‘Doctors can’t help much’: the search for an alternative

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SUMMARY

Background. *At a time of great scientific advance and a culture of evidence-based health care, there is increasing referral to and use of complementary therapies. An understanding of the meaning behind this paradox may usefully inform our orthodox practice.*

Aim. *To investigate why people attend complementary practitioners.*

Method. *Semi-structured interviews with a purposive sample of 20 people drawn from a study population of 176 people currently attending a variety of complementary practitioners in South West England. Data were collected and analysed using a constant comparative method.*

Results. *Most people had a chronic health problem, had already consulted their general practitioner (GP), and had their GP’s approval for seeking complementary therapy. Many people were attending a complementary therapist for the first time and most were fee-paying patients. People’s reasons for consulting were encompassed by three categories. The commonest of these is ‘Doctors can’t help much’, and the other two are ‘Doctors are hopeless’ and ‘It (orthodox medicine) may work but it’s not acceptable.’ The hopes and aims for treatment included long-term or short-term symptom relief, improvement in function, better understanding, advice on self-help or other therapies, gaining control, and improving their ability to cope with their illness. Some people’s main aim was to avoid or reduce orthodox steroid-based medication.*

Conclusion. *These people were seeking out holistic and patient-centred health care, and were making their own judgements about what constituted an acceptable level of risk from medication use. The advances of scientific medicine and expert evidence-based advice were not always relevant to them.*

Keywords: alternative medicine; complementary medicine; orthodox medicine.

Introduction

SCIENTIFIC medicine is making big advances in drugs, technology, and genetics, yet more and more patients use complementary therapies. Evidence-based medicine dominates our discourse, yet health professionals increasingly refer to and practise complementary therapies that have little scientific evidence of efficacy. What is the meaning behind these paradoxes, and what can we learn that will usefully inform our practice of orthodox medicine? Why do people go to complementary practitioners?

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Submitted: 6 October 1998; final acceptance: 2 March 1999.

There have been many surveys of the extent of complementary medicine use[1-5] but few qualitative studies to help us understand their meaning. Surveys show that around 30% of the British general public have consulted a complementary therapist at some time,[1] and that the majority of patients use complementary medicine alongside or after orthodox treatment.[2] In a series of questionnaire studies[6-8] Furnham *et al* identify the three most important reasons for seeking complementary treatment as i) a positive evaluation of complementary treatment as treating the whole person, ii) the ineffectiveness of orthodox treatment, and iii) concern about the adverse effects of orthodox medicine. Over 10 years ago (1986) Sharma interviewed a sample of established users of complementary medicine, and her results suggested that people were motivated by a rational and pragmatic concern to get relief from a specific disease on terms that were acceptable to themselves, and that treatment side-effects and the patient–practitioner relationship were both important. Similar concerns were expressed in two other qualitative studies of regular users carried out in the United Kingdom in 1984[9] and 1987.[10] In a more recent study of users of Chinese Medicine in the USA, patients did not reveal familiarity with Chinese Medicine *per se*, but experienced the care as holistic care: a model that Cassidy suggests could be used for improving orthodox medicine.[11]

In 1995 a national survey of general practitioners (GPs) showed that, in an average week, 45% of GPs recommended or endorsed the use of complementary therapy; 21% referred a patient for complementary therapy, National Health Service (NHS) or private; and 10% used the therapies themselves.[12] Surveys in Norway,[13] New Zealand,[14] and the Netherlands[15] gave similar results. A qualitative study of a group of GPs who employ homeopathy in their everyday NHS work[16] found that these practitioners saw their homeopathic practice as an attempt to recapture a holistic model of practice and to avoid the iatrogenic effects of orthodox medicine.

The interview study presented here seeks to update this earlier research by revisiting the question of why people attend complementary practitioners in the context of the rapidly changing NHS of the late 1990s. It also seeks to interview a more diverse sample of patients than previous studies, and to do so while patients are undergoing a course of complementary therapy.

Method

Setting and study sample

The patient interviews were part of a wider study that involved 12 complementary practitioners recruiting all their new patients over a four-month period in 1997. These practitioners included osteopaths, acupuncturists, massage therapists, a homeo- path, a reflexologist, a nutritional therapist, a physiotherapist (who identified herself as a complementary practitioner), a counsellor, and a healer, and they worked in seven different settings in Somerset, including general practice surgeries, complementary medicine centres, and home practice. Most of their patients were fee-paying, but one osteopath and the physiotherapist also saw NHS funded patients.

For the interviews, a sample size of 20 patients was considered capable of giving a wide range of responses and experiences while remaining a manageable number to transcribe and analyse.

