What kind of alternative is alternative medicine?

WESTERN medicine has been criticized in recent years, both from within and from outside the medical profession by those pressing for more patient-centred care and a model of ill health that goes beyond consideration of disease processes. At the same time there has been growing support for the use of self-care and the greater involvement of patients in their health care. It is in this climate that what has become known as 'alternative medicine' has grown.

Conventional medicine, for want of a better term, cannot of course claim to have a monopoly in health care, not least because there is no system of health care that can realistically expect to provide satisfying and effective treatment for all the illnesses of all the people. What must be challenged, however, is the widespread impression created by numerous articles in the lay and professional press that alternative medicine in some way offers a more whole person or holistic form of care. When osteopaths claim that illness can be due to misalignments or dislocations in the human skeleton or acupuncturists that the vibrating of a well-placed needle can relieve aches or pains they may in fact be offering an even more simplistic and reductionist model of illness than conventional medicine. That is not to say that such treatments may not be effective; but it is because great claims are made for these types of remedies that alternative medicine should, like any other form of health care, be scrutinized carefully. In particular, we should consider the implications that alternative medicine has for general practice, which deals with 90% of all health problems seen in the British health service.

For some acute problems seen in general practice, for example bacterial pneumonia, there are actual cures. For many problems, however, caring or symptomatic remedies are all that can be usefully applied and these vary from doctor to doctor. The treatment may range from the prescribing of symptomatic remedies, for example expectorants and analgesic drugs, through recommending non-pharmacological remedies, such as ice packs or rest, to simple reassurances about lack of seriousness and the likelihood that the problem will resolve itself. The latter approach, variously described as expectant treatment, masterly inactivity or 'tincture of time', can be traced to Hippocratic teaching, which held that each patient was unique, that each episode of illness was an experiment of nature with its own unique natural history and that treatment was a facilitation of the natural healing process. At that time the opposing school of thought in Greek medicine was represented by the Cnidians who believed that diseases were real, tangible and organic-based entities amenable to intervention.

Applying specific treatment for acute self-limiting illness can be criticized because the treatment may be 'wrong' or have a risk of side-effects. However, of fundamental concern is that this approach, in contrast to Hippocratic teaching, suggests to lay people that doctors have no belief or confidence in the natural healing processes and this encourages the presentation of minor self-limiting illnesses for professional treatment. This argument does not just apply to the prescribing of symptomatic remedies; osteopathy, homeopathy and acupuncture also perpetuate a 'Mr Fixit' image of primary care practice. Indeed, far from offering a holistic alternative to the reductionist biomedical model, in the treatment of acute problems alternative medicine is as open to charges of 'medicalization' as orthodox Western medicine. With chronic and recurrent health problems it is a different matter.

Patients with chronic health problems form a significant part of the workload of any general practitioner and, while some of these patients have problems with a well-defined organic pathology, for example ischaemic heart disease, obstructive airways disease or diabetes, others have no clear-cut or tangible basis for their dysfunction. Many labels have become associated with the latter group of patients: somaticizers, high attenders, fat-folder patients, hypochondriacs, patients with functional, psychogenic and psychosomatic complaints and so on. At best, some of these labels reflect a sociological or psychoanalytic interpretation which can sometimes help in the understanding of these patients, and at worst they portray a pejorative attitude cloaked in professional jargon. Nevertheless, patients with organic or functional illness or both suffer dis-ease and, whatever the basis of the problem, can only be fully understood and helped if the care is person-centred.

It would be foolish, however, to deny that frequent attenders test not only the clinical skills but also the patience and empathy of even the most caring doctors. In part this is the result of the limitations of the therapeutic choices, and it is in this area where alternative medicine can help. For chronic diseases a complete cure is an unrealistic goal and, as with acute minor illnesses, management is often a combination of symptomatic prescriptions, non-pharmacological treatment, advice and reassurance. Perhaps most important of all is the therapeutic bond between patient and doctor — a trusting relationship with a caring general practitioner who offers a long-term commitment to the patient.

To be able to help the patient usually means that the general practitioner has to have a repertoire of strategies that he or she will try depending on how unwell or unsatisfied the patient is. The ultimate skill is not to run out of therapeutic choices. To do so means failure and frustration and perhaps rejection for the patient. Of course, there are often few different approaches that can be employed, but there are ways of extending them. First, instead of a hierachical progression of treatments — for example changing from aspirin to mild non-steroidal anti-inflammatory drugs then to penicillamine and steroids when treating arthritis — general practitioners can move back and forth between different approaches: 'Let's try what we did two years ago — that seemed to help for a while'. Secondly, the growth of team care means that the different skills of different members of the primary care team can enlarge the repertoire, and, perhaps even more important, the addition of other professionals means that there are others to share and sometimes relieve the burden of care. This can help to keep failure and rejection from the door. For example, the care of a poor widow with recurrent low back pain may be helped by having a social worker and physiotherapist in the primary health care team. But is is unlikely that the social worker will restore the socioeconomic deprivation of the widow or that the physiotherapist will cure the pain. Like doctors, they bring their particular skills to the overall caring process, an element of which is simply their presence and their commitment to the patient. One clear attraction of alternative medical strategies for the management of chronic health problems is that they would offer additional skills and enlarge the repertoire available for the care of patients. In those practices and teams where some individuals have developed skills such as acupuncture, hypnosis and manipulation this is probably already the case. Unfortunately, alternative medicine is often only available privately and outside the practice and this can have disadvantages for patients with chronic health problems.

