

The National Registration and Accreditation Scheme: what would inclusion mean for naturopathy and Western herbal medicine?

Part I: The legislation

Jon Wardle
School of Population Health, University of Queensland
email: j.wardle@sph.uq.edu.au

Introduction

On 26 March 2008 the Commonwealth, State and Territory Health Ministers agreed to partake in a national registration scheme for health professionals to replace the State based regulation of health practitioners. This was part of a wider range of measures designed to reduce regulatory burdens, not just in health but in all areas of business in general. This led to the ultimate design and introduction of the National Health Practitioner Regulation National Law Act 2009 (Qld) (the National Law).

The legislation was designed and introduced in Queensland (which, being the only unicameral state in Australia, means that changes approved by the Ministerial Council – comprised of the Health Ministers from each State and territory and the Commonwealth – need only be ratified by the lower house to apply as law) with other states employing various ‘me too’ clauses in their respective laws. This means (in theory) that once the law has been amended in Queensland it automatically applies nationally. Additionally the legislation has enabled the creation of shared infrastructure between each of the professional boards, substantially reducing the variability and costs associated with health practitioner regulation. Full details are available at the website of the Australian Health Practitioner Regulation Agency (www.ahpra.gov.au).

Although currently including only regulated or partially regulated professions (Chinese medicine has been earmarked for inclusion in 2012 under the latter category), completely unregulated (in a statutory sense) professions may be considered for inclusion in this Scheme. It is likely that naturopaths and Western herbalists will be amongst the first of these professions considered for inclusion in the Scheme.

Why would the government be interested in regulating naturopaths and Western herbalists?

Previously the investigation of regulation of health professions had had a focus on the potential legitimacy of the professions involved. For example the Webb report (1977) investigating regulation of naturopathy in addition

to chiropractic and osteopathy suggested that as ‘the thoroughness with which the pharmaceutical industry has surveyed the global flora for pharmacologically active substances renders the probability of any significant range of effective herbal medicine most unlikely’, naturopathy should not be registered as it ‘may give a form of official imprimatur to practices which the Committee considers unscientific and, at best, of marginal efficacy’.

However legitimacy no longer informs these decisions and the need for statutory regulation of various health professions in Australia is now determined by the Australian Health Ministers Advisory Council Criteria, which are primarily based on risk to the public. The risks according to these criteria as they relate to naturopathy and Western herbal medicine have been outlined previously not only in various reports to the government (Lin 2005, Wardle 2008a), but also in this journal (Wardle 2008b).

Naturopaths and Western herbalists: too big to ignore

The high prevalence and primary care role of naturopaths and Western herbalists practising in the healthcare sector urged the Victorian government to investigate the regulatory requirements of naturopaths and Western herbalists in 2003. The report, published in 2005 (and made public in 2006) strongly recommended that naturopaths and Western herbalists be regulated by a statutory authority, under similar arrangements that state had undertaken for Chinese medicine and acupuncture. Other states, for example South Australia (Social Development Committee 2009), specifically stated that they would first observe the implementation of regulation in Victoria before determining their arrangements. However before the recommendations of the Lin report could be enacted, the announcement of the move towards national registration had occurred and the regulation of naturopaths and Western herbalists in Victoria deferred indefinitely.

It is likely that the same potential risks that encouraged the Lin report’s recommendations for statutory regulation of naturopaths and Western herbalists still exist, and in fact the increased numbers and higher profile of these professions may have made them more profound.

Naturopaths and Western herbalists are now a significant part of the healthcare sector. Nearly 10% of the Australian (female) population see a naturopath or Western herbalist (Adams 2007), and this rises to 16% in complex conditions such as cancer (Adams 2005). Naturopaths are already the largest complementary medicine profession in Australia – and one of the largest unregulated health professions. Furthermore naturopaths and herbalists are one of Australia's fastest growing professions (Australian Bureau of Statistics 2008). Early studies demonstrated that approximately one third of complementary medicine (CAM) patients relied on their CAM practitioner as their primary care provider (Chow, 2000), and this high level of primary care service provision has since been specifically identified in naturopaths and Western herbalists (Grace 2006, Wardle 2010). The success of naturopaths and Western herbalists has meant that they must now either improve the accountability and responsibility of their practice to ensure public safety, or risk having scope slowly eroded.

