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Editorial

David Peters

Editor-in-chief

This edition of JHH celebrates and collects several papers from The Prince's Foundation for Integrated Health's national conference *Putting People First*. Although widely interpreted as weaving complementary therapies into conventional healthcare, integrated medicine implies far more, because – as Michael Dixon puts it in his leader article – medicine, as it stands, may be in danger of disintegrating. It needs a new big idea: the concept of holism.

The biomedical model at its most radical assumes we can understand the living human organism in terms of its parts. Holism on the contrary insists that unpredictable qualities emerge as the parts come together, that the *whole* changes the way the *parts* function and therefore, in line with Engel's biopsychosocial model, that the study of every disease must include the individual, as well as their body and their surrounding environment, as essential components of the total system.[1] So the territory of holistic biopsychosocial healthcare is vast, and integrated medicine's task will be to manifest its theories in practice.

A broad and potentially united front – drawn from practitioners, politicians and the public – understands the need to reshape twenty-first century medicine. Perhaps we should take heart from George Engel then who, observing the shortcomings of biomedicine 30 years ago, wrote that 'nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on biomedicine as the only approach to health care'. For surely Engel foresaw a time when faced with undeniable economic, ethical and public health challenges, those who control resources would finally wise up. In this issue of JHH we argue that the time has come when those who control resources have little alternative but to steer away from the biomedical model and set the course of policy and practice in a more holistic and integrated direction.

Integrated medicine is not about bolting complementary therapies onto biomedicine, but it sees their significance; not only their potential clinical importance, but also how they might be a signpost. Do they not remind us of what biomedicine has forgotten or neglected, failed to incorporate or even perhaps even to comprehend? Writing in 1980 about a 'rebellion against the philosophical and clinical orientations of scientific medicine [that] has occurred in the United States during the 1970s, Warren Salmon, curious about why people were turning away from mainstream medicine, suggested it was because they felt biomedicine was about parts rather than persons, that its practitioners too often discouraged power-sharing, and that patients feared its treatments put them at risk.[2]

Thirty years on, when biomedicine has become even more corporate, impersonal, biotechnical, and fraught with risk than when Salmon and Engel were writing, their words seem all the more relevant. It is clearer too that complementary medicine's appeal lies in its being biomedicine's counterpart: personal and small scale, low-tech, low-risk, and conscious of context and meaning; encouraging of self-healing processes and participation, heavily reliant on the therapeutic alliance, aware of the mind and body connection, and of our relatedness to the natural world; above all, non-corporate. In so many ways complementary medicine is proudly counter-cultural in an age when so much of mainstream culture appears to be in freefall.

In this issue Jonathan Lord proclaims that the mainstream has much to learn from complementary medicine's perspectives. Articles from Professors Harald Walach and George Lewith observe the current anti-complementary medicine campaign: Walach reminding us that complementary medicine has become a significant economic and social presence, Lewith taking up the cudgels against those who, flying in the face of research evidence, tell the media that complementary medicine does more harm than good. In a related vein Hugh MacPherson and Catherine Zollman ask what we mean by 'evidence' for complementary medicine, and Karol Sikora and Michael Dixon – clinicians with front-line experience of integrating it into general and oncology practice – express distrust in the 'armchair physicians' who oppose efforts for higher education, regulation and more research for complementary medicine. Your editor argues that sustainable healthcare means we must find new directions. But diving deeper, William House maps some conceptual, organisational and economic currents that will make changing course more difficult. Background contributions from researchers Denise Peerbhoy and Damien Ridge offer examples of how community effort can create non-biomedical narratives to support wellbeing and recovery; a theme taken up by Chris Drinkwater in his deconstruction of obesity as a biomedical problem. Finally, Donna Kinnair and Michael Dooley consider how nursing and gynaecology will have to learn to embrace patient preference.

The range of contributors to the FIH conference confirms that outside the world of complementary medicine, many colleagues are exploring holistic solutions to the deepening crises of cost, cure and care that healthcare faces. If our medical system is to pull out of its high-tech nosedive and become more sustainable it will have to develop a new model of health, somehow find ways to de-industrialise and perhaps re-orient itself around medicine's timeless values. The great potential of integrated medicine will be realised as it finds ways of expressing these vital ways forward.

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News review

FIH launches GP membership scheme

NHS GP practices committed to providing an integrated approach to health and care will soon be applying for The Prince's Foundation for Integrated Health's new practice membership scheme. FIH Medical Director Dr Michael Dixon says: 'The scheme is a way of expressing a practice's aspirations and commitment to providing holistic personal care and the integration of conventional and complementary medicine. Given the ever-growing patient demand for integrated care, FIH anticipates that many GP practices will want to apply'. Membership will depend on the practice meeting a number of criteria and being committed to introducing specific features of good practice. The Foundation plans to develop silver and gold levels of membership and in time a service quality kitemark.

GPs call for complementary therapy on the NHS

A year-long pilot scheme in Northern Ireland has found significant health benefits for patients offered CAM via the public health service.

Following the pilot (extensively reported in JHH 2008, 5:1), 80% of patients reported an improvement in their symptoms, 64% took less time off work and 55% reduced their use of painkillers.

The scheme was commissioned by the Health Minister of Northern Ireland and implemented by Get Well UK, a social enterprise aiming to improve patient choice for those unable to afford private health care.

Despite initial scepticism, the GPs involved were almost unanimously in favour after seeing tangible results. In 99% of patient cases GPs said they would refer the patient, or a different patient, to the scheme again and in 98% of cases GPs said they would recommend the service to other GPs. However, they also called for more information to help build their understanding of CAM therapies.

In the pilot, 713 patients with a range of ages and demographic backgrounds and either physical or mental health conditions were referred to various CAM therapies via nine GP practices in Belfast and Londonderry. Key findings include:

Health improvement

- The proportion of patients reporting the most severe symptoms reduced from 31% before treatment to 5% after treatment
- 81% of patients reported an improvement in their physical health
- 79% reported an improvement in their mental health
- 84% of patients linked an improvement in their health and wellbeing directly to their CAM treatment
- 94% of patients said they would recommend CAM to another patient with their condition
- 87% of patient indicated a desire to continue with their CAM treatment

Painkillers and medication

- Half of GPs reported prescribing less medication and all reported that patients had indicated to them that they needed less
- 62% of patients reported suffering from less pain
- 55% reported using less painkillers following treatment
- The number of patients using medication reduced from 75% before treatment to 61% after treatment
- 44% of those taking medication before treatment had reduced their use afterwards

Health services and social benefits

- 24% of patients who used health services prior to treatment (ie primary and secondary care, accident and emergency) reported using the services less after treatment
- 65% of GPs reported seeing the patient less following the CAM referral
- Half of GPs said the scheme had reduced their workload and 17% reported a financial saving for their practice
- Half of GPs said their patients were using secondary care services less

Founder of Get Well UK, Boo Armstrong, says: 'The results from this project speak for themselves, with patients' health improving enormously. We need to secure investment for more integrated health projects across the UK to find out more about how these therapies can improve health and save money for the NHS. This work is perfectly aligned with the new vision of the NHS with quality and good patient outcomes at the heart.'

Michael Dixon, Chair of the NHS Alliance, says: 'The patient health improvements would not have been observed had CAM not been a feature of their treatment – a clear impetus for the NHS to back further schemes.'

Summit provides models for health reform

The recent Summit on Integrative Medicine and the Health of the Public at the Institute of Medicine (IOM) in Washington DC produced emerging strategies for addressing some of the major challenges inherent in health care – problems such as escalating costs and the rising incidence of chronic disease.

Sponsored by The Bravewell Collaborative, which works in partnership with The Prince's Foundation for Integrated Health, the summit gathered more than 600 distinguished scientists, leading clinicians, top policy experts and industry leaders to present research and explore how principles and best practices from integrative medicine could form the basis for effective health care reform.

Integrative medicine is an approach to health care that is ‘preventive, predictive and personalised’, said Ralph Snyderman, Chair of the Summit Planning Committee and Chancellor Emeritus Duke University. Harvey Fineberg, President of the IoM commented on ‘the burgeoning interest in the ideas and ideals of integrative medicine’.

The summit identified the following key points as crucial to meaningful change:

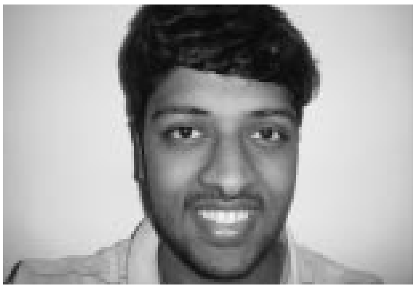
- **The progression of many chronic diseases can be reversed and sometimes even completely healed through lifestyle modifications.** The summit presented research demonstrating that lifestyle modification programmes have been proven to mitigate cardiac disease and several forms of cancer, among other chronic conditions.
- **Genetics is not destiny.** Recent research shows that gene expression can be turned on or off by nutritional choices, levels of social support, stress reduction activities such as meditation, and moderate exercise, thus reducing the potential for the onset of certain diseases.
- **Our environment influences our health.** Mounting evidence suggests that the environment outside one’s body rapidly becomes the environment inside the body.
- **Improving our primary and chronic disease care systems is paramount.** Summit participants widely agreed that our primary care system, including care for those with chronic illness, is in danger of collapse and must be retooled. The new system should focus on prevention and wellness, and put an empowered patient at the centre of care.
- **The reimbursement system must be changed.** The summit grappled with the current reimbursement system that rewards procedures rather than outcomes and urged payors to design and test new programmes.
- **Changes in education will fuel changes in practice.** Implementation of an integrated approach to health care requires changes in provider education. All health care practitioners should be educated in the importance of compassionate care that addresses the biopsychosocial dimensions of health.
- **Evidence-based medicine is the only acceptable standard.** Researchers and practitioners alike concurred that health care should be supported by evidence and urged further research and testing to expand the evidence base for integrative models of care.
- **A large demonstration project is needed.** Because funding for research on the effectiveness of specific models of care is difficult to obtain from standard grant channels, participants voiced support for a government-funded demonstration project that would fully demonstrate the effectiveness of the integrative approach to care.

Calling attention to the fact that the health care issues facing the United States are actually global issues facing the world, representatives from The Prince’s Foundation for Integrated Health added their voice to the call for reform. Dr Snyderman read a letter from The Prince of Wales to summit participants that urged both nations to support the creation of a health care system that places a greater emphasis on treating humans as whole beings – mind, body and spirit – and on prevention, as well as the cure, of illness and disease. UK attendees included Dame Carol Black, Chair of the Academy of Medical Royal Colleges, Sir Cyril Chantler, Chairman of The King’s Fund, David Brownlow, Chairman of The Prince’s Foundation for Integrated Health, and Foundation trustee Simon Fielding.

The Bravewell Collaborative provided scholarship funds for 10 of its Bravewell Fellows to attend. ‘By the end of the summit, it was clear that the science base is sufficient to justify the integration of mind-body-spirit approaches into conventional care, that the potential cost savings are enormous, and that the national need for new models of care that are about health rather than disease care is indisputable’, said Penny George, Co-Founder and Past President of The Bravewell Collaborative.

To learn more about the Bravewell Fellowship Program, visit www.bravewell.org. or http://www.fih.org.uk/what_we_do/bravewell_and_fih.html.

Student prize winner



This year’s winner of the David Cobbold student essay prize is Krisna Steedhar of Imperial College, London. David Cobbold, who died of cancer, was the brother-in-law of a BHMA trustee. His family gave £1000 to the BHMA to promote holism among students. An essay prize was felt the best way of honouring that. Unaware of this, in a postscript to his essay Krisna wrote: ‘Although I do not know who Mr Cobbold was or what he stood for, I am very grateful that he generously enabled this essay prize. During the course of writing, I have realised that I too am not exempt from the cynicism and loss of empathy catalysed by medical education. I entered medical school with noble intentions but somewhere along the line that resolve was eroded by exams and stress. Insight gained during the course of writing this essay has enabled me to recognise, and thus arrest this process. For this, Mr Cobbold, I am truly thankful.’

An abbreviated version of Krisna’s essay in on page 51. You can see the full version at www.bhma.org.

General practice – the future is integrated

Dr Michael Dixon

Medical Director, The Prince's Foundation for Integrated Health, Chair NHS Alliance

Working as a GP, my patients have increasingly persuaded me of the need to integrate orthodox and complementary approaches. My Devon practice includes therapists from massage and acupuncture to herbal medicine, healing and thought field therapy – a best practice example, if you like, of Lord Darzi's polyclinic plan. In my championing of frontline practitioners, primary care and integrative health, I believe patient involvement is critical.

The future looks good for the integrated GP and integrated general practice. Firstly, it represents a broader therapeutic approach which supports the increasing emphasis on patient choice. Secondly, the epidemic of long-term disease, often multiple, and our increasing elderly population will also require a new and more integrated method of treatment. Finally, the economic downturn will see a renewed focus on the holistic GP as the cost-efficient key to a sustainable health service.

In theory it might sound right, it always has, but GPs also now have the means through practice based commissioning (PBC) to make it happen. PBC's bottom line is cost-effectiveness and anything that improves an individual's personal health, their ability to self-care or prevents them requiring access to costly secondary care is likely to attract funding.

So much for the means and the theory – what exactly will this integrated future in general practice look like?

The future integrated GP as generalist

Most GPs will continue to spend most of their time as generalists looking after a registered list of patients. They are likely to offer integrated health and care on four levels:

- In the best tradition of general practice, the future integrated GP will provide a **'whole person approach'** towards diagnosis and treatment. Diagnosis will extend beyond the technical and the traditional biomedical to an interpretation of what it means within the context and perception of the individual patient. As a holistic practitioner, the integrated GP will be able to help patents prioritise and develop a positive approach towards improving their health. The integrated GP will also recognise the crucial importance of the therapeutic relationship between GP and patient.
- The future integrated GP will be able to discuss the widest range of safe and effective treatment options with their patients, which may include appropriate **complementary** approaches or other options such as exercise and nutrition. They will also provide patients with information and access to appropriately qualified and regulated practitioners. Many integrated GPs will also have some skills in complementary techniques themselves: for instance, basic skills in manipulation, acupuncture, or hypnotherapy and a limited range of herbal or dietary treatments and a basic knowledge of some mind/body techniques. This will create a growing demand for good primary care level (non-specialist) courses. In parallel GPs will need to develop a conceptual framework that describes which therapies can be successfully provided in this way and to what level without the need for higher or more specialist qualification.
- The future integrated GP will also be an expert in helping patients to **help themselves** improve their **personal health**. Practical help with self-treatment will include the provision of good information and advice and being able to direct patients to practitioners or programmes that can help them to manage their own condition. These might include general programmes such as the Expert Patient Programme, self-care support programmes for specific health problems or referral to practitioners in mind-body disciplines (such as autogenic retraining or bio-feedback) or counselling. Integrated GPs might develop their own repertoire of self-help therapies (such as creative visualisation of self-hypnosis) or may refer their patients to relevant literature or courses. Some integrated practices already provide self-help opportunities on site: yoga, Tai Chi, walking clubs or advice on healthy cooking and eating.
- Some integrated GPs may develop a fourth level of integration and take an active part in promoting the **health of their local community**. This might include innovative approaches to local health such as those currently being provided within healthy living centres or by green gym exercise schemes. Some integrated general practices could become catalysts for local community regeneration.

