Alternative or additional medicine? A new dilemma for the doctor

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SUMMARY. The growth of alternative medicine poses particular problems for general practitioners working in the National Health Service. This paper reviews the subject and presents preliminary results of a two-stage study of the prevalence of use of alternative medicine in a south London practice. Extended interviews with users explored motivations for choice of treatment and attitudes towards orthodox and alternative health care. The study suggests that many patients are making use of alternative medicine in addition to their NHS consultations without the knowledge of their general practitioners. The clinical and ethical implications of this pattern of illness behaviour are discussed.

The growth of alternative medicine

ALTERNATIVE medicine has expanded rapidly in the past 10 years. *Thorson's complete guide to alternative living* lists 145 organizations and training centres for alternative therapies in the United Kingdom,[1] the majority of which were established in the 1980s. Many 'self-development' and therapy centres (such as the Bodywork Institute, Lifespace, the Open Centre) offer alternative approaches to psychological, physical and spiritual well-being. In addition, an increasing number of general practices have added a non-medical counsellor to the primary care team to help cater for the apparently unmet needs of those patients with psychosocial problems.[2]

The numbers of alternative practitioners are growing at a rate 5.6 times greater than that of doctors: in 1981 there were 12 alternative practitioners per 100 000 population — that is, 27% of the total number of general practitioners.[3] The number of acupuncturists doubled between 1978 and 1981. In 1981 about 1.5 million patients made some 11.7 million consultations with non-orthodox practitioners;[3,4] the figure for 1985 has been estimated at 17 million consultations, compared with 600 million consultations with general practitioners.[5] On the assumption that an average fee for each visit to a non-orthodox practitioner is now £10.00, then as much as £170 million is spent anually, a figure equivalent to 13.8% of the payments to general practitioners by family practitioner committees in 1985.[5] The additional cost of vitamins, supplements, herbs and other preparations could reasonably bring the total cost to £250 million. The recent introduction of a private insurance plan for complementary health care (covering osteopathy, homoeopathy, acupuncture and chiropractic care up to a maximum of £1000 per annum) is an indication of the commercial scale of the alternative sector.

In 1983 a leader in *The Times* suggested that the reasons for the growth of this movement are attributable in part to the failures of the medical profession.[6] Increasing numbers of patients are opting for a non-scientific approach to health care and their motivation seems to be a growing mistrust of modern medicine with its 'dominant idiom of technology'.[7] The British Medical Association working party on alternative therapy has emphasized that the changing attitudes of society in the last two to three decades involve a growth of underlying hostility towards technology and science, allied to a mistrust of innovation, and a dislike of the progressive intrusion of bureaucracy which has led to a general criticism of 'governance'.[8] These feelings are directed against orthodox medicine along with other scientific disciplines. Furthermore, a proportion of the medical profession appears to be growing disenchanted with the present orthodoxies. A survey of 100 general practitioner trainees revealed that 18 were already practising some form of alternative therapy, and a further 70 expressed the desire to train in one or more.[9] A later study of over 200 general practitioners found that 41% had attended lectures or classes in alternative medicine; 16% currently practised a form of alternative medicine; and 42% wanted further training in one or other of the unorthodox techniques.[10]

Concurrently, there has been growing public awareness of health matters. In the 1980s 'fitness' and 'well-being' have become symbols of personal achievement and even of moral rectitude. A recent literature search revealed a great increase in the 1980s in the number of both academic papers and popular literature on alternative treatment. This coincides with the formation of the Research Council for Complementary Medicine in 1982 which received charitable status in 1983 and the Prince of Wales' public advocation of alternative treatments which led to the setting up of the BMA working party in 1983.

What are the implications of these trends and what can be learned from patients' use of alternative health care? To examine these questions a research project is being undertaken to estimate the prevalence of use of alternative care in one general practice population and to explore the situation from the standpoint of patients seeking alternative treatments. The two-stage study, in an inner London general practice with a list size of 5700, was set up following a report of several case histories of multiple therapy users.[11] Two alternative health centres had recently opened in the vicinity of the practice, offering a wide range of low-cost alternative therapies, and a weekly evening class on alternative medicine was being run by the local adult education institute under the tuition of therapists from the centres. Indeed, it was found that 15 such courses were being provided by the Inner London Education Authority in the 22 adult education areas in London.[12]

This paper presents some preliminary findings of the study and discusses some of their implications for general practitioners.

Prevalence of use of alternative medicine

In the first stage of the study the age–sex register of the practice was used to select patients for a study of the prevalence of use of alternative medicine. This was carried out as a series of age group censuses. Patients were sent a questionnaire with a list of the most widely known alternative therapies and were asked to tick any that they had used in the past 10 years, to add any others to the list and to indicate the conditions for which they had sought treatment. Users who were willing to be inter-

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viewed about their experiences were asked to give their telephone numbers. A reminder letter and second copy of the questionnaire were sent to all those who had not responded within four weeks.