The sampling strategy sought a maximum variation sample[17] for the dimensions of age, sex, presenting problem type and chronicity, and the practitioner seen. Twenty patients were interviewed by CP in their own home, and the interviews were audiotaped, with permission, and transcribed. The semi-structured interview schedule included open questions that encouraged the person to tell of their experience of illness and treatment in their own way. Using a constant comparative method,[18] data collection and analysis were conducted in parallel, enabling the flow of ideas between the two processes.

Data analysis

The analysis used a process of inductive coding[19] to develop a coding scheme that enabled all the data to be categorized according to clear written guidelines. The transcript data for each category were then collected together in separate files; for example, all the statements relating to people's aims in seeking complementary therapy were coded as category 2a and collected in one file. The data in each category was then summarized and themes were developed. During the development stage of the coding process, an experienced qualitative researcher, NB, independently coded three interviews and the results were compared. Either the differences were resolved or the coding scheme was revised.

Results

The number of new patients recruited into the main study was 176, which accounted for 57% of the new patients seen by the 12 practitioners in the chosen study sites over the four-month period. The presenting problem was categorized according to the International Classification for Primary Care, and 88% of cases were in the musculoskeletal category. The problem had been present for over a year in 41% of patients. The characteristics of the recruited patients, and of the sample interviewed, are shown in Table 1.

Twenty interviews of between 30- and 60-minutes duration were carried out, with six refusals. Interviewees included patients of 10 of the practitioners. Nearly half of the interviewees were consulting a complementary therapist for the first time, several people had tried one previous therapy for the same condition, and very few were regular users of complementary medicine. All except one interviewee had consulted their GP about their problem, and the exception was a man who had been referred by his GP for a previous problem to the same osteopath. The majority of people had told their GP, and several of those who had not said that their GP would approve because, for example, the practitioner practised in or alongside the GP surgery. Only one person was purposively holding back from telling her GP, the hesitation being partly fear of a negative response but partly the need to keep some control. Two people had received a negative response from their GP. One of these was a woman with pain in her hip:

> *'My doctor, he said it won't cure the bone — well I know that, but be for pain isn't it. There's a lot of doctors believe in it.'* [Patient 42, seeing an acupuncturist.]

For a substantial minority of interviewees, the GP had been the instigator of their treatment, either by a NHS referral or by suggesting they attend privately.

The analysis uses a temporal framework to follow individuals from their illness experience through their experience of orthodox treatment to their hopes and aims in going for complementary treatment. The structure of this analysis is shown in the left-hand column of Figure 1.

Table 1. Characteristics of the patients recruited to the study and of those interviewed.

	All patients recruited	Sample of patients interviewed
Number of patients	176	20
Sex		
Male	57	6
Female	119	14
Mean age (in years) (range)	48 (2–88)	51 (16–88)
Duration of symptom 1:		
<2 weeks	29 (16%)	1
2 to 4 weeks	18 (10%)	1
4 to 12 weeks	27 (15%)	3
12 to 52 weeks	29 (16%)	2
>52 weeks	73 (41%)	13
Type of problem, ICPC category:		
Musculoskeletal	155 (88%)	15
Psychological	6 (3%)	0
Respiratory	4 (2%)	3
Neurological	4 (2%)	1
Others	7 (4%)	1

Experience of illness

Two people had an acute problem that they had had for less than two months, and four more described an illness of less than one year. The remaining people had chronic problems that they had suffered from for several years, and five people described it as affecting them for most of their adult life. A wide variety of musculoskeletal problems were presented, but people with chest, nose and throat, and gastrointestinal problems were also included. On the basis of their illness experience, the interviewees can be split into two broad groups that have been labelled iteratively, by paraphrasing interviewees' words:

1. 'It makes life a misery'; people with severe and/or very bothersome symptoms and a low level of general well-being.

> *'I just really got fed up to the back teeth after two odd years of it making my life a misery. I'm only 26 and I thought, "this is ridiculous".'* [Patient 102, seeing a nutritionist.]

> *'I mean I'm a very active person and the fact that I can't walk is the end of the world as far as I'm concerned.'* [Patient 26, seeing an osteopath.]

2. 'Sometimes it gets me down'; people with symptoms of variable severity, but maintaining a moderate or good feeling of general well-being.

'It obviously got me down sufficiently for me to go to Dr M about it and then, when they were so long fitting me in … getting an appointment with the physio, yes. 'Cos I think I got to the point really when sometimes it was waking me up at night, but I mean my general health otherwise is really good.' [Patient 27, seeing an osteopath.]

