Holistic medicine

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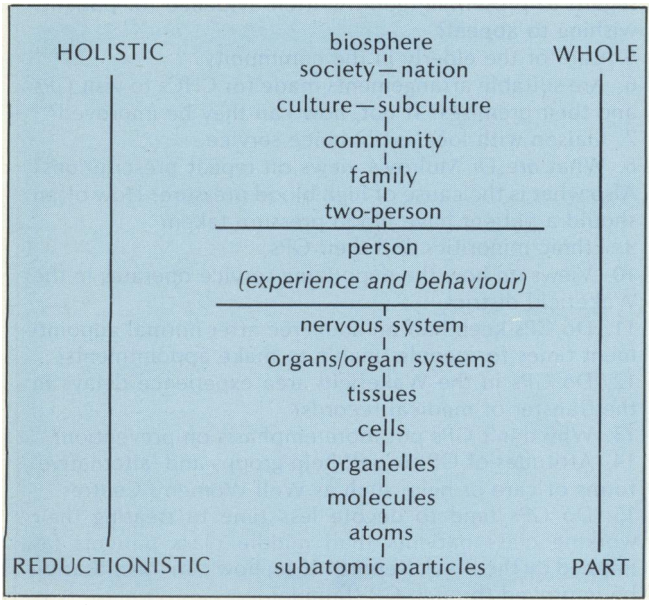
'It's what good medicine has always been all about.' It's just a collection of trendy, anti-authoritarian doctors.' 'It's the Yoga, jogging, yoghurt brigade.' I suspect there are a few other such epithets that have been used to describe the emergence of holistic medicine and the British Holistic Medical Association.

THERE has also been a more positive response—the association has over 350 medical members and 350 non-medical members, and the first issue of its journal has been well received. Joint ventures with the Royal Society of Medicine and the British Postgraduate Medical Federation are in progress. Enquiries from the public are hard to keep pace with and there have been over 80 requests for public talks since the launch of the association in September 1983. The topic has been on the programme for both the National Scottish and English trainee conferences. Three months ago, 50 medical students joined together to form the student section of the association, and in November this year there will be a conference to bring together the nondoctor groups under the umbrella of the British Association for Holistic Health.

Well, what is this thing called 'holistic medicine'? Essentially it brings together a number of different developments in medicine. Some of these developments precede the onset of modern medicine and some are an expression of the changes in our culture and society.

The word 'holism' was coined by Smuts in 1928 in his book *Holism and Evolution*. He used it to describe the philosophical systems that looked on *whole* systems rather than parts. Since Descartes, man's search for knowledge of the human condition has largely been governed by the philosophy of *reductionism*. That is, to study the workings of the human condition we have reduced each part to its smallest component. Thus we are now down to the molecular and genetic theory of understanding the causation of disease. Smuts felt that this had produced an imbalance in our approach to the study of the human condition and he outlined the opposite viewpoint.

The word holistic is taken from the Greek 'holos' meaning 'whole', 'complete'. The (w) is a recent addition in our own English language. I have found that more anger has been created by the spelling of holistic than by almost anything else—thus the rather long explanation.



Hierarchy of natural systems (after Engel).

The basic principles that underpin the practice of holistic medicine are:

1. *The whole is greater than the sum of its parts*

It is necessary when looking at a diseased or malfunctioning part to look at and be aware of the *whole,* for it may be that by our working with the whole, the part may regain its function. For example, reducing stress may reduce hypertension so that rather than be prescribed anti-hypertensives, patients can be taught breathing and relaxation exercises. A useful outline of this concept is that developed by Engel.

The same concepts are described in general systems theory and it is possible to extrapolate from the 'part' to the 'whole' and see human behaviour in terms of increasingly complex interacting systems. The linear model of cause and effect is only partly applicable to disease and health.

2. *The use of a wide range of medical interventions*

'If you take my prescription pad and my referral letter away from me, what else do I have?' The heartfelt plea of a trainee. We have limited ourselves in orthodox medicine to the belief that healing requires either drugs or surgery. It is very quickly apparent to most general practitioners that often the best 'alternative medicine' is to listen to the patient. Yet very few of us have had any training in this area and all the serious research indicates how bad we are at this sort of 'intervention'. Holistic medicine espouses the use of:

i. *Orthodox approaches*—drugs and surgery.

ii. *Whole person therapies and self-help skills*—breathing and relaxation, meditation, physical exercise, dietary counselling, visual imagining, listening and counselling.

iii. *'Alternative or complementary' methods*—acupuncture, homoeopathy, herbal medicine, chiropractic, osteopathy.

This is not the right place to describe each of these approaches nor the clinical efficacy of them. Suffice it to say that no one individual can utilize all these approaches, but that in my view, as primary care practitioners, we should know about their applications.

