ABC of complementary medicine

Complementary medicine in conventional practice

Catherine Zollman, Andrew Vickers

The past 10 years has seen a significant increase in the amount of complementary medicine being accessed through the NHS. These services are not evenly distributed, and many different delivery mechanisms are used, some of which (such as homoeopathic hospitals) predate the inception of the NHS. Others depend on more recent NHS reorganisations, like general practice fundholding and health commission contracting, or have been set up as evaluated pilot projects.

In general, development of these services has been demand led rather than evidence led. A few have published formal evaluations or audit reports. Some of these show benefits associated with complementary therapy—high patient satisfaction, significant improvements on validated health questionnaires compared with waiting list controls, and suggestions of reduced prescribing and referrals. However, data from other services are less clear, and many have not been formally evaluated. These pilot projects have also identified various factors that influence the integration of complementary medicine practitioners within NHS settings.

Complementary therapies have been available in the NHS since its inception

Causes for concern

While much needed evidence is gathered, the debate about more widespread integration of complementary medicine continues. The idea of providing such care within a framework of evidence based medicine, NHS reorganisations, and healthcare rationing raises various concerns for the different parties involved.

Conventional clinicians and managers want persuasive evidence that complementary medicine can deliver safe, cost effective solutions to problems that are expensive or difficult to manage with conventional treatment. Unfortunately, such evidence is both scarce and equivocal. Only a moderate number of randomised trials and very few reliable economic analyses of complementary medicine have been conducted. Moreover, no systematic process exists for collecting data on safety and adverse events.

Patients—Public surveys show that most people support increased provision of complementary medicine on the NHS, but this question is often asked in isolation and does not mean that patients would necessarily prefer complementary to conventional care. When planning services, it is essential to try to distinguish between patients' desires and defined patients' needs that can be met by complementary medicine. Patients also want to be protected from unqualified complementary practitioners and inappropriate treatments. NHS provision might go some way to ensuring certain minimum standards such as proper regulation, standardised note keeping, effective channels of communication, and participation in research. It would also facilitate ongoing medical assessment.

Complementary practitioners—Some practitioners support NHS provision because it would improve equity of access, protect their right to practise (currently vulnerable to changes in European and national legislation), and guarantee a caseload. It would also provide opportunities for inter-professional learning, career development, and research. Others fear an inevitable loss of autonomy, poorer working conditions, and domination by the medical model.

Integrating complementary medicine into conventional settings

Successful integration is more likely with

- Demand from patients
- Commitment from high level staff in the conventional organisation
- Protected time for education and communication
- Ongoing evaluation of service (may help to defend service in the face of financial threat)
- Links with other conventional establishments integrating complementary medicine
- Realism and good will from all parties
- Jointly agreed guidelines or protocols between complementary and conventional practitioners
- Support from senior management or health authority
- Careful selection and supervision of complementary practitioners
- Funding from charitable or voluntary sector

Problems are likely with

- Financial insecurity
- Time pressure
- Lack of appropriate premises
- Unrealistic expectations
- Overwhelming demand
- Inappropriate referrals
- Unresolved differences in perspective between complementary and conventional practitioners
- Real or perceived lack of evidence of effectiveness
- Lack of resources and time for reflection and evaluation

List adapted from the report of the Delivery Mechanisms Working Party of the Foundation for Integrated Medicine

Organisations promoting interdisciplinary cooperation in complementary medicine

Foundation for Integrated Medicine
Initiative of Prince of Wales, convenes working parties and events on aspects of integrated medicine
International House, 59 Compton Road, London N1 2YT. Tel: 0171 688 1881. Fax: 0171 688 1882

British Holistic Medical Association
Membership organisation for healthcare professionals with associate lay members
59 Lansdowne Place, Hove, East Sussex BN3 1FL. Tel/fax: 01273 725951. URL: www.bhma.org

Current provision in the NHS

In primary care

Most of the complementary medicine provided through the NHS is delivered in primary care.