Integrated GP specialists

GPs who have done advanced trainings might offer complementary services beyond their own PCT, perhaps in multidisciplinary clinics (eg funded by their practice based commissioner) in musculoskeletal medicine, pain control or the treatment of menopausal symptoms. Such clinics would be audited for cost-effectiveness particularly in relation to reducing the use of secondary care.

The future integrated general practice

An emerging cadre of integrated GPs would catalyse the development of integrated general practice. However, the ethos for integration would have to be owned by all members of the practice team. Then integrated primary care teams will develop their services in a number of ways:

- The practice and its practitioners (doctors, nurses and allied professionals) will seek to provide information on the best treatment options (conventional or complementary) for various conditions, where safe and appropriate. This will include face to face consultations, written material and possibly video and practical demonstrations in the waiting room.
- Clinicians will also signpost patients to appropriately trained and regulated complementary therapies and practitioners, whether NHS or private. Some clinicians in the practice may develop complementary skills themselves.
- Practices will develop closer relationships with appropriate complementary practitioners either working outside the practice or within integrated general practice – offering an NHS or private service. This will allow a two-way communication between the general practice and complementary practitioners overcoming the current situation where 50% of patients do not tell their conventional practitioners that they are seeing a complementary therapist.
- Practices may want to develop an increasing range of self-help/personal health opportunities for their patients. These might include libraries/electronic access/self-help classes/health facilities in-house or badged health activities outside the practice in the community (eg in supermarkets or public libraries). Practice patient participation groups, local media and direct connections to local health initiatives such as exercise prescription schemes and farmers markets' will provide breadth and depth to an integrated practice's health role.
- An integrated practice intending to extend its integrated team might want to invest any underspends made, on the provision of more comprehensive services within the practice, or to facilitate longer holistic consultations with integrated care practitioners. Alternatively, they might fund contracts with complementary practitioners to provide particular modalities of care (such as acupuncture) within the local NHS or to treat patients with defined problems (such as back pain) according to an established multidisciplinary protocol. Such a treatment might be offered in-practice or sub-contracted to an outside provider of complementary therapy services.

GP practices working together

Increasingly, however, practices are going to work together both as co-commissioners in PBC collectives, and as co-providers developing a wider range of local services provided outside hospital. The current political emphasis on PBC (from both main political parties) and plans to devolve provider functions from PCTs will accelerate this process and bring practices together as a means of amplifying the potential of general practice (especially in its integrated form) and also as a means of financial survival.

General practices working together in this way are likely to:

- Develop integrated clinics within the locality for the use of patients of member practices in disease areas such as musculoskeletal problems, chronic pain, infertility, migraine, functional bowel disorders, obesity and a potentially wide range of other conditions.
- Further develop their health creation role in a given geographical population. Using local media and working with other agencies such as local authorities and retailers, practice collectives will become powerful catalysts for innovative integrated approaches to self-care and improving health in the community.
- Establishing a comprehensive information base between the practices, they will be able to establish population needs, provide relevant information and advice on self-help and treatment options and signpost patients to a choice of local accredited service providers.

Conclusion

If the question is 'How do we provide patients with a wide range of safe, appropriate and effective treatment choices' then the answer has to be by offering them an integrated service in general practice. PBC may prove to be a powerful means of supporting integration, while an economic downturn will demand the cost effectiveness that integrated general practice, at its best, can uniquely offer. That will require an increasing number of GPs and practices, who are providing integrated health and care to demonstrate through audits and applied research that they what they are offering patients is better and, ultimately cheaper too. If we can show this we will attract the interest of commissioners and patients alike.

Whether general practice takes this integrated direction will depend on whether we are all prepared to be committed leaders in bringing this about. Politicians, policy-makers and senior NHS managers will come and go; the only constants are us and our patients. If we care enough about integration then now is the time to speak, act and deliver.

Complementary medicine helps patients

Integrated healthcare needs higher education, regulation and research

On January 30th *The Times* published a letter from three leading research directors (and retired Pharmacology Professor David Colquhoun) who were crowing with delight at the closure of Salford University's complementary therapy courses. Triumphal chuckles emanating from ivory towers have a way of irritating practicing physicians, as the two pithy reposts from *The Times* (February 3 2009) reprinted here amply illustrate.

No doubt to the dismay of your correspondents (letter, Jan 30) complementary therapies are being used by about 60 per cent of my cancer patients. They are used by millions who suffer from long-term conditions for which, despite the efforts of scientists, there is no effective conventional treatment. Many knowledgeable and trained doctors use complementary therapies in their everyday treatment of patients where it is appropriate.

Those of us who are faced daily by real human suffering use the best evidence available to help our patients. At the same time, patients do their best to help themselves. The ill-thought-through arguments of those who are not doctors – and so have no experience of the practice of medicine – are ridiculous.

According to the Department of Health, about one in five adults uses complementary therapies. That means we need more education for practitioners, not less. And we certainly need better research, not the Stalinist repression that Professor Colquhoun and his colleagues demand.

Armchair physicians are welcome to their views, but clearly patients know better.

Professor Karol Sikora
Professor of Cancer Medicine,
Imperial College School of Medicine, Hammersmith Hospital

Whatever your beliefs about complementary medicine (CM), many patients choose to see CM practitioners and an increasing number of frontline clinicians are providing access to them. It is, therefore, important that those CM practitioners are as well educated, trained, safe and regulated as possible.

Nor are these academics being fair by lumping all CM therapies together. Some, such as acupuncture and manipulation, have been validated by august institutions such as NICE and the Cochrane Collaboration. Others are less evidence-based but often used in areas (such as chronic tiredness, musculoskeletal pain or frequent minor infections) where the evidence base and effectiveness of conventional therapies is poor and where making a choice between the conventional or complementary or doing both may be appropriate and safe.

By supporting CM regulation, the Government is trying to ensure that it is as safe as possible whenever and wherever practised. It is in no position to dictate which therapies are proven or disproven because conclusive evidence often does not exist.

That is partly owing to the lack of research funding for complementary medicine — the UK Clinical Research Collaboration funding for CM research (according to its own 2008 report) came to a grand total of 0 per cent! It is also partly because we have failed to do the right kind of research, which needs to compare the cost effectiveness of CM therapies to that of other treatments currently given for various conditions.

Meanwhile, most academics and universities thankfully are and should continue to be open minded on this issue and the Government should continue to put patient safety first.

Dr Michael Dixon
Medical Director, The Prince's Foundation for Integrated Health

The campaign against CAM – a reason to be proud

Harald Walach
Research Professor in Psychology, University of Northampton

Summary

Does the campaign against CAM indicate that powerful factions feel threatened? A complacent CAM world has been slow to collect supporting data, but the waning of big pharma's once unassailable economic and clinical dominance may be a significant motivator for some who oppose integration. With biotech innovation slowing down, and adverse event scandals and research irregularities, users are distrusting flagship revenue-producing medications. As healthcare policy reshapes mainstream medicine we will need to understand the forces ranged against integrated medicine.

I have been involved in research in homeopathy, spiritual healing, CAM and mindfulness for two decades and am currently a research professor in psychology with the University of Northampton. I am President of the International Society for Complementary Medicine Research (www.iscmr.org), course leader of the MSc Transpersonal Psychology at the University of Northampton, editor of Research in Complementary Medicine/Forschende Komplementärmedizin (www.karger.com/fok) and Spirituality and Health International.

It should be obvious to everyone: for at least a few years now, there has been a concerted on-going campaign against complementary and alternative medicine (CAM). At first, it all seemed pretty innocuous: a meta-analysis published in *The Lancet*, claiming homeopathy was no better than placebo.[1] It was heavily criticised on methodological grounds,[2-4] and it contradicted *The Lancet*'s own tough criteria for publishing meta-analyses, but nevertheless, the editor of *The Lancet* proclaimed 'the end of homeopathy'. Then there was a letter (written without its consent on NHS-headed notepaper) calling on the NHS to cease offering CAM interventions such as homeopathy, as they are not 'evidence based'. Articles in the print media and elsewhere began to appear, stating that the NHS should only use evidence based interventions that are scientifically vindicated and that CAM, not being evidence based, should not be publicly supported. The homeopathic hospitals also came under pressure. And following enquiries based on the Freedom of Information Act, made to universities offering CAM courses, an article appeared first in Nature[5], then in the Times Higher Educational Supplement, demanding that those courses should not be taught in UK higher education institutions because CAM is not based on science. In addition, there have been requests for NICE to launch investigations into homeopathy/CAM. And on it goes.

Although homeopathy normally is at its centre, the campaign also extends to other branches of CAM: phytotherapy, osteopathy, acupuncture, spiritual healing and so on. So I think it is useful to stand back and observe what is going on here, and ponder the possible reasons for this backlash, as well as the way forward. I will do this in a series of steps. First, I will argue that part of the problem has to do with a certain complacency in the CAM community itself, and its fondness for being a cuddly counter-culture. But on its own, this is not sufficient explanation. Another reason is that this CAM counter-culture has established itself as an economic force. For CAM has grown stronger than its proponents realise: big enough in fact to have become a threat to the mainstream revenues of big pharma. It is hardly understandable why anyone should bother to campaign against CAM, unless what is happening behind the scenes is in fact not only a scientific debate, but represents a cultural, political, economic and paradigmatic struggle too. Let me point out several features of this process as I see it, and indicate some ways out of this polarised predicament.

CAM as counter-culture

Many doctors who turn to one or other CAM modality are dissatisfied with the restricted view offered by current medical training and paradigmatic understanding[6], which is based on a refined version of biological-mechanical engineering. The mainstream narrative runs like this. The body is a complex machine that functions according to mechanistic laws. We have not understood all of them, but we are on track to understanding them eventually. Meanwhile, we already have a pretty good understanding and are using this knowledge to hone our interventions, eg ever more finely crafted pharmaceutical agents that can target specific receptors and processes that have been identified to play a causal or at least important role in a particular disease process.

Take depression as an example. Biological psychiatry sees it as being due to compromised serotonin transmission; mainly too little serotonergic activity. So, using a little post-modern magic, it sets out to enhance this activity through selective serotonin re-uptake inhibitors (SSRIs). SSRIs exemplify the promise of the future: targeted drugs, developed on the basis of a causal biological theory, and manufactured to a scientifically rigorous standard. So, these drugs are developed, tested in blinded, randomised, placebo controlled studies of sufficient power, and marketed as the way to wipe depression off the planet; at least for those who can afford to buy them. And let us not forget the other side of the equation: those who produce SSRIs and similar drugs make huge profits because, since interventions for long-term conditions are very rarely designed to cure a disease once and for all, they normally have to be taken for a long time, sometimes lifelong. Hence big pharma is very big business indeed. Now, enter another interesting element: while other sectors of the economy thrive mainly on private consumption, pharmaceutical net earnings are largely from public sector money.

CAM doctors and practitioners are people who out of instinct or insight are not satisfied with this mainstream narrative. They feel that human disease is more complex than the breakdown of a complex engine and that human suffering needs a different answer to Prozac.[7,8] Hence, they have shifted to what they see as ‘holistic paradigms’. For example, homeopaths claim that all of a patient’s symptoms have to be taken into account: acupuncturists and practitioners of traditional Chinese medicine purport to correct imbalances in a patient’s system by regulating some mysterious life-force called Chi, which circulates in even more mysterious channels called meridians. In the case of homeopathy, the medications used generally contain no pharmaceutically active agents; in the second, treatment entails needles being stuck into those purported meridians, and taking herbs prescribed according to a diagnostic scheme that to the outsider seems as adventurous and unintelligible as the map to the treasure on Treasure Island. Other therapists have moved on to even more esoteric things: directing Ki, the Japanese little brother of the Chinese Chi, with their hands and thoughts; or tinkering with some deep-seated cell memories by manipulating, so they say, the matrix that holds all life and cells together; or touching and directing gently the pulses of the cerebrospinal fluid, having once learned to palpate its infinitely tiny undulations. Still others claim to talk directly to those in heaven responsible for the mess in a patient’s body and to tell them to stop their messing around, and to call in the invisible sweeping brigades to clear out the spiritual litter. The diversity of approaches is as numerous as milestones on the roads through the Roman Empire, yet the theories behind them seem as unrelated as a Pictish warrior would be to a Numidian slave. Arguably, the only common ground between all these CAM approaches is the complexity of their models, their talk of flowing life-forces, and their relative irreconcilability with the mainstream narrative. So together, they form a counter culture to the mainstream narrative.

One could go to great lengths trying to understand why CAM narratives have gained such momentum at the end of the second millennium. One element of any explanation would have to include the fact that the mainstream narrative is defective, especially in chronic diseases.[9,10] Many patients do not experience the benefits promised by biomedicine. Many medications do not work for a lot of people, and in those for whom they do work, deeply unpleasant side effects are the price paid.[11] Often treatments are short-term, getting rid of one problem only to produce another one in its wake. Patients are not stupid. They often realise these problems sooner than doctors too enamoured of their own theories to see the situation as it is. But even the push given by these obvious deficiencies in the mainstream system and its narratives are not enough to explain the rise of CAM. There are also many pull factors. Patients have adopted a more holistic view of the world themselves, incorporating spirituality, ecology, body-mind connections and so on, and are seeking treatments that respect, reflect and ideally work with such a background model.[12] In such a situation, it is easy to create a veritable counter culture. It is then ‘them’, the stupid, reductionists of the mainstream culture, against ‘us’, the truly enlightened, insightful, holistic, patient-centred ‘complex systems’ therapists. It is easy, in such a culture, to start believing one’s own ideas, to deposit one’s critical mind with the receptionist and bask in patients’ gratefulness. Are they not all benefiting from our treatments? We don’t really need data to prove this, do we? Everyone can see it. Have we not cured so many difficult diseases that have been unsuccessfully treated by the best mainstream specialists in the fields? And sure enough the word goes around; cured patients tell their neighbours, friends, aunties and parents, and by sheer word of mouth, the clinics are full. What more proof do we want? Patients are voting with their feet. The stamping can be heard in the psychiatrist’s office next door, who is wondering why the patient he put on Prozac the other week is now walking out of the homeopath’s office, throwing him a slightly irritated and superior smile. The counter-culture created by CAM doctors and practitioners has been very successful. It has grown, patients like it, and it has even started to produce some research output. But for the most part, CAM has been comparatively complacent. From my own perspective as a researcher, critical reasoning, systematic data collection and documentation, and planning of studies are strengths not uniformly possessed by all in the CAM field. Partly, this is due to the fact that the academic infrastructure which supports such work is largely lacking. Also, there is no immediate gain to be had from such work. And, it has to be said, there is a very subtle, narcissistic haughtiness: 'We are so much better than those mainstream guys. We do not need research: they do. Why should we bother, please, can anyone tell us? Let them come and ask us about our secret!'