Education as well as treatment

'Medicine is a subsection of education—please discuss.' This College's own efforts in prevention and promotional health have been impressive—and yet only a small amount of time is actually spent in health education—and the spin off has often been poor. We have not yet put into practice with patients what we have learnt in vocational training. For education of the self to be effective it has to have a large experiential component. We still turn out pamphlets explaining the dangers of smoking. Health visitors still give long talks to patients, and so on. We need to provide a totally different form of educational experience if our efforts are to be rewarded. At our own centre we now have over six classes a week of breathing, relaxation, meditation, Yoga and visual imagery. The classes are oversubscribed and the feedback is largely positive.

Doctor-patient relationship

This follows from the last principle and we are at last beginning to see a move in this direction. I believe we should have doctor-patient participatory groups, not just patient-participation. The traditional hierarchical structure of the doctor-patient relationship needs to be finally put to rest.

One of the main reasons why alternative practitioners have had such an increase in their clientele has been for this reason—not just because of their actual therapies. They are seen to be on the patients' side helping them to get better! Doctors are viewed as fighting the *disease* and all too often this involves fighting the patient—'It is better to know what sort of patient has the disease than what sort of disease the patient has.'

Physician—heal thyself

The increase in depression, divorce, alcoholism and suicide amongst doctors must become of central concern to the profession. No advances in health care will come about until we have tackled this problem. If we avoid it, the medical profession will be bypassed by patients as they seek help from other practitioners.

The problems start at medical school. The undergraduate curriculum is unbalanced and it is essential to introduce educational experiences which recognize and respect the autonomy of the student, that nurture and encourage his or her ability to respond to persons as well as to the diseases.

The Future

The British Holistic Medical Association was set up to foster and develop the principles and practice of holistic medicine. Membership is open to doctors of all fields and specialties and to medical students. It is embarking on an educational programme geared for the medical and allied professions, the public and medical students.

It has produced guides to the alternative therapies and a number of self-help cassettes for distribution directly to the public. There will be a close liaison with the British Association for Holistic Health. The next Annual Conference will be held in Oxford, 28-30 September. The theme will be the application of holistic approaches within the NHS. The two areas of clinical focus are cancer and birth.

Any further enquiries can be made to the British Holistic Medical Association, 179 Gloucester Place, London NW1 6DX. (Tel: (01) 262-5299.)

FROM THE FACULTIES

Yorkshire Faculty learns by answering questions

Although the Yorkshire Faculty took as their 'Spring Meeting' theme the dialogue between patients and doctors (a splendid and enlightening meeting), it has in general favoured approach to the community health councils at district level. Dr R. Mulroy reports.

IN the Wakefield district, the relationship between the community health council and general practice can at best be described as cool, if it exists at all. Stimulated by my faculty and the college, I, like Dr Murfin (April *Journal*, p.237) established contact with the local community health council secretary, Miss Lesley Pattenson. We arranged two meetings. On the first occasion, Miss Pattenson visited the half-day release scheme and met trainees and trainers. Two days later, I visited the community health council.

Miss Pattenson first confounded us with a questionnaire based on the origins, functions and constitution of our own community health council. Few of us scored a pass. She exposed the wide gap between the medical model and real life. She easily found gaps in our armour, though I felt that she had found some deficiencies that did not exist. (The burden of male chauvinism lies easily on my shoulders.) This session scored more heavily with the trainees for 'new knowledge' than any previous session in the last three years, apart from a session which we held with the police.

For my return visit to the community health council, I asked if they could give me prior knowledge of some questions they wished to ask. The panel shows the list of questions that was produced. Let me say that the first and most important aspect of the meeting was that the community health councils are on the same side as us. They do have an interest in the community and the patient. Of course, their ideas of general practice are coloured by the fact that their immediate knowledge of general practice is based, in the main, on patients' complaints. They hear little of the good things. Perhaps that is our fault. Can we remedy it? In 'informing' our local community health council, we may learn something. It is, I found, a salutary, rewarding and not painful experience.

List of items for discussion at Dr Mulroy's visit

1. Regular visiting for elderly or over 80s. Any regular check-ups on these patients?
2. GPs' training in counselling skills and communication. (What about GPs already in practice as well as trainees?)
3. What is the attitude of GPs to the use of generic drugs as opposed to commercially named products?
4. Attitude of GPs to patients 'thrown off' benefits, eg invalidity/mobility/attendance by DHSS, particularly in regard to presenting good written evidence for patients wishing to appeal?
5. Care of the elderly in the community.
6. Are suitable arrangements made for CHCs to visit GPs and their premises? If not, how can they be improved?
7. Liaison with local ambulance service.
8. What are Dr Mulroy's views on repeat prescriptions? Also what is the cause of high blood pressure? How often should a patient have blood pressure taken?
9. Ethnic minorities and their GPs.
10. Views on how the deputizing service operates in the Wakefield district.
11. Do GPs keep half an hour free after normal appointment times for people unable to make appointments?
12. Do GPs in the Wakefield area experience delays in the transfer of medical records?
13. Why don't GPs put more emphasis on prevention?
14. Attitudes of GPs to self-help groups and 'alternative' forms of care or help, such as Well Women's Centres.
15. Do GPs tend to devote less time to treating their working class patients than middle class patients (as implied by the Black Report)? If so, how can this situation be improved through GP training?