Is self regulation not enough?

Of course the more cynical reasoning for government interest in the regulation of naturopaths and Western herbalists may be due to the fact that the ability for the profession to self regulate has to date been a failure. This may only be partially true. Goods and services tax (GST) exemption of naturopathic and Western herbal medicine consultations had in fact been granted on the proviso that a national registration scheme was developed, and the major professional associations were given \$500,000 to bring this into fruition. The fact that this exemption has continued until now has had more to do with luck than design. This is particularly important considering CAM practitioners are not generally trusted by the 'non converted' public (Hardie 2008). This places the public at further risk when CAM practitioners are conferred 'false legitimacy' as the Australian public generally believe that the CAM sector is far more highly regulated than it actually is (MacLennan 2006). However even if mistrust is part of the sentiment behind government interest in the regulation of CAM therapists, it is important to understand what the legislation actually does, as there are important safeguards for naturopathic and Western herbal medicine practice and registration has very little to do with 'control' of a profession's activities.

Protecting the public – what it is all about

It is important to understand that this mistrust is often warranted. Whilst most practitioners undeniably do the right thing, there is a small but significant element (as occurs in any profession) that takes advantage of the unregulated nature of the industry. However statutorily regulated professions generally have well developed processes to ensure that those who do practice in an unethical or unprofessional manner are appropriately punished or removed from practice. For example the medical and surgical professions have not been harmed by the action

taken against former Bundaberg surgeon Jayent Patel, rather this has demonstrated that the public can have confidence in their specific surgeon as there is a process for 'weeding out the bad guys' in that profession. Similarly most naturopaths and Western herbalists will have little to fear from statutory regulation, although the hammer will come down hard on those deliberately doing the wrong thing.

The legislation is underpinned by a strong acknowledgement that accidents can and do happen, and action is generally taken against a practitioner only when it is demonstrated that the practitioner knowingly put the patient at risk – either through incompetence, negligence or by ignoring the limitations of their knowledge. To add to the Patel example, the criminal nature of his crimes come not from the fact that he caused patients' deaths, but rather that these deaths were primarily due to him performing surgical operations he knew he was unqualified to perform. Statutory regulation is implemented to protect public safety, not to specifically reduce particular scopes of practice or activity. In defence of our profession we often forget that we have a particular duty of care to the patient and that to practise is a privilege, not an automatic right. It is actually the public who are extended the right to accessible naturopathic and Western herbal medicine services, and they also have a right to be assured that these practitioners are bound by minimum standards of practice and training, or to be easily able to make an informed choice based on these factors. Regulation is about the patient, not the practitioner.

Who makes the decisions?

The National Boards are made up of between half and two thirds practitioner members with the remainder to be made up of community members. The Chair is to be a practitioner member. Practitioner members must be made up of practitioners who would be eligible for registration of the Board (for example practising or accredited naturopaths and Western herbalists). There must also be at least one member from each of the 'larger jurisdictions' (New South Wales, Queensland, South Australia, Victoria and Western Australia) and at least one member from one of the 'smaller jurisdictions' (Australian Capital Territory, Northern Territory or Tasmania). Additionally one of the practitioner members must be from a rural or regional area. The only requirement for community members is that they have not been or are not currently eligible for membership of the register for that Board. There are no geographical restrictions and members of other health professions are allowed to apply as community members. In fact, although not a requirement, having representatives of other health professions as community members is encouraged to promote dialogue between the Boards. The smallest possible configuration under these criteria is a Board comprised of 9 members (6 practitioner members, 3 community members), the configuration currently employed by the Chiropractic, Optometry, Osteopathy and Podiatry Boards.