Direct provision

Over 20% of primary healthcare teams provide some form complementary therapy directly. For example, general practitioners may use homoeopathy, and practice nurses may use hypnosis or reflexology. Advantages of this system are that it requires minimal financial investment and that complementary treatments are usually offered only after conventional assessment and diagnosis. Also, practitioners can monitor patients from a conventional viewpoint, ensure compliance with essential conventional medication, and identify interactions and adverse events.

A disadvantage is that shorter appointments may leave less time for non-specific aspects of the therapeutic consultation. Also, members of primary healthcare teams have often undertaken only a basic training in complementary medicine, and this generally forms only a small part of their work. Doubts about the effectiveness of the complementary treatments they deliver, compared with those given by full time complementary therapists, have been expressed. Although no comparative evidence is available, it is clear that limits of competence need to be recognised.

Indirect provision

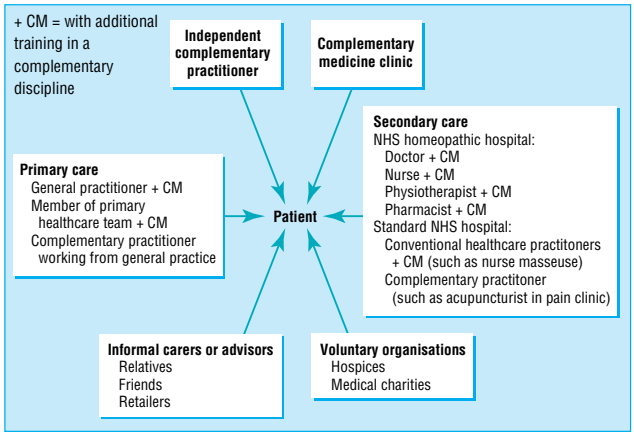
Complementary practitioners without a background in conventional health care work in at least 20% of UK general practices. Osteopathy is the most commonly encountered profession. Such practitioners usually work privately, but some are employed by the practice and function as ancillary staff. An advantage for patients is that general practices usually check practitioners' references and credentials. Although some guidelines for referral may exist, levels of communication with general practitioners vary widely and true integration is rare.

In specialist provider units

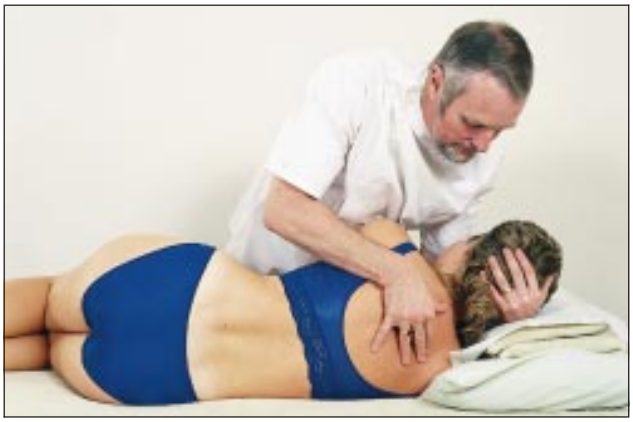
Five NHS homoeopathic hospitals across the United Kingdom accept referrals from primary care under normal NHS conditions: free at the point of care. They offer a variety of complementary therapies provided by conventionally trained health professionals. They provide opportunities for large scale audit and evaluation of complementary medicine, but many services have been cut in recent years.

Some independent complementary medicine centres have contracts with local NHS purchasers. For example, Wessex Health Authority has a specific service contract with a private clinic to provide a multidisciplinary package of complementary medicine for NHS patients with chronic fatigue or hyperactivity. Some fundholding general practices have delegated patients to independent centres such as local chiropractic clinics rather than employ complementary practitioners in house.