Assessment of orthodox treatment

People's experiences of treatment in the orthodox system interacted with their experience of the illness itself. This resulted in the three groups shown in Figure 1:

1. 'Doctors can't help much.' Most of this group attended orthodox practitioners but found them of limited benefit. Some were frustrated by long waiting lists, and some no longer attended because they had found in the past that orthodox medicine could not help them.

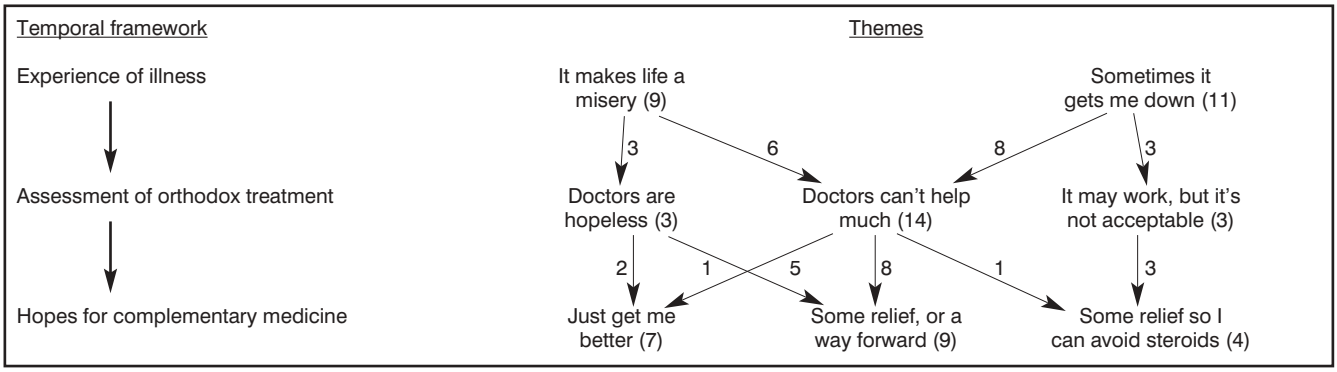

Figure 1. Temporal framework of main themes (the numbers refer to the number of interviewees in each group).

'No. I mean, I know she's a doctor and everything, but all she says is "nothing we can do for you at the moment and take a couple of painkillers".' [Patient 221, seeing an osteopath.]

'And have you seen your own doctor about your back and your shoulders or not?' [CP.]

'Only, no, no, no I went erm…didn't see the point of bothering him. I obviously went after I'd had the kidney stones because I didn't know what was wrong so he sent me for a complete check up...' [Patient 25, seeing an osteopath.]

2. 'Doctors are hopeless.' These three people felt rejected by orthodox medicine. They all came from 'it makes life a misery' but had much less disability than others in the group.

'He was so abrupt over the way he said he couldn't possibly do anything to bring back my sense of taste or smell, that was injured, that was past repair, and I said, "Well, what about my voice?" and he opened my mouth and put in the spatula and turned to the nurse that was in the room and he said, "What do you think of this for a case of thrush?" and I really felt like I was a dead rat being brought in, which really made me feel well, I've got to do something.' [Patient 141, seeing a reflexologist.]

3. 'It may work, but it isn't acceptable.' Unlike the other groups, these people had been offered orthodox treatment that was effective, or was expected to be. However, it was unacceptable because of fears of side-effects.

'Now, OK, but I'd prefer to do it without medication if I can, erm, 'cos I really have no idea what the effect of that over 40 years is likely to be, er, erm, I mean I take his point that the dosage steroid in the Becotide is very very small, erm, but, you know, if I can avoid it I will.' [Patient 237, seeing reflexologist.]

Hopes for complementary therapy

The hopes and aims people had when they started their current therapy could be encompassed by three themes.

1. 'Just get me better.' The interviewees in this group wanted long-term relief of symptoms, and did not suggest any other acceptable benefits. They were hoping for complete relief of symptoms, but two of them acknowledged that any degree of relief would be acceptable.

2. 'Some relief or a way forward.' These people had ruled out a cure. They were looking for any type of help or benefit, were open-minded about what that might be, and expressed a wide variety of possible benefits. This included reduction in symptoms either long- or short-term, improvement in function, better understanding, advice on self-help or other therapy, gaining some control, and improving their ability to cope with their illness.

'Anything to relieve the constant nagging pain and enable me to go on coping.'

'Mmm, 'cos you felt...?' [CP.]

'Well it was ridiculous. It is ridiculous just to go on, and go on, pulling yourself to shreds and well I don't think Dr M would be very impressed. You've got to take some action in time and I'm learning to do that.' [Patient 25, seeing an osteopath.]

'Relief! Just general relief. I was just hoping … I wasn't expecting a miracle cure, but I thought that he would be able to help me just get a bit better and to help myself … to be able to do the exercises and to carry on.' [Patient 26, seeing an osteopath.]