Figure 1

The objectives of the national registration and accreditation scheme
(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and
(b) to facilitate workplace mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and
(c) to facilitate the provision of high quality education and training of health practitioners; and
(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
(e) to facilitate access to services provided by health practitioners in accordance with the public interest; and
(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.
The guiding principles of the national registration and accreditation scheme
(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;
(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;
(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

Under any of these criteria any statutory naturopathic or Western herbal medicine Board will be 'controlled' by the profession, although under Section 7 of Schedule 4 members are required to act 'in the public interest' rather than the profession's interest. Section 40 of the National Law also requires that the Board must ensure that there is wide ranging consultation when developing registration codes, guidelines or standards, and that these must be publicly accessible on the Board's website. This consultative approach is extended to other functions including accreditation.

What does the regulation legislation do?

The National Law comprises a number of guiding principles and objectives (see Figure 1). There are numerous important safeguards here for professions. Some things will not change much from the current situation. For example sections 128 and 129 of the National Law will require mandatory continuing professional development and indemnity insurance for regulated practising professions, however there are some changes that will occur:

Education and training

Objectives (a), (c) and (f) relate to minimum standards of training for health professions. For naturopathy and herbal medicine these minimum standards would not only relate to minimum levels of health sciences, but also to ensuring minimum standards of history, philosophy and theory as well as minimum standards for clinical training.

This is particularly important considering the contemporary decline in these aspects of naturopathy and Western herbal medicine education in Australia (Evans 2000, McCabe 2008, Wardle 2008a). Furthermore in many instances current naturopathy and Western herbal medicine courses do not fulfil clinical training requirements espoused by the World Health Organisation for training CAM therapists (Evans 2000).

Regulation means the loss of philosophy in education: myth or reality?

Many practitioners exhibit concerns that regulation will erode the importance of naturopathic and Western herbal medicine philosophy in training (Canaway 2009). In many respects the profession has already lost control of its education sector. The fragmentation of the naturopathic and Western herbal medicine professions has in many ways led to the professions having reduced input on practitioner training, particularly now that the education sector has become dominated by private equity providers with no traditional link to the professions (Jones 2008). The consultation requirements and standardised minimum accreditation standards may reconnect the professions with the training of its practitioners. A good precedent to observe is the accreditation guidelines for courses regulated by the Chinese Medicine Registration Board of Victoria, which require not only minimum levels of academic training, but also proscribe minimum philosophy and history content and minimum clinical and training levels (Chinese Medicine Registration Board of Victoria 2006). Procedures for accreditation under the National Law require education providers to engage in professional development activities to support the viability and sustainability of the profession (Agency Management Committee 2009). This is particularly important at a time where graduate numbers are far outstripping public demand for services as the CAM education sector has become increasingly commoditised.

Does not degree accreditation already provide these minimum levels?

Contrary to popular belief, current Office of Higher Education (or equivalent body) accreditation for degree level has very little to do with actual course content (a matter it generally defers to professional representatives) and is focused far more on governance standards of the institution (MCEETYA 2007). In an unregulated profession with one strong association (such as Speech

Pathology or Dieticians) this arrangement can quite often work, however the extraordinary fragmentation and competition for members between professional associations in naturopathy and Western herbal medicine has led to a 'race to the bottom' that has seldom held education providers accountable for professional training standards (Lin 2009).

Regulation will mean a standardised curriculum: myth or reality?

Setting minimum standards is not the same as standardisation of course content. In fact guiding objective (f) (to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners) protects against any staid educational requirements from stifling professional development. In practice this would offer education providers flexibility in course delivery providing they meet those minimum requirements in the proscribed areas and do not endanger public safety. In every other health profession specific education providers differ in their approaches to practitioner education, and pride themselves on the individuality of their courses. There is no reason naturopathy or Western herbal medicine would be any different.

Practice standards

The objectives and guiding principles of the National Law do not impose unnecessary restrictions on practice apart from the insistence that practice not put the public at harm. In fact guiding principle (c) explicitly states that any restrictions on the practices of a health profession should only be placed to ensure public safety and or quality. Objective (f) states that the National Law should encourage flexibility and responsiveness (meaning to be able to cope with changes in public and professional developments), as well as being innovative in service delivery. The regulation of practitioners is based primarily on reducing risk not scope of practice.

Restriction of practice under regulation: myth or reality?

