 5:S1 2005.
Changing the knowledge base in Western herbal medicine

Sue Evans

Department of Natural and Complementary Medicine, Southern Cross University, P.O. Box 157, Lismore, NSW 2480, Australia

A R T I C L E   I N F O

Article history:
Available online 25 October 2008

Keywords:
Herbal medicine
Traditional knowledge
Evidence-based medicine
Vitalism
Australia

A B S T R A C T

The project of modernising Western herbal medicine in order to allow it to be accepted by the public and to contribute to contemporary healthcare is now over two decades old. One aspect of this project involves changes to the ways knowledge about medicinal plants is presented. This paper contrasts the models of Evidence-Based Medicine (EBM) and Traditional Knowledge (TK) to illuminate some of the complexities which have arisen consequent to these changes, particularly with regard to the concept of vitalism, the retention or rejection of which may have broad implications for the clinical practice of herbal medicine. Illustrations from two herbals (central texts on the medicinal use of plants) demonstrate the differences between these frameworks in regard to how herbs are understood. Further, a review of articles on herbal therapeutics published in the Australian Journal of Herbal Medicine indicates that practitioners are moving away from TK and towards the use of EBM in their clinical discussions.

C⃝ 2008 Elsevier Ltd. All rights reserved.

Introduction

There is a battle 'for truth' or at least 'around truth' – it being understood once again that by truth I do not mean 'the ensemble of truths which are to be discovered and accepted' but rather 'the ensemble of rules according to which the true and the false are separated and specific effects of power attached to the true' (Foucault, 1991, p. 74).

The massive increase in public acceptance of herbal medicine is evidenced by high levels of utilisation of products and practitioners, and this trend has been documented in Australia over the last decade, most comprehensively by MacLennan (MacLennan, Myers, & Taylor, 2006; MacLennan, Wilson, & Taylor, 1996, 2002). This acceptance has not occurred in isolation, but is influenced by competing and collaborating concerns of herbalists, herbal manufacturers and herbal educational institutions in whose interest it is to encourage the public's demand for herbal medicine. In addition regulatory bodies, consumer groups and orthodox healthcare professionals, who may have different aims and interests, also influence the context and possibilities of herbal usage.

While the increased public utilisation of herbal medicines is largely reflected in consumption of over-the-counter medications, here I focus on herbal medicine in a slightly different context: that of clinical herbal practice. Herbalists are defined as health practitioners who engage in extemporaneous compounding of herbs for therapeutic purposes for individuals under their care (Lin et al., 2005). This paper concerns Western, or European, herbal practice in Australia. It does not address for example the use of medicinal plants by Indigenous Australians, the use of herbal products sold in pharmacies and health food shops, or the prescription of herbal products as substitutes for pharmaceuticals by biomedical practitioners and others. It is also differentiated from herbal medicine used within other formal systems of traditional medicine, for example, Traditional Chinese Medicine and Ayurveda, systems of...
herbal medicine that arise from the cultures of China and India respectively.

In this paper influences from two systems of knowledge generation are identified within Western herbal medicine: Evidence-Based Medicine (EBM) and Traditional Knowledge (TK). I suggest that these systems are not readily compatible, particularly with regard to the controversial notion of vitalism, an idea which is rejected by the former and valued by the latter. I use the approach of Canguilhem on vitalism to suggest that this rejection or acceptance may have broad implications for the practice of Western herbal medicine. A comparison of the description of medicinal plants in two herbal texts, one recently published which uses phytochemistry and EBM as its basis, and the other a classic herbal of the early 20th century, which documents traditional lore, details the very different information that is communicated when using EBM or TK. This is followed by a review of the literature on herbal therapeutics published in the Australian Journal of Medical Herbalism (AJMH), which indicates that the ways in which practitioners describe their treatment of patients during the last twenty years has changed and reflects an increased reliance on EBM at the expense of TK.

This paper illustrates tensions between EBM and TK in the context of the daily practice of Western herbal practitioners and their continuing development of their knowledge base of the medicinal actions of plants. The work contributes a different perspective on the existing discourse on traditional knowledge and Western science (Connor & Samuel, 2001; Dods, 2004; Dutfield, 2003; Laird, 2002; Mazzocchi, 2006) in that it considers the practical effects of these contrasting approaches on the development of knowledge within a non-indigenous professional group in a non-traditional society.

Cultural and regulatory context

The complex processes which have led to the increased acceptance of Western herbal medicine have affected the practice of herbal medicine itself as well as the type of herbal products which are manufactured (Jagtenberg & Evans, 2003). When the new wave of public support for herbal medicine first became evident in the late 1970s and 1980s, herbal leaders, initially in the UK, were clear that in order for public acceptance to occur, herbal medicine needed to be redefined as scientific herbal medicine and distanced from folk medicine and witchcraft (see Griggs, 1997; Zeylstra, 1992). This view has been adopted in Australia and is reflected for example in the educational requirements for professional membership of the National Herbalists Association of Australia (NHAA) which has a long history of lobbying for the professionalisation of herbalists. From this perspective, the appropriate modernisation of the knowledge base, the way to ‘bring herbal medicine into the 21st century’, involves employing the discourse of science to explain the medicinal actions of plants (Mills & Bone, 2000).

However this emphasis on science is not uncontroversial within the herbal profession, and has led to divisions between herbalists. These divisions between practitioners who support the ‘scientisation’ of herbal medicine and those who do not, have been evident for some years (Conway, 2005; Dougherty, 2005; Griggs, 1997) and the term ‘phytotherapy’ is now used to refer to rational, scientific herbal medicine (Heinrich, Barnes, Gibbons, & Williamson, 2004; VanMarie, 2002) More recently the term ‘traditional herbal medicine’ has been used by some authors to refer to the practice of those herbalists who challenge the primacy of science as an appropriate foundation for herbal practice. Traditional herbalists employ a herbal philosophy which emphasises vitalism and holism and a very individualised approach to treatment (Baer, 2004; Coulter, 2004; Dougherty, 2005; Singer & Fisher, 2007). Their ideas are congruent with those of commentators who hold that herbal medicine, like other disciplines within Complementary and Alternative Medicine (CAM), can be distinguished from biomedicine by reference to underlying principles which are not just distinct from biomedicine but incompatible with it (Capra, 1982; Coulter, 2004). It is this tension between scientific and traditional knowledge and their application to the clinical practice of herbal medicine that is the focus of this paper.

Evidence-based medicine (EBM) and herbal medicine

Evidence-based medicine has become popular in the West since the 1990s. It was developed as a way to evaluate and generate biomedical knowledge, and of linking research findings with clinical application. A classic, often repeated definition of EBM is the following:

Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. (Sackett et al., 1996, p. 71).

EBM has had a major impact on the process of clinical decision-making by making such processes more transparent. This has allowed an increase in the participation of patients and funding bodies (in particular the State and medical insurance companies) who have found a role alongside medical practitioners in decision-making in regard to treatment (Rodwin, 2001). EBM has become broadly accepted as an appropriate basis for decisions around patient care, and made doctors more accountable, although it is not without its critics in terms of the extent and manner of its application (see for example Holmes, Murray, Perron, & Rail, 2006).

By establishing hierarchies of evidence, EBM ranks the evidence base on which clinical decisions are made. Of
primary importance, therefore, are definitions of evidence, and so the question ‘what counts as evidence?’ arises. At the top of the EBM hierarchy is evidence that arises from the results of randomised controlled trials (RCTs) (preferably a review of a number of individual trials), and at the base is evidence drawn from the opinions of individual practitioners, and empirical practice. This hierarchy is illustrated in Table 1. Level 1 evidence, i.e., systematic reviews of RCTs, is thus considered to be more reliable evidence (more ‘true’) than level 2 evidence, with one relevant RCT, or level 3.1 evidence where trials are not randomised, and so on. Thus while RCTs are not the only type of evidence accepted within EBM, they are the ‘gold standard’ of research and considered most reliable.

Concerns have been raised with regard to the application of EBM as a treatment rationale for herbal medicine. Some authors suggest that EBM is paradigmatically incongruent with core natural medicine principles including vitalism and holism (Coulter & Willis, 2004; Jagtenberg et al., 2006), and that RCTs are inappropriate tools with which to assess herbal medicine (Baer, 2004). RCTs work best when examining a single intervention. Clinical herbal practice rarely involves single interventions, but rather is characterised by its use of individual and complex interventions. Because it is tailored to treatment of an individual rather than of a condition, individuals with the same condition are likely to receive different treatments. Such an approach is complex not only because individual herbs are complex substances containing a range of constituents, but also because herbalists individually formulate combinations of herbal extracts (Casey, Adams, & Sibbritt, 2007). Thus treatment is routinely complemented by individualised therapeutic advice, for example involving changes to diet and lifestyle (Green, Denham, Ingram, Sawkey, & Greenwood, 2007; Jagtenberg et al., 2006), and the resulting complexity of herbal practice cannot be reflected if reduced to single interventions required by conventional RCTs. Other methodologies are required to allow for assessment of highly complex interventions.

Further, it must be noted that the gathering of evidence, particularly Level 1 evidence (RCTs), is expensive. In a political climate where the state is reluctant to provide funding for research generally, the burden of funding research falls to manufacturers, who use these research results in advertising and to provide evidence to fulfil registration requirements of their products. This introduces bias in terms of the types of interventions that are researched, which if funded by manufacturers are likely to be limited to commercially significant products. Substances and interventions without such potential application are left off research agendas and this includes much of herbal practice.

As stated previously EBM, with its focus is on measurable clinical results, is now the standard applied to judge the efficacy of biomedical treatments. It is of particular interest to herbalists because it has been argued that within the framework of EBM, any therapeutic intervention may be established as valid if appropriate evidence (preferably Level 1) can be provided (Ernst, 2000). Explanations with regard to plausibility of mechanism of actions are not required if the evidence is provided. However this is not only a ‘carrot’ to herbal medicine offering acceptance via the use of EBM. At least one call has been made for the rejection of clinical herbal practice on the basis of an absence of RCTs investigating the efficacy of individually prescribed herbal mixes (Guo, Canter, & Ernst, 2007).

**Traditional knowledge (TK) and herbal medicine**

In this paper, the term ‘Traditional Knowledge’ is used to cover a range of fields that are variously referred to Traditional Ecological Knowledge, Indigenous Knowledge and folk knowledge. All of these terms relate to the knowledge that has been developed by indigenous and traditional cultures with regard to their environment. Discussion of TK is found within a wide range of fields including anthropology and ethnobotany (Cotton, 1996); conservation and ecological studies (Alexiades & Laird, 2002; King, 1996); development studies (Bodeker, Kronenberg, & Burford, 2007; Rahman, 2004) and, where it is related to Intellectual Property issues, law (Gollin, 2002; Lettington, 2002; Tobin, 2002).

Bourque, Inglis, and LeBlanc (1993, p. iv) define TK as

...the knowledge base developed by indigenous and local peoples over many hundreds of years through direct contact with the environment. It includes a detailed knowledge of plants, animals and natural phenomena, the use of appropriate technologies for hunting, fishing, trapping, agriculture and forestry, and a holistic knowledge or ‘world view’ which parallels the scientific discipline of ecology.

TK has received increased attention since the Rio Earth Summit of 1992, which as part of an agenda aimed at ensuring long term planetary sustainability, and emphasised the need to further recognise and appreciate the contribution of indigenous people’s ecological knowledge. Following the argument of Ellen and Harris (1999) that folklore, for example as related to bee-keeping or pigeon-fancying, gardening or using medicinal plants, should be understood as the TK of the West, it is argued here that traditional knowledge of the Western materia medica, with its basis in folklore may be considered as part of the surviving TK of the West.

Johnson (1992), a Canadian anthropologist, characterises the features of TK from work with indigenous communities. Broad similarities can be identified between the features she lists and those found within the folk understandings of Western herbal medicine. Three of these

---

**Table 1**

Hierarchies of evidence in evidence-based medicine

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Systematic review of all relevant randomised controlled trials (RCT)</td>
</tr>
<tr>
<td>Level 2</td>
<td>At least one relevant randomised controlled trial</td>
</tr>
<tr>
<td>Level 3.1</td>
<td>Controlled trials without randomisation</td>
</tr>
<tr>
<td>Level 3.2</td>
<td>Case control or cohort studies involving more than one centre or research group</td>
</tr>
<tr>
<td>Level 3.3</td>
<td>Multiple time series with or without intervention</td>
</tr>
<tr>
<td>Level 4</td>
<td>Clinical opinions of respected authorities, descriptive studies or reports of expert committees</td>
</tr>
</tbody>
</table>

Adapted from Willis and White Evidence-based medicine and CAM (Willis & White, 2004, p. 50).
characteristics are of particular interest here. Firstly Johnson suggests that traditional knowledge is generated over an extended period of time, by the ‘folk’ rather than by experts, using observation, not experiments. This parallels the generation of knowledge in herbal medicine. There are very few records of herbs being ‘discovered’ by individuals or groups in the way that scientific discoveries are made; rather, knowledge of medicinal plant uses is developed within the community. Secondly, she suggests that traditional knowledge is transmitted orally, which is consistent with Lyotard’s (1997) discussion of narrative as the primary form of transmission of traditional knowledge. While contemporary Western culture is not an oral culture, transmission of information about plants via narrative continues to occur. References to medicinal plants within stories and songs are a fruitful line of investigation, as demonstrated in work examining references to medicinal plants in popular songs (Evans, 2001). Finally Johnson places an emphasis on spirituality within traditional knowledge and an understanding that matter has a life force and that human life is not superior to other life forms. The acceptance or rejection of this perspective is associated here with the acceptance or rejection of the notion of vitalism. While some herbalists employ this approach, others find it problematic, especially when they are trying to establish herbal medicine as scientifically credible.