The gaps in the CAM database and in the mainstream narrative

On a scientific gut-level type of evidence, CAM is quite successful in open, uncontrolled, general practice. [11,13-18] We do not have many studies, but those which we have demonstrate that roughly 60–70% of all patients visiting CAM doctors say they feel significantly improved after roughly three months. Rarely do we know how that would compare to conventional practice, but the real-world comparative studies which we do have show that some CAM practice is just as good as conventional practice, sometimes better, and often cheaper. There are many studies I would love to see done, which could provide very good gut-level evidence for CAM, which have not been done so far:

- long-term, real-world comparative studies, looking into the follow-up costs and proneness to deteriorations and chronicity in patients treated by diverse CAM modalities and conventional practice
- pragmatic randomised studies in cost-intensive chronic diseases comparing CAM care with conventional care
- longitudinal studies of children and other patients who follow a minimal intervention strategy, sound dietary advice and healthy living, compared with the standard conventional interventionist, could-not-be-bothered and doesn't-really-matter attitude of (bad) GP practice.

No such trials are underway. If they were, it is likely they would have provided the data we now don't have, and which now makes CAM vulnerable to attack.

The gut-level real-world effectiveness of CAM has an older brother: the real-world unsuitability of some major gunships of conventional pharmaceutical wisdom. Although most pharmaceutical interventions have gone through rigorous RCTs and survived (otherwise they would not be on the market), many don't stand the test of time or of real life: patients don't like them because of their side effects; doctors don't like them because they are unpredictable in their efficacy for individual patients; the public purse does not like them because their efficacy is too small compared to their costs (and the danger of the side effects). The latter has been the reason why NICE refused to take any of the newly-developed anti-dementia drugs on to the books for public reimbursement. For examples of the first two reasons let's again look at the classic case: SSRIs. It was with an unprecedented public advertising campaign that SSRIs were hailed as happy pills, the wonder drugs that would wipe out depression and sadness. The perception, even of the educated public, was that at least one problem could now be fixed. But when we look at more recent literature, we find two striking counter-examples. Two meta-analyses, conducted independently but on roughly similar material and with the same intention, have shown that the effects of SSRIs were grossly overstated. [19,20] Not overestimated; overstated. Both meta-analyses had used material that had to be submitted for regulatory purposes to the FDA, but had otherwise been unpublished. Both found that the public image presented by the published data was comparatively favourable, an effect size of roughly $d = 0.7 – 0.9$ of a standard deviation vis-à-vis placebo (such an effect size is a dimensionless measure of a difference between the treated groups and the control groups, in this case of placebo controls, standardised by the common standard deviation: this is why one can express the difference as a proportion of a standard deviation). However, both meta-analyses found that this effect size dropped to $d = 0.3$ standard deviations, once all unpublished studies were taken into account, because of course in the majority of cases the unpublished studies were negative. To put this figure into perspective; NICE has stipulated that in the case of depression an effect worth paying for out of public funds is $d = 0.5$, half a standard deviation. We have conducted a meta-analysis on the effects of mindfulness meditation in health conditions. [21] Control groups in those studies were mostly weak, such as waiting list controls, and we have found a robust effect size of $d = 0.53$. Our distant healing study, where patients with chronic fatigue syndrome received distant healing or had to wait, was also about $d = 0.3$ in effect size between those who received healing and those who had to wait.[22] A third of a standard deviation is really a small effect. It might be important, if the disease is very difficult to treat, or the intervention comparatively cheap. But it is surely too small an effect to be advertised widely as a breakthrough.

The second of the two SSRI meta-analyses made an even more disconcerting point: most of the effects of anti-depressants really are due to the placebo effect, ie the perception and hope of the patient to have received good treatment. Arguably, this is also a major vehicle for therapeutic effects in CAM[23], and my view would be that the best therapist is the one who can produce the strongest placebo effect with the least effort and side effects: for one definition of a placebo effect really is a self-healing response.

So, the emperor really has no clothes, it seems. SSRIs have been denuded of their mythical status. One might now say: well surely this awkward situation with the placebo effect only applies in clinical trials. So to settle the question of what happens in real world practice, the biggest outcome study in psychiatric history was launched, called the STAR*D trial .[24] It was a complex, non-blinded, non-randomised outcome study that sought to reflect normal practice in a large number of outpatient clinics in the US. The treatment protocol started with a simple SSRI, followed up those patients who did not benefit from it with a more complex, or perhaps a mix of two SSRIs, or an SSRI and an another type of anti-depressant, then moved on stepwise moving from simple and less invasive drugs to more recent and more complicated ones, four steps in all. The results of this very complex and long-winded study can briefly be summarised. After step one 33% experienced a sustained recovery, 33% later relapsed, and 16% of all patients had intolerable side effects. After each further step, the recovery rate became poorer, and the side effects worse. Overall, it was possible to gain a sustained recovery in 43% of all patients, and after the first step, the succeeding three steps taken together could only produce an incremental sustained recovery rate of 6%. Thus, in real life, less than 50% of all depressed patients seeing a psychiatrist will experience a sustained recovery with any one of the modern anti-depressant drugs. (One editor has taken this result as a proof that the current paradigm of biological psychiatry and pharmacological treatment of depression is just plain wrong [25]). At the end of the research paper there is a lengthy (more than one page of small print) conflict of interest statement which I use in my lectures to sensitise students to the problem of financial stakes that the pharmaceutical industry holds in the steering of research, in the forging of paradigms, and in the maintenance of the status quo.

Evidence and the efficacy paradox

So it seems the mainstream narrative is not all that clean, sober or convincing. Yet trusted evidence for efficacy can be shown for all of those medications. In that sense, they are 'evidence based'. But what do we really mean by 'evidence'? Is it a question of whether something is better than placebo in a highly artificial, experimental setting? Or is it a question of whether an intervention is useful, accepted and effective long term in real-life conditions without producing too many side effects? If scrutinised properly, the term 'evidence based' is a battle cry that can mean quite different things to each of the warring sides. Let us make this clear with an example. I have pointed to a paradox, which I call the efficacy paradox .[26,27] This arises, because we normally view efficacy only in terms of a difference between a treatment and a control; normally placebo. If this difference is large enough, in relation to the sample size of a study, we call it significant and say the treatment is efficacious. If it is too small, we say the treatment is not efficacious. At no point in the equation do we consider the absolute effect of a treatment. This, however, is the only effect that matters to a patient. If a patient is seeing a doctor, he or she wants to know what the chances are that whatever the doctor decides to do – giving a pill, praying, putting on leeches, sticking in needles, dropping some sugar globules free from active molecules and a lot of purported information in her bag, sticking magnetic coils into her shoes – her symptoms are going to subside. Now we have an obvious paradox in the situation where a treatment appears very effective overall but a clinical trial shows these outcomes differ very little from those of patients in a control group given a placebo treatment. Perhaps this is because the non-specific effects of the treatment are large, but the specific effects are very small. By virtue of our current definition of efficacy we would have to call this treatment ineffective. The paradox is that another treatment, though it might have much less overall effectiveness, (and hence the patient's chances of seeing the symptoms vanish are less) might be called efficacious because there is a significant difference when compared with placebo.

Clearly, something is wrong here. The paradox arises because the pharmacological paradigm is only interested in differences, and makes the wrong assumption that the placebo effect is always a stable entity, like the Arch-meter buried in the vaults of Paris, which will always read one meter. But on the contrary, the placebo effect is highly variable, and dependent on context, patients, practitioners and so on. Hence the conventional efficacy paradigm is really measuring with a measuring rod that is shrinking and expanding as we measure. Hence what we call efficacy really is only one aspect of efficacy, namely efficacy against placebo. It is interesting for regulators, because it tells them whether there is anything specific in a new intervention that is worth considering at all, given that side effects have to be taken into account. But real-world effectiveness is the whole bar, all the effects, non-specific ones included. This is all the main consideration for patients; plus the side-effects, plus the costs, plus the longevity of therapeutic effects.

Until recently this efficacy paradox was just a nice thought to play around with. But for a couple of years now, we know it is real. The large German acupuncture studies have all been three-armed. [28-30] They tested

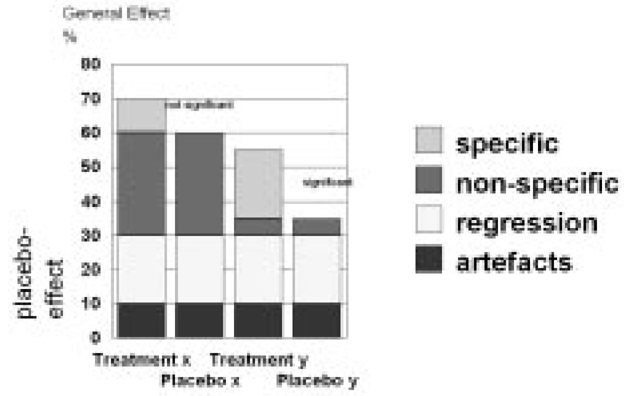


Figure 1 – Illustration of Efficacy Paradox: Treatment X is supposed to be not statistically superior to its control, Placebo X, hence deemed 'ineffective', although the overall effectiveness is higher, while Treatment Y is said to be statistically superior to its Placebo Y and hence effective. The paradox arises, because the variability of the size of non-specific effects is not taken into account.

acupuncture versus sham acupuncture (a minimal kind of acupuncture that inserts needles superficially in points agreed by specialists to be non-therapeutic), versus the best that conventional therapy could offer. The trials considered migraine prevention, osteoarthritis of the knee, and chronic low back pain. While acupuncture outcomes were not significantly different from placebo acupuncture, in two of the studies both acupuncture and sham acupuncture were nearly twice as effective as conventional treatment, with a large effect size and high statistical significance. The conventional treatment offered here was best evidence based, according to guidelines, and delivered to a high standard by well-trained doctors. It was not delivered as a hopefully weaker control, for the expectation originally was that it represented the standard and that acupuncture would be lucky to measure up to it. As it happened acupuncture, but also sham acupuncture, were not only statistically but also clinically more effective than conventional, guideline-supported, best evidence based treatment.

What are we to make of this? Abandon conventional back pain treatment, which in this case consisted of a mix of painkillers, mobilisation, physiotherapy, back training and patient education? Should we just advise doctors to stick needles into patients anywhere, just not too deep, tell patients this is the most recent Chinese gimmick and that it will cure them, let them rest for 20 minutes while the next 10 patients are getting their needles put in, and that's it? Probably not. But these German acupuncture studies tell us three things: (i) on what swampy and treacherous ground we tread when we use the word 'evidence'; (ii) how surprisingly strong CAM treatments, even apparently silly ones, can prove to be once studied; (iii) how badly the deck is really shuffled and biased in favour of the all too powerful conventional crowd.

Conclusion: Be proud, not afraid, fight back and don't duck.

Now let us pull the arguments and facts together. Fact 1: We have a mounting campaign against CAM treatments. The battle is said to be between 'evidence based' treatments versus 'non-evidence based' treatments. Fact 2: (though CAM has not done its homework and collected strong enough data to make the point) CAM might be quite useful in real life, even though its specific effects might not be strong enough to show specific in an RCT. By its very nature CAM produces quite strong non-specific effects; in fact to a degree that in some comparative trials its results can dwarf the best of what conventional evidence based treatments have to offer. But then we run into problem number one: there is hardly any data to prove this, and problem number two: such data are not easy and cheap to come by. They need considerable study, skill and money. For example, the German acupuncture trials cost roughly 10 million Euros. Fact 3: that some recent flagship medications and projected frontrunners in the income generation machinery of big pharma have recently come under severe attack. SSRIs are much less effective than stated; actually less effective than NICE demands, and quite costly in terms of side effects. Anti-dementia drugs have cost billions to develop, and given nothing in return, as NICE has slashed them. And then there is Fact 4: big pharma is reeling from a series of extremely expensive side-effect scandals, starting with hormone replacement therapy, and ending with COX2 inhibitors.

So I have come to the conclusion that big pharma is scared, and I would argue that the current witch hunt to weed out allegedly non-evidence based practices is the consequence of twin developments. On the one hand the favour CAM has found with the public, and on the other the increasing pressure that the pharmaceutical companies have come under. So big pharma is doing the only sensible thing it can by attacking where it knows its enemy is weakest: for its lack of data. I think a second conclusion is inescapable: that CAM as a movement and as a culture should be proud and ashamed at the same time. Proud, because little David has got big Goliath scared. But at the same time ashamed that we have lost so much valuable time through complacency and narcissistic self-indulgence.

> I have come to the conclusion that big pharma is scared.

I have a suspicion that whoever rides into battle for big pharma does so because they are well protected and well paid. Like the mercenary Lombard Riders of fifteenth century Europe big pharma's troops are feared because they are well trained and well equipped. These mercenaries generally decided the battles, but they were also quick to swap sides if pay was lacking or their side's luck turned. The most dangerous moment for a fencer (according to my daughter who is a fencer, and told me this recently) is the attack, because it is then that they have to drop their guard, and so this is when the counter-attack happens. I would argue that we should start striking back now for the attack has opened an avenue for counter-attack. So have we asked the pertinent questions about conflicts of interest in research; have we investigated where the money is coming from that supports the anti-CAM campaigners; have we found out enough about the funding structures that keep those groups afloat, and the dinners and cocktail parties where promises and nice ideas are exchanged?

It is time for a counter-campaign; for some critical analysis, some investigative journalism, some discourse and social analysis to uncover the background that supports the campaign against CAM. I also suggest we start collecting the sort of data whose absence allowed the campaign to begin in the first place: data about CAM's real world outcomes and effectiveness. And I think it would be wise to demonstrate to our colleagues struggling with the realities of conventional medical practice just how short-sighted and silly the current concept of evidence really is, since it is only modelled along the lines of pharmacological research. I am quite sure they will listen. After all, they have roughly the same problems as we do.[31] Only those who live in ivory towers and feed on the food lifted up to them in baskets, who do not have to care for patients and don't have to solve practical problems, can indulge in abstract debates about evidence, while the rest of their colleagues have to actually deal with people who are suffering, solve clinical problems and avert human disaster. This is the territory where we can meet, and where practical, sober, sound data collected in the real world will begin to speak clearly.

