Complementary practitioners as part of the primary health care team: evaluation of one model

CHARLOTTE PATERSON

WENDELL PEACOCK

SUMMARY

Background. *A four-partner, non-fundholding, urban practice with 6000 patients has since September 1991 worked closely with nine complementary practitioners working part time on a private, fee-paying basis.*

Aim. *This study set out to describe and evaluate a model of integrating complementary practitioners into the primary health care team.*

Method. *A description of the model operating in the practice was compiled. Qualitative analysis was carried out of semistructured interviews with all members of the primary health care team using the method of a cooperative enquiry. Retrospective quantitative data on patients attending complementary practitioners were also examined.*

Results. *The model allowed patients to refer themselves or be referred by a team member, encouraged communication between team members, and did not require any specific funding. After two years the model had been largely successful in preventing conflict over power, control and decision making; had maintained commitment to the idea of integrating complementary and allopathic medicine; and was self-funding. However, despite varied mechanisms set up to share knowledge and ideology, the rate of change in this area was slower than expected and referral rates were varied. The dilemma of charging patients for complementary medicine in an environment where health care is free emerged as a major concern among the doctors and practice staff.*

Conclusion. *The method of cooperative inquiry allowed the whole team to gain an understanding of other viewpoints and to use the research to tackle the problems raised. This model could be adopted and used by any enthusiastic general practice.*

Keywords: complementary medicine; primary health care team; interprofessional relations; general practitioner services.

Introduction

THE development of primary health care facilities which embrace the participation of complementary practitioners as part of a multidisciplinary team is occurring all over the United Kingdom as a result of patient demand[1] and general practitioner interest.[2] Studies of patients using complementary medicine show that the majority view it as an adjunct, rather than an alternative, to allopathic medicine and most have consulted their general practitioner in the first instance.[1,3-6] Studies of general practitioners show an increasing interest in and acceptance of complementary medicine but a low rate of actual referrals.[2,7,8]

Models for cooperation between complementary and allopathic medicine in the primary care setting are varied,[9-11] but fall into three broad groups: those where complementary practitioners rent rooms in a medical centre but are otherwise separate, those where complementary practitioners are employed by a practice in a role similar to a practice nurse, and those where doctors and complementary practitioners attempt to work collaboratively while accepting each others' professional independence. Experience with these models has highlighted several recurring problems such as power issues between doctors and complementary practitioners, ignorance of each others' clinical methods, and funding.[11,12] Almost all of these models have maintained the traditional relationship between the doctor and complementary practitioner, that is, the doctor retaining clinical responsibility and acting as gatekeeper in the referral process. Many of the models so far evaluated have been set up with research or charity funding or as pilot projects by health authorities.

A model to try to overcome some of these problems has been set up and has been in operation since September 1991 in one practice. The aim of this study was to describe the model, and evaluate the extent to which it was providing and integrating a range of complementary and orthodox therapies within general practice.

Method

The study was carried out in a four-partner, non-fundholding urban practice in Taunton, Somerset. The practice has 6000 patients and the workload is equally shared by four partners, with a fifth, semi-retired, working one session a week.

An independent investigator (W P), previously unknown to the practice, carried out a qualitative investigation between September 1993 and January 1994.

The qualitative process was influenced by the model of cooperative inquiry[11-13] whereby all those involved work together as co-researchers and co-subjects. As co-researchers all the practice team participated in the thinking that went into the research — framing the questions to be explored, the methods to be used and together making sense of their experiences. As co-subjects they participated in what was being studied. The method engages participants in a cycle of action and reflection and in some respects parallels the audit cycle, but in a qualitative and less standardized way. It appears particularly appropriate for groups wishing to use research as both a practical and theoretical tool in innovative settings.

Initial brief meetings were held with all of the primary health care team to discuss what information they would like to see emerging from the study. From the notes of these conversations, interview schedules were constructed to be suitable for the four groups: seven nurses (including one midwife and one health visitor); 10 receptionists (including one practice manager and two

C Paterson, MRCGP, general practitioner, Taunton. W Peacock, BA, research assistant, Centre for Complementary Health Studies, University of Exeter.