Restriction of practice is an issue that is often mistakenly used as an argument against the imposition of statutory regulation by naturopaths and Western herbalists (Bensoussan 2004, Canaway 2009, Rogers 2007). In some jurisdictional contexts this may be accurate however in the Australian context it is not. These concerns are completely irrelevant to registration although could be relevant under naturopathic or Western herbal medicine inclusion in a publicly funded fee for service scheme such as Medicare. When accessing public funds restrictions are often placed on practice by the government paying for these services. This is because the system is designed to serve everybody, rather than specific individuals and therefore every individual practitioner may not always be able to get exactly what they want. It needs to be placed in the context that there

is a limited health budget for an unlimited number of health problems which makes prioritising essential. For example at a national health system level too many expensive pathology tests may mean that a child with leukemia is unable to receive medication. However the issue has little if anything to do with registration.

Then why are regulated medical practitioners punished for using CAM?

In the context of publicly funded health systems, restrictions on practice are often a pragmatic reality. Whilst most medical doctors would prefer to do longer consultations, the system or health budget cannot bear this. Doctors are free to consult for as long as they wish, although Medicare will only pay for limited time consultations. Longer consultations are often the reason that many 'integrative' doctors are brought before the Professional Services Review. In some instances these may be appropriate, particularly in complex or chronic conditions, and for this reason 15% of investigations do not result in action taken. If these doctors had performed their services in private practice and had not charged them to the public purse they would not have been brought before review in the first place. The over ordering of pathology tests is another reason 'integrative' doctors are brought before review. If there is clinical justification for these tests there is generally no issue. However if it is proven that practitioners are simply using protocols of pathology tests, or are immediately utilising more expensive tests without performing other cheaper diagnostic measures to determine their need (for example neglecting physical diagnosis or case taking), then practitioners are held accountable.

It should be noted that the issue here is charging the public purse and not inappropriate practice. Doctors enjoy an incredibly flexible and wide ranging scope in the private sector; in fact unless there is evidence of placing the patient at undue or uninformed risk, there are remarkably few restrictions on practice. For similar reasons, although regulation will have little impact on reducing the scope of practice of naturopaths and Western herbalists, the inclusion of these therapies on some publicly funded schemes may do so. That is not to say that naturopaths and Western herbalists should not seek to be included in publicly funded care, but rather that they exhibit careful thought in how this is enacted, and that the fee for service model espoused by Medicare may not be a good fit for the profession. It also points to the fact that CAM practitioners need to be more proactive in lobbying for improved health funding models that afford improved public access to their services, one which not only treats all health practitioners fairly but can also more effectively help combat the new health challenges of the 21st century.

Restricted acts

There are some restricted acts under sections 121-123 of the National Law which are limited to certain professionals. These are manipulation of the cervical

spine (other manipulation is not restricted), dental acts and the prescription of optical devices. Endorsements are required for additional acts or titles such as the use of the title 'acupuncturist' and access to scheduled medicines which are available to all regulated professions. It has recently been announced that three previously restricted Chinese herbs, ban bian lian (*Lobelia chinensis*), zhi fu zhi (*Aconitum carmichaelii*) and ma huang (*Ephedra sinica*) would be made available to regulated and endorsed Victorian Chinese medicine practitioners by listing in Schedule 1 of the Victorian Poisons List of the Poisons Code, and that this may serve as a trial for national implementation coinciding with national registration of Chinese medicine practitioners in 2012 (Chinese Medicine Registration Board of Victoria 2010). This may set a precedent for allowing access to previously restricted herbs under similar endorsement arrangements to registered naturopaths and Western herbalists.

Mandatory reporting

One of the more controversial changes introduced into the National Law is mandatory reporting. This applies to health practitioners, employers of health practitioners and education providers. Under this provision those who fail to report 'notifiable conduct' are deemed to be equally at fault as those performing 'notifiable conduct'. This is taken as meaning that duty of care to patients extends to knowledge of unethical or unprofessional conduct as much as it does to performing it. There are some exceptions, for example if the reporting practitioner believes that reporting will put the patient at further risk or if they reasonably know or believe that the conduct has already been reported.