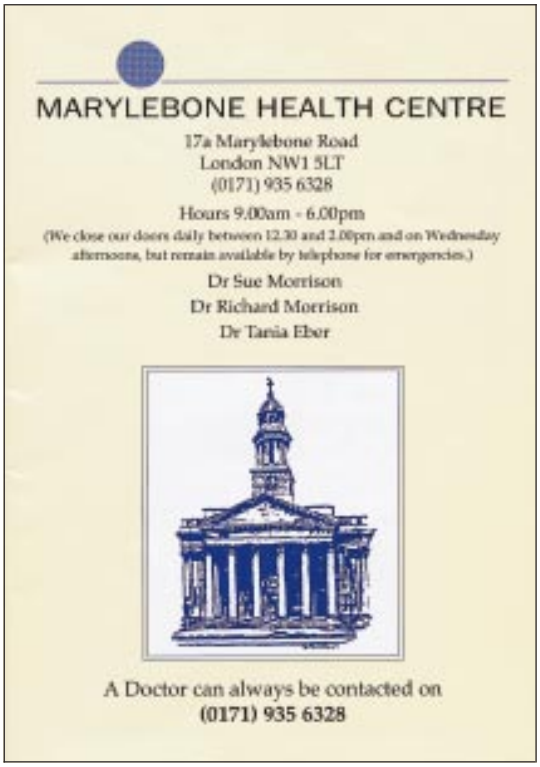
A few health authorities have set up pilot projects for multidisciplinary complementary medicine in the community or on hospital premises. Advantages have included clear referral guidelines, evaluation, good communication with general practitioners, and supervised and accountable complementary practitioners. However, such centres are particularly vulnerable when health authorities come under financial pressure. Examples are the Liverpool Centre for Health and the former Lewisham Hospital NHS Trust Complementary Therapy Centre, which was closed when the local health authority had to reduce its overspend.



Model of provision of complementary medicine



In many general practices osteopathy is provided indirectly by an independent complementary practitioner



Marylebone Health Centre was one of the first general practices to offer multidisciplinary complementary therapies to NHS patients. It provides osteopathy, massage, naturopathy, and homoeopathy

In conventional secondary care

Many NHS hospital trusts offer some form of complementary medicine to patients. This may be provided by practitioners with or without backgrounds in conventional health care. However, the availability of such services varies widely and depends heavily on local interest and high level support.

Funding for complementary medicine

Complementary medicine can be provided by conventional NHS healthcare professionals as part of everyday clinical care. This requires no special funding arrangements. General practitioners cannot claim item of service payments for complementary treatments they give to their own NHS patients.

Since 1991, health authorities can reimburse general practitioner principals who employ complementary therapists, although the staff budget is limited and a complementary practitioner is therefore employed at the expense of another member of staff. General practitioner fundholders have had additional control over staffing budgets and fundholding savings, which some have used to purchase complementary therapies. Primary care groups have greater power to allocate funds as they choose, but it remains to be seen whether complementary medicine will be identified as a priority by sufficiently large numbers of general practitioners for the creation of any new initiatives. Indeed, the change from general practice fundholding to primary care groups may mean that some established complementary services will be lost.

Local health commissions and authorities have sometimes used money for research and development, or for waiting list initiatives, to finance complementary medicine. Block service contracts or individual extracontractual referrals can be made with complementary medicine providers, but in practice financial constraints restrict this type of access.

Funds from the voluntary sector or charities may also be sought. The complementary therapy service at the Marylebone Health Centre in London was initially funded by a research grant from a charitable trust. Fundraising and donations by the local patients are now essential to its ongoing financial viability. In addition, some charities, such as the London Lighthouse for people infected with HIV, subsidise complementary medicine for people who could not otherwise afford treatment.

Some occupational health and private medical insurance schemes fund complementary therapies.