Submitted: 18 July 1994; accepted: 23 September 1994.

secretaries); five general practitioners (including the founder of the practice who had recently retired); and nine complementary practitioners. There were some differences in the questions according to the roles or tasks involved and interviews with individuals took one hour for doctors and complementary practitioners and 30 minutes for nurses and receptionists. Topics covered by all the interviews included: personal and practice aims and roles; attitudes to and experience of complementary therapies; opinions on the concept of integrating complementary and conventional medicine and how this works in practice; relationships between team members; communication and learning between team members; referrals; perceptions of patients' responses to the scheme; and fears, hopes and ideals.

Responses were transcribed onto cards and summarized for each question and group of respondents. The main issues which emerged were identified and described. A report containing the summaries of the responses and the main issues was circulated to all general and complementary practitioners and a meeting of all practitioners was convened for discussion of the issues.

Quantitative data for patients referred by doctors and attending complementary practitioners over the 12-month period April 1992 to April 1993 were collated.

A description of the history and day-to-day organization of the model in the practice was compiled by W P.

Results

Description of the practice

In August 1991 the practice moved into new purpose-built premises in an area of mixed housing. A small group of complementary practitioners had been involved in the planning of the premises and further practitioners later joined the practice with the agreement of the whole group of general and complementary practitioners. All complementary practitioners held appropriate qualifications and their training and previous experience were important factors in their selection by the group. Most of the complementary practitioners had thriving practices in the locality. At the time of the study the practitioners comprised two osteopaths, a homoeopath, an acupuncturist, a massage therapist, a reflexologist, a speech therapist, an Alexander technique teacher and a chiropodist (for practical reasons quantitative data were not collected for the speech therapist or chiropodist). Each practitioner worked between half and one day a week in the practice and paid a rental for the room used. General practitioners and complementary practitioners signed a formal letter of agreement relating to rent, services, professional insurance and so on before the complementary practitioner began work in the practice. Patients booked appointments with complementary practitioners through the practice reception staff. Patients could refer themselves or be referred by a member of the practice team including other complementary practitioners; referred and self-referred patients from outside the practice could also attend. Patients paid fees direct to the complementary practitioner. All the complementary practitioners offered free 10-minute appointments for enquiries.

When a doctor made a definite suggestion that a patient see a complementary practitioner the doctor filled in a referral card with the presenting problem, doctor's diagnosis and treatment aims. This referral, and future attendances if they occurred, were logged in a book. The card was provided for all consultations and acted as a cooperation card as well as being of use in audit and research.

Doctors were careful to make the suggestion of complementary therapy only one of several options offered to the patient and to continue to offer conventional care and follow up. The referral differed from a hospital referral in that patients made their own appointment with whom and where they wished and they did not have to choose 'in-house' practitioners. Close cooperation between doctors and complementary therapists enhanced the sharing of diagnoses, investigation results and progress during treatment. This allowed patients to consult both types of practitioners openly and concurrently.

Informal opportunities for discussion arose over coffee and other breaks and at the weekly lunches in the practice. Doctors and complementary practitioners observed each other's consultations and complementary practitioners observed each other. A monthly meeting between doctors and complementary practitioners dealt more formally with organizational issues and decisions, and with the presentation of case studies for educational purposes. Some open evenings were held for staff, and for patients.

Quantitative investigation

During the 12-month study period a total of 386 different patients were seen by the seven complementary practitioners and 202 of these were registered with the study practice. The number of consultations per patient varied between practitioners but 324 patients (83.9%) were seen fewer than six times (Table 1). For the eight-month period, July 1992 to April 1993, a total of 157 practice patients were referred to complementary therapists, of whom 77 (49.0%) attended (Table 2). Data collected during the first four months of the study period were excluded from the analysis as they were found to be unreliable owing to practice problems with data collection. The variation between doctors' referral rates was large, both in the number and pattern of their referrals and the number of patients who actually attended.

Qualitative investigation

The interviews revealed that organizationally the model worked well. However, it was reported that cooperation cards sometimes

Table 1. Number of patients attending each practitioner, by number of consultations over the 12-month study period, April 1992 to April 1993.