First, alternative medicine is seen by many patients with chronic disease as a new hope for cure, a clear and attractive alternative to the caring contract that has been offered at the local health centre. The prevailing publicity about acupuncture, homeopathy and osteopathy concerns their successes, often after years of failure of conventional treatment in the hands of the NHS. When will this vulnerable group of chronically ill patients hear about the failures of alternative medicine? Secondly, when alternative medicine exists outside rather than within the primary health care team, seeking help elsewhere is bound to disrupt the therapeutic potential of the patient's relationship with the doctor and with other professionals, which has been built up over many years within the primary health care team. This cannot simply be dismissed as an example of professional jealousy since most general practitioners would be delighted if their patients could find cures elsewhere as easily as this. What tends to happen is that the alternative therapies do not help or bring only transient improvement or can no longer be afforded, with the end result that the patient returns to the general practitioner and the whole caring contract and relationship has to be re-established.

General practitioners, more than any other group in the health service, can tolerate uncertainty. They know that many illnesses cannot be described by existing diagnostic taxonomies and that the success of care does not always depend on explaining or understanding the detailed mechanisms of health problems and their treatment. The apparent success of many of the currently popular alternative strategies could be of great value to many of the patients seen in general practice. This is more likely if such strategies are seen as alternative treatments within the context of primary health care teams rather than as 'alternative medicine'. The emergence of the concept of 'complementary' rather than 'alternative' medicine bodes well for the future.

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Performance review: contribution from the family practitioner committees

THE RCGP, through its quality initiative, has made performance review one of its main activities for the next few years. Family practitioner committees (FPCs) also have a role to play in making performance review a normal part of a general practitioner's work.

In March 1982 the Department of Health and Social Security (DHSS) issued advice about the National Health Service (NHS) planning system.[1] The guidelines recognized that district plans should cover all primary health care and not only those aspects of community care which are the direct responsibility of health authorities. The NHS now recognizes the need for information systems which can highlight areas of poor performance. Advice about operational requirements and guidelines for 1985–86[2] have now been issued to FPCs and they have been asked to consider the format of their annual programmes. FPCs will wish to take careful note of the views of the medical profession when preparing their proposals for change and development. While in no way wishing to dilute the statutory role of local medical committees in advising FPCs, the Council of the Society of Administrators is keen to foster the links that have been developed with the Royal College of General Practitioners (RCGP) and it has been suggested that the next step might be for local links to be forged between FPC administrators and the College faculties. Such a forum could provide an ideal opportunity to relate relevant parts of the quality initiative to a particular local situation. It would also present administrators with an opportunity of explaining their Committee's own proposals.

The key to collaboration between FPCs and family doctors over performance review and to collaboration with district health authorities (DHAs) lies in unlocking the vast store of information FPCs hold, not only about patients but also about a whole range of services provided by family doctors. The introduction of new technology will help FPCs to improve and extend the assistance they can give to general practitioners and to the rest of the NHS. During the coming year it is likely that half the FPCs will computerize their patient registration data. The remaining FPCs should follow over the next few years. The DHSS is also developing, in consultation with FPCs, computer finance packages which will enable FPCs to make payments more efficiently. As the registration system and the finance system are developed it should be possible for FPCs to provide a range of information to family doctors about their practices and also to compare practices in the same area, district and region. This will need to be done in consultation and agreement with the profession. Several examples spring to mind: the provision of more sophisticated and up-to-date prescribing information, including costings; the analysis of lists of patients by age, geographical location and sex; the analysis of night visit, temporary resident, maternity and other items of service claims and rates of vaccination and immunization. FPCs are ideally placed to assist in implementing screening programmes in primary care. At long last positive steps are being taken to introduce effective computerized call and recall arrangements for cervical screening. It will be a comparatively simple matter for FPCs to develop other screening programmes in consultation with the profession. There is a need for flexibility in the introduction of new developments. Neither the profession nor FPCs should wait until national schemes have been agreed. The RCGP and the Society of Administrators should encourage local initiatives.

The DHSS has raised the issue of making wider use of the personal registration data held by FPCs.[3] The exchange of information which does not breach confidence is not a problem but the fact that the personal data held by an FPC was given solely by a patient seeking to register with a doctor, must be respected. Nevertheless, it ought to be possible for DHAs and FPCs to agree on the exchange of a range of information which could be channelled back to general practitioners as part of a general information exchange.

The Government has taken the opportunity presented by the change of status of FPCs to strengthen links between community health councils (CHCs) and FPCs[4] although many FPCs and CHCs have already established good relationships. New regulations place FPCs on the same footing as DHAs with regard to their relationships with CHCs. FPCs will now have to consult CHCs about matters affecting the provision of family practitioner services and will be required to meet CHCs formally as well as informally at regular intervals.