Medicolegal considerations

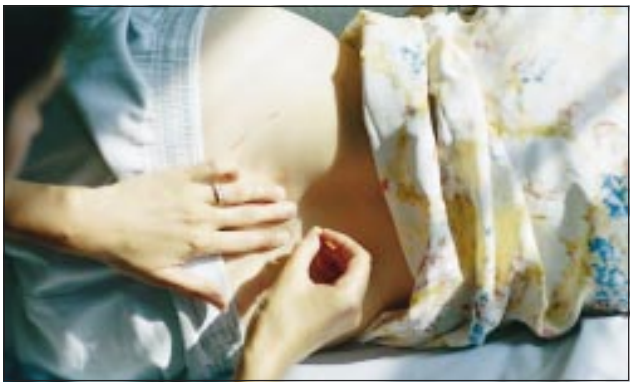
If doctors participate in patients' seeking complementary therapies—by advising, treating, delegating, or referring—they need to be aware of the medicolegal implications. Although each case is judged on its merits, certain guidelines apply.

Doctors who practise complementary therapies

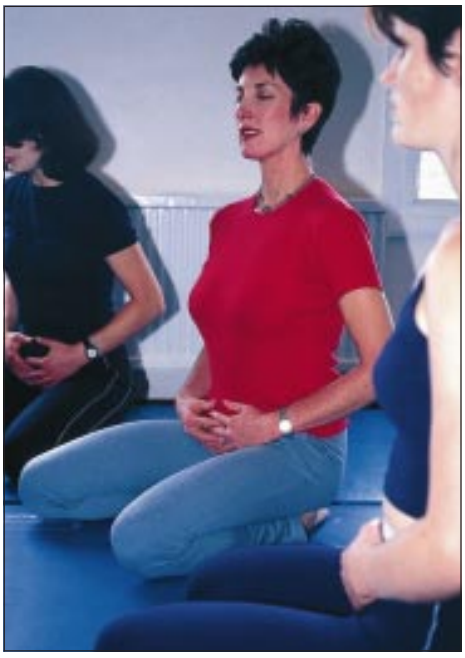
Under the Medical Act of 1858, conventionally trained doctors can legally administer any unconventional medical treatments they choose. However, as with most medical practice, the "Bolam test" is used to determine appropriate standards of care. This means that "a doctor is not guilty of negligence if he or she has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art as long as it is subject to logical analysis." In other words, if a doctor has undergone additional training in a complementary discipline and practises in a way that is reasonable and would be considered acceptable by a number (not necessarily a majority) of other medically qualified complementary practitioners, his or her actions are defensible.

Examples of complementary medicine in secondary care

Complementary therapy	Healthcare professionals
Pain clinics	
Acupuncture	Anaesthetists, physiotherapists, palliative care physicians, professional acupuncturists
Physiotherapy departments	
Manipulative therapy, acupuncture	Physiotherapists trained in manipulative medicine or acupuncture
Rheumatology departments	
Manipulative therapy	Osteopaths, chiropractors, orthopaedic physicians
Hospices	
Aromatherapy, reflexology, massage, hypnosis, relaxation, healing, acupuncture, homoeopathy	Nurses, doctors, complementary therapists, occupational therapists
Clinical psychology departments	
Hypnosis or relaxation training	Psychologists
Obstetric departments	
Yoga, acupuncture	Midwives, physiotherapists



An increasing number of hospital pain clinics now offer acupuncture as a treatment for chronic pain



Some complementary therapies, such as relaxation, can be delivered effectively in group sessions, which improves their cost effectiveness

Referral to medically qualified practitioners

A doctor who asks another doctor to provide complementary medicine is in the same legal situation as when referring to a doctor for any other services. As long as the decision to make the referral is appropriate, all further responsibility regarding the complementary treatment is taken over by the doctor providing the specialist service.

Delegation to non-medically qualified practitioners

This situation, more than any other, concerns doctors who wish to make complementary medicine available to their patients. Despite theoretical worries, however, it is considered a very low risk area by medical defence societies. The situation may change if complementary medicine becomes more widely used.