The problem of vitalism

The Enlightenment and the subsequent rise of modern science is a significant watershed in the development of Western herbal practice. The Enlightenment initiated a separation between secular and sacred domains and knowledge. Prior to this time, the earth was understood as alive and humans were seen as part of, not separate from, the cycles of nature (Leslie, 1994; Sheldrake, 1990). The Macquarie Dictionary defines vitalism as

the doctrine that ascribes the functions of a living organism to a vital principle distinct from chemical and other forces (Delbridge, 1981, p.1940)

A range of terms has been used in Western herbal medicine to refer to this principle, and the following table has been constructed to summarise the major ideas (Table 2).

<table>
<thead>
<tr>
<th>Concept</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitalism</td>
<td>Life cannot be understood just through principles of physics and chemistry (Sheldrake, 1990, p. 79)</td>
</tr>
<tr>
<td>vis mediatrix naturae</td>
<td>An understanding, originating with Hippocrates, that the body has a natural tendency to recover from disease (Pitman, 2005, p. 107; Whorton, c2002, p. 6)</td>
</tr>
<tr>
<td>Vital force/life force</td>
<td>Self-regulating and self-healing, creative, directive intelligence; the Archeus of Paracelsus (Wood, 2000, p. 14); of early naturopath, also of Thompson and the Eclectics (Wood, 2000, p. 102)</td>
</tr>
</tbody>
</table>

The terms listed in this table are often used interchangeably within herbal medicine, but they have arisen in different contexts, in different historical periods, and are not identical. Vitalism refers to a quality that animates all biological entities (McCabe, 2000; Sheldrake, 1990) whereas vis mediatrix naturae (the healing power of nature) is a description originating in the Hippocratic writings, of a principle by which the body recovers from disease (Pitman, 2005). The Roman physician Galen used the term pneuma to refer to a vital spirit (Nutton, 2004) whereas later writers from the 19th and early 20th century, including the American herbalist Samuel Thompson, understood vital force to be a concrete, robust force (Wood, 2000), and one which moves the body towards healing.

The terms listed above introduce a rich tradition of vitalistic thought within Western philosophy which has underpinned the practice of Western herbal medicine from the time of Hippocrates until the present. However vitalism remains problematic for science, which attempts to understand the world without recourse to such concepts. Greco (2004, p. 690) for example, states that among many scientists vitalism is ‘associated with lack of intellectural rigor, anti-scientific attitudes, and superstition’. Coulter and Willis (2004, p. 588) claim that vitalism is ‘the basis of the claim that biomedicine and CAM are distinct paradigms’ yet its existence is rejected by science. While Smuts (1926) suggested that the term ‘holism’ would be an appropriate substitute for vitalism which was more broadly acceptable to scientists, some now consider the term has now become unhelpfully vague, being used to refer to ‘any therapy that does not consider its clinical perspective to be reductionist’ (Kaptchuk, 1996, p. 44).

Georges Canguilhem’s (Canghuilhem in Delaporte, 1994) perspective on vitalism allows its role in clinical herbal practice to be considered from a slightly different perspective, and also explains the influence on clinical practice of its adoption as a clinical principle. Understanding vitalism as a moral position rather than a scientific fact, Canguilhem suggests that vitalism does not need to be proven, but, as a morality, can be chosen. He explains vitalism as ‘a biology for physicians sceptical of the healing power of medication’ (Canguilhem in Delaporte, 1994, p. 287). He suggests that treating ‘as if’ vital force exists leads to clinical thinking which promotes therapeutic conservatism, because intervention is understood as a method by which the vital force and vis mediatrix naturae can be supported.

This perspective is used by herbal practitioners who see their work as enabling self-healing to occur, rather than to understanding their prescription of herbal remedies as directly countering pathological processes. This is one reason for their preference for multi-intervention treatment (e.g., a combination of a number of herbs, dietary changes and changes to lifestyle) rather than the reliance on a single therapeutic substance or intervention. This approach does not require high doses of herbs (as they are prescribed in combination with other treatments), which in turn reduces the amount of raw material required for treatment. Concentration and dosage become a consideration as the demand for medicinal plants increases, which is a contributing factor to broader pictures of environmental
stress as plant populations are over-harvested (Hamilton, 2004; Jagtenberg & Evans, 2003). The importance of vitalism relates to its role in encouraging minimal intervention and clinical conservatism.

Canguilhem’s appeal to vitalism as morality is not likely to be accepted by scientists who see no place for such appeals within in scientific endeavour. However some practitioners and patients are sceptical of the ability of scientific progress to lead to social progress, citing continuing problems – for example the current widespread ecological degradation, unremitting cycles of poverty, and continuing civil unrest – that remain unsolved (Capra, 1982; Gross, 1992; Harding, 1986; Jagtenberg, 1987; Shell-drake, 1990; Wright, 2004). For these groups, arguments about the implications of vitalism as a therapeutic principle which may lead to a more ecologically sustainable future for herbal medicine through decreasing the amount of raw material required in the manufacture of herbal products, may carry more weight.

**Application of EBM and TK in the clinical practice of herbal medicine**

In an attempt to further explore the issues surrounding EBM and TK in herbal clinical practice, a comparison was undertaken between two herbal texts which describe the medicinal actions of plants from very different perspectives. Braun and Cohen’s (2007) Herbs and Natural Supplements 2nd Edition is based on EBM, while Grieve’s (1931) Modern Herbal is a classic of European folklore of medicinal plants. Further, in order to investigate the relative use of traditional and evidence-based knowledge within the context of Australian herbal practice, a review of the Australian Journal of Medical Herbalism (AJMH) was undertaken in relation to articles about herbal therapeutics. These articles were chosen as they provide descriptions by herbalists of the application of herbal medicine for specific conditions. The language used in descriptions of clinical application of herbal medicine was examined for indications of the reliance of the authors on evidence-based information and concepts associated with traditional understanding of herbal treatment.

**EBM and TK in the herbals**

The differences between EBM and TK are not limited to an acceptance or rejection of vitalism. EBM encourages clinical accountability and addresses the idea of risk, both of which are major drivers in healthcare provision while TK allows for the inclusion of cultural associations and environmental considerations. The challenge which has arisen for herbal medicine is that moves to ‘become more scientific’ involve the preferencing of EBM and the rejection of the folk aspects of the craft which are most closely related to TK.

EBM and TK both have their own ‘rules of truth’ which are used to determine the ways that knowledge about medicinal plants is presented. An illustration will clarify this point. Descriptions of a common medicinal plant, rosemary (*Rosmarinus officinalis*), in two herbals are presented in the following section (within Western herbal medicine, herbals are books that record the uses of medicinal plants). This particular plant has wide utilisation in both contemporary and traditional herbal medicine. Neither Braun and Cohen nor Grieve has been chosen as a ‘typical’ herbal, if there be such a thing, but they have been chosen because they illustrate very different approaches to communicating knowledge about plants. Grieve uses TK (which allows for the maintenance of a vitalistic perspective) as a basis for the material she presents, while Braun and Cohen use EBM (which does not).

These books have very different origins and aims. Braun and Cohen’s (2007, Preface) stated aim is to provide up-to-date information on the ‘modern uses and scientific research’ of herbs and nutritional supplements commonly used in Australia and New Zealand. The emphasis in this book is firmly on documenting the published scientific evidence relating to individual herbs and nutritional supplements. The authors see the book as ‘contributing to “raising the bar” in the complementary medicine debate (and promoting) a spirit of collaboration between all healthcare professionals and their patients’ (Braun & Cohen, 2007, Preface). As such, its focus is on addressing the needs of these professionals. This includes providing the answers to the questions they may have about evidence, efficacy of herbs in the treatment of specific pathologies, possible connections between plant constituents and therapeutic actions, and possible interactions between pharmaceuticals and herbal products. In contrast, Grieve’s book (‘Mrs Grieve’ to generations of herbalists) grew out of a series of leaflets she wrote for the Home Office to encourage Britons to harvest medicinal plants as part of the war effort during World War 1 (Bennett, 1991) and it was welcomed by its editor, Hilda Leyel, as including ‘traditional lore and properties of plants’ (Grieve, 1931/1980, p. xiii). It is not a handbook specifically for practitioners, and does not suggest approaches to treatment. It records a broad range of information about each plant.

Both books comprise of a series of monographs about individual herbs. Braun and Cohen also include foods and nutritional supplements, while Grieve limits herself to medicinal plants. Each herbal monograph begins by presenting the relevant common name, Latin binomial, part used and botanical family. This information is largely similar between the books, differences occurring mainly where plant families or Latin binomials have changed between 1931 and 2007. Each monograph also includes a list of plant constituents, therapeutic actions, and indications, i.e., examples of conditions in which the plant may be useful. However, the differences between the herbals go further than simple reflections of historical styles and content. Braun and Cohen’s book reflects scientific understanding while Grieve’s documents broad cultural knowledge.

Of particular interest is the way in which risk and danger are addressed in the two herbals. Braun and Cohen are concerned with risk, whereas Grieve discusses danger but not risk. The difference between risk and danger is identified by the Macquarie Dictionary as the presence of chance – risk is ‘exposure to the chance of injury or loss’ (Delbridge, 1981, p. 1491) whereas danger is the ‘liability or
exposure to harm or injury' (Delbridge, 1981, p. 471). One aspect of the rise of the ‘risk society’ (Giddens, 1991, 1999) is the importance now placed on risk management within healthcare delivery. Risk management has become integral to assessments of quality in healthcare, and increasingly is backed by procedural if not legal requirements (Swage, 2000). Questions of the level of risk posed by herbal medicines are necessarily raised as its use becomes more widespread (Bensoussan, Myers, Scott, & Cattley, 2005). However this concern is reflected in modern herbal texts (including Braun and Cohen), not those texts that record traditional information (including Grieve) when concern was limited to ‘danger’, typically by the ingestion of toxic plants.

Within Braun and Cohen’s text the concern with risk is reflected in subheadings which include not only ‘toxicity’ but also ‘significant interactions’, and ‘contraindications and precautions’ which ensures that readers are well versed in possible sequelae. Grieve’s information is limited to the signs of poisoning and appropriate interventions required by a relatively small number of particularly toxic herbs, e.g., belladonna Atropa belladonna and foxglove Digitalis purpurea.

A further point about risk should be considered. While the argument might be made that Braun and Cohen’s work represents advances in herbal knowledge, it is also relevant that the authors differ in what is actually referred to by the word ‘herb’, that is, what the authors take as their central subject matter. Grieve refers to individual plants, i.e., the plant itself and unprocessed or minimally processed plant material. She makes suggestions as to the variety of ways in which the plant may be understood and cared for and the ways in which herbal material may be prepared. In contrast Braun and Cohen do not use information regarding the crude plant, but rather their information is derived from research which has been undertaken

on a particular herbal extract or preparation at specific doses, and the evidence for the efficacy of herbal preparations must be related back to the preparation used in the research (Braun & Cohen, 2007, p. 18)

Thus Braun and Cohen substantiate their claims by reference to herbal products, and very specific, often highly concentrated, herbal preparations, while Grieve’s focus is the plant itself. This relates back to the issue of risk. For Braun and Cohen, risk is an issue related to specific products, although in practice it may be extrapolated to other products of the same plant species. Importantly, risk is associated with the threat of litigation, which requires someone to take the blame. It is possible to blame, and sue, the manufacturer of a product which has caused harm or the practitioner who has prescribed it: it is impossible to sue the plant itself.²

² However the plant itself may be ‘banished’. In Australia, if a plant is considered sufficiently dangerous its supply may be limited by its inclusion in the Standard for Uniform Scheduling of Drugs and Poisons, and depending on the Schedule on which it is placed it may be available for example only via a pharmacist, or medical prescription, or it may be completely prohibited for sale or supply.

The herbal in detail: Rosemary (Rosemarinus officinalis)

After a very brief summary of the history of the plant’s uses, Braun and Cohen’s monograph addresses those actions of the preparations of rosemary for which there is evidence, both in vitro and in vivo (Braun & Cohen, 2007, pp. 545–548). In vitro evidence for rosemary includes antioxidant, antibacterial anti-inflammatory, hepatoprotective and chemoprotective and antimutagenic activity. In vivo evidence, including the ‘gold standard’ of randomised controlled trials, supports its use for increased mental concentration, alopecia, and as an antispasmodic, and chemoprotective agent. This research is reported in detail, and other activity, with ‘lower’ levels of evidence including its effect on menopausal symptoms, is briefly mentioned with the suggestion that they require further investigation. Thus the presentation of this material is consistent with an evidence-based framework.

