A model of cooperation between complementary and allopathic medicine in a primary care setting

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SUMMARY. This paper describes an acupuncture and osteopathy service offered free of charge to patients at a National Health Service general practice. The background to the setting up of this service, its organization, funding, aims and philosophy, and the ethical and legal implications for the general practitioners whose patients are treated by complementary therapists are discussed. This service provides a model of cooperation between allopathic and complementary medicine in a primary care setting and could be copied elsewhere.

Introduction

THE Wells Park general practice in Sydenham, South London offers complementary therapies to its patients and other local people. These therapies are provided on the premises and are free of charge. It is beyond the scope of this paper to address the question of evaluating the efficacy of alternative therapies, and this has been discussed elsewhere.[1-3]

While this is not the only example of cooperation between complementary and conventional medicine in primary care, little has been published on this subject.[4] However, there is clearly a great deal of interest among the medical profession. In 1983 Smith described an upsurge of interest, with general practitioners reporting referral of patients to non-medical practitioners and a demand from general practitioner trainees for knowledge of alternative techniques such as acupuncture and homoeopathy.[5] A more recent study reported that 72% of a random sample of general practitioners had referred patients to an alternative practitioner in the previous 12 months.[6]

Background to the provision of acupuncture and osteopathy

The Wells Park practice has two principals and serves a predominantly working-class area. It shares its premises with the Wells Park health project, a community health project which tries to encourage local people to recognize and tackle the socioeconomic, environmental and personal factors which affect their health. The project's aims include promoting a holistic view of health and providing improved access to health provision, including alternative medicine. Although the project is functionally separate from the practice there are close working links; a broadly common population is served by both, and there is formal and informal cooperation on a day-to-day basis.

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In 1984 the health project conducted a survey of the health needs, experiences and expectations of the local population. It emerged that 30% of the population had consulted, or would have liked to have consulted an alternative therapist at some time (unpublished results). This indication of a demand for access to alternative therapies led to consultation with the general practice, after which the project set about securing funding for a part-time acupuncturist and a part-time osteopath.

Aims of the acupuncture and osteopathy service

The aims of the acupuncture and osteopathy service, shared by the general practitioners, the health project, and the therapists themselves, were:

1. To explore the viability of providing complementary medicine in conjunction with National Health Service primary care.
2. To facilitate access to complementary therapy for those who would not otherwise have the opportunity to experience it, by providing a free service in a familiar and accessible setting.
3. To promote a holistic view of health, illness and therapy and to improve local health provision.
4. To enable the various types of therapists to familiarize themselves with other traditions of healing and discover ways in which their respective therapies might complement each other.

Funding the service

In March 1987 the health project secured one year's money from a national charity, the Network Foundation, to establish the service. This was followed by a further six months' funding from the same source. Before this money ran out, various sources of statutory funding, as well as charities and businesses were approached, and further small contributions were obtained. In addition, a user group of current and past patients has been established, which has the objective of generating fund-raising schemes to enable the service to continue.

Ethical and legal considerations

The coexistence of complementary and conventional therapies has ethical and legal implications for the general practitioner because referring to another practitioner can be considered to be a delegation of duties. If the alternative practitioner is medically qualified, then the referral causes no official ethical difficulty (Somerville A, BMA Ethics Department, personal communication), but if not, it is the general practitioner's responsibility to ensure that the practitioner is competent. The general practitioner should have some familiarity with the practitioner's work and qualifications, and should continue to oversee the treatment. At the Wells Park practice, these conditions can be fulfilled because of the close cooperation between the general practitioners and the alternative therapists. In addition, the general practitioners and the health project are jointly responsible for appointing the alternative practitioners. There is no general guidance from the defence organizations on the question of possible litigation: each case would be considered individually. In theory the general practitioner might share liability with the alternative practitioner, and this might extend to other organizations or people who had lent credence to the alternative practitioners. However, the alternative therapists have their own insurance.

The professions supplementary to medicine act 1960 specifies the paramedical professions to which doctors can refer without legal or ethical problems. These include chiropodists, occupational therapists and physiotherapists but osteopaths and acupuncturists are not mentioned. The professions on the list are supervised by boards who promote high standards of therapy and training. New professions may be added by the Privy Council, provided both houses of parliament agree.

The General Medical Council welcomes the increasing use of new non-medical specialties and has no desire to restrain the delegation of treatment to these specialties, providing the treatment falls within their sphere of expertise.[7] It may well be that complementary disciplines should now be considered for inclusion in the list of professions supplementary to medicine.