To date results have been collected for all the 70-year-olds and all the 35-year-olds registered with the practice. The older age group was chosen to explore the anticipated high use of alternative treatments among those with chronic conditions, such as arthritis.[13] The 35-year-old group was selected for comparison and because the group was likely to include parents of young children.

Twenty four of the 27 70-year-olds responded compared with only 53 of the 80 35-year-olds. The data showed an age bias in the use of alternative therapies, with only one (male) user among the 70-year-olds compared with 25 of the 35-year-olds. In the 35-year-old group, more women (17/44) than men (8/36) were users. Although the range of conditions for which treatment had been sought was very extensive, back pain and psychological symptoms were the most common. Over 20 forms of therapy were listed by respondents, including (in order of popularity): osteopathy, homoeopathy, acupuncture, herbalism, counselling, hypnosis, massage, chiropractic, Alexander technique, faith healing, private allergy clinics and fortune telling.

Patients' use of and attitudes to alternative medicine

The questionnaire on use of alternative therapy was also sent to 42 'selected' patients of a range of ages whom the general practitioner had reason to believe were actual or potential users of alternative therapy. Each of these individuals was matched for age and sex with a 'control' patient from the register for purposes of comparison.

On the basis of the variety of their use of alternative medicine, 20 respondents from among these two groups and from the census samples were chosen for interview by the research worker (J.M.) in the second stage of the study. Seventeen of the 20 interviewed were women, 10 with young children; 15 had had tertiary education and 15 were owner occupiers. Most were aged between 30 and 45 years. The interview explored their use of alternative treatments; their evaluation of the efficacy, safety and value for money of each treatment; sources of information and referral; attitudes to scientific medicine; health information sources; and any relevant religious or philosophical beliefs. Respondents were asked for their consent to their general practitioner (S.S.) contacting their therapists to seek an assessment of the patient's condition and the treatment given. The interviews with patients lasted betwen one and two hours. Several themes emerged from the interviews.

Pathways to alternative medicine

Pregnancy and the early years of motherhood were key stages of life at which women became attracted to alternative treatment because they felt some orthodox medicines were too dangerous for the fetus and the young child. The National Childbirth Trust, health visitors and voluntary societies for particular health problems were important sources of information, often advocating the alternative approach to treating common paediatric problems, such as asthma, eczema and colic, as well as alternatives to the orthodox childhood immunization schedule. Recommendations from friends and neighbours were also influential for both men and women respondents.

Illnesses and illness behaviour

The group was not composed of committed self-care enthusiasts, since none had rejected orthodox medicine. Most were frequent attenders at the practice and had been referred recently to orthodox specialists. The additional rather than exclusive use of alternative measures was the norm. Alternative treatments were commonly used for first aid purposes or for minor conditions which respondents did not feel warranted medical attention. This category included burns, bruises, skin rashes, colds, aches and pains, and minor abdominal symptoms, particularly in children. All respondents said that they had sought a medical diagnosis for unfamiliar 'serious' conditions before embarking on alternative treatment. They had then decided whether to accept the prescribed treatment or to seek an alternative option. The rejection of orthodox treatment was often made on the basis of the invasiveness of the prescribed treatment (for example, the insertion of grommets for a child's chronic serous otitis media; surgery to remove a second kidney stone). Much anxiety was expressed about the long-term consequences or toxicity of antibiotic medication and this had led most of the mothers in the sample at some time to seek 'harmless' alternatives such as homoeopathy or osteopathy for their young children.

Patients' subjective assessments

Patients often used more than one alternative approach, particularly where a therapist offered several skills. Selectivity in the type of treatment thought to be most appropriate to the particular condition is illustrated by the following two cases:

> Mrs A favoured acupuncture (when she could afford it) and osteopathy for her back pain. She had attended a course on homoeopathy and kept a large box of remedies for use in her children's illnesses and for first aid. She was consulting a medical herbalist for gynaecological problems.
>
> Mrs B consulted an acupuncturist for a gastrointestinal condition to avoid the use of prescribed drugs during pregnancy. She was being treated by a herbalist to help prevent recurrent cystitis, though she took antibiotics when an attack occurred. Her children were receiving treatment from a homoeopathic paediatrician for asthma and otitis media.