The research on which this information is based is carried out on specific extracts, and the results claimed only for those extracts, rather than for the crude plant. The focus is therefore on herbal products that have demonstrated measurable outcomes in the relatively short period of a clinical trial. In order for a herb to ‘prove’ its therapeutic potency in a clinical trial it needs to be presented in a form that is standardised (for reliability and consistency) and concentrated (to provide a measurable physiological change in a short period of time).

In contrast, the description of rosemary given in Grieve’s Modern Herbal (Grieve, 1931/1980, pp. 681–683) begins with a botanical description of the plant and its habitat, and recommends methods of cultivation. She lists constituents and describes the effect that the herb has on the human body (tonic, astringent, diaphoretic and stimulant) and suggests therapeutic applications for it (for alopecia, as an application for paralysed limbs, as a cordial for weak hearts, for specific types of headache, and so on). She goes on to detail the uses of the plant in cultural events (weddings, funerals, as protection against disease and evil spirits, during Christmas festivities). Literary references (Ben Jonson; Thomas More) and references to historical figures (Anne of Cleves; Elizabeth, Queen of Hungary in 1235) and historical herbas (Gerard’s Herbal; Bancke’s Herbal) are included alongside recipes for the home preparation of medicines and detailed instructions for their application. Thus her monograph draws on a broad cultural history and details of the folk knowledge and common use of plants in different geographic areas of the UK as well as other parts of the world. Her focus includes the living plant as well as the plant as a crude drug, and the cultural references indicate an appreciation of the plant that goes well beyond constituents and specific actions. Thus Grieve’s description of rosemary encompasses a very broad range of information.

Braun and Cohen’s focus on the herb as a commodity to be bought and sold excludes any clear sense of the intrinsic value of the herb as herb for either spiritual or more pragmatic reasons such as ecological sustainability. This view contrasts with Grieve’s broad-ranging information, which includes myths, stories and anecdotes, recipes and household hints. Her book documents folk knowledge that has been used for generations to assist individuals and communities to care for themselves.
This discussion demonstrates the differences between herbal knowledge based on EBM and herbal knowledge which is developed from folk knowledge or TK. The ‘scientisation’ of herbal medicine can be understood as a strategy of professionalisation (VanMarie, 2002). Braun and Cohen’s book is appropriate for herbalists who are professionalising in a society where EBM and risk management are firmly embedded in the understanding of what it means to be a health practitioner, and when sophisticated herbal products are increasingly popular. Grieve’s book, on the other hand, is more of a handbook of traditional knowledge of European herbal medicine. Her work contributes a multi-faceted view of the plant within the context of its physical and cultural environment, and encourages the maintenance of an older folk tradition of medicinal plant use via its inclusion of stories and recipes. Her approach is congruent with a traditional vitalistic perspective, although she does not overtly refer to plants in this way. With its detail on the growing needs of each remedy, her work can be used as a resource for those herbalists who wish to develop a sensitivity regarding the physical requirements of their use of individual herbs.

This is of particular significance given that the experience of most herbalists and consumers in Australia is with plant products (usually liquids, tablets or capsules) rather than with unprocessed fresh or dried plant material, or the plants themselves (Casey et al., 2007). Traditional knowledge with its emphasis on plants as plants involves a connection with the environment becomes more tenuous with the increasing use of sophisticated plant products.

**Articles on herbal therapeutics in the Australian Journal of Medical Herbalism (AJMH) 1989–2008**

The AJMH has been published by the NHAA since 1989 and a statement in each issue describes it as including ‘material on all aspects of medical herbalism, including philosophy, phytochemistry, pharmacology and clinical application of medicinal plants’. A review of original articles published between the Vol 1:1 in 1989 (month not stated) and Vol. 19:2 in June 2008 located a total of 285 original articles. In order to explore the ways in which herbalists describe their treatment of patients, articles written by clinical herbalists on herbal therapeutics, i.e., the herbal treatment of specific conditions, were identified. In total, 31 articles on herbal therapeutics were found.

Articles excluded from the review included those that dealt with the actions of individual herbs or groups of herbs; those that dealt with specific conditions and not their herbal treatment; articles on therapeutics not written by practising herbalists and those that dealt with individual case histories without including discussion of the specifics of the condition and broad therapeutic approaches to its management.

While the total number of articles is small, further analysis of their content is justified because of the unique place this journal has within Australian herbal practice. It is the sole Australian journal that deals specifically with the clinical practice of herbal medicine. A broad analysis is presented in Table 3 below, with the articles collated in five-year periods.

Two initial points are made in relation to this table. Firstly the number of articles on herbal therapeutics published in the Journal has decreased during the last decade. Twenty-two articles were published on therapeutics out of a total of 149 (14.76%) articles in the first ten years whereas 9 articles were published on therapeutics out of a total of 136 (6.6%) articles in the next decade. Secondly, it is of note that herbalists publishing in this journal overwhelmingly use the language and concepts of biomedicine: almost every article in this review includes biomedical concepts, most commonly in the description of the condition treated. This indicates that herbalists’ understanding of illness is congruent with that of biomedicine.

The review also demonstrates an evidence-base for clinical practice through references both to clinical research into herbal interventions and phytochemical research with regard individual plants and their constituents. While such references were largely absent prior to 1992, nearly three-quarters (14 of 19) of the articles published since then refer to literature in these fields.

Just under half of the articles (15 of 31) refer to concepts that can be seen as part of traditional herbal philosophy, a philosophy that is essentially vitalistic. These concepts include references to humoral medicine based on the four-element theory, to physiomedicalism which arose in the 18th century US, and include functional diagnostic categories used by herbalists including lymphatic congestion, enervation and organ dysfunction. It is of particular note that while during the first five years of the Journal’s publication specific references to vitalism almost equalled those of herbal philosophy (9 references to vitalism, 11 to herbal philosophy), this is no longer the case and there have been no references to vitalism in the last five years.

The review shows that an evidence-base for practice is increasingly apparent in descriptions of therapeutic interventions, and references to herbal philosophy and to vitalism are decreasing. Discussions with the editor of the Journal indicate that an emphasis on science within the Journal’s focus has meant that articles on herbal therapeutics are now expected to be more research-based than they were in the early years of the Journal (pers.comm.

**Table 3**

Therapeutics articles in the AJMH

<table>
<thead>
<tr>
<th>Volume, date</th>
<th>Original articles</th>
<th>Articles on herbal therapeutics</th>
<th>Refer to biomedical concepts</th>
<th>Evidence base for practice</th>
<th>Refer to herbal philosophy</th>
<th>Refer to vitalism</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994–1998 Vol. 6–10</td>
<td>71</td>
<td>10</td>
<td>10</td>
<td>7</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>1999–2003 Vol. 11–15</td>
<td>72</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2004–2008</td>
<td>64</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>(to June) Vol. 16–20(2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Anne Cowper 3 June 2008). No claims are made here as to the extent to which these the articles reflect the actuality of clinical herbal practice.

**Discussion and conclusion**

While lip service has been given to attempting ‘a grand synthesis of the new and the old, a hybrid that vigorously does justice to both’ (Mills, 1991, p. 11), the nature of the tradition that is the source of the old knowledge and the complexity of practically effecting such a combination receives scant attention in herbal discourse. Such an approach would need to incorporate research from medical and plant science alongside research informed by the diverse branches of social sciences and the humanities including anthropology, history, philosophy, politics, sociology, cultural studies, visual arts, music and literature. This discussion is not yet evident. While ‘traditional use’ is accepted as a basis for therapeutic claims made about herbal products (in Australia at least), current herbal literature is increasingly focused on phytochemistry and clinical trials. Rather than being incorporated into existing traditional herbal knowledge, these disciplines are replacing it. The concern of some educationalists that the ‘imposition’ of science comes as the cost of these older approaches to practice (McCabe in Lin et al., 2005) is borne out by the review of articles in the AJMH.

Tensions between the use of herbs as phytopharmaceuticals and the use of herbal medicines prepared traditionally have been discussed previously (Jagtenberg & Evans, 2003). In this paper I use the work of Canguilhem to extend that discussion to the broader question of herbal practice. Canguilhem’s (Delaporte, 1994) suggestion that vitalism leads to therapeutic conservatism opens up a discussion of the implications of treatment approaches (in this case the use of vitalism as a therapeutic principle) and is important in this context. His further suggestion that vitalism should be understood as a moral position rather than as a scientific fact may be central to the development of a modern herbal medicine which allows traditional knowledge — where vitalism and the sanctity of the earth is central — to be valued in its own right and in all its complexity.

To reiterate, EBM encourages the development of herbal knowledge based on products made from plants rather than on the plants themselves. The use of manufactured herbal products distances us, rather than connects us, with the plants in their raw, or natural, state because to a consumer, a herbal pill appears more similar to a drug than a herbal tea or combination of extracts. Arguments that such distancing is an inevitable part of modern life do not take into account the popularity of farmers’ markets, organic produce and the slow food and fair trade movements. Locally grown good quality medicinal plants and low-tech products made from them are a logical complement to these activities.

The integration of EBM and TK could contribute to a revitalised approach to herbal practice in part by opening up a debate not only on the political and economic consequences of ‘what counts as true’ in herbal medicine, but the therapeutic and environmental consequences of traditional vitalistic and emerging phytotherapeutic approaches to practice as well. As participants in a developing area of study, herbalists are in a unique position to formulate new ‘rules of truth’ for the discipline. However the evidence presented here suggests that, at least for Australian herbalists publishing in their professional journal, no such task is currently being undertaken.

**References**


Evidence-Based Medicine and Naturopathy

MONIQUE LEWIS, B.A. (Hons.), and JUDY SINGER, Dip. Applied Science (Naturopathy)

ABSTRACT

Evidence-based medicine (EBM) has been advocated as a new paradigm in orthodox medicine and as a methodology for natural medicines, which are often accused of lacking an adequate scientific basis. This paper presents the voices of tradition-sensitive naturopathic practitioners in response to what they perceive as an ideologic assault by EBM advocates on the validity and integrity of natural medicine practice. Those natural medicine practices, which have tradition-based paradigms articulating vitalistic and holistic principles, may have significant problems in relating to the idea of EBM as developed in biomedical contexts. The paper questions the appropriateness of imposing a methodology that appears to minimize or bypass the philosophic and methodological foundations of natural medicine, and that itself seems primarily driven by political considerations.

INTRODUCTION

This paper has developed as a response to the emergence of evidence-based medicine (EBM) as a “new paradigm” in orthodox medicine and a “new” rationale for health policy workers. The authors’ position is intended to reflect the logic of different naturopathic modalities in showing how the idea of EBM is problematic for naturopathy and other disciplines and practices that deploy “evidence” in their texts and professional lives. EBM assumes a hierarchy of knowledge and method, and is an implicit, if not explicit, critique of nonorthodox systems of health and healing. For instance from a pro-EBM position, it has been suggested that the evidence accepted by naturopathic practitioners is less valid and less reliable than “science-based” evidence. This is the kind of unresearched dogma that has stimulated the writing of this paper.

Evidence and evidence-based practice needs to be understood as context dependent, and bounded by philosophic assumptions. The authors argue that the premises of EBM as developed by Sackett and his medical fellows are often inapplicable to these other modalities. EBM does have a role to play in complementary and alternative medicine (CAM), for example, but, as part of the mix of evidence, and not as a gold standard of clinical practice and research. That is, natural scientific and medical reasoning are relevant and sometimes part of CAM and allied modalities, but they do not necessarily represent the dominant or preferred logic of these practitioners.

School of Natural and Complementary Medicine, Southern Cross University, Lismore, Australia.

Rhetoric about the dangers of nonorthodox medicine has been so abundant in scientific medical journals, the media, and science-dominated tertiary institutions, such that bashing the nonorthodox has virtually become common sense for medical doctors and professional scientists. See, for example, Sackett et al., and Ernst.

As Singer and others have pointed out, CAM is a biomedical construction that tends to presuppose and validate the idea that CAM should converge toward the logic of biomedical and scientific orthodoxy. (Singer J, Fisher K. Appropriateness and resistance: The impact of the mainstreaming of traditional herbalism, forthcoming.)
The authors argue that a hierarchy of knowledge that privileges the randomized controlled trial (RCT), “scientific objectivity,” statistically based “truths,” and other canards, runs counter to most naturopathic ideologies and practice; and that demands from doctors, scientists, and policy makers for more hard evidence in the mix will contribute only tangentially to a further understanding of these medicines.

The present concern is with the potential for EBM rhetoric and institutional pressures to make naturopathy more submissive to medical dominance and widely coerce nonorthodox systems of health and healing to the mainstream, and to some extent to be co-opted by biomedical orthodoxy.4,5

The authors do not claim to represent all CAM and naturopathic practitioners, because this is a paradigmatically diverse group, but to the extent that these practitioners embrace holism and vitalism as core beliefs and practices, these views may be seen to resonate with what the authors contend is a more traditional standpoint. This perspective does not reject science, evidence, or empirical research, which will become more apparent in the following. Rather, the authors simply contend that these more traditionally based beliefs and practices are often marginalized and excluded by opponents and fellow practitioners keen to mainstream and institutional pressures to make naturopathy more submissive.

CLASSICAL EBM

The ideas of William Sackett are considered seminal in the current literature dedicated to EBM, as any web search will show. Sackett et al.1 have defined EBM at some length, which is reproduced below for the insights this definition brings to the understanding of the epistemologic and institutional power relations presupposed as "normal.”