The organization of the service

The acupuncturist and the osteopath work for one day each week of seven and six hours respectively, in one of the general practice treatment rooms. They are self-employed and self-administering. Patients call the health project for an appointment, and the message is taken by project workers or recorded on the telephone answering machine. The therapists contact the caller by letter or telephone to arrange an appointment. Reception of patients is carried out informally by health project workers.

Survey of the service

The service began in September 1986, and a survey commenced in May 1987. The following information was collected as patients booked in: the characteristics of the patients seen, the patients' ability to pay for treatment and their previous knowledge of the therapy, the referral routes, the reasons for treatment, the conditions treated and the duration of the condition prior to treatment.

Characteristics of patients

One hundred and ninety seven patients were treated by the alternative practitioners over the period May 1987 to August 1988 — 90 by the acupuncturist and 107 by the osteopath. A few patients were treated by both practitioners. Of the patients seen by the acupuncturist 64% were women, as were 73% of those seen by the osteopath. The osteopath saw patients of all ages including four patients aged under 20 years and four aged 70 years or over. The acupuncturist saw only patients aged 20 years and over but they were evenly distributed throughout the age groups.

Ability to pay and previous knowledge of the therapy

Of the 107 patients seen by the osteopath 47 (44%) said they could have afforded to have private treatment but for 18 of these patients (38%) it would have been with difficulty. The remainder said they could not afford private treatment. Of the 90 patients seen by the acupuncturist 25 (28%) could have paid for treatment but for 13 of these (53%) it would have been with difficulty. Among the remaining 65 patients 61 could not afford treatment and four did not reply. Two patients seen by the acupuncturist would not have had private treatment on principle.

Among the acupuncture patients 21% had had acupuncture before, 14% had considered doing so and 64% had not previously considered such treatment. Sixteen per cent of the acupuncture patients had never heard of it. Among the patients seen by the osteopath 15% had had osteopathy before, 17% had considered doing so and 68% had never considered such treatment. Eighteen per cent of the osteopathy patients had never heard of it.

Referral patterns and reasons for seeking treatment

Of the acupuncture patients 86% were Wells Park patients who had been referred by doctors, other practice staff or health project workers, or who had referred themselves. Among the osteopathy patients the corresponding figure was 90%. The remaining patients were from other practices; 6% of acupuncture patients but no osteopathy patients had been referred by other local general practitioners and 7% of patients from each group had referred themselves (information was unavailable for 3% of osteopathy patients).

Reasons given by patients for seeking treatment varied according to the therapy (Table 1). Osteopathy patients were more likely to have sought treatment as a result of their doctor's suggestion, and less likely to regard it as a 'last resort' than acupuncture patients.

Table 1. Reasons given by patients for seeking treatment.

Reason	% of patients giving reason	
	Acupuncture ($n = 90$)	Osteopathy ($n = 107$)
Suggested by doctor	58	83
Last resort	27	3
Treatment is readily available	20	26
Suggested by family/friend	13	12
Dislike taking drugs	8	1
Interested in treatment	2	6
Heard about it on TV	1	—
Suggested by acupuncturist	—	6
Other	9	—

Some patients gave more than one reason. n = total number of patients receiving treatment.

Conditions treated

Table 2 shows the range of conditions treated by the two therapists. The acupuncturist treated a wider range of conditions than did the osteopath, who treated mainly musculoskeletal problems and joint and muscle strain (92% of conditions treated).

Duration of condition prior to treatment

Patients treated by the acupuncturist tended to have had their condition for longer than those treated by the osteopath (Table 3). Fifty three per cent of acupuncture patients had had the condition for more than two years, as opposed to 25% of osteopathy patients while 25% of acupuncture patients had had their condition for 11 years or more, while only 10% of osteopathy patients had had the condition for this long. Correspondingly, more osteopathy patients had had their condition for three months or less (44%) than had acupuncture patients (22%).

Discussion

The complementary therapists reported differences between the patient population served in this setting and in their private practices. Not surprisingly, the patients were poorer than those seen privately, and were less familiar with complementary therapies. The osteopath reported a higher proportion of women than she would expect to see privately while the acupuncturist treated a higher proportion of people with life-threatening illness such as ischaemic heart disease in addition to their presenting symptoms. These differences, and the therapeutic context itself, bring specific benefits and problems.