The consolatory benefits of a lengthy consultation with a sympathetic therapist were mentioned more often than any curative powers attributed to the different therapies. Irrespective of ideology or treatment approach, listening and counselling skills were highly valued in the alternative sector and believed to be lacking within the constraints of a medical consultation:

> Mrs A: 'It's the human factor that's missing from the NHS. It's too scientific.'
> Mrs B (after consulting a homoeopath): 'I felt like a million dollars. I've never had so much attention in my life.'
> Mrs C (on her natural therapist): 'Absolutely marvellous, very reassuring, the best £8 I've ever spent.'

In their expressions of the 'wholesome' and 'holistic' nature of the alternative treatments they had tried, respondents laid particular stress on the 'individual' and 'positive' approach of the therapists:

> Mrs A on general practitioners: 'With some conventional doctors, their theories relate to everybody. It's not an *individual* diagnosis.'

That patients should feel they are being treated as individuals with the opportunity to present their health problems in the way they perceive them has been shown to have therapeutic benefits.[14] Nevertheless, not all alternative practitioners were seen as giving an individual service:

> Mr B on alternative practitioners: 'I feel that I have fallen prey to some self-interested individuals who put their own

theories forward as the solution to all ills without any real concern for the *individual*.'

Commentary

In the last two to three decades the development of public information has enabled the majority of the population to take an active interest in health matters. This has led to more demands for patient choice in treatment and to what has been termed 'consumer sovereignty', in health care decisions.[15] It is apparent that a proportion of patients are growing confident enough to decline medical interventions which do not suit their own particular 'tastes' or health beliefs, and to seek from their general practitioners a form of 'negotiated guidance' in treatment decisions.[16]

If, as our study suggests, substantial numbers of patients in some age groups are seeking alternative health care how much of this comes to the attention of the general practitioner? Many patients, it appears, are using both orthodox and unorthodox health care simultaneously for the same condition: a hypertensive patient recently consulted his general practitioner after instructions from his homoeopath to request that the prescribed dosage of hypotensive drugs be reduced by one half. Since conflicting advice is inevitable, whose recommendations is the patient to follow on different occasions? Many of our interviewees expressed their views on the nature of disease and treatment in terms of belief rather than factual understanding. While much research is directed at causal factors and treatment outcome, including the efficacy of alternative treatment, it seems that there is a strong tendency on the part of patients to choose the approach which most suits individual beliefs and tastes. In the light of information we have collected so far, use of alternative treatment does not lead to an equivalent reduction in demand for general practice consultations; both sources may be consulted for the same illness episode. The view that formal training and accreditation of alternative therapists would relieve the doctor of treating much of the non-life-threatening illnesses, for which costly high technology services are not appropriate, would seem to be fallacious.[17]

The traditional antipathy between the medical profession and alternative therapists may mean that patients will be reticent in discussing their use of unorthodox treatments with their general practitioner. A clinical report is very rarely sent by the non-medical practitioner to the general practitioner: in our study a summary was provided by only two of the 12 therapists when requested by the general practitioner. The others either failed to respond to the request or sent a printed leaflet about the treatment offered by the therapist or about their organization, without any information on the individual patient. It is therefore left entirely to patients to decide whether or not to disclose any information on the alternative treatments they are undergoing. When such disclosures are made, how should they affect the doctor's management plan for the patient's current condition?

Patients' conditions can be examined conveniently in relation to three broad categories: (1) 'Structural' disease or clearly delineated conditions, which include well differentiated organic conditions such as pneumonia, appendicitis, peptic ulcer. For conditions of this nature an effective or palliative treatment is available, and most patients would consider a medical consultation to be essential. (2) Disorders of function, which include the less well-defined conditions and groups of symptoms best exemplified by migraine, musculoskeletal pain, allergic symptoms and dyspepsia. For most of these conditions there are no clear-cut therapeutic measures. (3) 'Problems of living' and the vulnerable personality, which may involve the same sorts of symptoms and complaints as in (1) or (2) but in addition indicate the need of patients for long-term support to enable them to cope with their daily lives.

With the current organization of the National Health Service some patients in all three of these categories are likely to consult both their general practitioner and an alternative practitioner. The probability would vary for each category, with the frequency rising from category (1) to category (3). Our interviews suggest that patients seeking alternative medicine would not question the application of orthodox medicine for 'structural' diseases such as those of category (1), although some would also employ concurrent non-orthodox therapy (for example, in the case of cancer). Respondents, however, believed that category (2) type disorders respond well to alternative treatments such as osteopathy and acupuncture. Most preferred to seek medical advice first and to get the cooperation of the general practitioner in finding an appropriate alternative therapist. Patients (often frequent attenders) whose problems fall into category (3) may be particularly vulnerable to some of the more dubious alternative practitioners and fringe organizations who make extravagant claims for self-improvement.