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High costs, large disease burden

Complementary medicine to the rescue

Jonathan Lord, MD.
CEO Navigenics, former CEO Humana EU

I have been on a personal journey to transform healthcare to a system that honours personal sovereignty, values and preferences. I began my career as a forensic pathologist. Confronted by medical errors, I became active in the introduction of continuous quality improvement, efforts to improve patient safety, and shared decision-making. In an era of diversity, I have been working to create a fair, non-judgmental and respectful approach to patient care.

Summary

One of today's greatest health challenges is the rising burden of disease and the associated costs. There are good arguments – financial and health-based – for using more CAM to help people be healthier.

I have a friend in New York who is a practitioner of Body Talk, a healing system based on the idea of enhancing the communications networks of the body. Before I met her face to face, I met her virtually on Facebook, due to our common interest in creating health. She believes Body Talk could play an important role in improving population health. While I am not an advocate for any particular approach, I agree that complementary and alternative medicine certainly has a role to play.

So my friend convinced me to give Body Talk a try. Our bodies, she explained, know how to take care of themselves, but the stresses of life throw them off. 'What Body Talk does is get all the parts working together as a team', she said, 'so you begin to function as one whole person instead of many different parts'. Body Talk practitioners use touch and a gentle tapping technique on the head 'to capture the brain's attention', as my friend puts it. The theory is that the combination of touch and tapping gets the communication going again between parts that have not been talking, enabling 'the innate wisdom of the body' to take over and 'do its own natural thing'.

'It's almost impossible to get your logical mind around it', she says.

I'll say. But as science itself is showing us, healing isn't always about what's logical or what's provable through randomised trials.

My Body Talk friend hasn't been to medical school, yet the medical field could learn a thing or two from her and practitioners of other types of complementary and alternative medicine. They know about personalising their treatments, taking time with their patients, building relationships, tapping into emotions and spiritual beliefs, and other ingredients of healing that doctors often miss.

> ‘…healing isn't always about what's logical or provable…’

Their various approaches are a reminder that the world is a diverse place, and that people look for healing and experience it in different ways. Some people get a pain and run for an MRI. Others go to Body Talk or a good masseuse or drink supplements and herbal potions. It's long been accepted that when patients believe they will receive benefits from a treatment, the chances are greater that they will. And it's also true that these people who take care of themselves in ways that are outside of Western medical traditions are a generally healthy group.

Today, every health system in the world is dealing with the same set of challenges: costs that are increasing at a higher rate than inflation, and the rising burden of chronic disease.

In the US, for example, the Center for Disease Control reports that an astonishing 70% of all medical expenses are for preventable illnesses and conditions. Demographics tell the story: people living in societies of abundance like ours are becoming older, sicker and fatter every year.

How do we reverse this trend? The biggest opportunity lies in helping people adopt healthy behaviours. That is something complementary medicine seems to be doing pretty well. Health systems ought to take advantage of that.

Help people be healthier. Help them need the medical system less. Help them understand that health is a result of all the little things they do every day – all the little choices they make about what and how much they eat, and how much activity they get – not something that generally happens randomly. And when they get sick, help them learn to be expert patients instead of passive subjects waiting to be fixed. Educate them and put them in charge of their own care.

> ‘One of the great ironies of modern healthcare systems is that the incentives are exactly backwards. They reward people for poor health behaviours by paying the bills for their illnesses. Meanwhile, they pay almost no expenses for people who are devoted to their health but have chosen an alternate route.’

And yet one of the great ironies of modern healthcare systems is that the incentives are exactly backwards. They reward people for poor health behaviours by paying the bills for their illnesses. Meanwhile, they pay almost no expenses for people who are devoted to their health but have chosen an alternate route.

So in this year when healthcare reform is the hot topic, especially in the US but also in other places where costs and the illness burden are out of control, here are two questions that should be asked. Would more people be healthy if more complementary and alternative approaches to care were covered by insurers and health systems? Would that help more people manage their health? Logic would say the answer to both of those questions is yes.

In fact, it’s amazing to me that health systems do not encourage the expansion of this group of people who don’t rush to see a doctor when they feel punk, don’t look for the most expensive treatments, drugs and technologies, and, in fact, are taking pretty good care of themselves. But despite some enviable health outcomes, practitioners of complementary and alternative medicine and their patients remain on the outside.

> ‘…the overwhelming need today is to find ways to engage people in their own health…’

The reason that is commonly given for their exclusion is that complementary medicine is not evidence based. But that’s at least a little hypocritical. As a team at Dartmouth College has been showing in a research project that has been ongoing for 20 years, there’s no evidence that traditional healthcare systems are systematically delivering evidence based care, either.

The Dartmouth Atlas of Health Care lays out the great variation in medical treatment patterns around the US – patterns that show that the treatment any sick person gets has more to do with where that person lives and discretionary decisions by physicians than with any evidence based standard for outcomes. CAM is hardly alone in operating outside of the strict boundaries of science.

It’s also important to remember that being in favour of the expansion of complementary medicine does not mean being opposed to traditional Western biological medicine. Most of us, when we become seriously ill, want all the white-coated experts, prescription drugs and technology modern medicine can assemble.

But the overwhelming need today is to find ways to engage people in their own health and lessen the burden of progressive, preventable chronic disease. In our healthcare system, doctors are simply too busy and in too much of a hurry to serve as coaches, educators, motivators and collaborators. CAM practitioners, on the other hand, exist to play that role – and without the office overhead and salary expectations doctors have. That makes it easier for them to choose to operate in a slower, more personal way.

My friend the Body Talk practitioner speaks, relates to her patients and uses the language of healing in a different way than mainstream medical professionals do. That’s because she’s not a medical professional – she’s an artist – a dancer. In fact, the way she found her way to Body Talk and complementary medicine was in a quest to teach her body to jump higher.

Now she’s very passionate about health and is very good at leading others to it. What she has to offer isn’t what everyone is looking for, but different kinds of people will need different paths to health.

Our health systems ought to rethink the way they exclude resources like my Body Talk friend. Instead, they should be helping practitioners of complementary medicine engage in their important work.

Challenges in interpreting and applying the evidence for CAM and IM

Catherine Zollman
GP
Hugh MacPherson
Senior Research Fellow, University of York

My interest in complementary and integrative approaches began as a medical student when I attended one of the first ever BHMA conferences in Oxford. Since then I have been fascinated by the challenge of combining the art and science of medicine and have tried to develop holistic strategies for facilitating patient recovery and wellbeing as part of my conventional general practice work. I am also very interested in how we can apply scientific rigour to expand our understanding of healing and healthcare, in a way which embraces patients' individuality.
Catherine Zollman

I trained in acupuncture and Chinese herbal medicine in the early 1980s and continue to practice in York. I founded the Northern College of Acupuncture and steered it towards the first acupuncture degree course in the UK. I also set up the Foundation for Research into Traditional Chinese Medicine and then joined the Department of Health Sciences, University of York. My research interests are varied, and include evaluating the safety and effectiveness of acupuncture, as well as neuro-imaging to explore the underlying mechanisms of acupuncture's action. I am co-ordinator of the STRICTA initiative – an international group of experts aiming to improve standards of reporting of clinical trials of acupuncture.
Hugh MacPherson

Summary

This paper explores the reasons why evidence based medicine has only a limited role in informing real world practice. We set out why this appears to be an issue particularly for complementary, alternative and integrated medical practice. We also address the need for a research agenda that focuses on developing evidence that is relevant to the field. This will include research beyond placebo-controlled trials and that will incorporate characteristics of a patient-centred medicine.

Introduction

The systematic development of knowledge about the benefits and risks of healthcare interventions has advantages for all stakeholders in health: patients, practitioners, providers, commissioners, funders and society at large. This applies across the span of healthcare modalities, including the fields of complementary and alternative medicine (CAM) and integrated medicine (IM). These approaches to healthcare, which have developed a large public following despite being relatively poorly researched, have attracted a lot of controversy and polarisation of opinion about efficacy and risks.[1] However, CAM and IM may be of economic importance if they can improve our management of chronic disease which currently consumes about 78% of health expenditure.[2]

In many spheres there is an assumption that if we apply the tools and methodology of evidence based medicine (EBM) as defined below[3] to CAM and IM, we will be able to identify what works and what doesn't. While this approach is well intentioned in moving us towards more rational choices and more equitable provision of healthcare, it is not without its limitations. The primary problem, for caregivers and receivers, is that, even in an area where research has been undertaken, the available evidence base provides us with data that are very difficult to apply in practice with real individual patients. This difficulty is not unique to CAM or IM interventions.

It is the aim of this paper to explore the reasons why evidence based medicine has, so far, had only a limited role in informing real world practice (and particularly real world CAM and IM practice) and to set out how a more relevant evidence base for CAM and IM interventions might be developed. It will do this firstly by examining the strengths and limitations of EBM as originally envisaged and as currently used, and then by illustrating the limitations of this approach when applied a) to CAM and IM interventions as commonly practised, b) to the patients who might benefit most from these interventions, c) to the types of patient response that CAM interventions might facilitate and d) to the synergistic interaction between the first three factors that occurs in routine care when real patients and clinicians map out a management plan for an individual patient.

The strengths and limitations of evidence based medicine in informing clinical practice

Evidence based medicine has been defined as:

> *'The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice.'* [3]

The importance of the patient in this approach has been stressed. 'Evidence based medicine… requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients' choice, it cannot result in slavish, cookbook approaches to individual patient care.' [3] Therefore the application of evidence based medicine is based on the triad of research evidence, clinical judgement and the care of individual patients. The problem that has arisen, however, is that research evidence, and one type of research evidence (the randomised controlled trial) in particular, has been seen as the main driver for evidence based medicine and consequently clinical judgment and patient choice have often become subsidiary in the development of clinical guidelines.

EBM aims to minimise bias of all types in the process of evaluating the efficacy and effectiveness of therapeutic interventions. This is a laudable aim though, in practice, it is hard to do without oversimplifying the research questions. From the user's point of view, the ideal research output is a clear yes or no answer to the question of whether a given intervention works better than another option. Clinical judgement and patient choice can be subject to many forms of bias and so the form of research that gives the least biased and clearest yes/no type answers is the RCT. RCTs work on the premise that the study population is homogeneous, ie similar in all relevant aspects except whether they receive the particular intervention being tested or not. Thus any changes seen between the groups at the end of the study will be entirely attributable to the effect of this one aspect (ie receives treatment X or does not receive treatment X). By defining strict inclusion criteria to a trial, researchers aim to exclude any patients in whom the results might be attributable to something else. For example, patients are often excluded if they are on other medication, if their diagnosis and therefore the natural history is in doubt, if they have other complex problems, and if they might use some other form of treatment or self-help during the course of the trial. Recognising that patients are not all the same, RCTs attempt to ensure the two groups (treatment and control) are not systematically different in any major way by allocating patients randomly to their groups. Ideally, the two groups will be similar at baseline. 'Blinding', which means keeping patients unaware of which treatment they are receiving, is highly desirable for answering some research questions, especially those where patient preference and expectation factors, which can be a source of bias, are to be minimised. If there are a lot of important variables, particularly if these have not all been identified and so cannot be baseline checked, trials with large numbers of patients help to increase the chances of obtaining similar groups at baseline. Large numbers also help increase the power of a trial to detect small but important clinical effects.

If individual RCTs are insufficiently powered, the practice of increasing their overall power by combining their results in a systematic review or a meta-analysis is widely used. To avoid retrospective bias (ie collecting several types of data and, once they have been analysed, selecting only those outcome measures which show the desired effect) RCTs require a pre-defined 'primary outcome measure' by which the success or otherwise of the treatment will be decided. As a result of all these measures, the results of well-conducted RCTs are highly rigorous, likely to be free from most kinds of bias and unlikely to give spurious results. However the very measures which make the results so reliable (internally valid), also constrain the research questions and often demand a certain abstraction from reality to make the intervention and the patient population fit the research model. The more complex an intervention, the more heterogeneous the patient population, the more different types of practitioner and practice of that intervention there are in reality and the more that all these factors are interrelated and interdependent, the more abstracted from reality the research questions (and therefore the answers) will be.

Despite the huge amount of EBM-related research activity in the NHS over the last 15 years, one of the more extraordinary facts to emerge recently is that 46% of commonly-used clinical interventions are based on 'no known evidence', which compares unfavourably with the relatively small 13% that have 'known effectiveness'.[4]

This demonstrates the presence of a significant 'evidence gap' which becomes apparent when clinicians try to apply EBM to real-world clinical work. The available evidence simply does not address the common questions concerning patients, conditions and treatments seen in practice. This evidence gap is also large when it comes to trying to take research-based decisions about the appropriateness of CAM and IM approaches for individual patients.

> The more complex an intervention, the more heterogeneous the patient population, the more different types of practitioner and practice of that intervention there are in reality and the more that all these factors are interrelated and interdependent, the more abstracted from reality the research questions (and therefore the answers) will be.

One of the reasons is that evidence-based medicine deals best in certainties and is well-suited to reductionist models of illness (such as germ theory) where there is a single causative agent for each disease and where one therapeutic strategy is likely to help all patients with that illness. Much clinical practice involves more complex situations, where the matching of treatment to patients is more subtle. Twenty-first century science, which now embraces the complexities of genomics and systems biology, helps us understand the basis of individual variation in illness causation and therefore demands a more holistic or systems-based model of illness than EBM can easily cope with.

Applicability of RCT evidence is limited by complexity of CAM interventions

The overall evidence for the reliable, reproducible effectiveness of most CAM interventions is weak or absent, though isolated pockets of strong evidence are slowly emerging. For example, in the case of acupuncture for chronic pain, recent systematic reviews with pooled data from meta-analyses are showing a clear effect for acupuncture for osteoarthritis of the knee.[5,6] In general the simpler the intervention (eg a fixed combination of acupuncture points to use in each patient or a single herbal remedy – like Saw Palmetto or turmeric) the easier it is to use an EBM approach and to get consistent results.

Interventions which are more complex (like a tailored and response-adjusted homeopathic or traditional Chinese medical treatment) or which require patient participation (like effecting dietary change, teaching Alexander Technique or using personalised creative visualisation) are much harder to evaluate with RCTs (especially if both blinding and concordance are required). Many CAM and IM interventions in practice are multi-modal and may include elements of psychotherapeutic counselling, motivational interviewing, stress management and dietary advice as well as the 'main' intervention. The choice of which of these to offer, and to what extent, will be determined by individual patient and practitioner factors. In an RCT of such an intervention it can prove problematic to ensure that each patient in the active treatment group of gets an 'equivalent' intervention. Because the very heterogeneity of patients is what often determines their CAM/IM treatments in practice, it is difficult to then consider patients as homogeneous for the purposes of the study.