A major benefit of practising complementary medicine in a primary care setting is that it provides a unique opportunity to

Table 2. Conditions treated by acupuncture and osteopathy.

	No. of patients	
	Acupuncture	Osteopathy
Musculoskeletal conditions		
Degenerative/osteoarthritic:		
Back/hip	18	20
Neck/shoulder	11	23
Knee	6	8
Other	4	6
Rheumatoid arthritis	5	1
Ankylosing spondylitis	2	—
Joint and muscle strain in:		
Back	6	28
Back and leg	5	11
Neck/shoulder	3	20
Other	—	5
Other conditions		
Migraine/headache	8	7
Depression/tension/anxiety	14	3
Bowel disorders	4	1
Skin conditions	8	—
Gynaecological problems	7	—
Asthma	5	—
Trigeminal neuralgia/Bells palsy	3	—
Vertigo/dizziness	3	—
Addiction (drugs/eating)	3	—
Urinary problems	2	—
Post-operative pain	1	—
Other	6	—
Total[a]	124	133

[a]38% of acupuncture patients and 24% of osteopathy patients presented with more than one condition.

Table 3. Duration of condition prior to seeking treatment.

	% of conditions treated	
Duration	Acupuncture ($n = 124$)	Osteopathy ($n = 133$)
<1 month	*12*	*26*
1–3 months	*10*	*18*
4–6 months	*11*	*8*
7 months–2 years	*14*	*23*
3–5 years	*10*	*12*
6–10 years	*18*	*3*
11–20 years	*16*	*8*
> 20 years	*9*	*2*

n = total number of conditions treated.

offer these therapies to a wider population. Patients can be speedily referred if necessary, either to their general practitioner, or for hospital-based diagnostic tests and there is the opportunity to discuss patients' history and progress with the general practitioner. In addition, access to medical records when permitted by the patient helps to provide a fuller picture of the patient's therapeutic needs.

When the service first started it was found that general practitioners were making inappropriate referrals. There was tendency, for example, to refer mainly elderly patients for pain relief. This problem diminished as the general practitioners became more familiar with the boundaries of the alternative therapies through liaison with the therapists, although they admitted to a residual temptation to refer 'difficult' patients.

There are also difficulties inherent in the character of the patient population. Some conditions, particularly chronic non-somatic conditions, relate to the patient's socioeconomic situation, and are unlikely to respond quickly to therapeutic intervention at the late stage at which they are presented. This presents a dilemma for the therapist, as treating the late presenting patient may delay treatment for others with more recent conditions who are more likely to respond to treatment. Another problem is the length of the waiting list which results partly from the problem of delayed treatment, and partly from an apparent infinite demand on a circumscribed service.

The general practitioners have reported no problems arising from the provision of complementary therapies on the premises, and have benefited from the pooling of expert opinion. Since this facility has been available they have made fewer referrals to hospital physiotherapy departments, fewer referrals to orthopaedic and rheumatology departments, and issued fewer prescriptions for pain-killing drugs. A number of patients successfully treated by the therapists would otherwise have continued to see the general practitioner, probably on a long-term basis. On three occasions serious conditions which had not been diagnosed by the general practitioner emerged as a result of the patient talking to the osteopath and revealing symptoms which, perhaps owing to embarrassment, a shorter consultation time, or aspects of the doctor–patient relationship, had not been disclosed to the general practitioner.

Conclusion

This new approach comes at a time of great change and three initiatives from the European Community are relevant. All drugs and remedies used in the EC, including herbal and homoeopathic remedies, are to be reviewed by the end of 1990. A research programme will be started to investigate how complementary medicine can be integrated into existing systems of health care delivery. Finally, common European standards are being encouraged by a directive that complementary practitioners should have completed three years of government approved tertiary education.

We should like to open a debate about the formal acceptance of some complementary disciplines to the list of professions supplementary to medicine. This discussion would need to include the views of alternative practitioner's organizations. The discussion may have a number of repercussions for medical practitioners: for instance, questions about the legitimacy of our own medical views of cause and effect, about the way we relate to patients, and about teamwork and respect for others.

The provision of free acupuncture and osteopathy at the Wells Park practice has been a successful exercise in cooperation between alternative and allopathic medicine, and there is no doubt that patients have benefited from it. Given general practitioners' interest in alternative medicine, we would like to suggest its relevance as a model for similar projects elsewhere.

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