	No. of patients attending by no. of consultations					
Practitioner	1	2–5	6–10	11–15	16–20	Total
Osteopath 1	39	56	10	1	0	106
Osteopath 2	40	41	6	2	0	89
Homoeopath	29	29	6	1	0	65
Acupuncturist 1	9	23	13	4	2	51
Massage therapist	15	18	2	1	0	36
Reflexologist	3	9	8	1	0	21
Acupuncturist 2	2	11	5	0	0	18
Total	137	187	50	10	2	386

Table 2. Number of practice patients referred by each doctor to each type of practitioner and number attending over an eight-month period (self-referred patients excluded).

Type of practitioner	No. of patients referred (no. attending) by referring doctor					
	Dr A	Dr B	Dr C	Dr D	Dr E	Total
Osteopath	10 (8)	15 (9)	20 (12)	16 (3)	4 (2)	65 (34)
Acupuncturist	1 (1)	15 (6)	9 (5)	3 (0)	1 (1)	29 (13)
Homoeopath	0	12 (4)	4 (3)	7 (2)	3 (2)	26 (11)
Massage therapist	0	3 (3)	15 (6)	2 (0)	0	20 (9)
Reflexologist	1 (1)	9 (4)	4 (2)	1 (1)	2 (2)	17 (10)
Total	12(10)	54(26)	52 (28)	29 (6)	10 (7)	157 (77)

went astray and receptionists sometimes had difficulty making appointments because the complementary practitioners were available only once a week.

The interviews confirmed the large inter-doctor variation in the number of patients referred to complementary practitioners with some saying they often overlooked the complementary option, while others felt it had become a part of their approach to health care. The responses of the nurses were similarly varied. The complementary practitioners noted that the variety of conditions referred increased with time. All the complementary practitioners would have liked more referrals and felt this would come about by the doctors gaining deeper understanding of the therapies and 'incorporating the knowledge into decision making'.

Relationships between doctors and complementary practitioners were viewed as friendly and open by all of the members of all four groups, and the doctors regarded the complementary practitioners as professionals on an equal footing with themselves. The practitioners were more varied and uncertain of their role in the practice, generally seeing the doctors as having 'more say on how things were run' and themselves as 'a complement'. However, they felt part of the decision making process for decisions that affected them. With the exception of the practice nurses, the practice staff, including the midwife and health visitor, felt positive about the availability of the therapies, and about the practitioners themselves. The practice nurses had little contact with and were relatively uninterested in the complementary practitioners.

Most of the respondents, especially the receptionists, stressed the desire to know more about complementary therapies. Time was a major restraint in communication and for some of the doctors and complementary practitioners this was seen as a frustrating restriction on depth of communication. The monthly meetings and observing each other's consultations were both valued by all the general and complementary practitioners. Several of the complementary practitioners commented on their new insight into the pressures of general practice and the new experience of working in a team. There was a general desire for more learning opportunities among the members of all four groups.

There was a great diversity of aims and philosophies regarding complementary therapy among the respondents, and within each group. There was no clear or shared view for the practice in the future. Despite this there seemed to be a commitment to the model as described here and a desire to build on the progress that had been made to date. Two of the four doctors who were currently practising felt their perceptions of health and illness were changing because of the incorporation of complementary therapies into the practice. The complementary practitioners held diverse views with some content with the *status quo* and others frustrated by the slow rate of change.

The dilemma caused by the complementary practitioners charging for their services in an environment where health care is provided free emerged as an important issue in this inquiry. Complementary practitioners did not see this as a problem, indeed many expressed the view that payment is an important part of their patients' commitment. However, there was a strong feeling among the remaining members of the practice that they are part of a health service which provides health care free at the point of delivery; the great majority felt that the cost of treatment was the primary reason why patients did not consult the complementary practitioners, and were uncomfortable about suggesting that their patients pay for treatment.

Discussion

Conducting descriptive and qualitative research within a single practice has limitations. One of these is the inevitable effect of the desire for the venture to succeed on the responses of some participants. To minimize this effect an independent researcher was used, and all members of the team were interviewed, thus including many different perspectives. Many interesting questions lay outwith the scope of the research, especially the patients' experiences and opinions without which this can only be a partial description of the scheme. The cycle of action and reflection which is central to such a cooperative inquiry requires continuing input to maintain and initiate improvements: it is too early to know whether this is sustainable, but enthusiasm remains high.