Twenty-first century science, which now embraces the complexities of genomics and systems biology, helps us understand the basis of individual variation in illness causation and therefore demands a more holistic or systems-based model of illness than EBM can easily cope with.

Many CAM and IM practitioners stress the importance of the quality of the patient-practitioner interaction, which includes the ability to relate to and provide a meaningful encounter to the patient, the patient's experience of their practitioner's empathy, the active seeking of involvement from the patient[7], which is obviously highly variable and depends on individual patient and practitioner factors. The aim is to facilitate the body's own self-repairing (homeostatic) abilities and deliberately use non-specific techniques (such as suggestion, making meaning, empowerment, rapport) as well as their specific discipline, to enhance their effectiveness. The specific and non-specific effects of these interventions are often synergistic so trying to separate the effects of one from the other for the purposes of an RCT may reduce the measured effect size. If a study participant has strong preferences about the treatment they are receiving, then it will influence their willingness to be in a trial, and will affect outcomes [8], which makes trial data less applicable to real world practice.

Applicability of RCT evidence is limited by heterogeneity of practitioners

CAM practitioners are heterogeneous in terms of what they deliver and how they deliver it.[9] An individual practitioner will also react and therefore adapt their practice differently to the different patients they treat. This variation in styles and approaches makes it challenging to find the best practitioner for an individual patient. What is good for one person may not necessarily suit another. Also, even if research shows that acupuncture is effective in migraine, will a patient be able to find a local acupuncturist who practices in a similar way with similar skills to the acupuncturist who took part in the study/ies? Finding the right practitioner, in the right CAM discipline, for the right patient may be more akin to being a marriage broker than following a protocol. We would not contemplate trying to choose a spouse or life partner on the basis of RCT evidence.

Patients who might benefit from CAM/IM approaches are often not suitable to enter RCTs

Many patients for whom CAM treatments might be appropriate have chronic or recurrent health problems, multiple diagnoses/pathologies, relapsing and remitting functional problems or unexplained medical symptoms. There are also patients who have tried or are taking multiple medications, or those who do not respond to, do not want, or cannot tolerate conventional treatments. None of these groups of patients are likely to meet the inclusion criteria of most RCTs. Pregnant women, children and patients who have already received other CAM treatments are other patient groups who are higher than average CAM users and who are currently not well represented in RCTs. Patients who are actively seeking long term changes in health status, function or wellbeing and are keen to be involved in making lifestyle changes to support this are another high CAM use group who are unlikely to volunteer to participate in an RCT. Because RCTs tend not to include many of these patient groups for whom CAM might be most appropriate, we consequently do not have a robust and reliable evidence based way of managing their problems.

Applicability of RCT evidence limited by unpredictability of patient responses

Clinical experience shows that it is common for patient responses to CAM therapies to be more varied and less predictable than their responses to conventional care (and responses to conventional care are not always predictable!). For example a few patients may respond dramatically while others are unchanged and some may even be made worse. The problem is that RCTs are designed to provide evidence about a normally distributed population, and their results may not help practitioners who are interested in applying this evidence to individual patients. Outcomes are much less predictable at the individual level,

Added to this, in practice there is often not just large variability in the size of patient response but also in the nature of the response. It is therefore sometimes hard to predict not only whether but how someone will respond to CAM/IM treatments and it is therefore often difficult to capture patient responses to CAM with simple, predetermined outcome measures. If the CAM/IM intervention is designed to facilitate the body's healing and development, rather than to treat or suppress a particular symptom, it is not surprising that the effect may not always be easy to predict. Eczema may not improve but the patient may feel less distressed about it or might notice improvement in another longstanding problem such as hay fever. RCTs therefore run the risk of disregarding important but unpredicted outcomes, perhaps broader changes that result from a more holistic approach.

Interaction between the patient, their condition, their treatment

Many patients, when presented with a range of treatment options, will have a sense of what they think they need. Some of these will not enter (or stay in) a clinical trial as they already know what type of treatment they would like to receive. For those who do take part, the very process of randomisation, especially if there is some attempt at blinding, may take away some of their ability to 'work with the treatment', and patients in trials might end up 'playing their part' in a trial.[10] At worst, such patients will be constantly trying to work out if they are receiving active or control treatment. It is unlikely that evidence from such trials will reflect how they would normally experience the same treatment in routine care

Combining RCTs in a systematic review and possibly pooling data in a meta-analysis, is considered a way of obtaining more definitive evidence. A drawback of this is that when we combine individual RCTs the heterogeneity of these studies can make the interpretation more difficult. For example the trials might all be measuring slightly different treatment regimes, with different practitioners with different skill levels and approaches, with different patient populations with different diagnoses being studied under different conditions, and all looking at different outcome measures. The results are often inconclusive, and for good reason: the primary research isn't good enough, the sample sizes are often too small and the studies are too heterogeneous. Commonly the outcome of these reviews is inconclusive, though incorrectly their conclusion is labelled 'negative'.[11]
It is important to clarify that no evidence of an effect is not the same as evidence of no effect.

In summary, there is a mismatch between the existing evidence base and real world patients. And this mismatch will not be corrected by simply generating more of the same type of evidence. What we need is research that is more relevant to the real world context, as this may go some way towards helping us choose an individualised health intervention.

Towards building a relevant evidence base for CAM therapies

The need for relevant approaches to research clearly follows from the difficulties in interpreting the current evidence as addressed above. First we need to move away from 'hierarchies of evidence', as these can lead to an undermining of the value of using a broad range of research methods.[12] Not all research questions can be answered by a placebo-controlled trial. For example, evidence on safety will require large numbers of observations and patients in order to identify rare and possibly serious adverse events, and randomised controlled trials are not appropriate for collecting such evidence. We also need to move towards methodologies that are appropriate for complex interventions.

A useful framework for the clinical evaluation of complex interventions has been provided by the Medical Research Council.[13] This framework encourages researchers to identify the population that will be most eligible, clearly define their intervention and establish the optimum outcome measures, all as part of their pre-trial preparation. When considering research into CAM for specific conditions it is useful to identify from general practitioners the conditions for which current treatments might be perceived as least effective[14], and from patients the conditions for which they most commonly seek CAM therapies. This information, which can be used to guide clinical practice and referrals in real life, should be more often incorporated into trial design. Such considered approaches to clinical evaluation are likely to result in more relevant trials and more applicable results.

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There are different types of randomised controlled trial, explanatory and pragmatic, each best suited to addressing certain sorts of research questions.[15] The more pragmatic approaches to trial design can better address questions about the overall effectiveness of an intervention. Pragmatic trials are particularly appropriate for CAM therapies where the aim is to optimise patient and practitioner interactions, use longer-term follow ups and conduct economic evaluations.[16] The argument that 'placebo' effects make a significant if not entire contribution to the overall benefit is one that is often put forward. It is the research question that drives the methodology, and some trials are simply not designed to establish separately the 'specific' and 'non specific' contributions to the overall effect. Addressing this issue of the extent of the 'specific' effects requires careful consideration of several issues.[7] For many CAM therapies it is very difficult to have a scientifically robust sham or placebo control. In research into acupuncture, for example, the limitations of sham needling as a control are much discussed.[17] Furthermore from the perspective of the patient, the extent that the overall benefit is 'non-specific' it does not matter, rather they would see themselves as beneficiaries of a good patient-practitioner relationship. Whether there is an overall improvement or not is what counts for patients!

Beyond RCTs, there is a case for valuing and funding high quality observational research into CAM therapies. We need to encourage the most intelligent, open-minded but yet constructively critical discussion of the results obtained, discussion that should avoid the polarised: 'Does it work? Doesn't it work?' dichotomy. Rigorous, well funded and broad ranging observation of the effects of CAM and the types of situation and people for which it is most likely to be helpful, is needed before we can develop intelligent hypotheses about which patients, which conditions and which therapies should be tested under more controlled conditions. It might be useful to identify possible predictors of when a particular therapy might be most beneficial. This could generate future studies with greater predictive power and focus the hypotheses that could be tested in further RCTs.

What is needed is more evidence that is relevant to the patients, the therapists and the settings. Future research will need to consider a range of evidence beyond placebo-controlled trials.

Research should not discount the benefits of strong patient-practitioner relationships, the broader outcomes that might be experienced beyond single symptoms, and the active involvement of patients in their trajectory of recovery.

Our understanding of CAM and how it interacts with the complexity of a living organism is incomplete. An understanding of the likely neural pathways by which an intervention works will lead to more appropriate controls, better understanding of confounding variables and a greater ability to target treatments to individuals and situations where they are most effective. We therefore need to continue with basic science research that has a focus on the 'mechanism of action'. Such research is likely to be far more productive in understanding the specific effects of components of CAM therapies than RCTs and in solving the problem of establishing adequate 'placebos' or shams that can function as effective controls.

Conclusion

There is a gap between the current limited evidence base for CAM therapies and the understanding required for clinical judgements to be made about their relevance for individual patients. We need better to understand the reasons for this mismatch between research evidence and clinical practice; a mismatch which of course is a feature of both conventional and CAM therapies. Key factors include the complexity of the chronic conditions that are so prevalent and the heterogeneity of CAM practitioners and their interventions.

What is needed is more evidence that is relevant to the patients, the therapists and the settings. Future research will need to consider a range of evidence beyond placebo-controlled trials.

Research should not discount the benefits of strong patient-practitioner relationships, the broader outcomes that might be experienced beyond single symptoms, and the active involvement of patients in their trajectory of recovery.

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EVENTS

MAY

30 **The Art of Well-being: 7 tools for coping with the ups and downs of life.** With Jan Alcoe author of Lifting Your Spirits: seven tools for coping with illness. Brighton. Details at www.hypnotherapyforliving.co.uk, jan@hypnotherapyforliving.co.uk

JUNE

23-24, Sept 24

Cognitive behavioural therapy I cancer and palliative care: 'first aid' training in basic skills. A St Christopher's Hospice education centre event. London. See www.stchristophers.org.uk.

JULY

4-5 **Four elements seminar**, School of Homeopathy, Stroud, with Misha Norland, Jeremy Sherr and David Mundy. See www.homeopathyschool.com, email info@homeopathyschool.com.

9 **Music therapy at the end of life: changes, challenges and moving forward.** A St Christopher's Hospice education centre event. London. See www.stchristophers.org.uk.

18 **Lifting Your Spirits: seven tools for coping with cancer.** A one-day workshop for people with cancer and their carers. Brighton. Details at www.hypnotherapyforliving.co.uk, jan@hypnotherapyforliving.co.uk.

To publicise your event send details to Edwina Rowling
at erowling@tiscali.co.uk. Deadline for next issue: 18 June 2009

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Vested interests and the greater good

William House

GP, researcher, commissioner, BHMA trustee

After being a full time GP for 30 years I now spend my time trying to improve the healthcare provided in the NHS through practice based commissioning, primary care research and trusteeship of the BHMA. I combine these with reading widely and with enough clinical work at local surgeries to stay in touch with the people. Having a foot in practice, research, and commissioning gives me unexpectedly helpful insights into the mostly hidden workings of the NHS.

Summary

The title of this article expresses an essential tension we have to live with. How we negotiate this tension will determine whether we thrive, or even survive, as a species. Currently we are not doing well. So much is obvious from the inequalities between rich and poor, and the degradation of the environment.

Over the past 10 years the NHS has become more commercial in its structure. This is a deliberate political move to counter what was seen (probably rightly) as a 'monolithic' organisation which is inefficient and unresponsive. It is the contention of this paper that this commercialisation has increased the influence of various sorts of vested interest to the detriment of the greater good. It has created a different kind of unresponsiveness determined by powerful vested interests rather than inertia. This is not to say that vested interests are necessarily bad, but there is a balance to be struck. Our capitalist society depends on competing vested interests: they help to provide the energy for innovation and hard work. This is ethically justified as 'enlightened self-interest' which implies a balance in the tension between self-interest and concern for the other. The tension between competition and co-operation runs throughout nature and is part of the basis for evolution – so has a long and respectable heritage. But the balance must be right.

Six sorts of vested interest are seen at the upper levels of the NHS hierarchy.

1. Making money for individuals, corporations, institutions and shareholders.
2. Political decisions that garner popularity and votes.
3. Career advancement for individuals.
4. Promotion of commercial, academic, large charity and corporate prestige.
5. Promotion of national prestige and investment from overseas.
6. Preferential treatment for the personal survival of individuals.

These motivations (none in themselves necessarily bad) give rise to a collection of interrelated manifestations seen in everyday NHS work. Many of these amount to the shadow sides of medical advances in fighting disease. For instance, patients often have expensive and complex tests and treatments where simple and cheaper alternatives would be as good or better; or medical treatment is given where no treatment or entirely different (non-medical) intervention would be better; or medical treatments aimed at a short term fix are used where longer term measures might be more sustainable; or staff are so mesmerised by the technical process that patient dignity and welfare are neglected – the disease is mistaken for the patient. A more insidious manifestation is the effect of the lack of altruism at the top of the NHS spreading through each layer, like the ripples in a pond, to the uncaring treatment of the most vulnerable patients by the most vulnerable staff at the bottom. In complexity science this is known as a fractal pattern, and such repeated patterns are a feature of all complex systems in nature.

The exercise of vested interests usually involve centralised power in the hands of a few individuals. Power is exerted through control of funding, control over publication and media publicity, control of career advancement, corporate entertaining, gifts and sponsorship and through lobbying activities. Healthcare lobbying has become a big business in its own right.

The following sections describe some of the manifestations of this exercise of power.

Vested Interests

Medical model

The focus on the medical model of care, as opposed to biopsychosocial, public health or other models, encourages technological fixes at the expense of social solutions and individually tailored therapy. It also provides scope for portraying social problems as medical problems and so suitable for medical treatment. This diverts attention and accountability away from difficult social issues and towards politically easier medical ones, so suits politicians as well as purveyors of industrial healthcare. This fix-it culture of commodified healthcare products combines with patient-as-consumer to produce a doing-things-to-people style of healthcare. These 'things' often involve complex treatments that baffle the average patient who may then become disempowered, fearful and passive. This generates a compliant and lucrative healthcare market in which low cost home-remedies are seen as a threat. Of course, complex medical treatments can save and prolong life, but their shadow is misplaced medical treatments for fundamentally social problems and the loss of resilience and self-sufficiency in the population – none of which can be easily measured and is therefore liable to be ignored.

