Holistic health care?

In recent years, 'holistic health centres' have mushroomed. Such establishments, which sometimes also use the term 'integrated' or 'integrative' instead of holistic, offer a range of 'alternative' therapies and promise to treat not just the patients' somatic problems but to also address their psychological and spiritual needs. Patients normally pay out of their own pockets. Here I discuss two (partly hypothetical and necessarily simplified) scenarios in order to critically analyse this practice.

Our patient is a 56-year-old male carpenter, Mr Nash, who has always been physically active, is not overweight, has smoked about 20 cigarettes per day for the last 30 years, and last consulted his GP 1.5 years ago. He enjoys 1–2 pints of beer per day, takes no prescription medicines and states that he has no relevant medical history; both his parents suffer from cardiovascular problems. Mr Nash seeks medical help because he has not felt well for about 4 weeks. In particular, he suffers from insomnia, fatigue and pain in his left-upper arm and shoulder. He believes that these symptoms started when, together with a friend, he carried a fridge-freezer to his fourth floor flat.

THE 'HOLISTIC' APPROACH

Mr Nash decides to follow his wife's advice and visits a local holistic health centre. He initially sees a practitioner who takes a brief history and refers him to the centre's homeopath, chiropractor and healer. The homeopath takes a detailed homeopathic history which lasts 90 minutes but does not examine him in any other way. Eventually the homeopath prescribes a homeopathic medicine explaining that it is individually tailored for the patient and should improve his insomnia and fatigue. Mr Nash is given a follow-up appointment 2 weeks later. The chiropractor conducts a manual examination of the spine, takes several X-rays and diagnoses subluxation of several vertebrae. He explains that, in his view, these abnormalities are the likely cause of the patient's pain and proposes a series of 10 spinal manipulations. The healer asks Mr Nash to sit in a chair and gently moves her hands over his body. She explains that this sends out healing energy enabling his body to heal itself. The session, which Mr Nash finds agreeably relaxing, is repeated on a weekly basis.

Both the homeopaths and the chiropractor also give lifestyle advice regarding a well-balanced diet, smoking cessation (which, they claim, could be helped by acupuncture), regular physical activity and sleep hygiene. Both practitioners suspect that Mr Nash suffers from psychological problems and recommend counselling. The patient (who indeed has considerable family problems) does, however, not want to talk about 'such things'.

Despite good compliance, Mr Nash continues to feel ill. In particular, he finds physical exercise increasingly difficult and has the impression that it aggravates his pain and leads to breathlessness. Two weeks later (at this stage the out of pocket costs for the treatments exceed £600), he experiences sharp chest pain and collapses while walking up to his 4th floor flat. In hospital, he is diagnosed with a massive myocardial infarction and treated conventionally. Eventually Mr Nash undergoes double-bypass surgery and subsequently makes a good recovery.

THE CONVENTIONAL APPROACH

Mr Nash rejects his wife's advice to 'go holistic' and consults his GP who takes a medical history, conducts a physical examination, measures his blood pressure (165/100 mmHg), and finds ischaemic changes on the resting ECG. A subsequent ECG on a bicycle ergometer is discontinued because of chest pain and overt ischaemic ECG changes. Mr Nash is admitted to hospital where coronary heart disease with two stenosed coronaries is confirmed. He undergoes angioplasty the next day. The medical team also identify the following risk factors: hypertension, diabetes, hypocholesterolaemia, smoking and distress. After returning home on β-blockers, statins and aspirin, Mr Nash finds it difficult to control his diabetes with diet alone; antidiabetic drugs are therefore added to his list of medications. A supervised smoking cessation programme seems to have the desired effect. The medical team urges him to see a clinical psychologist, but he refuses to discuss the causes of his stress on the grounds that it relates to very private family matters.

COMMENT

Hypothetical scenarios such as those above may seem somewhat contrived. They are, however, not unrealistic and make a number of points clearly. Holism is currently used by many as an attractive label to recruit customers. The claim to treat mind, body and spirit certainly sounds good and agrees with today's 'Zeitgeist'. However, this claim can be misleading, particularly if the treatments do not address the most urgent problem effectively. Clinicians must have sufficient diagnostic skills to identify life-threatening conditions and their risk factors regardless of whether they are doctors or complementary practitioners. Unless this precondition is fulfiled, their interventions can put patients at risk. Arguably the 'holistic approach' is fragmented and the 'conventional approach' can prove to be more holistic than the naïve holism displayed by some complementary practitioners.