The results of this exploratory research suggest that the model described has resulted in a group of complementary practitioners being integrated in a friendly and respectful way into a primary health care team. The research has not only delineated some of the advantages and problems of the model, but by its methodology has also promoted greater discussion, understanding and in some cases resolution of the problems.

The model has been largely successful in preventing conflict over power, control and decision making. A complementary practitioner is now invited to attend partners' meetings.

The mechanisms set up to share knowledge have been useful, but were constrained by lack of time, and team members had to accept a longer term view for changing knowledge, practice and attitudes. Meetings have been rearranged to be more clinically oriented.

There was a great diversity of aims among the participants but this research has set in motion the search for united practice aims and increased awareness of the need for continuing dialogue. Referral from doctors and self-referral from patients has been slower than anticipated; it seems that even with a committed group long held patterns and barriers are slow to change.

A major dilemma posed by this model of care is that of charging patients for complementary medicine in an environment where health care is provided free. This dilemma has led to plans

for further research into the characteristics, attitudes and health beliefs of the patients who are referred and those who do and do not attend complementary practitioners.

This model of integrated care is an evolving one and so far is standing the test of time and scrutiny. It could be adapted and used by any enthusiastic group of doctors and complementary practitioners.

References

1. Fulder SJ, Munro RE. Complementary medicine in the United Kingdom: patients, practitioners and consultations. *Lancet* 1985; **2:** 542-545.
2. Anderson E, Anderson P. General practitioners and alternative medicine. *J R Coll Gen Pract* 1987; **37:** 52-55.
3. Moore J, Phipps K, Marcer D, Lewith G. Why do people seek treatment by alternative medicine? *BMJ* 1985; **290:** 28-29.
4. Murray J, Shepherd S. Alternative or additional medicine? A new dilemma for the doctor. *J R Coll Gen Pract* 1988; **38:** 511-514.
5. Thomas KJ, Carr J, Westlake L, Williams BT. Use of non-orthodox and conventional health care in Great Britain. *BMJ* 1991; **302:** 207-210.
6. Sharma U. *Complementary medicine today: practitioners and patients.* London: Routledge, 1992.
7. Wharton R, Lewith G. Complementary medicine and the general practitioner. *BMJ* 1986; **292:** 1498-1500.
8. Franklin D. Medical practitioners' attitudes to complementary medicine. *Complementary Med Res* 1992; **6:** 69-71.
9. Budd C, Fisher B, Parrinder D, Price L. A model of cooperation between complementary and allopathic medicine in a primary care setting. *Br J Gen Pract* 1990; **40:** 376-378.
10. Bishop M (ed). A medical marriage. *Int J Alternative Complementary Med* 1992; June (suppl): 19-23.
11. Reason P, Chase HD, Desser A, *et al.* Towards a clinical framework for collaboration between general and complementary practitioners: discussion paper. *J R Soc Med* 1992; **85:** 161-164.
12. Pietroni PC. Beyond the boundaries: relationship between general practice and complementary medicine. *BMJ* 1992; **305:** 564-566.
13. Reason P, Rowan J. *Human inquiry: a sourcebook of new paradigm research.* Chichester: John Wiley, 1981.

Acknowledgements

This project would not have been possible without the involvement and close collaboration of the doctors and complementary practitioners in the practice and we also thank all the practice nurses and staff. We are grateful for the encouragement and support of Simon Mills, Roger Hill and Annie Mitchell, and to Leone Ridsdale for helpful comments. This study was supported by a grant from the Medical Research Council.

Address for correspondence

Dr C Paterson, Warwick House Medical Centre, Holway Green, Upper Holway Road, Taunton, Somerset TA1 2YJ.

Food for thought...

'The weights used in deriving an individual's risk factor score for stroke are as follows:

Score = 9 x age (years)
+ 2.85 x systolic blood pressure
+ 70 if angina present
+ 90 if smokes 1-20 cigarettes per day
or + 130 if smokes more than 20 cigarettes per day.'

Coppola WGT, Whincup PH, Papacosta O, *et al.* Scoring system to identify men at high risk of stroke: a strategy for general practice.
April *Journal,* p. 185.