The practice of EBM means integrating clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgement that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patient’s predicaments, rights and preferences in making clinical decisions about their care. By best available clinical evidence we mean clinically relevant research often from the basic sciences of medicine but especially from patient centred clinical research into the accuracy and precision of diagnostic tests (including the clinical examination) the power of prognostic markers, and the efficacy and safety of therapeutic rehabilitative regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious and safer. (pp. 71–72)

Closer reading of this text reveals a number of dualisms/dichotomies in the reasoning. These dualisms line up under the difference between clinical expertise and clinical evidence, and reveal something of the institutional basis and power relations expressed in the idea of EBM. “External,” “basic” scientific research, “tests,” “markers” and the logic of the laboratory are contrasted with the “internal,” subjective, individualistic practices and diagnoses of clinicians in the privacy of the clinic. This kind of dualistic logic is problematic for naturopaths, namely herbalists and hom[oe]opaths, in this study. It also reifies a public/private dichotomy that subtly reinforces the legitimacy and logic of state-controlled bureaucracy.

This kind of dichotomizing logic also buttresses the idea that there is a legitimate hierarchy of knowledge and method with the RCT as the gold standard and the clinician’s notes, observations, and judgments right down there in status with ethnography, sociology, and anecdote.6 As shown in this paper, there are practitioners of naturopathic modalities who do not subscribe to this hierarchy at all; they tend to see this as a form of nonholistic reductionism. The more insidious effect of this scientific approach to evidence is that other naturopathic (and alternative) practitioners may simply assume that their craft is actually incompatible with “legitimate” science and medicine, and that they are just silly or nonscientific. Rather, this paper suggests that the general incompatibility results not from a failure of reason or logic, but to differences in cosmology and methodology that stem from the naturopath’s genuine commitment to holistic health and the idea of participation in complex systems. This line of analysis speaks to the idea of paradigmatic difference and the logical inability of orthodox medicine or science in correcting, or coopting, healing modalities that are based in traditional approaches to health and healing.

EBM AS A HEGEMONIC CULTURAL MOVEMENT

Given that EBM involves elites, institutions, notions of progress, and much funding, it might be considered a hegemonic cultural movement generated as a continuation of the ascendency of medical dominance.5 In the United Kingdom, EBM has been identified by medical powerbrokers as a paradigm shift in medicine, and applied as a rationale for pub-

---

1As discussed in Evans’ forthcoming Ph.D. dissertation (Southern Cross University, 2006).

4Evan Willis and other sociologists of medicine have defined medical dominance to be constituted through hegemonic cultural practices.7
lic policy making, or in effect, the further marginalization of competing approaches to health. This cultural movement has registered as an explosion of institutions dedicated to the teaching, researching, and proselytizing of EBM.1 There are dedicated journals, postgraduate courses and conferences, databases, and Web resources hosted by a plethora of centers and groups.

In the United Kingdom, EBM has been an integral part of the process of changing the organization of the health system. EBM prioritizes quantifiable data and quantitative research. This evidence, in conjunction with the statistical deployment of databases, has been able to provide meta levels of analysis and has particularly empowered statisticians, epidemiologists, and other quantitative analysts in the determination of health policy and infrastructure, as Charlton and Miles point out.2 The impact of EBM in Australia and the United States does not appear so overwhelming, but there is one major institutional driver that has been identified as controlling in these countries, the insurance industry.4 Although the detailed process may vary from country to country, the broad project is the same as it has been for centuries: Attack the medical competition; show no intellectual tolerance; and only take those prisoners who can be converted.

Of course, the general idea of evidence in medicine does not automatically entail the RCT, but it should be noted that alternative or traditional views that are not grounded in evidence from RCTs tend to be dismissed or marginalized as less valid. Sometimes this may be legitimate, but the purpose of this paper is to challenge the idea that the RCT is, or should be, the gold standard for CAM and naturopathy. One can only hope to begin this discussion in a short paper, but the general position is, nonetheless, that naturopathic research can proceed using evidence that is scientifically valid (i.e., empirically testable) without necessarily negating assumptions of holism or vitalism. This philosophical view cannot be argued in this short paper beyond asserting that naturopathy needs to continue to legitimize a variety of methodologies and epistemologies as part of its eclectic nature. Empiric evidence remains critically important, but science and the proponents of EBM need to be further educated about the wisdom of tradition. Of course, this does not exclude the converse either. The authors seek to promote discourse, not dogma.

**In Australia, naturopaths are typically trained in a number of modalities, usually herbal medicine, nutrition, homeopathy and tactile therapies (massage). Within clinical practice, practitioners may specialize in area(s) of interest. Practitioners may vary in the extent to which they embrace science and medicine as fundamental in their beliefs and practices.

In 2003 a Web site in the UK was found to list the following indicators: seven postgraduate courses, 33 journals with an EBM focus, 12 databases with an EBM focus, and a whopping 77 EBM “health web resorts which are Centres, Units and Collaborations” (e.g., The Cochrane Collaboration), among other activities and organizations. Accessed December 8, 2005: http://www.herts.ac.uk/lis/subjects/health/ebm.htm.

#In Australia, theses of Evans and Howden (Southern Cross University, 2006) do begin to quantify these matters.

**The authors know of no reliable quantitative data about these differences, but the forthcoming theses of Evans and Howden (Southern Cross University, 2006) do begin to quantify these matters.

**The authors suspect that most clinicians, both medically orthodox and naturopathic, would share misgivings about the possible “tyranny of EBM.” This is actually Sackett’s own phrase for the overenthusiasm for EBM. Although the individual responses presented in the following do not constitute a survey of practitioners as one might perform in a more extended analysis of these fields, they are typical, based on the authors’ professional experience, related research, and the existing curricula of college and university courses. As the summary-analyses that which accompany each statement attempt to show, there is a strong consensus that EBM is antithetical to holistic and vitalistic philosophies of health.**

Other shared concerns also arise.

### TYPIFYING THE PROBLEMS NATUROPATHIC PRACTITIONERS CONFRONT

The contributing authors of this paper and other colleagues constituted themselves as a small focus group that might explore the philosophic, methodologic, and professional dilemmas that EBM raises for naturopathic modalities.

Members of the working group were asked to consider what problems EBM raised for them as naturopathic professionals. The individual responses, as presented in the following, are most revealing. In the responses of the homeopath and two herbalists, the extent of the paradigm divide between EBM and their concerns is profound. Both modalities use evidence but in a holistic and vitalistic context.

The reflections of these naturopaths on the working logic of their modalities (their clinical logic) appears more complex than that of the RCT (the gold standard in EBM) and a generally reductive approach to the question of evidence. The authors suspect that most clinicians, both medically orthodox and naturopathic, would share misgivings about the possible “tyranny of EBM.” This is actually Sackett’s own phrase for the overenthusiasm for EBM. Although the individual responses presented in the following do not constitute a survey of practitioners as one might perform in a more extended analysis of these fields, they are typical, based on the authors’ professional experience, related research, and the existing curricula of college and university courses. As the summary-analyses that which accompany each statement attempt to show, there is a strong consensus that EBM is antithetical to holistic and vitalistic philosophies of health.**

Other shared concerns also arise.

### AN HERBALIST’S RESPONSE TO EBM

My concerns regarding the adoption of EBM as a basis for medical decision making relate (a) to the underlying aims of, and values reflected within, our medical system, and (b) its applicability to CAM.

**Values.** EBM is held to contribute to “better” health outcomes and “more effective” medicine. However
discussion is curiously absent regarding the values behind such statements, and questions such as “how should better health outcomes be measured?” and “what would a better health system look like?” have not been part of this debate.

For example to what extent are longevity, or the “saving of lives” markers of medical “success”? Given finite resources, is a society “healthier” when the bulk of its population is over 50, or over 80? Is it a sign of health when 90% of very premature babies survive but require more medical interventions for the rest of their lives?

Equations between “better medicine” and “more EBM” do not include the environmental impact of particular interventions. If such considerations were included in discussions of “best practice,” a preferred treatment may be a medicinal plant that is 30% less effective but 90% less environmentally demanding than a pharmaceutical. However if these considerations are not included, the preferred treatment may be a drug which is 30% more effective and 90% more environmentally demanding.

CAM. Concern from herbalists and naturopaths in Australia (and elsewhere) regarding the application of EBM to CAM has focussed primarily on methodological issues, especially hierarchies of evidence, and the difficulties of applying of RCTs within disciplines where a multi-interventionist and individualistic approach to patient treatment is the norm. It is not only that treatment within the naturopathic disciplines involves multiple interventions, but also that practitioners consider multiple indicators of patient distress and improvement.

These treatments are complex, and the systems they seek to change are similarly complex. RCTs are a valuable source of information: it is their preferencing over other types of evidence which is problematic. The practical reality is that most RCT’s are carried out by companies attempting to amass sufficient data to fulfil regulatory requirements for introducing a new product onto the market. Such trials aim to assess the safety and efficacy of particular products to alleviate particular symptoms or diseases. They contribute only marginally to the individualised prescriptions and advice which makes up the bulk of clinical herbal practice.

Summary

This account argues that:

1. EBM lacks concern for community health.
2. EBM does not account for ecologic considerations; and
3. Because herbal medicine is holistic and health oriented, it opposes complex interventions and interactions in naturopathic practice to the reductive process of isolating single factors and simple cause–effect relationships.

A HOMEOPATH’S RESPONSE TO EBM

The meaning of the word “evidence” changes according to who is allowed to define it.

The “evidence” of EBM is largely that which arises from the Random Controlled Trial (RCT). It involves levels of significance of the chance of removal of individual symptoms (in past cases) and bears no relevance to future cases except in terms of the “probability” of “success” or “failure.” It is incapable of predicting “success” (or failure) in any one individual case.

The “evidence” of homeopathy is twofold and is specific to the individual case.

- On the one hand we have the “evidence” of the remedy as collected in “provings”—the symptoms produced by feeding carefully controlled doses of a substance to “healthy” human beings
- On the other hand we have the “evidence” collected from the patient—an holistic picture of the totality of symptoms being experienced by the patient, constructed in a way that is readily comparable with the evidence of the provings.

It is the philosophy of homeopathy—that “like cures like” (*similia similibus curentur*)—which links these two pieces of evidence. This philosophy states that a match of the “major” symptoms of the remedy with the “major” symptoms of the patient will assist in the movement toward “cure.”

Disease, according to EBM, is characterized by a collection of (largely unrelated) symptoms, the mere removal of which is then said to constitute “cure” (or at least “success” in an RCT).

Homeopathy, on the other hand, is based on an Hippocratic, humorally based model of the human being—consisting of earth, water, air and fire (body, mind, soul, and spirit). The homeopath is therefore interested in all aspects of the human being in-so-far as they “point” to the nature of the dis-ease.

In homeopathy “success” is the improvement of “well-being” and “quality of life” resulting from the matching of the totality of symptoms of the patient with the totality of symptoms of the remedy. This will normally (although not necessarily) also involve the removal (or at least the easing) of the symptom picture. The symptoms are not the disease—they point to the nature of the disease. Dis-ease, within this model, is a necessary means to growth and human evolution, and longevity is a possible consequence rather than an aim.
Summary

In this practitioner’s view:

1. Statistically based inferences about the likelihood of outcomes for typical cases are of little use in the treatment of individual cases. The homeopath follows patient symptoms over a length of time and the analysis of patterns of change requires holistic logic and practice. That is, in individual cases it is not possible to isolate symptoms and causes from the whole person. Knowledge from RCTs would be of little use in therapeutic practice.

2. The kind of evidence involved in homeopathy derives from controlled processes that have been largely validated through continued observation and assessment and documented since the time of Samuel Hahnemann, (M.D.) at least. The kind of data generated in this historical process could not be replaced by data from RCTs.

3. The logic of the RCT is alien to hom[oe]opathy as shown by the difference in their desired outcomes.

A NATUROPATH’S RESPONSE TO EBM

Naturopathy, a Western nonbiomedical ethnomedicine is based on holistic and vitalistic principles8 whereas biomedicine, the prevailing ethnomedicine is based on scientific reductionist principles.9,10 Given such extensive difference it is inappropriate to superimpose reductionist methodologies that are paradigmatically incongruent with the holistic practice of naturopathy.

The notion of “the whole being greater than the sum of the parts” epitomises the philosophical differences between “traditional naturopathy” and scientific medicine.11 Traditional naturopathy does not easily fit into a scientific research model. For example, three patients presenting with migraine as their primary health concern are likely to receive three very different herbal formulas that take into account the unique nuances of the individual. As EB methodology gives primacy to RCTs which is based on limiting as many variables as possible, application is methodologically incongruent to traditional herbal/naturopathic treatment. It is of course possible to apply EB methodology to a named active isolated plant constituent or to a specific nutrient. However, traditional naturopathy is base on the understanding that a plant’s efficacy is based on the synergy of the whole plant rather than a so called “active constituent.” RCTs simply cannot cope methodologically with the holistic nature of naturopathic medicine.