Holistic practitioners claim to treat the causes rather than the symptoms of a disease and argue that the cause–effect relationships of conventional medicine often do not apply to the complex situation of whole human beings. The above scenarios suggest that such views can be simplistic. Underlying causes of illness often exist on many levels. Mr Nash's symptoms were caused by myocardial ischaemia, which was caused by coronary stenoses, which was caused by arteriosclerosis, which was caused by a multitude of risk factors, which were caused by a complex mix of genetic and environmental factors. These interrelationships need to be first understood and subsequently acted upon; the most

urgently treatable problem (coronary stenoses) must be solved without delay. Other causative levels (that is, risk factors) can be addressed later. In this and many other situations, the spiritual needs of the patient may require addressing but are not a priority.

The hypothetical scenarios also imply that holism can have its limits, for example, when the patient does not cooperate. In real life, this frequently seems to be the case. Mr Nash was not fully compliant with dietary measures and did not want to talk about his family problems. Holistic health care is an ideal that many clinicians subscribe to, but it does not work if patients do not want it.

It could, of course, be argued that the scenarios I have created here are exaggerated caricatures of reality and that the conventional approach is a rather optimistic description of what might happen to a patient in the current NHS. This may well be true. My aim was not to depict 'real life' but to tease out potential problems with the current misuse of holism. Caricatures can make certain features more obvious than reality. If nothing else, my approach implies that naïve holism may be attractive to many patients, but that it can be a dangerous distraction from the most important issues in health care. Yet I do believe that holism is important — too important to be delegated to alternative practitioners! Those who agree with this view should consider ways of reintroducing it into modern medicine where it may have gone missing.

In conclusion, good health care is likely to be holistic but holistic health care, as it is marketed at present, is not necessarily good. The term 'holistic' may even be a 'red herring' which misleads patients. What matters most is whether or not any given approach optimally benefits the patient. This goal is best achieved with effective and safe interventions administered humanely — regardless of what label we put on them.

Edzard Ernst

Personal profile on pain

Living with constant pain is a problem not only for the sufferer, but also for their family, friends and indeed everyone who touches their life. We all have a threshold of pain where one can endure no more without medication, or any of a variety of treatments. With the assistance of these it is hoped that one can enjoy life as near normal as is possible. Beyond that level is the great unknown, of side effects from increased medication, and in some cases mood swings on a daily basis. These side effects vary greatly depending upon pain threshold, specific case history, and medication prescribed solely for the individual; in extreme circumstances there can be dramatic consequences.

It was while at the limit of my personal pain threshold, and a resulting discussion with my GP, that my quest for knowledge about the long-term use of opioid medication began. Put simply I have a desire to know what lies ahead of me, with regard to quality of life and how best to assist my ailing body in order to cope as best I can in the future.

I have led a full and varied life for 56 years. Occupations have spanned professional football, civil service scientific work and hard manual labour. From a very young age, sport of all kinds, competition and a desire to be the best, with along the way injury, wear and tear, as well as broken and damaged bones, have all contrived to place me in my current condition. Mine is either a case of bad luck or inevitability, but deal with matters I must, as there is no alternative. Hence my discussion with my GP, which followed many years of excellent care from the NHS.

With the Honiton Surgery being a Research Practice, the idea of tackling my circumstances and fears through the mechanism of a fully accredited research project for the community appealed to my GP, because as well as being of benefit to me personally, it could also be a worthy subject to apply for funding to see if my situation was common among others taking strong opioid medication for chronic non-cancer pain. With the guidance and help of my GP I was invited to attend a course on research methodology in Exeter with the assistance of the Folk.us organisation. On the course I studied grounded theory, qualitative and quantitative research, phenomenological study, as well as the basics of research in the wider community. It was necessary to do this to satisfy the stringent requirements of the ethics committee in order to be granted an honourary research contract to assist the research team at the Honiton surgery under the guidance of the Exeter Primary Care Trust. The whole process was of great interest, reward and fulfilment to be among professional dedicated people and be allowed to take a small part in their never ending efforts for the community.

The project took the form of compiling knowledge in a qualitative approach from interviews with people suffering and coping, on a daily basis, with pain management in their own individual circumstances to try and determine, by thematic analysis, any recurring details or patterns common to all sufferers of pain who are taking strong medication. The interviews were transcribed and the research team met periodically to discuss and evaluate the relative merits of the individual interviews. The overall results produced really interesting and in some cases surprising points of similarity, which could be grounds for further professional investigation on a wider basis.

Brian Ruel

The results of this study are presented on pages 101–108.