Section 140 of the National Law sets out what constitutes 'notifiable conduct' and includes practitioners who have: (a) practised the practitioner's profession while intoxicated by alcohol or drugs; or (b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or (c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or (d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

Exactly what constitutes a significant departure from acceptable professional standards is determined by professional peers (including the wide ranging consultation in developing practice standards under section 40), not bureaucrats or the medical profession. The key factor is that departure from these standards must have placed the patient at significant risk of harm. Voluntary notifications can be made however these are at the discretion of the practitioner. The investigation processes under division 8 of the National Law offer significant protections against frivolous claims. Moreover there are significant civil protections against fraudulent

allegations by practitioners against other practitioners, as is demonstrated by the recent awarding of \$70 000 in damages to a Perth naturopath after defamatory emails were sent to colleagues by another naturopath (2010).

Training requirements

One of the prominent concerns of CAM practitioners facing statutory regulation is whether those without degree qualifications will be automatically excluded from the register. Entry requirements for the register will be ultimately the decision of the relevant Board however transitional arrangements are allowed under section 303 of the National Law. In the case of partially regulated professions, to be included in the scheme in July 2012, the eligibility requirements are that the practitioner (a) holds a qualification or has completed training in the profession, whether in a participating jurisdiction or elsewhere, that the National Board established for the profession considers is adequate for the purposes of practising the profession; or (b) holds a qualification or has completed training in the profession, whether in a participating jurisdiction or elsewhere, and has completed any further study, training or supervised practice in the profession required by the Board for the purposes of this section; or (c) has practised the profession at any time between 1 July 2002 and 30 June 2012 for a consecutive period of 5 years or for any periods which together amount to 5 years.

Only practitioners with Bachelor degrees will be eligible: myth or reality?

This means that practitioners in approved courses or who are independently assessed (in a similar manner to a clause 2 application of the NHAA) will be eligible under (a); that those whose training is deemed insufficient will be allowed to participate in further education to meet standards under (b); and that those currently recognised as practising professionals will be given appropriate grandparenting arrangements. Even if Bachelor degree levels are identified as the minimum standards, as per previous government recommendations (Expert Committee on Complementary Medicines 2003, Lin 2005) and as observed in previous CAM practitioner precedents of Chinese medicine, chiropractic and osteopathy, the focus of regulation will be on reaching these standards over a period of time rather than imposing them arbitrarily and education providers and practitioners will be given time to meet these new standards. Graduates after this time however will be required to have recognised training. Part 7 of the Act also sets out a number of alternative types of registration to standard registration, including limited or provisional (for example this may allow treatment of limited or non increased scope for those who have not been trained in some areas) and non practising registration (for example those involved in academia or administration rather than practice but unwilling to give up their identity as a naturopath or Western herbalist).

Conclusion

Statutory regulation of naturopaths and Western herbalists is not a foregone conclusion. There is no automatic process for considering unregulated professions under the Scheme, and instead an application for consideration must be lodged with the Secretariat for the National Health Workforce Principal Committee. However numerous stakeholders have indicated a desire to lodge an application in the future. Even in the unlikely (at this stage) event that naturopaths and Western herbalists are not included in the statutory Scheme, a voluntary register, the Australian Register of Naturopaths and Herbalists (www.aronah.org) has been established mirroring the legislation of the Scheme. Furthermore a national scheme for unregistered practitioners based on negative licensing similar to the New South Wales Unregistered Practitioners Code of Conduct is currently being considered to complement the National Registration and Accreditation Scheme. In any outcome it is likely that naturopaths and Western herbalists will be required to implement many of the recommended responsibilities, accountability measures and obligations observed within the National Law. Part 2 of this series will outline what these changes will actually mean on the ground for practitioners' clinical practice in naturopathy and Western herbal medicine.

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- Jon is a naturopath practising in Brisbane and an NHMRC Research Scholar at the School of Population Health at the University of Queensland. He also holds a visiting appointment at the School of Medicine, University of Washington. Jon is Director of the Network of Researchers in the Public Health of Complementary and Alternative Medicine's (NORPHCAM) Research Capacity Stream. He holds editorial positions on a number of journals including the *International Journal of Naturopathic Medicine*, and is co-editor of the text *Clinical Naturopathy: an Evidence Based Guide to Practice* published by Elsevier. His research interests include complementary medicine policy and integration.