By imposing EBM, naturopathy is not legitimated according to its own paradigmatic definitions, but rather, is evaluated according to the parameters set by the scientific model resulting in the marginalization and corruption of “traditional naturopathic knowledge.” This is exemplified in the practice of “scientific herbal medicine” (phytomedicine) in which only herbs subjected to and validated by RCTs are legitimated as effective medicines. Such herbs are then symptomatically prescribed to treat specific disease states, rather than applying a whole person/whole plant approach. The knowledge base of traditional naturopathy is taken out of context and inappropriately manipulated to fit a scientific paradigm.6 As a result, traditional knowledge and practice is dismissed, devalued and in real danger of becoming extinct!

Summary

According to this practitioner:

1. Naturopathy is based on holistic and vitalistic principles.
2. Biomedicine is based on reductionism and is paradigmatically incongruent with naturopathy.
3. EBM marginalizes and corrupts traditional naturopathic knowledge.

A NATUROPATHIC EDUCATOR’S RESPONSE TO EBM

EBM represents a style of thinking that appears to exclude the possibility of a truly holistic approach to health care. The hierarchy of evidence includes, in theory, a range of approaches that encompasses different treatment strategies and types of authority. The reality is quite different, with the RCT dominating the validation of knowledge and empowering a specific branch of health care to continue its domination. The approach rests on a completely unquestioned assumption about the superiority of Western based biomedicine. The concept that there might be other ways of looking at health is not even raised it is so remote to the theoreticians who advocate the use of EBM. Vitalism lies at the heart of natural medicine, a deep respect for the body’s self-healing capacity and a commitment to working with that innate force. Vital force! How does the RCT cope with that! Where does preventative medicine fit in? What about traditional practices?

Untested, blanket acceptance of EBM education has serious ramifications for CAM. When the educational direction changes, there is the potential to create a whole new style of thinking in the next generation of practitioners. If the structures of EBM are taken into the classroom and given as untested authority of the integrity of CAM, then somehow CAM has surrendered its authority to an external measure, without so much as a whimper. Upcoming practitioners will
teach, as they have been taught. If they are not given a deep understanding of what holism and vitalism means, rather only the small range of science-based versions of CAM as validated by EBM, then the profession will change and holism as a concept will become diluted.

Summary

In this educator’s opinion:

1. EBM is antithetical to holistic and vitalistic approaches to health care; and
2. There is danger that EBM will be accepted uncritically in educational institutions.

CONCLUSIONS

The word “evidence” recently has gained a new weight in medical discourse and institutional life, but in Australia so far EBM has mainly impacted only rhetorically on naturopathy. EBM has been touted as a “new paradigm” and as a corrective for outdated, bad or unscientific practices. Although it may be true that some medical and health practices are not supported by a weight of evidence and that this can lead to harm, it does not follow that doctors, scientists, or any bureaucrats should have a monopoly on the meaning and deployment of evidence.

As discussed, the core assumptions and institutional focus of EBM is largely antipathetic to those naturopathic modalities that emphasize vitalism and holism in their foundations. This critical issue of course refers to the broader question of naturopathy’s survival within a culture that is socially, politically, and economically dominated by biomedicine. The RCT and other empirical modes of health research are undoubtedly valuable additions to health-related stocks of knowledge, but in the context of both the institutionalization of naturopathy and the basic comprehension of naturopathic modalities, it is emphasized that naturopathy needs to be understood as having and requiring firm foundations in traditional and nonorthodox modalities of health and healing first and foremost. These philosophies are the baseline of the naturopathic approach and need to be respected and preserved when there is any move by external forces to create an integrative shift in healthcare practice.

REFERENCES


Address reprint requests to:
Sue Evans, B.A. Dip. Ed., M.N.I.M.H.
School of Natural and Complementary Medicine
Southern Cross University
P.O. Box 157
Lismore NSW 2480
Australia
E-mail: sue.evans@scu.edu.au
Global Herbal Medicine: A Critique


ABSTRACT

Herbal medicine finds itself at a crossroads. If it continues to become mainstreamed in a commodity-driven health industry, its focus will change from craft-based tradition to globalized industry. On the other hand, if the fundamental importance of tradition to indigenous and non-indigenous medicine is respected, ecologic and cultural issues arise. Central here are the issues associated with control of both land and culture. Many indigenous cultures and their local ecologies are currently threatened by globalization. Historically, successful large corporations have neither respected the environment nor easily acknowledged indigenous claims to land and intellectual property, so no easy resolution of these conflicts seems likely. Our case study of Mapuche medicine allows us to explore the social and cultural conflicts that many practising herbalists experience. We argue that because of the basic contradictions involved, the protection of cultures and ecologies that underpin the discipline must be made a clear priority. We argue that local cultural traditions are clearly at odds with a globalizing herbal industry.

INTRODUCTION

This paper is based in the idea that the traditions of herbal medicine (in the Americas, Europe, Asia, Africa, and Australia) have common cultural roots in shamanism and Nature worship—practices that have provided humanity’s most archaic psychocultural memories and that remain relevant to our understandings of the past and future of herbalism and “natural health.” These earliest cultural–spiritual practices survive in many indigenous cultures as well as in many forms of natural and complementary medicine and, for some, continue to underpin the search for ecological sustainability and personal health. Such ancient wisdom does, however, continue to challenge the logic of a globalized herbal industry.

The example we develop in this paper is that of the medicine of the Mapuche people in southern Chile.

In so far as ancient modalities are animistic, cosmologic, and ecologically situated, the historical lineage of herbal medicine is “outside the square” as far as the Western mainstream has been concerned—since at least the scientific revolution and arguably since the advent of a Christian Europe. Pre-Christian (or indeed post-Christian) spirit worlds and cosmologic principles that impinge on human worlds have been, and still are, at odds with both scientific and religious orthodoxy, the broad sweep of modernization,* and now, with globalization as we go on to discuss.

Nonetheless, the continuing resilience of non-Cartesian–Newtonian practices challenges

*That is, the typically Western processes of progress and development based on industry and high technology. See the preeminent sociologist Anthony Giddens (listed in references) on modernity for a sociologic account of these ideas.
those dominant “establishment” views, which are fundamentally based in positivism† and the desire to market medicine as a commodity. In the case of herbal medicine, the continuing antipathy of many traditional herbalists to global herbalism is based in the fundamental contradiction between Earth-centered views that preserve the local and the more abstract globalizing views of the scientific establishment and big business. This tension between the beliefs and practices of a corporatized and commodity-driven herbal products industry and the holistic Earth-centered cultures of indigenous peoples, and many Western natural therapists, has stimulated this paper about the conflicted nature of contemporary herbal medicine in the West.

Recent experience with indigenous Mapuche in Chile‡ further illustrates this “local versus global” culture clash. We argue that the shamanically based herbal medicine of the Mapuche provides salient insights about the meaning and consequences of the concept of “tradition” in herbal medicine. In particular, we argue that traditional herbal medicine is dependent on the preservation of local cultures and local ecologies. This radically challenges global herbalism and the mass production and commodification of herbally based substances.

As we write this paper, the World Health Organization’s first global strategy for traditional medicine (launched May 2002) is eloquent proof of the need for urgent consideration of the consequences of globalization on herbal medicine. The aims of this project include promotion of the rational use of traditional medicine, minimum training for traditional medicine practitioners, and clinical research into safety and efficacy of traditional medicines. The assumptions underlying this approach seem to promote the interests of a global herbal industry over the protection of local traditional practice. Finally, we note the increasing media concerns with the probity of corporate behavior in the United States at least, in the wake of the Enron collapse.

GLOBAL HERBALISM

The increasing transcendence of social time and space by new technologies and internationalized markets was originally termed globalization by sociologists and political theorists (e.g., Giddens, 1991). The concept was first introduced by Marshall McLuhan (McLuhan, 1964), the Canadian media specialist who used the term global village to describe the effects of new communication technologies on social and cultural life. More recently the economic impact of the globalization has been frequently emphasized.§

In 1986 the economist Peter Dicken addressed the “massive shifts” that had been occurring in the worlds manufacturing industries. He identified the three major forces involved to be transnational corporations, national governments, and revolutionary developments in “enabling technologies” (in communication, production, and organization) (Dicken, 1986).

Global herbalism we see as expressing all these forces and although the idea of globalization now raises many issues across disciplines, the three forces Dicken identifies are sufficient to define the major political economic dimensions of the global herbal industry. This includes the movement of transnational companies into the herbal and health food industries, the explosion of government interest in

---

†In his classic treatise, the Polish philosopher Leszek Kolakowski summarizes positivism’s central assumptions as: (1) the rule that all knowledge is ultimately based in sensory perception (phenomenalism); (2) the rule that all knowledge can be traced to individual facts (nominalism); (3) the rule that refuses to call value judgements and normative statements knowledge; and (4) a belief in the essential unity of the scientific method (the globalizing methodological claim of the physical sciences). These philosophical principles may be essential to the natural sciences, but they are definitely problematic for any natural medicine within a holistic framework.

‡We acknowledge the invaluable assistance of the Sociocultural Centre, Catholic University of Temuco, Chile to Sue Evans in enabling this. Particular thanks to Dr. Teresa Duran.

§See for example the Organisation of Economic Cooperation and Development definition of globalization as “the geographic dispersion of industrial and service activities (for example research and development, sourcing of inputs, production, and distribution) and the cross-border networking of companies (for example, through joint ventures and the sharing of assets.” (Bannock et al., 1998) (In references).
regulation of the industry, and the incorpora-
tion of new techniques into the manufacture of
herbal goods. No longer is the simple herbal
tincture or herbal tea the “norm” when taking
herbal medicine.

Today the term has also become the theme
of social movements dedicated to “anti-global-
ization.” In these discourses, globalization has
been seen widely as an extension of the logic
of capitalism rather than something new (see
Harvey, 1989). We are less accepting of its in-
evitable: in the case of herbal medicine we
do feel that new possibilities arise as a result of
globalization, but so far we have seen only a
side of capitalism that erases rather than en-
courages difference and competing views. We
hope to see an heterogeneous capitalism that
can facilitate the development of tradition, but
the obstacles we discuss in the case of the
herbal industry show no early signs of resolu-
tion. At least we still live in a world not totally
dominated by the logic of growth, develop-
ment, and corporate profit. The continued ex-
istence of traditional Western herbal medicine,
a practice, which itself, has a long history of in-
terlinking the global and the local by incorpo-
rating herbs from far and near (e.g., the spice
trade), demonstrates this fact.

Nonetheless, the current globalization of the
herbal industry is a phenomenon of interna-
tional capitalism and a contributing cause of
multiple inequalities (such as the poverty of
peasant farmers and the destruction of ecolo-
gies). It also has a more subtle counterpart (i.e.,
the taken for granted dominance of “science”
and “technology,” which, used as social and
cultural policy, continue to attack different
cultural frameworks as primitive/prescence/
irrational). In this way it privileges material-
ism, growth, and “development.” Our experi-
ences with the Mapuche further illustrate this
cultural clash. Traditional Mapuche medicine
seems unable to be globalized or to incorporate
generic herbal products into its practice. The
shamanic cultural framework of these people
is paradigms apart from hard science, clinical
trials, mass marketing, and the incorporation
of standardized extracts into the craft.

In short, the so-called globalization of soci-
ety and culture has influenced contemporary
Western herbal medicine in a number of ways
that challenge the rationale of traditional
herbalism. As herbal medicine becomes an
international industry—global herbalism—it is
pushed toward a positivist and reductionist
philosophical appreciation of the use of medi-
cinal plants. This global ‘take’ on the herbal in-
dustry is far from the Mapuche medicine we
go on to describe, and is also quite at odds with
the philosophy and practice of traditional
herbal medicine.

Global herbalism as industry

As an industry, global herbalism markets
herbal preparations as drugs, or medical com-
modities in a lucrative trade in wild-crafted
and cultivated herbs. In its search for novelty
and market advantage, this trade relies on
constituent chemistry and new production
techniques, international advertising and mar-
keting, and transfer pricing (among other
transnational tax-avoidance schemes). The in-
dustry is supported by scientific and techno-
logical specialisms whose research and devel-
opment is strongly led by the needs of industry
and markets.

As this industry has moved from a small
business to one of interest to much larger cor-
porations, globalization amounts to the inter-
nationalized rationalization of raw materials,
processing, and marketing. In that respect a
herbal product is little different than a Toyota.

These globalizing processes have already
had profound policy effects in the Australian
context. Since the entry of major pharmaceuti-
cal companies into the marketplace, the regu-
latory requirements for herbal products has
changed in their favor and the disadvantage of
small, low-tech manufacturers of traditional
herbal products. The last 15 years has seen the
disappearance of small herbal manufacturers,
their place taken by larger herbal (and natural
medicine) companies and pharmaceutical
companies.

Under the banner of improved safety and ef-
ficacy for consumers, this has occurred in two
ways. First, governments, through their regu-
latory authorities have “raised the bar” for
small manufacturers in areas where pharma-
ceutical companies have expertise and the abil-
ity to absorb increased costs (e.g., with regard
to the code of good manufacturing practice
[GMP], a code developed for the pharmaceutical industry). Second, the application of new pharmaceutical manufacturing techniques to herbs and the industry’s continual search for “novel products” has redefined the industry and leads to difficulties in defining “herbal medicines” under relevant legislation.