Research and development

The explicit hierarchy of research evidence that defines what is considered reliable is based on narrow criteria that privilege numerical measurement and statistical manipulation over descriptions and narratives. In the field of applied clinical research this makes research projects complex, difficult to conduct and expensive, so available only to large institutions and even then prone to inconclusive findings. The narrowly defined standards for evidence favour research into technological interventions at the expense of the difficult-to-measure world of human relationships and values, which may never be funded and so not conducted.

The dissemination of research findings is similarly controlled through a hierarchy of healthcare journals ranked according to 'impact factor' based on citation frequency. Higher ranked journals tend to be more readily available, hence cited more often – a self perpetuating circle. Some of these journals depend on pharmaceutical advertising, although their editors would claim this does not restrict their editorial freedom. Much reliance is placed on the peer review of submitted articles, but the specialisation of research fields is such that the pool of experts from which to choose referees may be small and this clearly places control in the hands of a few.

Original research articles are often difficult to understand for the non-specialist and relying on the authors' conclusions can be misleading since they do not always concur with the actual data. [1] Shortened and simplified versions intended for public, practitioners and commissioners (sometimes in the form of a press release from an organisation's PR department) are even more likely to fail in giving the full impression of uncertainty and complexity. This particularly applies to the many guidelines based on published research and compiled by expert groups, including the National Institute for Health and Clinical Excellence (NICE), which play a large part in determining what sort of healthcare is commissioned. The reasons for this are many and related to the technical complexity of the material, the poor availability of many specialist journals outside academic centres and the vast volume of published research literature – more than 7,000 reports, editorials and letters every month relevant to primary care alone. [1] It is relatively easy to enhance the visibility of some findings and to ignore others according to the favourability to a vested interest or dominant discourse, particularly if the latter appear in little known journals – to 'bury bad news' in the welter of information. [1] In some cases inconvenient research findings are not published at all. Even where there is lay and practitioner representation on influential committees, real power resides with those of high status. [2]

The result of all this is that much of the R&D process has become controlled by a relatively small number of academics, politicians, economists, commercial and charitable corporate executives, and the media. This centralisation of control renders the process vulnerable to all six sorts of the vested interests described above, to a bias in favour of technological treatments, unnecessarily large research expenditure, and the stifling of small- scale local research and radical innovation. This is not an accusation of wrongdoing so much as a systemic perpetuation of the status quo ante upon which many individuals and institutions depend.

Implementation of research findings into practice: Evidence based medicine

Control of the research agenda, funding and dissemination effectively enables control over what constitutes medical knowledge. The public and even those who deliver care in the NHS have only token influence. What is taught to practitioners as medical knowledge and what the public come to expect in the way of medical treatment is controlled by organisations that have or are vulnerable to vested interests. Furthermore, academic institutions increase their prestige when their research findings are incorporated into clinical practice, creating an incentive to market their results rather than present them in a value-free way.

Continuing professional education for doctors is largely funded by the pharmaceutical and biotech industries, as are many healthcare conferences. This buys privileged access to doctors and helps to maintain a focus on healing by medical technique and provides a forum for industry-friendly messages to be heard. In primary care, approved ways of practising based on this 'evidence based knowledge' are built into clinical computer systems and into the pay structure of GPs (Quality and Outcomes Framework – QOF). So even for practitioners who avoid industry-sponsored events and who distrust the evidence, there is virtually no escape. Clearly, the risk from all this is that the treatments provided are those that suit the healthcare industry rather than the clinicians and the suffering population.

Political involvement

Close involvement of politicians in the setting of the healthcare agenda and practice gives rise to initiatives that might fulfil a political manifesto but are unlikely to improve the health of the nation. These become 'must do' interventions which primary care trusts are required to commission regardless of local (and perhaps, in the eyes of some, national) needs. This can be demoralising.

Individual treatment choices

All of us have a vested interest in the health and survival of ourselves and our loved ones. At times of illness most people want the best treatment available. Whatever altruism they might show when they are well is overwhelmed by their suffering and fear. The reality, however, is that no developed country can provide all available treatments to all of their population – some sort of rationing has to happen and this occasionally hits the headlines, such as over the costs of new cancer drugs. It is also right to say that self-reliance and resilience are part of health, and this involves deciding to soldier on through some illnesses even if there is a possible remedy.

The greater good

In the face of all these vested interests how can anyone find the right balance with the greater good? What is the greater good in relation to healthcare? Over the past few years there has been a major drive in the NHS to increase the influence of the individual patient over the healthcare they receive (partly to help drive up standards) but the patient also has a vested interest, as already noted. While the individual patient's wishes are important they cannot be equated with the greater good. However, it is now possible through patient and public involvement and practice based commissioning to reclaim some decision-making from the centre. Redistribution of power to localities will create diversity and vibrancy, build communities instead of crushing them and provide some resistance to national vested interests. Locally generated research would have a similar effect and both must be pursued vigorously. While this should help, if done alone it will increase the disjunction between national and local agendas and that would be bad for the NHS. A unifying thread is needed.

NICE attempts this by using a utilitarian measure for assessing the 'cost effectiveness' of new treatments. This involves attaching monetary value to suffering, death and survival – a health economist's version of the greater good rooted in the philosophy of John Stuart Mill: the most good for most people.[3] This sits very uneasily within our consumerist, secular and individualistic society. In this context, the individual self-sacrifice required when the utilitarian calculations come out against a new treatment is greeted with media outrage and calls for justice and rights. When this is played out in the law courts the vested interests often carry the day.

Surely the greater good must involve some clarity over what health is like. At the beginning of this article I invoked inequalities and environmental damage as evidence for being too far away from the greater good. If we believe that health transcends the individual, then we cannot be truly healthy while our neighbour is suffering or our community is in disarray or our environment is being damaged. All the great world religions have a notion of the greater good which resembles this. But if we cannot call upon the Scriptures as our authority when we try to rein back the vested interests, what can we call upon? There is no shortage of great writers we could quote, but perhaps most powerful is the notion of harmony with ourselves, with our fellows and with nature. The practical application of this is to insist that everything we do contain the seeds of sustainability. Every healthcare intervention should have some element that helps to correct the deep imbalance that underlies the problem, and might eventually render the intervention unnecessary. Currently one of the hallmarks of modern mainstream healthcare is the absence of this sort of sustainability. However, with imagination and a broadening of the narrow understanding of evidence, it can be done.

What this amounts to is requiring the great modernist project of salvation by the accumulation of knowledge to give some ground to the spiritual, even postmodern, project of knowing the knower. Then we may have a health service in which people matter. These ideas have their roots in a profound spirituality that treats all of nature as one wonderful self-sustaining organism. It just might be enough to motivate the critical mass of people necessary to make it happen. Yes, we can!

> *No man is an island, entire of itself; every man*
> *is a piece of the continent, a part of the main.*
> *If a clod be washed away by the sea, Europe is*
> *the less, as well as if a promontory were, as well*
> *as if a manor of thy friend's or of thine own*
> *were. Any man's death diminishes me, because*
> *I am involved in mankind; and therefore never*
> *send to know for whom the bell tolls; it tolls*
> *for thee…*[4]

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More harm than good?

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Summary

All medical interventions involve balancing benefit and risk. CAM has a poor evidence base associated with very little research spending, as does much chronic benign illness managed conventionally. Adverse reactions to conventional interventions are common, dangerous and expensive. CAM appears to be relatively safe and possibly equally effective although more research is needed. The evidence for the effectiveness and safety for some interventions has been selectively misrepresented by those who oppose CAM. They have suggested inappropriate research methods and exaggerated the risks, thus unhelpfully polarising opinions and denying patients an integrated approach to their condition.

I work as a doctor practicing integrated medicine (acupuncture, homeopathy, nutritional medicine and conventional medicine) and lead a CAM and integrated medicine research group within the department of primary medicine at Southampton University.
We focus on differentiating the specific from the non-specific effects of CAM and developing models that will help to explain the patient-perceived benefits of these interventions. We are currently interested in pain, arthritis and cancer as illness models investigating the effects of acupuncture, healing, homeopathy and herbal medicines.

Introduction

As soon as one intervenes medically you run the risk of doing some harm. The harm itself may be inconsequential – a small bruise from a blood test or a 15-minute wait for an appointment because of some pressing medical emergency. Clinical intervention involves some level of diagnosis and usually some discussion about treatment, if not the prescription of an actual treatment, be it conventional or complementary. Medical intervention therefore comes with an understanding of relative risk and, indeed, relative benefit. Oncologists who intervene by prescribing powerful chemotherapeutic agents for cancer know that they run a very considerable risk with the associated very high probability that the drugs that they prescribe will trigger unpleasant and sometimes lethal adverse reactions. Conversely, a GP looking after somebody with a bad back or irritable bowel syndrome is most unlikely to run the risk of a severe or life-threatening adverse reaction as a consequence of a prescription. Most chronic benign illnesses seen in general practice are 'managed' by treatments that have a relatively limited evidence base.

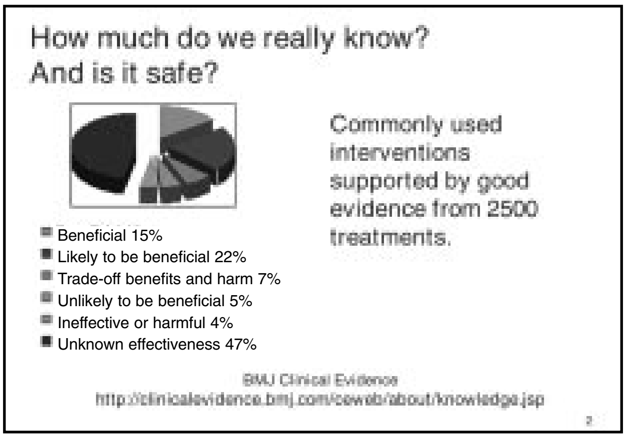
Harm and risk are complex issues. It appears that consultant obstetricians pay approximately 3000% more in yearly insurance premiums than qualified medical herbalists, suggesting that actuaries have an astute financial understanding of relative medical risk and that obstetricians are very likely to do harm and get sued while this is very unlikely if you are herbal practitioner. Surgical mistakes occur in 4-7% of surgical procedures carried out in the UK [1] and the NHS spends ever more of its valuable cash defending against litigation and mistakes. This now runs into billions of pounds each year and must represent at least a crude indicator of the risk and consequent damage inflicted on the UK population by our conventional medical institutions. It has been suggested that up to 15% of hospital admissions are iatrogenic and that there more than three quarters of a million adverse reactions to conventional medication in the United States each year. This must represent considerable harm; is there enough

Harm and actuarial risk in medicine

- Actuarial indemnity costs over £30K pa for an obstetrician and under £100 for a herbalist.
- Surgical mistakes occur in 4-7% of surgical procedures.
- The NHS spends over £2 billion a year and rising on its clinical mistakes
- Up to15% of hospital admissions are iatrogenic.
- 770,000 are harmed by ADRs in the US each year, 70% are avoidable.

benefit to balance this risk?

Many of those who attack complementary medicine claim they do so from a bastion of scientific purity which encompasses a strong evidence base backed by substantial evidence from placebo controlled randomised studies. The BMJ clinical evidence website would suggest otherwise; 95% of our doctor/patient consultations occur in primary care and for many of these consultations there is very limited evidence that treatment is prescribed.



How much do we really know?
And is it safe?

Commonly used interventions supported by good evidence from 2500 treatments.

- ■ Beneficial 15%
- ■ Likely to be beneficial 22%
- ■ Trade-off benefits and harm 7%
- ■ Unlikely to be beneficial 5%
- ■ Ineffective or harmful 4%
- ■ Unknown effectiveness 47%

BMJ Clinical Evidence
http://clinicalevidence.bmj.com/ceweb/about/knowledge.jsp

Risk vs benefit

All medical interventions involve a risk-benefit judgement. Have we investigated someone's irritable bowel enough to make sure that the person in front of us doesn't have Crohn's, ulcerative colitis or a cancer? Within complementary medicine we need to improve the quality of education in order to make sure that diagnostic errors occur only very rarely. Sometimes in conventional medicine we prescribe treatments that may be damaging or dangerous; for instance the prescription of non-steroidal anti inflammatory drugs accounts for an estimated 2,000 deaths per year in the United Kingdom and 15,000 hospital admissions for gastro-intestinal bleeding. [2] These drugs are usually prescribed for chronic benign illness which may be helped equally effectively by acupuncture and osteopathic techniques. Clearly we need more evidence within the area of complementary medicine to better understand what we should do and how we should do it, but with the lack of current research funding for CAM we are unlikely to achieve that objective.[3]

There are real risks associated with complementary medicine and they do need to be managed. Probably the most substantial risks that have come to light recently have been related to herbal medicine. Sometimes herbs can contain very dangerous chemicals, but often it is the method of extraction of the herbal remedy that cause the problems, as in the case of kava. The banning of potentially poisonous herbs like aristolocia and ephedra would appear to be very appropriate within a culture which considers safety as important as we do in Europe. The UK MHRA has an important policing role in relation to these issues and is actively co-operating with the European Herbal Practitioners Association to assure that the appropriate legislation is in place to protect and enable both herbalists and the population at large to receive appropriate and safe remedies prescribed by people who are properly trained. However, many of the adverse reactions historically associated with complementary medicine appear to have been the product of a combination of poor science and scaremongering. Ernst made a number of claims that acupuncture was a damaging and dangerous therapy [4] but subsequent prospective studies in the United Kingdom and Germany [5-7] have laid this myth to rest. Some of the original case reports suggested that someone at a party inserting a sewing needle without any training or registration was actually doing acupuncture. Consequently the adverse reaction that ensued was reported as an adverse reaction to acupuncture, when in reality the person inserting the needle had made absolutely no claim to be an acupuncturist!

The debate about chiropractic is of a similar nature. There have been a small number of case reports of people having vertebro-basilar (VBA) strokes after high velocity manipulation of the neck. As a consequence several studies have looked at adverse reactions to chiropractic; Theil *et al* [8] published a prospective study involving approximately 80,000 chiropractic manipulations and were able to identify a number of minor adverse reactions, but no serious problems. Cassidy published a careful case controlled study that looked at the incidences of VBA strokes in two Canadian states over a period of 10 years.[9] Each stroke reported (818 over the 10-year period) was matched with four case controls and pre-stroke visits to chiropractors and GPs, all of whom were carefully assessed for the symptoms of headache and neck pain. Cassidy concluded that it appears a small number of patients present to their attending physician with these symptoms and then go on to have a VBA stroke. The incidence of stroke after visiting a non-manipulating GP was the same as that after visiting a manipulating chiropractor, so the logical deduction from this data is that VBA strokes, while they do happen, tend to present with neck pain and headache, and sometimes to chiropractors. But the fact that manipulation occurred appears to be purely incidental. This is further supported by Boyle *et al's* work.[10]
It appears that a simplistic and naive interpretation of a small number of case reports has led to a considerable furore that is actually unsupported by a more thorough investigation of the relevant evidence. Those suggesting that chiropractic is damaging and harmful have interestingly made no reference to these studies and the possibility that their arguments may be fallacious.