Doctors must ask themselves three main questions:

- Is my decision to delegate to this complementary therapy appropriate?
- Have I taken reasonable steps to ensure that the practitioner concerned is qualified and insured?
- Has my medical follow up been adequate?

To date, no claims or cases have been sustained against doctors who have delegated to complementary practitioners.

Delegation to state regulated complementary practitioners

Now that osteopaths and chiropractors are state regulated, delegating to these practitioners is medicolegally similar to delegating care to a physiotherapist or other conventional healthcare professional.

Further reading

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- *Complementary medicine: new approaches to good practice*. Oxford: Oxford University Press, 1993

The ABC of complementary medicine is edited and written by Catherine Zollman and Andrew Vickers. Catherine Zollman is a general practitioner in Bristol, and Andrew Vickers will shortly take up a post at Memorial Sloan-Kettering Cancer Center, New York. At the time of writing, both worked for the Research Council for Complementary Medicine, London. The series will be published as a book in spring 2000.

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Medicolegally acceptable delegation to non-medically qualified complementary practitioners

Initial decision to delegate to a practitioner must pass Bolam test

- Evidence based decisions are most persuasive
- Commonly accepted but unproved indications are also acceptable

Doctors must take reasonable steps to ascertain that practitioners are appropriately qualified

- It is usually sufficient for delegating doctors to ensure that they are a member of the main professional regulatory body responsible for that particular discipline
- The main bodies require members to be fully indemnified

Doctors must retain "overall clinical responsibility"—that is, ensure appropriate follow up, reassessment, etc

- Doctors should not issue repeat complementary prescriptions without having or obtaining sufficient information to ensure safe prescribing

Obtaining lists of the main professional registers

Council for Complementary and Alternative Medicine (CCAM)
Deals with registration of acupuncture, herbal medicine, homoeopathy, and osteopathy
63 Jeddo Road, London W12 6HQ. Tel: 0181 735 0632

British Complementary Medicine Association (BCMA)
Deals with registration of wide range of complementary practitioners including reflexologists, aromatherapists, craniosacral therapists, nutritional therapists, and hypnotherapists
249 Fosse Road South, Leicester LE3 1AE. Tel: 0116 282 5511

Key evaluation reports from NHS complementary medicine services

- Richardson J. *Complementary therapy in the NHS: a service evaluation of the first year of an outpatient service in a local district general hospital. November 1995*. Report prepared by Health Services Research and Evaluation Unit, Lewisham Hospital NHS Trust, London
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- Rees R. Evaluating complementary therapy on the NHS: a critique of reports from three pilot projects. *Complement Ther Med* 1996:254-7
- Scheurmier N, Breen AC. A pilot study of the purchase of manipulation services for acute low back pain in the United Kingdom. *J Manipulative Physiol Ther* 1998;21:14-8

The pictures of Royal London Homoeopathic Hospital and acupuncture are reproduced with permission of the Royal London Homoeopathic Hospital. The picture of osteopathy is reproduced with permission of the General Osteopathic Council. The picture of group therapy is reproduced with permission of BMJ/Ulrike Preuss.

One hundred years ago

Alcohol and life assurance

The excessive mortality in the assured who are engaged in the liquor trade has for a long time exercised the minds of the directors of life assurance companies. The figures put forward by the Abstainers and General Insurance Company present the drink question from another point of view. From a report made by Mr. James Meikle upon the mortality experience of the Abstainers' ordinary department during the first fourteen years of the company, it appeared that but forty-eight deaths had occurred out of each hundred anticipated under the H^{m}. table. If this experience continues to prevail in the future, abstainers will have justice on their side if they claim that they should pay a lower premium than those persons who habitually take alcohol, even though in small quantities. It will, however, be necessary to ascertain how long the applicant has been a total abstainer, as reformed drunkards who have become abstainers are not good lives. (*BMJ* 1899;ii:487)