3. 'Some relief, so I can avoid steroids.' For these people, avoidance, or reduction in use of steroid drugs was the main aim of treatment. In order to achieve this they were looking for some reduction in symptoms.

'It was an alternative for me to try rather than having steroids shoved up my nose.' [Patient 100, seeing nutritionist.]

'I hate taking drugs. One thing, I'm allergic to nearly every one of them, and erm, you know, I've got to get back to natural really. I'm all for natural, erm, if there's a natural steroid. Is there a natural steroid that I can take?' [Patient 41, seeing an acupuncturist.]

The relationship of this grouping to their illness and treatment experience is shown in Figure 1.

Discussion

The trustworthiness of the qualitative data collection and analysis in this study has been enhanced by several of the techniques suggested in the literature.[17-21] The identity of the interviewer, CP, as a GP, has been attended to and reflected upon throughout the project by both authors. For example, CP's interview technique was closely monitored by NB, a sociologist, to refine question wording, and coding categories and emerging themes were reviewed together several times. In addition to the patient interviews reported here, the study involved focus group discussions with the practitioners involved, and outcome questionnaire completion over four months, thus allowing triangulation of data

from all three data sources. The results were presented to the practitioners involved and their comments sought, and a leaflet summarizing the results has been sent to all participants with an invitation to respond. Despite these efforts, the limitations of this study include the effect of the 'medical gaze', the sample size of 20, the single snapshot interview, and the restriction of the study to one region of the UK.

The purposive sampling, from a large population of consecutive patients of a variety of therapists, resulted in a study sample that is likely to include many of the diverse experiences of patients who attend complementary practitioners in the South West of England in the late 1990s. They differ from people interviewed by Sharma[1] and Murray[4] in their inexperience of complementary medicine: nearly half were trying it for the first time. Not only had all of them consulted their GP about their problem, but most people had discussed, or felt free to discuss, their complementary therapy with their GP. Several patients were attending complementary practitioners on the referral or suggestion of their GP, and most of these were new users of such therapy. A longer term study would be required to find out how many of the new users in this study became regular users of complementary medicine.

Most of the patients in this study had chronic conditions that were often causing severe disruption to their lives and that orthodox medicine could not treat successfully or could only treat with a prescription, which was not acceptable because of fear of side-effects. The importance of medication avoidance or reduction for some patients has been found in other studies of patients of both complementary and orthodox medicine.[1,8,10,11,22,23] In this study, this related to steroid-based medication in all cases, but this may be a feature of this particular sample. The current evidence-base of orthodox medicine focuses on efficacy, and health professionals make value judgements on what constitutes acceptable risks from side-effects of drugs. This study reminds us that many patients make their own judgements about risk.

Everyone was looking for symptomatic relief but most people with the more chronic conditions were not expecting a 'cure', rather they were looking for 'help of any kind'. Individuals often could not specify what this would be before starting treatment, but came to appreciate such things as gaining control and coping skills and securing support and hope through the patient–practitioner relationship. This supports the suggestion from other studies[1,8] that the reasons for beginning complementary medicine may be different from the reasons for continuing it. It would also appear that these patients are either seeking out or coming to appreciate holistic and patient-centred care in a similar fashion to the patients of Chinese Medicine practitioners in the USA who were investigated by Cassidy.[11] This suggests that, not only are the big advances of scientific medicine irrelevant to these patients, but that they may be diverting orthodox practitioners away from the needs of patients with chronic disease, and leaving a vacuum that complementary medicine is filling.

Further research is needed to assess the longer term effects of the perceived benefits and to investigate in-depth how people combine the benefits of complementary and orthodox care. Meanwhile, reflecting on the aims and benefits described by these patients may enable us, as orthodox practitioners, both to improve our own practice and to facilitate appropriate complementary practitioner referrals.

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Acknowledgments

The following practitioners and receptionists were collaborators in the study: Rosemary Norton, Lyn Harris, Anne Bingley, of Chard Natural Health Centre, Hollywood Street, Chard, Somerset; Kate Stoner, Liz Truman, Gill Brydon, Elaine Bynon, of Irnham Lodge Complementary Health Centre, Minehead, Somerset; Harvey Fudge, Anna Paris, Hazel Newman, of The Blackdown Practice, Hemyock, Devon; Philip Walpole, Mary Lowe, of Hammet Street Practice, Taunton, Somerset; Fiona Mahoney; and Sally Hill. We would like to thank the interviewees for their time and thoughtfulness, and Alison Wright for transcribing the data. The study was funded by a grant from the Scientific Foundation Board of the Royal College of General Practitioners.

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