There is pressure on regulatory authorities to define herbal products in ways that benefit the industry. For instance, in Australia, prior to the introduction of the Therapeutic Goods Act in 1989, herbal products were in regulatory “limbo,” neither foods nor drugs. When the Act was introduced, many herbs were legally defined as therapeutic goods, and the category of “traditional herbal use” was established. This allows herbs with a history of medicinal use to be publicly available without having to undergo expensive clinical trials. At that time (1989), the low-technology nature of herbal manufacture provided limitations to the strength and therefore dose of herbal products. More recently, pharmaceutical expertise has been widely applied to herbal manufacture, and has resulted in the development of herbal products many times stronger than those previously available.

There is no question that consumers have a right to quality assurance with regard to herbal products, and aspects of GMP, used appropriately, facilitate that assurance.

However, the marriage of regulation (in the form of GMP) and the application of new manufacturing techniques to herbal medicine makes for an interesting loop. As the herbal products found on the shelves of retail outlets and within herbalists’ dispensaries are increasingly removed from the raw herbs themselves (with the use of pharmaceutical techniques to produce concentrated and standardised products and by the introduction of “new” exotic herbs that are not commonly known by practitioners or the public) these regulations become essential. As the regulations become more complex and demanding, products are developed that fit these new regulatory requirements. The traditional use of local plants, simply prepared in water or alcohol for conditions and in concentrations that have been used historically, did not require such regulation and often did not fit it.

The ability to produce concentrated extracts and active ingredients may again facilitate mass production, but the question needs to be raised as to whether products of vastly different concentration remain sufficiently similar, to allow information about appropriate use and safety to be extrapolated from one to the other. In the terms of traditional herbal medicine high doses and strong preparations are rarely the most effective therapeutics. They are also seen to be wasteful. This is not the only issue. The assumption that traditional practices can only benefit from standardization and mass marketing runs counter to the traditions of herbal medicine and its fundamental reliance on local culture and local ecology, as we go on to discuss.

Clearly global herbalism is at odds with the philosophy and practice of traditional herbalism. At the cultural heart of global herbalism, market-driven pragmatism and the strong technological orientation of new academic and industrial specialisms such as phytochemistry do not encourage significant ethical, ecological, or metaphysical considerations. Their main concern is to arrive at the “normal science” phase of development when problems such as those outlined above can become routine and mass production can proceed (c.f., Kuhn, 1962). At this stage technical considerations can dominate the science (and of course the science can become more attuned to the needs of the marketplace). Whatever one’s historical or sociologic view on the phases of development of science and technology, there can be no doubting the enormous pressures on all contemporary academic and industrial researchers to relate to economic and industrial considerations. This is particularly evident in pharmacology, biochemistry and chemistry, the major disciplines in charge of the scientific cultures of global herbalism.

At present the main problems in phytochemistry for example, do appear to be highly technological. What chemical constituent of the plant determines its clinical efficacy? Can clinically measurable effects be found for a substance? How can specific amounts of specific constituents be ensured within the plant? Is the magnetic resonance imaging spectrometer powerful enough to detect small amounts of
substance and provide reliable analytical data? These typical research questions do not respond to the philosophical concerns of traditional herbalists. They do, however, provide a basis for a global herbal products industry.

Global herbalism as philosophy

In dealing with these essentially technological problems, herbally focused scientific specialisms do not need a philosophical basis more complex than positivism and materialism. While their techniques can provide useful health adjuncts, many herbalists believe that these techniques are commonly overused and tend to discourage active involvement in good health practices.

As a philosophical system, Western herbalism belongs to a broader vitalist tradition, which is holistic rather than reductionist and mechanistic. Central to this tradition is the underlying assumption that life and health depend on energetic processes and a fundamental life force.

Vitalism is clearly not uniquely Western. Its basic assumptions underpin many medical traditions from traditional shamanism to Ayurveda and Traditional Chinese Medicine (TCM). In the West, vitalism has been characterized by the following assertions: (a) the body possesses an inherent intelligence or wisdom, and has an innate capacity to heal itself; (b) the task of the patient and the practitioner is to support this healing process; and (c) clinical emphasis is on treatment of the individual and on processes of recuperation and reestablishing health rather than on the standard treatment of specific, named, diseases. Given that traditional herbal practitioners today rely on concepts such as life force and energetic processes, it is no wonder that non-Western health traditions have become popular throughout the English-speaking world.

In short, while biomedical sciences are a significant part of any reputable training course for Western practitioners of natural and complementary medicine, many practitioners do not rely on “straight science” for their philosophies of healing and cosmological overview. For instance, over recent years the approaches to diagnosis and treatment of both TCM and Ayurveda have become popular among groups of Western herbalists, and Westernized books and courses targeted for this specific market have been developed (e.g., Lad and Frawley, 1986; Tierra, 1988). Frawley (1989) describes this new synthesis of herbal tradition as a new movement towards a global herbal medicine that includes the best developments in the medicines of all lands. A new naturalistic planetary medicine is emerging, largely through a reexamination of the older Eastern and traditional medicine of native peoples throughout the world.

That is, Eastern philosophies have broadened the historical and cultural scope of Western herbalism. This is globalization from within the domain of natural health and healing as it were; all these moves remain among or between holistic paradigms developed as systems of health. They are attempts by herbal practitioners to articulate and develop their work.

In this respect Western herbalism has been transfused with non-Western ideas, now reflected in the diversity of Western herbal practitioners’ world views. However, aspects of a philosophy of Western herbal medicine remain evident. Initial results from ongoing research among herbal practitioners in two major Australian cities indicate not only that the concept of vital force is widespread, but also that traditional Western concepts as toxicity, enervation and suboptimum organ function are of practical use to contemporary practitioners. These concepts are used in everyday practice together with understandings derived from pathology and physiology.¹

In a rapidly changing field, it is globalization that comes in the guise of science, technology, and progress that is more likely to destabilise the traditions of Western herbal medicine. This is the direction from which an industry led profession will come. Phytochemistry and biomedicine encourage a different kind of globalizing health philosophy and practice.

¹Research in progress, Sue Evans.
THE “DISGODDING” OF THE WORLD

This globalization is merely an extension of the Western philosophical project of scientific “rationalization” that began around 1600 with the scientific revolution. As the founding sociologist Max Weber first indicated, the development of Western culture and society has required the “rationalization” of all spheres of society and the “disenchantment” of the world (e.g., Weber 1971, 1974). Only through the “disenchantment” or “disgoddling” of the natural and social world has secular reason been able to emerge and science and technology become able to deliver a global health industry. It follows that a global herbal industry (or any other modern industry) has depended on this secularization for its emergence.

In summary, as well as being an industry, global herbalism is also a contemporary expression of the scientific and technological revolutions that have come to stand for the idea of “disgodded,” “mechanistic,” and “modern” views of the natural (and social) world. This “disgoddling” and mechanization was of course never complete, but as a metaphor it does describe a major power shift in Western culture from “traditional” alliances of church and state to more modern societies that are industrial, secular, and democratized. One legacy of this cultural shift (into modernity) is great abuse of the natural environment, with mad-cap attempts to focus all efforts on mass production, mass markets and mass marketing. In this, local, indigenous, and traditional practices become so many obstacles to the growth of large firms (and large profits) and the control of medical practice.

The first world may have eventually been beneficiary of these modernizing processes, but this largesse was not extended to the third world. Despite the best efforts of the World Bank and the United Nations in early projects such as the introduction of new crops, fertilizers, pesticides, and mechanization, the peoples of the third world tend to remain “dirt poor.” Away from those places where matter is observed to be inanimate, where nonhuman life is without “soul,” and where human reason is the pinnacle of evolution, other cultures have continued on with different cosmologies and different “realities.” We argue that any homogenizing view of reason, progress and modernity hides the difficult fact of the continuing struggle of local (and often indigenous) cultures struggling to survive against a capitalism without heart, face, or sense of history and the future. In the case study we go on to discuss, it happens that the reason of science as we know it does not prevail in the minds of Mapuche healers. Traditional Mapuche healing cultures are holistic rather than reductionist and mechanistic.

Medicine of the Mapuche

This brief case study has been developed to contrast global herbalism and its infrastructure with Mapuche medicine. It could be read, we suggest, as another instance of the cultural resilience of indigenous peoples and of the cultural impasse that traditional herbalism presents to global herbalism.

The Mapuche are the largest group of indigenous people in Chile, and one of the largest in South America (Barrera, 1999). Many live in the region of the Arucania, south of Santiago. Temuco (675 km south of Santiago, population 210,000) is the most important city in the area. The Mapuche are a people used to struggle: They were not conquered by the Incas, or later by the Spanish, and while they share many problems with other indigenous groups around the world, they have managed to retain many aspects of traditional life. This is particularly so for those who still live in rural areas (about 20% of Mapuche in Chile)

---

1See Berman (1981) in references. The historian Theodore Roszak (1970, 1972; in references) is particularly famous for his treatment of these radical themes. The work of Rupert Sheldrake is more recent and probably better known among contemporary herbalists. Sheldrake (1990, in references) describes the “desecration” and “domination” of nature since the Scientific Revolution. See also “The death of nature,” Chapter 1 in Jagtenberg and McKie (1997, in references).

Mapuche medicine is only comprehensible within the context of Mapuche culture, a discussion that is well beyond the scope of this article. However, in common with other indigenous cultures, the Mapuche understand illness to originate from a number of causes, including (but not limited to) imbalance in one’s habits of life (diet, sleep, anxiety, etc.), or a disregard for specific values of the community, or from spiritual agencies which may involve malevolence from another person (Caniullan, 2000). In other respects Mapuche medicine is fully vitalistic, as defined earlier.

There are different levels of herbal medicine practiced within Mapuche society. Minor ills may be treated with herbs within the home, but for more serious illnesses the machi, or shaman, is consulted. The herbs used for simple illnesses within the home may be of either indigenous or nonindigenous origin: In one study, the number of indigenous and nonindigenous plants used in domestic medicine was equal (Citarella, 2000). The nonindigenous plants are mostly European plants, probably introduced into Chile with the conquistadors, with Spanish colonization.

The machi use indigenous plants in their treatment of more complex illnesses. Many herbs used by machi (as distinct from those used for domestic medicine) are not cultivated, as “place of growth” is intrinsic to the value of a plant, not just the botanical species. Place of growth, time of harvest, and phase of the moon at time of harvest are important considerations in their use of plants (Caniullan, 2000).

What is particularly at odds with the logic of global herbalism is the fact that medicinal plants can only be protected if the land is protected. Changing patterns of land use have devastating effects on the availability of plant medicines to the machi. The development of medicinal gardens to protect these plants is not possible, because of the relevance of the local ecology to the machi and Mapuche medicine (Caniullan, 2000).

In short, not all the world has ended up with a despiritued mechanical cosmology. For the shaman and natural therapist, “the world” is something with which to be in communicative interaction. Holistic healing is predicated on the idea that all human meaning unfolds in relation to other energies and intelligences, and human society—all of which are part of a dynamic, interactive system.

TRADITIONAL HERBALISM:
THE THING ABOUT PLACE

Many of the paradigm conflicts that we have been addressing have been well canvassed in the romantic, post-1960s discourses of ecoactivists and healers but the special magic of “place” provides an angle of vision that, in the context of the herbal industry, helps explain just how far an economy and industry dominated by the demands of capital growth is from the needs of traditional herbalism or shamanic healing.

The idea of place—a location in space and time—is familiar to us all as a fact of daily life. What is less familiar is the idea that this is rarely just a point in Cartesian–Newtonian or Einsteinian space. Locations may have meaning and purpose and define the identity of their inhabitants. And they are contested and cultivated by all manner of life forms.

The idea of place is paradigm dependent. The arch-positivist, for instance, does not see, or value, the relationship between a particular healer and a particular herb in a particular place. Subtle realities such as dreams and idea of a trans-species web of life just do not count as evidence or reality here.

In the case of traditional herbalists, such as the Mapuche in Chile, and aboriginal Australians, place is about indigenous rights and rights of access (and ownership) of land, with its ecosystems. Places are also deeply cultural in being alive and imbued with spirits of that location (Evans 2002).

José Alwyn states:

It is not by chance that the Mapuche called themselves “the people of the land.” They used the term futal mapu, which means “all our land” to indicate that the land was not only composed of the soil, but also by what was under the surface, by the rivers, the forests, and all that existed above the surface of the earth. They also referred to the land as Nuke mapu or mother earth,
meaning that the land gave everything, and that in accordance with the magic and religious world of the ancestors, it had to be cared for and protected.**

Traditional herbalism is practised in this generally animated context. Traditional European herbalism as practiced in Australia may refer to the signature or “personality” of a herb, which is at least regarded as encoding some sort of ancestral wisdom. Some medical herbalists in the United Kingdom are exploring the contributions of Goethean science combining objective and subjective approaches to reality, to contemporary herbal practice. Such practices may be a far cry from full-blown mystical participation with Plant Gods, but clearly European herbalism has strong links to the conservation movement and the post-1960s, post-hallucinogenic, newly tribalizing, New Age traditions in esoteric and traditional healing.

