

Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

### Complementary medicine in the medical curriculum

Dr Rampes and colleagues (January 1996 *JRSM* pp 19–22) well demonstrate the desire of medical students to have an understanding of complementary medicines and in particular acupuncture. They go on to suggest that a national core syllabus (for acupuncture, for instance) should be developed.

That medical students, and even qualified doctors, should have a better understanding of such therapies is perhaps without contention. What needs debate is who should provide the input to such courses and what the content should be. Not surprisingly the article suggests that medical students would wish to refer a patient to a medically qualified therapist and that they would prefer to be taught about complementary therapies by the medically qualified.

Traditional acupuncture and all that it involves in diagnosis and treatment has been developed and refined over thousands of years and is the form of acupuncture practised by the 1800 members of the British Acupuncture Council (BACc). There are many other practitioners who perform a style of acupuncture which is often described as trigger point acupuncture not involving traditional acupuncture diagnosis. Trigger point acupuncture may be effective for some conditions but clearly needs to be seen as distinct from traditional acupuncture.

The British Acupuncture Accreditation Board has been set up in conjunction with the BACc to ensure that colleges offering training for acupuncture meet certain standards. Only suitable students who qualify are accepted onto the BACc register. We would suggest that those BACc practitioners involved with training in such accredited colleges be asked to contribute to the national core medical syllabus. In this way medical students would have an opportunity to learn fully about acupuncture.

It is unlikely the suggested core contents of the curriculum for acupuncture can be

met without involving both the BACc and colleges that are fully accredited.

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Dr Rampes and colleagues seem to illustrate exactly why we should *not* introduce complementary medicine into the medical curriculum, or at least not in the form advocated by the authors. They repeatedly refer to ‘teaching of basic principles of, or training in the practice of, complementary medicine’. Only when one gets right to the end is the question of the ‘evidence base’ even mentioned. This seems to be the wrong way round. We need to be satisfied that the evidence base provides a strong argument for the effectiveness of the treatments being advocated *before* we introduce them into the curriculum. It is, after all, mandatory for conventional drugs that their efficacy, as well as their safety, should be demonstrated before they are introduced (and taught); the criteria for ‘alternatives’ should obviously be no less strict. Unfortunately, the whole article seems to be written on the premise that the treatments being advocated are effective: otherwise why offer training in the practice of them? And the suggestion that we should be ‘teaching the basic principles’ implies that there are some basic principles to teach. To suppose that the writings of Hahnemann constitute basic principles requires the faith of a religious zealot. The plain fact is that there are no basic principles to teach—just an assortment of dogmas of dubious truth (indeed, in many cases, of dubious meaning).

The article starts by pointing out there is widespread interest in alternative medicine in the general population and among medical students. This is true, but why? There is sound evidence that giving a totally inert preparation to a sick person can ameliorate both symptoms and signs. The *placebo effect* is real and it is quite powerful. What we have to do is to teach students to distinguish clearly between placebo effects and true effects of the therapy itself. Both effects may, in some cases at least, be similar as far as the patient is concerned, but it is intellectual fraud to confuse them, and in some cases, where a genuinely effective treatment exists, dangerous to the patient. Of course wishful thinking has always been popular, not only in ‘alternative medicine’,

but in conventional therapeutics too (whatever happened to ipecachuana cough mixtures and nux vomica ‘tonics’?). That is understandable, but it is our job to distinguish wishful thinking from truth.

We agree with the suggestion in a BMA report *Complementary Medicine: New Approach to Good Practice*<sup>1</sup>, that ‘consideration should be given to inclusion of a familiarisation course on non-conventional therapies’. In view of the widespread interest in such therapies, an attempt should be made to impart to medical students a serious assessment of the evidence that exists concerning their effectiveness. This is not quite the same thing as Rampes *et al.* (who cite the BMA report twice) are advocating. The problem is that such teaching must be done by people who are qualified to assess the evidence properly. It is ironic that the only time one of us [DC] has had the opportunity to analyse the raw data for a trial of homoeopathy<sup>2</sup>, an elementary statistical error was found that invalidated the conclusions that had been drawn<sup>3</sup>.

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#### REFERENCES

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- 2 Fisher P, Greenwood A, Huskisson EC, Turner P, Belon P. Effect of homoeopathic treatment on fibrositis (primary fibromyalgia). *BMJ* 1989;299:365–6
- 3 Colquhoun D. Reanalysis of a clinical trial of a homoeopathic treatment of fibrositis. *Lancet* 1990;336:441–2

#### Useful plants

Sir Francis Avery Jones (December 1996 *JRSM*, pp 717–719) presents an interesting historical survey of medicinal plants, but the extreme brevity of the final section entitled ‘Today’ implies that these plants have little or no role in modern medical practice. In fact, the practice of European herbal medicine is alive and well both within the National Health Service and in the private sectors. At this health centre, patients are able to consult both their own general practitioner and a medical herbalist. Herbal medicine lies very comfortably alongside orthodox allopathic practice. Potent tinctures of many of the