CAM helps. We know from a recent BMJ article that peppermint oil, a traditional herbal remedy, is one of the better treatments for irritable bowel. [11] Cochrane reviews continually suggest that hypericum (St Johns Wort) may be beneficial in depression [12], and undoubtedly Alexander Technique is of substantial benefit to those who suffer from back pain.[13] We know that acupuncture helps a variety of different painful conditions and a recent article by Cummings [14] illustrates this beautifully. Acupuncture provided within the context of a clinical trial or simply evaluated as part of routine care provided approximately the same benefit for a variety of conditions including headaches, osteoarthritis of the knee, back pain and neck pain. Treatment with so-called placebo Strietberger needle resulted in pretty much the same clinical benefit so sceptics suggested that acupuncture was no more than placebo. However Cummings points out that these treatments were often more than twice as effective as an equivalent conventional intervention and that this was hugely cost-effective. Perhaps we can't design a workable acupuncture placebo, however what we do understand from this data is that it is entirely reasonable for the German health insurers to reimburse acupuncture for the treatment of pain. It is much safer than conventional treatment involving non-steroidal anti-inflammatories and seems to do the job much better than the equivalent best available treatment within conventional medicine.

Surely this isn't a time for conflict between CAM and conventional medicine, but rather a time to provide an integrated approach to medical care so the patient can have the best of both worlds. Our 'dependence' on placebo controlled randomised clinical trials clouds the issue as far as acupuncture is concerned largely because we don't know exactly how real acupuncture works and what could effectively and sensibly be delivered as an appropriate placebo. If we stick to the issue of harm and benefit there is no doubt about the conclusion; one would use acupuncture every time for musculo-skeletal pain.

> People want an integrated approach to cancer using conventional medicine as their primary management.
>
> BUT
>
> Polarisation triggers mistrust and abandonment of conventional care.

Destroying the theraputic relationship

Patients often come to their doctor with a whole variety of conditions seeking help and reassurance. If it is a chronic benign condition they may consider some acupuncture, herbal medicine or some homeopathy. Almost always with cancer they will see their oncologist as their primary carer but may wish to use some aromatherapy, massage or even acupuncture to help with side effects in their conventional treatment, or to create a peaceful therapeutic space for themselves or to generally improve their wellbeing. When patients lose trust in conventional physicians who ridicule their valued approaches, a vital therapeutic relationship may be compromised. The patient perceives that they are trying to help themselves and assist the physician but the physician may see 'their patient's' use of CAM as a threat or something that is not evidence based, or something even that might replace their primary conventional treatment. Nothing could be further from the patients mind, but that implicit threat and the destruction of the therapeutic relationship that may come with it helps no one. In such medical 'turf wars' it is always the patient that loses. An integrated approach to these problems which is appropriate and thoughtfully based on best available evidence and best practice will allow us to avoid such conflicts and provide better care for vulnerable patients

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Integration, long term disease and creating a sustainable NHS

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As I get older I find the questions I ask myself about sustainability get more pointed and personal. What sustains me physically, personally, ecologically; what sustains my relationships: with family, friends, community; what sustains me professionally or spiritually? It seems to me that medicine in its present form is in so many different (but related ways) becoming unsustainable, and must reconsider its core purposes and the processes whereby it achieves them. We have reached a point where medicine, our society and the biosphere can only remain sustainable if above all, we commit ourselves to creating health at every level – from the genome to the ozone layer.

Summary

Healthcare faces three interconnected crises of cost, cure and care. Costs are soaring as a pandemic of chronic disease outstrips the development of cures, and caring is losing ground as medicine industrialises and its commitment to timeless principles wanes. Our medical system can pull out of this high-tech nosedive and become more sustainable if it develops a new model of health, recovers timeless shared values, and explores the potential of integrated medicine.

Crisis 1: costs

Expenditure on the NHS has climbed from less than 5% to more than 8% of GDP in the last decade. The WHO says 66% of all premature deaths are due to chronic diseases, and that nearly 400 million people will die of a chronic condition in the next decade.[1] In England, over the last two decades life expectancy for men increased by about five years, but healthy life expectancy by less than three. This means that more people are old and sick – mainly due to chronic mental and physical illness. One in four people in England is affected by obesity, rates are rising rapidly, and it already costs £3.7 billion every year.[2] Wealthier nations experience high levels of stress, anxiety and depression, which predispose their populations to physical diseases. WHO predicts that by 2020, depression will be the world's second biggest health problem and that it will be more dangerous than the top four chronic conditions: angina, arthritis, asthma and diabetes. [3] In England where one person in six experiences mental health problems, it costs the country £76 billion a year in health and social care services and lost economic output.

Crisis 2: 'cures'

The technological arms race between science and disease makes for high costs, unacceptable side-effects and increasingly resistant infections. Yet bio-technical medicine has found no cures for pandemic type 2 diabetes, most cancers, cardiovascular disease and mental health problems. Health and social care budgets are spiralling out of control as medical systems wage biochemical warfare on diseases mediated largely by lifestyle, stress, addiction, and a deteriorating environment. The 2004 Wanless report warned that without a major change in direction the NHS will become unsustainable by 2023, by which time its costs will absorb more than 12% of the GDP. [4]

Wanless, envisioning the only viable option for a sustainable NHS as one supported by full public engagement, redefines public health as 'the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations – public and private, communities and individuals'. Such a journey towards a sustainable NHS will require the compass of a new model of health, a map of shared values and some crucial innovations that create milestones on the way.

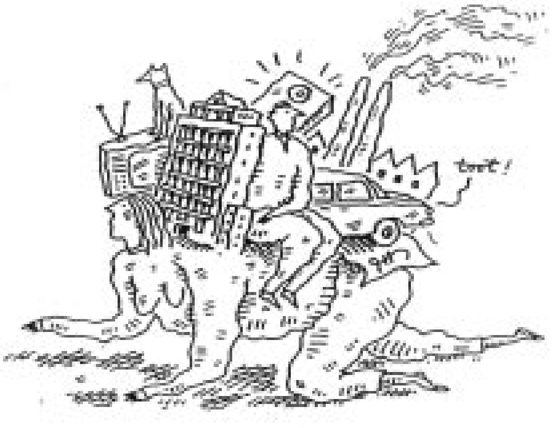
Crisis 3: commitment, caring and compassion

Doctors' traditional role of caring for suffering people is morphing into the pursuit of centrally driven targets, guidelines and QOFs. There is a growing sense of professional malaise as levels of doctor drop-out and impairment rise, and the humble crafts of caring lose ground.[5] Yet when we are ill, compassion is what we crave: we need support, guidance and the care of those who accompany us. Hard-pressed healthcare workers know about the daily struggle to care, and they are social capital whose compassion healthcare organisations need to nurture. Organisations perceived as caring are more productive, less litigated against, have less absenteeism and recruit better. [6] There is also some evidence that compassion improves healthcare outcomes. [7] So it is good management to support compassion, and Lord Darzi mentions it in his NHS Review, reminding us 'the NHS is there when we need it most. It provides round the clock, compassionate care and comfort…[that] …should be as safe and effective as possible, with patients treated with compassion, dignity and respect'. [8] The government is now seeking ways of measuring and delivering compassion in the NHS. (So watch out for the new compassion targets). But the notion that we, and our patients, are just biochemical machines hardly encourages compassion.

Solution 1: a better model of health

If 21st century healthcare is to find a way out of its three-fold crisis we must question the assumption that tinkering with biochemical pathways and gene sequences will one day wipe disease out. There is a terrible denial at work in this idea, and behind it hide some essential facts of human life. We do not flourish in isolation, nor can we breathe air laden with pollutants for long, or live on junk food, or thrive in overcrowded cities where poverty, sensationalist media and fundamentalist dogma fuel hatred and violence, or prosper long in nations addicted to the growth of carbon-burning economies that foul the atmosphere and kill the oceans. The quest for sustainable medicine cannot be separated from these larger issues.

Alongside the intricate analysis of the genome, we now need a story about health that can reconnect the parts into a whole: minds with bodies, cells and tissues into persons, individuals into meaningful social groups, and the human species into the community of beings living on the blue planet that gives us life. [9] Affective neuroscience, evolutionary and systems biology, and eco-psychology provide scientific foundations for this new narrative. But though the new story cannot do without the backing of science, I find it fascinating that traditional medical systems tell a similar tale of inter-connectedness, and insist that health and wellbeing depend on the flow of self-regulatory information that connects humankind and nature.



Caring in context.

This is not a way of promoting 'alternative' medicine as the goal; rather that CM remind us of what hi-tech medicine is missing. CM signifies the yearning for a more holistic approach, and it is intriguing that traditional Chinese medicine has a common diagnosis for the worldwide explosion of chronic inflammatory diseases and our ecological predicament. Both represent a process TCM calls 'damp-heat': metabolic excess producing toxic metabolites that accumulate as circulation stagnates and excretory processes fail: Gaia, like so many of its inhabitants, has a chronic inflammatory disease. Politics and science will play a part in finding the cure, but to turn the planetary tanker round, the real drive must come from the information flow of new and better stories about our health and our humanity.

Solution 2: shared values

The story that global warming is some post-hippy fantasy was finally laid to rest by Stern's 2007 review of climate change economics.[10] Post-Stern, planetary and personal wellbeing are forever intertwined, and entangled with global patterns of over-production and excess consumption. Bio-technical single-solution approaches won't cure the kind of whole person and whole system problems that confront twenty-first century medicine.

Mainstream medical thought and practice are bound to mirror the culture of unlimited growth and progress that created them. But the hectic pursuit of magic bullets has had cultural side-effects: the illusion that we can live lives that are personally, communally and ecologically unsustainable, because cocktails of pharmaceuticals can keep us alive into an (albeit impaired) old age. Unknowingly, biomedicine may have colluded with the consumer ethic of working like ants, 'relaxing' like couch potatoes, and living as though sex, food and drugs were value-free commodities. The glamour of high-tech medicine also took the wind out of public health's sails, which lost much of its political traction, and has yet to regain it. Yet it was public health reform that cleansed the noxious cities of the 19th century, and it is public health rather than big pharma that will have to meet the deadly twin threats of climate change and chronic disease.[11]

If what's good for chronic disease – eating low in the food chain, more exercise, coherent communities, environmental compassion – is good for the planet too, and integrated medicine's biological gains and social advantages reinforce one another, then its holistic solutions ought to snowball. Take one example: the agribusiness worldwide – especially livestock production – accounts for about a fifth of total greenhouse-gas emissions. [12] So reducing our consumption of saturated fats and meat would make the climate more stable while helping prevent cardiovascular disease and bowel cancer. Or consider air pollution, which every year kills nearly a million people prematurely. Most of the pollution is transport-related, as are the road accidents that cause another million-plus deaths annually and ten million serious injuries worldwide. [13] More low-carbon transport (using one's legs is a particularly good example) would slash accident statistics and carbon footprints, while helping curb the pandemic of metabolic syndrome. Happily, there is serious political commitment to improving the wellbeing of people with chronic disease; a 2007 DH report provides convincing evidence for the effectiveness of self-care support methods ranging from information and self-care support devices to self-care skills training, care farms, nature walks and support networks for people with chronic diseases. [14]

Our broader model of health and healthcare will need to build resilience at many levels – from the genome to the ozone layer. It will have to promote compassion, inspire community healing and make global health creation an international priority. Healthcare will mean integrating the analytic wonders of biomedicine with the understanding of complexity emerging from 21st century sciences.

Integrated primary care

Would the judicious integration of complementary therapies (CT) help make the NHS more sustainable? Catch 22: we wont know unless we begin to introduce integrated primary care strategically, and invest in cost-effectiveness research to demonstrate whether it works in practice. There are precedents: crucial forms of service innovation – mainstream integration of counselling and hospice care are good examples – preceded experimental evidence for their effectiveness. They addressed costly, poorly met needs. And so it is with chronic illness, stress-related and painful conditions, all of which are 'effectiveness gaps' for conventional medicine. Such problems are complementary practitioners' daily bread, and surveys suggest high levels of satisfaction and useful outcomes. Their growing popularity with the public and acceptance by mainstream practitioners coincides with increased interest in lifestyle change, health promotion and low-technology treatments; approaches which if they could be integrated into primary care might provide inexpensive, safe ways of augmenting conventional medicine. Integrated medicine would be centred on primary care, emphasising prevention and based on modern medicine, while also making other effective approaches – including complementary and mind-body medicine and self care support – available according to need and appropriateness. [15] Practice Based Commissioning (PBC) can ensure that clinical standards for IM are well defined, that the processes of clinical governance are extended to cover CT, and that services provide local audits. On this basis, relevant aspects of CT can now be integrated strategically into the NHS.

Integrated medicine marries the art and science of medicine. The resurgence of the biopsychosocial model [16] enriched by behavioural medicine and the wisdom of traditional systems could make healthcare not only more effective, and sustainable, but also more creative and professionally satisfying. Biomedicine's threefold crisis and widespread expressions of professional support for a new direction, as well as early indications of IM's potential, and the possibility that it could address poorly-met needs and encourage creative engagement, informed choice and self-care, proclaim that now is the time to put IM to the test.

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Approaches to healthcare: connectedness and spirituality

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A recurring feeling is one of emptiness and mammoth challenge, yet at the same time of potential for greatness and vision in service delivery. This feeling has inspired me to write this article. I am especially interested in the impact of the arts, culture and values on people's health and wellbeing.

I was moved by the following words from a client when they were asked to say what they felt was unique about the CatchOn2us approach. *'I would sell it on the caring side of it. You know no matter when you go to CatchOn, you're not just a bod, walking in, people doing stuff. There's a genuine concern there.'* This notion was central to the CatchOn2us philosophy and underpins the methods used for facilitating personal transformation and wellbeing.

Summary

This paper explores the importance of the relationship between healthcare practitioners and clients in a particular healthcare setting. The research reviewed user narratives to explore the experience and health impact of contact with this service. The results revealed evidence of a 'response shift', ie changes in people's self-perception of their quality of life.

A significant feature of the healthcare provided was the therapeutic value of the practitioner-client interaction itself.