With its emphases on mass production, biochemistry and standardization, global herbalism provides an antithesis to the magic of the local. On the other side of the paradigm divide, contemporary herbalists have some historical and cultural constraints to deal with (i.e., they often have a far more tenuous relationship to their land than the traditional herbalist) and it can be argued that the use of medicinal plants that originate from an everlarger potpourri of cultures, serves to make that relationship even more distant.

**CONCLUSION**

Apart from the obvious contradiction between corporate capitalism and all craft-based indigenous cultures, there is a continuing contradiction between the “world views” and cultural practices of indigenous and traditionally based herbalism and the scientific specialisms which support, and create global herbalism. This tension spreads from the forced insensitivity of pragmatic specialisms to the deeper concerns of herbalists with questions of place and ecologic integrity. More fundamentally, the physical and biomedical science’s dismissal of metaphysics, spirituality and value judgements marks a basic paradigm divide between traditionally based natural healing modalities and biomedicine and the physical sciences. Our case study of Mapuche medicine is just one typical example of the paradigm wars that face traditional cultures and healers.

In our view global herbalism and the science and technology that support it are based in abstraction. That is, they are in the service and confirmation of general principles in the case of conventional science, and the global growth of capital in the case of industry. This desensitization to the special needs of “the local” has placed many indigenous cultures at risk and fuels the continuing opposition of herbalists, and many others, to the overexploitation of herbs. Our case study of Mapuche medicine demonstrates how fundamental tensions exist between local cultures and practices and the corporate logic of global industries.

Bureaucratic regulation and incorporation into systems and structures dominated by transnational corporations are incompatible with traditional health systems. Only if local cultures are able to retain their own meanings and autonomy, such that shamanic (and related) practices are not disempowered by competing cultural practices, will these approaches flourish as viable alternatives, and perhaps even yet complementary systems of medicine and health.

**REFERENCES**


Address reprint requests to:
Sue Evans, B.A., Dip.Ed., M.N.I.M.H.
School of Natural and Complementary Medicine
Southern Cross University
P.O. Box 157
Lismore, New South Wales 2480
Australia

E-mail: sevans2@scu.edu.au
The herbalist: Sue Evans

Sue Evans, BA, DipEd, MNIHM, MNHAA, is a lecturer in herbal medicine and PhD candidate at Southern Cross University.

The traditional knowledge base of Western herbal medicine is generally neither acknowledged nor valued, but rather presented as an ‘impediment’ to be ‘overcome’ if herbal medicine is to be accepted by mainstream healthcare.

In an ongoing bid for legitimisation, herbal educators place increasing emphasis on the biomedical sciences, largely ignoring or decontextualising traditional knowledge, or using it as a shortcut in the selection of plants for symptom treatment or for new (herbal or pharmaceutical) drug development. Exhortations to ‘modernise herbal medicine’ involve replacing traditional knowledge with scientific knowledge.

More recently, this also means adopting the hierarchy of evidence promoted by evidence-based medicine, in which information supported by randomised controlled trials is given preference over that derived from the application of first principles, or gained in clinical practice, i.e. empirical knowledge.
No monopoly on truth
Scientific knowledge is not a substitute for traditional knowledge, nor is traditional knowledge an 'inferior' or 'undeveloped' form of knowledge. They have different aims and structures, and make different contributions to knowledge. Because the nature of these differences has been rarely acknowledged, the place of traditional knowledge within contemporary herbal medicine is unappreciated.

How do these bodies of knowledge differ? Science is said to deal with cold, hard facts, while critics equate traditional knowledge with subjectivism, hearsay and partiality. Science offers sophisticated and detailed descriptions of phenomena in the world around us, and verifies these descriptions via the development and repeated testing of hypotheses. Such testing must take place under 'rigorous conditions', which means that it occurs in very specific ways, following very specific rules, in order for the findings to be accepted as legitimate by the scientific community, i.e. a community of peers. Science also claims universality — i.e. that its findings apply in all contexts — and prides itself on being objective and value free.

Traditional knowledge, on the other hand, does not claim universality, but is highly context dependent, and openly expresses values. Characteristically, it is transmitted in the form of narrative — i.e. via stories — and aims to convey a very wide range of information.

For example, an analysis of 17th-century herbalist Nicholas Culpeper's herbal monographs reveals that he does not just describe the medicinal uses of these plants. He typically includes how and where the herb grows, particularly where it 'delights to grow'; its medicinal actions and toxicity; his opinion as to its value and the best ways to prepare it; the opinions of other herbalists and historical figures (and what Culpeper thinks of their views); and perhaps its astrological associations (astrology itself being a code for a range of information, and well understood by the 17th-century educated elite).

More than monographs
However, there is more to herbal practice than the information found in herbal monographs, just as there is more to medical practice than is found in a MIMS. The philosophy underpinning the traditional knowledge base and practice of herbal medicine involves an acceptance of ideas of holism and vitalism, as well as a connection with the natural world.

Current attempts of herbalists to legitimise their practice using the discourse of science, and the knowledge requirements of other health professionals wishing to prescribe herbal medicines, alongside commercial demands for ever-increasing consumption of evermore concentrated herbal preparations, threaten this philosophy.

Science and technology have brought us many benefits, but they are also associated with an unparalleled disconnection from and destruction of the natural environment. If unfettered development in the absence of the limits provided by overarching values (such as those provided by traditional frameworks), combined with human greed, can lead us to ecological disaster, then perhaps a reassessment and rational adoption of traditional values should be considered.

Within herbal medicine, when commercial realities rule and shareholders' interests take automatic precedence, complex, concentrated and expensive phytopharmaceuticals are preferred over simple unpatentable herbal preparations, as they turn a greater profit. The underpinning knowledge developed for the former is science, and for the latter is tradition. In this scenario, the values of ecological sustainability and fair trade are soon sacrificed, and the principle of 'walking softly on the earth' becomes increasingly difficult to equate with herbal medicine. This is not only the ultimate irony but also the ultimate tragedy of modern herbal medicine.

This is not an argument for a return to some mythical romantic past where traditional knowledge is given automatic precedence over other forms of knowledge. However, the recasting of herbal medicine as just another tool of biomedicine wastes a valuable opportunity to develop a form of medicine that is effective, environmentally friendly, empowering to patients, and cheap. A thoughtful and thorough consideration of traditional herbal knowledge, using but not enslaved by science, can, I suggest, lead to the development of just such an approach to herbal practice.

References
1. My remarks refer to the practice of Western (European) herbal medicine rather than the broader field of natural medicine, or of other herbal traditions such as traditional Chinese medicine or Ayurveda, as that is my area of expertise.
3. Consequent to its claims of universalism, science judges traditional herbal medicine according to its own scientific criteria. It does not grant other knowledge systems that which it claims for itself: the right for knowledge to be reviewed from within its own paradigm, according to the values and conventions of that framework. Surely this is the meaning of 'peer review'.
The challenges of teaching herbal medicine within the university system

Sue Evans

In thinking about this topic I realised that really this talk is not so much about the challenges to herbal medicine in the university system, but it is more about the challenges to herbal medicine education generally. I think that these challenges may be more pronounced in the university system but I don’t know that they are intrinsically different there to the rest of the herbal education sector.

As many of you know I am interested in the way that contemporary western herbal medicine in Australia is informed by both science and tradition, and today I will talk about the nature of the difference between those two ways of knowing or those two epistemologies.

We are practitioners of a traditional craft which almost disappeared as a professional practice in the English speaking world during the first three quarters of the last century. We often forget that 50 or so years ago in the period immediately following WW2, herbal practitioners were few in number in the English speaking world. Indeed for a period of about 25 years of that time between 1943 and 1968 herbalists in Britain were technically practising illegally (Griggs 1997) – our craft was in danger of extinction. Herbal medicine was seen to be outmoded and irrelevant, unscientific, its knowledge base dismissed as a historical relic, practiced only by a very few eccentrics. Traditional use as recorded in the herbals and herbalists’ case notes, was not seen as something that would have a lot to offer a first world country in these modern times and it was expected by many to disappear. Our society generally does not put a lot of faith in tradition or even in history – we tend to see ourselves as thoroughly modern, and we excise the past.

Around 25 years ago a group of herbalists in the UK decided to begin an attempt to legitimate the practice of herbal medicine by showing herbal practice to be rational and comprehensible within the terms of science. This project has fundamentally changed how we understand what we do. I would argue that whatever the case now, the project of interpreting herbal medicine within the discourse of science was initially a project of legitimisation, it was intended to legitimate herbal medicine in the eyes of the broader community and thereby ensure its survival or at least ensure it did not go completely underground.

This project of legitimisation was well underway when, around 15 years ago, the whole field of natural medicine became the focus of enormous public interest. This public interest took two forms – firstly, people became more interested in using the services of practitioners of all forms of natural medicine, and they became interested in self-prescribing, and secondly we saw the introduction of a plethora of products onto the market to fulfil that demand. This has lead to the need for governments to be involved in introducing regulation of herbal products, and as we see today, the regulation of herbal medicine practitioners.

This is the context in which we find ourselves. Our practice nearly disappeared over the last century: now we have the blessing and the curse to be centre-stage. What interests me is how these developments have affected herbal practice, and in particular how we as practitioners understand what it is that we do – both in terms of our diagnosis and our treatment. How do we, as herbalists, understand what it is that herbs do? What is the interplay between science and tradition in the everyday practice of the herbalist? Do we see herbs as basically acting in the same way as pharmaceuticals or as something else? If we see ‘something else’ what is that ‘something else’ and how do we learn it, how was it passed on to us and how do we pass it on to the next generation?

Over the last 15 years herbal medicine in the English speaking world has moved into universities. In Australia some private colleges offer their own degrees and some work with universities in that the university provides part of the training and the provide college provides part and the student is awarded a degree. There are now two universities where herbal medicine is taught by the university as part of an undergraduate degree - Southern Cross University in Lismore and the University of Western Sydney.
In both cases the herbal medicine is taught as part of a naturopathic degree. In the universities, as in the private colleges, herbal education has two planks, two aspects, two epistemologies - science and tradition.

Since the Enlightenment science has become one of the dominant ways of knowing in the West. Combined with technology it has resulted in huge changes to the way we understand the world around us and has contributed to the enormous changes in the material conditions of our lives – those changes that characterise modernity.

However as herbalists we also say that we ‘know’ what our medicines do because we have learned from the accumulated wisdom of many people who have used these plants in the past and who have recorded the actions of these plants in themselves and others. What I want to do today is to look at the nature of scientific knowledge and the nature of traditional knowledge.

Science

What is science? What does it mean to understand something scientifically? I will sketch broadly here, accepting that the detail of my argument would be qualified and challenged by many philosophers of science. However I suggest that for our purposes they are useful to give an overview of what science is.

Firstly science usually refers to natural and physical science – especially chemistry, physics and biology. It is said to be the disinterested study of the real world: it attempts to characterise the structure of reality. It is claimed that it is based on observable universal facts, i.e. facts that transcend nations and cultures. These facts are formalised as scientific statements.

Methodologically, science proceeds by inventing hypotheses and systematically testing them against observation and experiment. To illustrate this point let us take some research that was conducted involving rosemary and which was recently published in the journal Phytotherapy Research. (Hossein-zadeh 2003).

The end result of the scientific enquiry involves both verification and falsification.

Verification or proof

A matter is not so because a scientist say it is so, but he or she must produce proof. This proof must satisfy his peers, that is, his equals, those who are as expert in his field as he is. Scientific discourse involves developing an argument as to why this proof should be accepted, and dealing with those who put counter arguments, that is, dealing with refutations to one’s arguments.

This refers to the importance of a scientific community. If research is to be accepted by one’s peers, they (the peers) must accept that the experiments carried out on the mice indicate that the results logically supports the conclusions. That is, the experiment must make sense in a rational, deductive way, and there must be enough information to allow the experiment to be repeated (although in fact it rarely is).

We know that in order for this article on rosemary to be published in Phytomedicine Review, it first had to be accepted by the journal’s editorial board, and this involved a process of peer review. If anyone subsequently reading the report disagrees with any aspect of it, they are encouraged to write to the editor with their concerns and it is likely that the letter, with or without a response from the authors of the original article, will be published in the journal as well.

Confusingly for those of us who are not scientists, not only verification but also the issue of falsification is also important in this process. One of the philosopher Karl Popper’s major contributions to science was the idea that scientific statements should be able to be falsified, or disproved. Thus scientific statements need to make clear, precise claims about the world which, according to Popper, should stand until and unless they are falsified when they are rejected. The aim of science should be to disprove these statements, because by disproving them we get closer and closer to the truth.

As an example the statement that ‘all swans are white’ was held to be true until the first black swan was observed, when this statement was rejected, and another perhaps ‘all swans native to Europe are white’ was seen to be more true.

Any acceptance of the truth of the statements a scientist makes, is conditional and not finally established. Lyotard (1997) says:

‘The truth of the statement and the competence of its sender are thus subject to the collective approval of a group of persons who are competent on an equal basis.’

In practice while all scientific statements need to be falsifiable, not all falsified statements or claims are immediately rejected: however falsification does weaken a statement and repeated falsifications may eventually cause its rejection. If
someone else does some research to show that extracts of rosemary do not have the action claimed here, these claims are weakened and when the balance of evidence shifts from this to another understanding of the action of rosemary, the first is discarded.

Thus science involves a fairly specific methodology, it involves notions of proof, and of argument. Science is always tentative, in that the results are always open to falsification.