'historic' herbs mentioned in the paper are routinely dispensed by the local pharmacy, e.g. *Filipendula ulmaria* (meadowsweet), *Glycyrrhiza glabra* (liquorice). Patients referred to the medical herbalist are prescribed an alcohol-based tincture comprising 1–6 different species. The whole plant is used in such preparations, and not an isolated extract of an individual compound as would be the case in the preparation of a plant-derived drug within the pharmaceutical industry. The materia medica comprises about 150 different herbs, mainly dispensed as tinctures but some as topical preparations. These forms of prescriptions clearly distinguish European herbal medicine from homoeopathy and Chinese herbal medicine whose clinical practices and materia medica are entirely different. There is much media confusion regarding these three 'alternative' therapies.

We have found that certain conditions respond better to herbal medicine than to orthodox drugs—e.g. irritable bowel syndrome and other gastrointestinal disorders, the treatment of which has become a special interest of the medical herbalist at this centre. Some of the herbs' unique properties (not mirrored by any allopathic alternatives) allow safe effective relief from symptoms which cannot be controlled by standard preparations.

The information derived from modern biochemical analyses of medicinal plants allows the historic uses to be fully appreciated and understood on a sound scientific basis. Thus today's medical herbalist can achieve excellent results by drawing upon the latest research as well as on a wealth of historical data.

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### Do community hospitals reduce use of DGH beds?

Dr Hine and colleagues (December 1996 *JRSM* pp 681–7) elegantly demonstrate the reduced use of central inpatient services associated with the availability of community hospital beds. However, I was surprised to find no reference to work I published with colleagues in 1994 recording a decrease in cancer deaths in central specialist inpatient beds (district general hospital) where community hospital beds were available to general practitioners.<sup>1</sup>

Our data, collected in an analogous situation in Exeter and East Devon, revealed that the place of death for patients with access to community hospital beds was as follows: home 29%; community hospital 39%; DGH 17%; nursing or residential home or hospice 14%. For patients without access to community hospital beds the place of death was home 41%, DGH 39%, nursing or residential homes and hospice 20%.

The presence of community hospital beds was associated with a significant reduction of deaths in the DGH ( $P < 0.001$ ) and with a greater number of patients receiving terminal care under their own general practitioner (74% of cases with community hospital beds versus 51% of cases without community hospital beds,  $P < 0.001$ ). By extrapolation to the rest of the UK we estimated that around 8% of all cancer patients might be dying in community hospital beds, a figure approaching that occurring in inpatient hospice beds.<sup>2</sup>

Hine and colleagues are right to state that community hospitals are one option for providing accessible (and appropriate) care and merit systematic evaluation of costs and benefits. This is one of the stated aims of the Community Hospitals Association (CHA), and I would encourage researchers to communicate details of work in progress or completed to me in my role as CHA committee member with an interest in related research.

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### Hospital-at-home

We were disappointed to read (October 1996 *JRSM*, pp 548–551) that a hospital-at-home service providing intensive home care for the early discharge of adult patients was more expensive than keeping the patients in hospital. For 4 years we have had a children's hospital-at-home service providing care for children discharged home early. This has included children on traction with fractured femur and children on traction

following operations for congenital dislocation of the hip. In no case have children's nurses visited the home after traction has been discontinued. The average length of stay in hospital of children having fractured femurs or hip surgery has been reduced from 6 weeks to 1 week. This service avoids children being unnecessarily kept for long periods in hospital. The children require one visit a day by a nurse, and we have had no complications.

We would not want the financial failure of an adult hospital-at-home service to discredit the concept of what is both a humane and a cost-effective way of treating young children at home who are on traction for several weeks.

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### Is the erythrocyte sedimentation rate outdated?

Kanfer and Nicol (January 1997 *JRSM*, pp 16–18) advocate abandonment of the erythrocyte sedimentation rate (ESR) in favour of plasma viscosity. This would be premature, until viscosity can be measured as an emergency, 24 hours a day. Let me give an example. Giant cell arteritis, characterized by a high ESR, is one of the greatest emergencies in general medical practice. A quick estimation of ESR is required in any patient around age 60 who complains of intractable headache, particularly occipital and temporal, pain in the face, jaw and mouth exacerbated by chewing, with tenderness over the scalp and over the temporal and cranial arteries. In such a case steroid treatment must be started immediately, and the patient should not leave until the ESR is known. In less obvious cases steroids may reasonably be withheld pending the result of an ESR done on the spot, but not for the time taken by a routine hospital laboratory to measure viscosity. The ESR, simple to estimate, is ideal for the doctor's surgery, for the district hospital's outpatient clinic, and for use at the bedside. A delay of even a few hours in starting steroid therapy may result in irreversible visual failure<sup>1</sup>. Further, an elderly patient presenting with sudden loss of vision in one or both eyes requires an immediate intravenous injection of 10 mg