One related issue merits special comment. The rapid developments in diagnostic and therapeutic techniques in the recent past have led to changes in the relation between patient and doctor.[8] Whereas formerly doctors were able to provide comfort and support to patients but not always much in the way of effective therapy, the general practitioner now offers a more comprehensive service, but with a consequent diminution in the time available for lengthy discussion. Increasing numbers of general practitioners are taking clinical psychologists and counsellors into their practices (in part with family practitioner committee reimbursement), with the aim of reinstating a declining aspect of general practice.[18] However, it is doubtful whether this type of ancillary service could provide for more than a very small proportion of the potential need, and the effectiveness of these interventions has not been clearly established. Furthermore, a recent study of the role of attached counsellors in general practice concluded that the issue of the training and payment of counsellors requires urgent attention.[2]

Implications for the general practitioner

Alternative treatment is clearly making an impact upon orthodox medicine and upon the behaviour of some patients. The general practitioner cannot ignore this growing trend and is already faced with a number of unanswered questions which may be categorized as follows:

Clinical responsibility

General practitioners are responsible for the continuing medical care of patients registered on their lists through their contractual obligations to the family practitioner committee. If a general practitioner regards the use of unorthodox treatment outside the NHS as potentially harmful to a patient, must he or she continue to accept clinical responsibility? What, for example, is the responsible course of action for the general practitioner who finds that a child is suffering as a result of unorthodox treatment selected by the parents without medical consultation?

Out of hours and holiday cover

The general practitioner is the only provider of primary health care and advice for patients 24 hours a day. Out of office hours, an ill or distressed patient needing attention is forced to call a general practitioner even if the condition is being treated solely by an alternative practitioner. How can a patient avoid a potential conflict of medical management? Further, if a general practitioner fails to provide personal medical services for a period

of more than six months without making due arrangements with the family practitioner committee, the doctor's name can be removed from the medical list. Will alternative practitioners involved in continuing care make 'due arrangements' in similar circumstances?

Continuity of care

Whereas within both the NHS and the private sector it is customary to exchange clinical information between doctors, there is no established mechanism for the sharing of information between the orthodox and unorthodox sectors. How might this be established?

Ethical and disciplinary codes

A registered medical practitioner is bound by the principles laid down by the General Medical Council and any breach of this code can lead to disciplinary proceedings. What codes should exist for alternative practitioners and their respective professional bodies? Although there exist a number of small organizations by which alternative practitioners may be trained and accredited, not all practitioners are registered with these bodies. An attempt to establish agreed educational standards and codes of practice for alternative practitioners of various techniques is currently occupying the Council for Complementary and Alternative Medicine. The aim is that the affiliated groups will become 'self-regulating professions fully able to take their rightful place in the health care system'.[19] However, the Council comprises only nine of the numerous associations of alternative therapists, and they acknowledge that there are enormous difficulties in achieving consensus on educational standards and ethics.

Delegation and negligence

Within the disciplinary framework laid down by the General Medical Council the principles of delegation are well described. Referral by a doctor to a medically qualified alternative practitioner differs in no way, medico-legally, from a referral to any other doctor. However, referral to a non-medically qualified practitioner is also covered by the principles laid down by the General Medical Council:[20]

> 'a doctor who delegates treatment or other procedures must be satisfied that the person to whom they are delegated is competent to carry them out. It is also important that the doctor should retain ultimate responsibility for the management of his patients because only the doctor has received the necessary training to undertake this responsibility'. (paragraph 42)
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> 'For these reasons a doctor who improperly delegates to a person who is not a registered medical practitioner functions requiring the knowledge and skill of a medical practitioner is liable to disciplinary proceedings...[The GMC] has also proceeded against doctors who by signing certificates or prescriptions or in other ways have enabled persons who were not registered medical practitioners to treat patients as though they were so registered'. (paragraph 43)

The question of negligence is particularly topical in view of increasing litigation by patients and soaring Medical Defence Union subscriptions. If a general practitioner delegates the management of a patient to a non-medically qualified alternative practitioner and the patient is harmed or believes himself to be harmed, then the general practitioner is liable for negligence. But what, precisely, is delegation? According to the General Medical Council it includes the giving of permission as well as a straightforward referral. If this referral takes the form of 'the giving of permission', will the general practitioner always satisfy himself that the practitioner has the professional background and training to carry out the particular procedure? Since there exist a plethora of professional and diploma-awarding associations in the alternative sector, it is difficult for the general practitioner to be assured of the qualifications of individual therapists.

Conclusion

There is no doubt that the public's growing acceptance of alternative medicine is affecting the attitudes of many patients and doctors. This is despite the arguments over the actual or imagined efficacy of many types of therapy. If general practitioners are to recognize alternative practitioners as potential allies and if patients are to continue to use orthodox and alternative treatments in combination then these areas of concern must be confronted.

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