Tradition

The second plank of herbal education is traditional knowledge. Let’s look at what ‘traditional knowledge’ may mean and the role it plays in herbal practice. Tradition is a word often used in anthropology. Contemporary western herbalists are clearly not a ‘traditional people’ in the sense that anthropologists would use the term, we do not follow a ‘traditional’ way of life. It is arguable whether or not contemporary western herbal medicine is a ‘traditional practice’ given that many aspects of our practice are thoroughly modern. By modern I do not just mean scientific as referring to our diagnosis and prescribing and to our understanding of our materia medica, but also I mean the way our practices are structured and how we behave as professionals. In these ways we more resemble 21st century healthcare practitioners than traditional healers.

However we do claim to be practitioners of a traditional form of medicine, and the knowledge we use is handed down. This claim is of enormous political importance in that complementary medicine is defined in the Therapeutic Goods Act (1989) as follows:

Part 6.4—Complementary medicines

52F Definitions

In this Part, unless the contrary intention appears:

active ingredient means the therapeutically active component in a medicine’s final formulation that is responsible for its physiological or pharmacological action.

complementary medicines means therapeutic goods consisting wholly or principally of one or more designated active ingredients, each of which has a clearly established identity and:

(a) a traditional use; or

(b) any other use prescribed in the regulations.

designated active ingredient means an active ingredient, or a kind of active ingredient, mentioned in Schedule 14 to the Therapeutic Goods Regulations.

traditional use, in relation to a designated active ingredient, means use of the designated active ingredient that:

(a) is well documented, or otherwise established, according to the accumulated experience of many traditional health care practitioners over an extended period of time; and

(b) accords with well-established procedures of preparation, application and dosage.

Note: An example of traditional use is use in Chinese traditional medicine.

Thus in Australia the whole field of complementary medicine is defined as having some connection with traditional practice. The definition of traditional medicine as accepted by the TGA is for our purposes too limited, and after looking at a variety of discussions on the nature of tradition, the broader definition which will be discussed here is as follows.

Tradition as it is defined here includes:

1. a particular body of doctrines, beliefs, customs etc that belongs to a special people, religion, country, family, etc

2. something, such as a doctrine, belief, custom story, that is passed down from generation to generation, especially orally or by example

3. the continuous development of artistic, literary or musical principles or conventions (2001)

This definition encompasses not only the sense of transmission of ideas and practices, but also the connection of tradition with a particular group of people, and the understanding that tradition can change and develop, it does not fossilise

Tradition in herbal medicine involves:

1. a particular body of doctrines, beliefs, customs etc that belongs to a special people, religion, country, family, etc

Within contemporary herbal medicine, a specific group, eg family or regional group, develops a particular approach including beliefs or customs.

A materia medica, the group of herbs used as medicines, is usually characteristic to a particular society who arguably owns the intellectual property on the medicinal uses of those plants. Thus we refer to the Chinese materia medica, the European materia medica or the materia medica of the Mapuche people of Chile. The choice of plants in a materia medica has a relationship, either current or historic, with a specific geographic area.
Often some of the herbs in the materia medica will be native to that area, and gathered locally; others will be species that have been introduced to that area, and will be gathered locally. Yet others will be traded, and may originate from some distance away. In my practice I use the European materia medica because I am of European descent. The plants I use are largely native to Europe. They are not usually native to Australia, although they may have been introduced there. They are the plants of my culture, not my birthplace. Some are also traded, for example spices, which have been part of trade between the East and West for millennia, and a number of plants, have been introduced via the materia medica of the United States.

2. something, such as a doctrine, belief, custom story, that is passed down from generation to generation, especially orally or by example

*Within contemporary herbal medicine, the handing down or transmission of herbal knowledge occurs orally and by example*

As a herbalist the knowledge basis of my craft is information which has been handed down. How do I know the medicinal actions of the herbs that I use, and how do I know how to apply that knowledge? The actual knowledge pertaining to each herb — what it does, the part that should be used, when it should be harvested, how it should be prepared, has been handed down from generation to generation. Within European herbal medicine, much of this knowledge has been handed down via the written word, however some aspects are never written down, but are communicated orally or by example.

It is not only what the herbs do — the materia medica — which has been handed down in this way, but also the philosophy of treatment, the understanding of the nature of health and the reasons for disease. An understanding of this philosophical aspect of herbal medicine is as essential to practice as an understanding of the herbs we use. It informs how we approach the patient, how we understand what the problem is, and how we diagnose and therefore prescribe.

Traditional knowledge is likely to be based on narrative, in fact traditional knowledge is commonly handed down through stories. Oral transmission of bodies of knowledge is through stories. Narrative and science have different ends in mind, and obey different rules. Let’s take a moment to think about how scientific knowledge and traditional knowledge differ in terms of how they are communicated. As I have discussed already, there are rules for the development of scientific knowledge, and the end result of scientific investigation is the establishing of facts that elucidate the nature or behaviour of aspect of the world. The statements are mostly denotive, that is they describe.

However the types of statements which are made in a narrative account of a herb, and the information conveyed there, are more varied. While there will be denotive statements, there are also many other types of statements.

We have already discussed a piece of scientific research on the actions of rosemary. Let us now look at Culpeper’s approach to the same plant. (Culpeper 1653, 1995) If we look at the monograph on rosemary we find the following types of statements:

*Denotive statements are those which describe, or stand for. It flowers in April and May with us, and sometimes again in August.*

*Evaluative statements make judgements about worth. It is an herb of as great use with us in these days as any whatsoever...*

*Denotive statements are ones involving moral obligation. (re an oil of rosemary) ...an oil will distil down...to be preserved as precious for divers uses, both inward and outward.*

*Historical statements include Both Dioscorides and Galen say....*

We also find statements which reflect the philosophy of diagnosis and prescription which was prevalent in that period of time. By the warming and comforting heat thereof it helps all cold disease both of the head, stomach, liver and belly.

Narrative forms of discourse are highly complex and aim to transmit a broad range of information, much more than facts that pertain to the ‘real’ world. Narrative communicates the history, values and philosophy of a culture — in this case that of 17th century British herbal medicine.

3. the continuous development of artistic, literary or musical principles or conventions

*In the development of contemporary herbal medicine there is an uneasy balance in the maintenance of the old and the incorporation of the new.*

While traditional practices can be criticised both for romanticising the past and resisting the new, no living tradition is immune to change. Traditions
are not static, and change does not invalidate tradition.

The way we think and understand reflects our culture and so it involves an understanding of science. Contemporary western herbal medicine is based on both science and tradition, yet as the French post-modern philosopher Lyotard claims, the two are based on ways of knowing that are so different that one cannot be evaluated in the terms of the other. Knowledge based on science follows a different logic to that based on traditional knowledge: different rules are involved; different evidence acceptable, different ends are in mind.

We have discussed elsewhere the issues of practicing herbal medicine in contemporary, globalised society (Jagtenberg 2003). A couple of additional points need to be made regarding the challenges facing us.

The first involves sustainability and possible extinction of species. We have seen this year, firstly in the New Scientist article last January (Edwards 2004), and secondly in the release last month of the World Health Organization’s guidelines on Good Agricultural and Collection Practices (GACP) (WHO 2004) for medicinal plants, that the issue of the sourcing of our medicinals demands our attention. Inappropriate harvesting, the destruction of traditional communities, the degradation of lands traditionally used for collection of medicinals and the (to date) very limited emphasis on cultivation of medicinals combine to emphasise the urgency of the issue.

The second issue is dislocation from the environment. For many years we have been confronted by the question – how does one be an urban herbalist? There are many ways in which individually we strive to connect with the natural world – through cultivating our gardens with include specimens of medicinals, through wild crafting and making our own medicines albeit on an intermittent and very small scale. However this continues to be a challenge and is becoming more of a problem rather than less as the physical forms in which our medicines are traded increases in volume resemble pharmaceuticals rather than a simple dried plant.

So what are possible ways forward for practitioners of contemporary western herbal medicine in Australia? My suggestions are threefold. Firstly in order to strengthen our traditional connection with our plants in their environment, we need to decrease, not increase, the number of plants in our materia medica. As Nigel Gericke said with regard to the use of Harpagophytum by the Bushmen in the Kalahari, we are tending to narrow down the uses of plants to one or two uses, ignoring the so-called ‘minor’ uses. We are therefore forgetting the broad range of uses of many of the plants that grow easily and well within our local area, and which can be usefully employed without the difficulties which world trade forces onto herbal medicine. We need to know fewer plants more deeply, rather than knowing a little about more plants.

Secondly in our education system we need to pay more attention to the nature of tradition, to understand its strengths and weaknesses. We need to begin by introducing foundation units in history and philosophy, by including this discussion in every year of naturopathic education, and by emphasising projects which investigate these topics within research and postgraduate programs.

Thirdly we need to see science and tradition as part of a continuous development of knowledge. As 21st century herbalists we are not an indigenous people; we do not live a traditional lifestyle. Science is part of this new way of understanding: it is not our total understanding. We need both science and tradition in order to develop our understanding of our practice, our patients and our plants. We need to have a combination of scientific knowledge and traditional knowledge rather than be either scientific or traditional practitioners.

References


Evans, S. Contemporary western herbal medicine: the interplay of tradition and of science (Poster, Abstract). Revista de Fitoterapia 5:S1 2005.

Contemporary western herbal medicine – the interplay of tradition and of science.

SUE EVANS
School of Natural and Complementary Medicine, Southern Cross University, PO Box 157 Lismore NSW 2480 Australia.

The resurgence of public interest in and demand for western herbal medicine has been well documented. In recent years, herbal medicine has become a widely accepted part of healthcare. However, the effect of this mainstreaming on traditional herbalists (previously a marginalized group) has not been comprehensively explored. This paper shows that there is an uneasy relationship for the conjunction of different paradigms.

The broad aim of my research was to enquire into the practice of contemporary western herbal medicine in Australia, in particular the ways in which practitioners viewed their own practice, and the cultural context within which they operate. To this end, herbal practitioners in two Australian cities were interviewed. These practitioners are in private practice as independent prime-contact clinicians, treating patients independently of medical practitioners. The herbalists were interviewed concerning aspects of their clinical practice, including the relative place of herbal philosophy and the natural scientific assumptions of biomedicine.

Semi-structured interviews were conducted with 16 herbalists. 8 in Melbourne and 8 in Brisbane. The informants were asked about their thought processes during consultation, with regard to diagnosis and prescription, and the extent to which they are informed by concepts from both biomedicine and traditional herbal medicine. In particular they were asked about the idea of ‘vital force’, because vitalism remains a core assumption in all traditional herbal practice.

The respondents were 11 women and 5 men. In Australia, it is estimated that 75% of herbalists are women. The respondents were aged between 25 and 50 years, and had been in practice between 2 and 20 years.

The methodological framework was grounded theory, including ethnographic research using basic social science based methods, predominantly interviews, surveys and participant observation.

Research findings: a brief discussion

All the respondents stated that they were doing ‘something more’ than biomedicine. All saw their herbal practice as not simply based on biomedical understandings of disease processes, but something different. Additionally, all practitioners saw their practice as being informed both by traditional herbal medicine, including the concepts of ‘vital force’ and ‘physiological enhancement’, and by biomedicine, which emphasises pathology.

Two thirds of the respondents expressed that they experienced some conflict between science and traditional herbal philosophy. Those who had most recently entered practice experienced the most conflict, those who had been longest in practice experienced least conflict.

The herbalists were questioned about their understanding of ‘vital force’. This is an idea in traditional European herbal medicine that suggests that nature is a living entity. It posits that Vital force is found in all living things. Within this perspective, disease is seen to be a result of a weakened vital force, and traditionally the aim of treatment is to strengthen the vital force, which is seen as the way to stimulate health. This idea is rejected within the field of biomedicine. All but one of the respondents stated that they found the idea of ‘vital force’ to be a useful concept in practice and some practitioners stated that it was fundamental to their practice.

Fourteen of the sixteen respondents were of the opinion that traditional herbal philosophy is poorly documented. This is to be expected where oral transmission and practical example remain central in the training of traditional practitioners.

Summary of research findings

The major findings of this research can be summarized as follows:

1. Australian herbalists are using current biomedical understandings but see themselves as not limited by this. Their therapeutic aims are informed by tradition, and include the concept of vital force, and the idea of physiological enhancement. The practitioners contrast this with biomedicine’s focus on treatment of named diseases, which often involve clear pathological change.

2. All practitioners described their clinical practice as drawing on both traditional understanding and biomedicine. Some raised concerns as to a conflict between traditional practice and biomedicine, whilst others had found ways to accommodate the two perspectives.

3. Most respondents stated that they felt that the traditional aspects of herbal medicine were poorly documented. It appears that they learn integration, and the practical application of philosophy through practice, rather than during their training. The commercial context of herbal practice appears to be at the forefront of most practitioners’ minds. Thus although it was not an area identified by the interviewee, 50% of respondents expressed concern that herbal medicine was becoming increasingly product oriented rather than plant oriented – particularly at practitioner seminars.

The practice of contemporary western herbal medicine appears to be a rapidly changing field. The interplay of ideas that are based in natural science and those which originate from traditional practice should be elucidated.