Introduction

This article explores factors that affect the 'therapeutic relationship' (ie the relationship between a person caring for a client or patient, whatever intervention they are using) as a catalyst for healing, and the potential clinical implications for service users' experience. It is based on an evaluation of *CatchOn2us*; an innovative Healthy Living Centre project, which used complementary medicine techniques delivered through community therapeutic care workers (CTCs) drawn from the local community, many of whom had been long-term unemployed, and who became part of the project's 'social capital'. Clients were encouraged to try different complementary approaches, and in doing so liaised with several CTCs trained in certain aspects of the *CatchOn2us* toolbag, such as massage, aromatherapy, Shiatsu, and reflexology. These therapies were intrinsic to the CatchOn2us model of healthcare.[1]

The *Catchon2us* programme ran in modules across 10 consecutive weeks, with clients choosing an intervention of their choice each week. *CatchOn2us* was offered to a population who would not normally have had access to complementary therapies, and who were able to self-refer for these therapies free of charge. *CatchOn2us* sought to promote a positive definition of health focusing on empowerment, personal development, perceived control, emotional health, and self-defined quality of life (QoL).

This paper documents service-users' experience and reflections on the service, and how they felt it influenced their QoL. In the article, QoL refers not only to health or a physical state, but also embraces subjective wellbeing and happiness, ie how satisfied and good a person feels about their life [2] and their ability to cope with their own health problems.

More specifically, the investigation sought to document what aspects of the therapeutic interactions clients gave significance to, and the impact this had on their health and wellbeing. It built upon existing research which had shown that the therapeutic relationship influences people's perceptions of the care and benefit. [3] The research method involved exploring people's stories about their experience of *CatchOn2us*, seeking common themes or values emerging from those stories, and highlighting individual client's 'lived experience' through direct quotes. The method implicitly attempts to move the focus away from an illness and patient hood [4] in order to hear the voices of persons living their life. It is anticipated that the findings of the research will be useful for people who perceive themselves to be ill and/or vulnerable, as well as for clinicians, academics, and healthcare strategists.

Methodology and design

The research was the result of a commissioned evaluation for which ethics clearance had been granted as part of an application for a wider study. The sample comprised 34 clients (out of approximately 600 people who had accessed the service during 2002) who had completed the 10-week programme of treatments no more than one month previously. All interviewees provided written consent to be interviewed and recorded on tape. Interviewees were asked how many times they had visited their general practitioner during the time they had attended *CatchOn2us*. One person refused consent to be recorded on tape but consented to interview.

A semi-structured, open-ended interview about the client's experience was used to explore clients' perceptions and experiences of the *CatchOn2us* service. Several areas of focus were supported by pre-planned questions identified from previous stakeholder meetings. These included asking how *CatchOn2us* had contributed to their health, wellbeing and overall quality of life, and whether they felt that it had changed the way they felt about themselves, family, and friends. The interviewer also elicited their general perceptions of the service, and the therapeutic care workers' practice. Interviewees were also asked to provide feedback about any changes or improvements they would like to see in the service. Additional questions probed clients' responses allowing them to elaborate more fully. Interviews lasted between 45–60 minutes, and 34 interviews were circulated among four researchers for theme analysis and reliability checking.

The chosen method was Constant Comparative Analysis 5, an approach now applied widely in qualitative research, whereby the researcher takes one piece of data (for instance one interview, statement or theme) and compares it to all other pieces of data looking at what makes this piece of data different and/or similar to other pieces of data. This method is inductive, the researcher drawing out new meaning from the data as the analysis proceeds. In this study the analysis involved three independent raters and the principal evaluator in interpreting the interview material, using the usual stages of CCA.

1. Coding – searches for general patterns and ideas in the interview data without imposing any preconceptualised ideas. The themes and constructs derived from examining all interviews were categorised using open-coding so that 'in-vivo' codes could be incorporated, ie codes that were often used by service-users themselves. This qualitative process involved establishing inter-rater agreement on the main categories/themes grounded within the data, and the further breaking down of themes. All transcripts were systematically coded and each rater contributed a selection of quotes to illustrate the themes they had found.
2. Content analysis documented all the agreed categories, constructs and themes found by all the raters in all the scripts so that the concepts most cited could be decided.
3. Concept mapping which linked the concepts grounded within the data involved all researchers. The participatory nature of this evaluation entailed relaying this information to the CatchOn2Us team to obtain their perspective on what they felt were the most significant aspects in the data.

Key findings

Sample characteristics

Nine men and twenty-five women, all Caucasian, were interviewed. Six were unemployed, six employed, and twenty-two were retired. Eleven of them lived in electoral wards which were among the fifty most deprived in England.[6] Contrary to other research findings which have found strong beliefs in favour of CAM among first- time users[7], the majority of clients attending *CatchOn2us* had not used any form of CAM previously, had little expectations in their use, and no experience of complementary approaches. Members of this sample cohort had made an average of 1.74 visits to a general practitioner in the ten-week period.

A key link that emerged in several of the identified categories was the link between the therapeutic relationship and the perceived efficacy of interventions used. Feedback from clients about important emergent categories associated with the therapeutic relationship, including comparative approaches, service perception and development, perception of quality of life, health and wellbeing is given later in this article .

The therapeutic relationship

Clients identified *CatchOn2us*' highly interpersonal and supportive approach as a key factor in the project's success. Although the project's calm and inviting environment was felt to play a part, it was the interpersonal elements that were viewed as the more vital ingredients in *CatchOn2us*' approach. One individual qualified '*the approach*' (particularly '*the sanctuary*' and '*at ease feeling*' that it created) as being most crucial to the benefit she perceived, and spontaneously attributed

85% of this effect to 'the approach' and 15% the physical treatment.

The nature of the therapeutic relationship created a certain interpersonal space which was felt to be different from other healthcare experiences: *'They give you something, that added extra that you don't get in the medical profession… there's no panic when you go in there, and you're not waiting in the queue and getting your name called, and getting agitated…'* . Asked about interpersonal skills, interviewees responded that the team allowed users to feel cared about, and that their actions indicated attention, and a concern for dignity and respect for clients. For one service user, the team's actions towards people were viewed as 'sacrosanct'); others recounted their feeling of being the central focus of the CTC when at *CatchOn2us*. "*The big thing with CatchOn is that they treat the person, not the complaint. When Margaret was working on my leg and my arm, she was working on me as a person.'*. *'I don't know where they get their patience from because they treat everybody as if you're the only one there – they've got all the time in the world for you.'* This focus, together with the opportunity to talk with therapists about various problems, was seen as the beginning of a self-development process: *'I felt as if I could tell them some of my problems. I was able to talk to them about a relationship I shouldn't have been in. Because I had plummeted, I was vulnerable, and allowed myself to get into this situation. Just talking things over, since then I've broken this relationship off. I feel better, happier in myself.'* Here the response shift is facilitated by the client's perception that they are not just another body or number but a human being, who can share their problems with another.

> The big thing with CatchOn is that they treat the person, not the complaint. When Margaret was working on my leg and my arm, she was working on me as a person.

The way therapists brought aspects of their own personal lives into the interaction, although valued by some, was questioned by others because it was felt to detract from the care and attention that a client should receive, and so was perceived as not always helpful. As part of a wider conversation with one client expressing disdain around this she highlights: *'It was friendly, and sharing ideas and thoughts, but it wasn't working through feelings. It wasn't getting rid of the stuff that was making me anxious. …'*' She continued to talk about how the service was about touch, and that other settings need to be accessed for addressing psychological issues. For others this approach was felt to create equality within the client relationship. As expressed by one woman: *'Within a few minutes of meeting, she diffuses a situation by making it quite clear she has her own problems to overcome, and that's why she was working at CatchOn2us. I think that's always a leveller.'* The openness of CTCs about their personal lives appeared to create a relaxed and enhanced connection for some, and possibly a distancing for others. These perceptions may have influenced the response shift for clients.

Reference to spirituality was touched on in several instances, and clients suggested that the underlying essence of spirituality was about being part of a larger group, and of feeling connected to that group. The CatchOn2us environment was explicitly stated as a 'spiritual' place in a way that could not easily be expressed: *'There's nothing mysterious about CatchOn, but there's something spiritual there. Tapping into things that a lot of us don't know anything about.'* Some referred to '…a feeling of warmth, and healing even – a spiritual energy'; others focused on the spiritual qualities of CTCs and their potential to act as a catalyst for the response shift. For example one woman stated: *'Spirituality, God. That's very important to me. She [the therapist] is a healer, because of the work she does down here.'* Another woman stated: *'You can see a lot of people coming in for treatment….that actual touch brings something out of them.'*; *'You feel loved at CatchOn …. When you go to the doctor, they just throw a prescription at you … I think as much as anything it's not that they're experts at massaging or anything like that but the fact that they're tender loving carers.'* Perceptions of care, love and touch were perceived as an essential part of the healthcare package and a significant part of the interaction between practitioner and clients in facilitating a response shift.

All staff were considered to have a highly professional yet courteous approach. There were different viewpoints among clients about the expertise of the CTCs. Some felt that although they were doing an excellent job they were not 'real experts': *'I don't mean this as a criticism of CatchOn2Us, but there's a certain amount of amateurism, you understand what I mean, it's not hard professionalism there and I think that's nice. … I've been to experts and I know the difference, but what they don't have in experience they have in feeling… You feel that they are a human being and that they do care about you. And that's the thing that you don't get an awful lot of.'* Here, response shift seems to be intensified by a perception of lack of expertise.

The idea of integration of CatchOn2Us with mainstream healthcare was mixed. Some felt that the service could be adjoined to a hospital for easy access; others liked the idea of a couple of doctors working at CatchOn2us as a means of referring service users, but others were less positive about these options. *'Each doctor's surgery should have a little place with CatchOn's people in it… I don't think that would really be feasible. It really would be better to go to a different place for the CatchOn2us treatment,* *because the doctors are completely different there. They wouldn't want people talking and being nice to people would they?'* Although not specifically stated as a criterion for response shift, this example illustrates the perceived significance of communication styles and philosophies at work in healthcare delivery, and how they may help build (or undermine) the foundations for a response shift.

Response shift: personal development and transformation through connectedness

CatchOn2us participants reported physical, emotional, and personal development as a result of attending the project. Interventions were seen to have both specific as well as more general effects. Three such non-specific effects on quality of life included: a feeling of connection/belonging, learning and re-evaluation about the self and others, and increased coping. All seemed to signify a sense of personal development or change, otherwise known as a response shift, ie a person's change in behaviour and underlying assumptions about values and standards in relation to their quality of life. 8 These were often seen as inextricably linked with the therapeutic encounter.

Some clients pointed out different strategies and techniques which they had learned from CTCs during their time at CatchOn2us, such as relaxation and imagery skills that helped them to cope with stressful life events and the strain of long-term conditions. They explained how in an effort to cope with chronic illness learning and increased knowledge had enabled them to begin re-evaluating their body. Indeed, for some CatchOn2us was inspirational, helping them to cope with life itself. Here access to education through the CTCs was felt to influence a response shift for some clients. *'I feel that there were just certain situations, while being here, I felt I'd been able to get through them a little better. The staff have also given me books to read or advise me.'*

It appeared that CTCs taking an interest in their clients' health sometimes encouraged clients to take an interest in it themselves. Several clients shared a sense of CatchOn2us having given them back a sense of control that enabled them to engage in more positive health practices and have a greater awareness of their body and health. Feelings of increased awareness and control over the body were the main changes noted by clients, as highlighted in the quotes below which demonstrate a positive shift away from previously 'dependent' ideas and/or cycles of behaviour. This shift appeared to have arisen primarily from CTCs paying attention to an individual's story, and either making suggestions to help them with health issues they were experiencing, or simply listening attentively.

> *'I think the main thing is that I've realised I can change, I can be a bit more healthy and make myself a bit more mobile. I think it is something that helps you make yourself feel good as you get older.'*

Illustration by Linda Kirkpatrick

> *'It (CatchOn2us) just pointed me in the direction of looking at the lifestyle I was leading, and the way I was dealing with it. The stress I was under was escalating until I actually came here, and it really made me think.'*
>
> *'I know now it [the pain)] is not the be all and end all. It's not frightening to me any more… I've learned so much where drugs are concerned… I believe in working the body through things now…'*

Catchon2us encouraged personal development in the areas of confidence, self-expression, assertiveness, acceptance and the knowledge that practising these attitudes can improve health, wellbeing and quality of life. Sometimes, improved perceptions were based on something specific a CTC had said or done. This often involved some form of education for the client, or a clients' response to an intervention, as the following quotes, representing the journey of many clients, illustrate.

> *'It taught me to converse. When I was young, I used to read a lot of books. And then it was alcohol, of course. I do find it hard to deal with stuff. I don't like to confront people. It's built my confidence up, and I'm a little bit more assertive.'*
>
> *'And when I had the massage and the reflexology it sort of, you know, made me relax and realise … if there's anything you can do about it do it, if there's nothing you can do about it don't worry. And it's true.'* (Woman referring to her brother's recent death, and implying that she perceived the relaxation process was helping her cope with this loss)

Discussion

The impact of the therapeutic relationship on health and wellbeing: quality of life and personal transformation

This evaluation, drawing on the findings of a relatively large number of interviews and narrative-based research found, as others have before [9,10], that the therapeutic relationship is important in the healing process. It also advances certain ideas about the therapeutic relationship, in particular highlighting the effects of various aspects that clients felt had facilitated response shifts (changes in behaviour, values and thought process). These included the CatchOn project environment itself, and even more so the characteristics of CTCs, certain therapeutic interactions with them, and the dignified approach to healthcare [11] implicit in the CatchOn2us approach. Clients' perceptions of becoming part of a change process (whether in the re-evaluation of their body, sense of personal control, or understanding of new ways of personal coping) were significant, as were opportunities for learning about health and wellbeing. The findings provide an innovative exploration of how atypical service users (of a free service and predominately from a deprived socio-economic background) perceive complementary medicine and its benefits.

The project's overall approach and the characteristics of providers allowed clients to increase their sense of ownership of health process and learn about their potential for health and wellbeing. Aspects of the service and CTCs may have allowed some clients to connect with higher values [12], as certain findings suggests that clients appreciated and obtained additional benefit from caring that had a more spiritual component. If, as others have suggested may be the case [13,14,15], a spiritual component can enhance the potential for health and healing, then this supports clients' expressed desire for integrated healthcare in a system that acknowledges that a person's body and mind, spirit and life context are all involved in illness and in the processes that may stimulate recovery.

Several comments from clients reveal changes in how they thought and felt about their bodies after attending CatchOn2us. Although no specific typologies of change can be derived from the study itself, a method developed by others suggested itself. [17] When interpreting these clients' narratives there was a real sense that some people had become more connected to their body – more accepting of and more comfortable about their body. Through learning and being listened to they had reached a greater self-understanding of their body, and felt they could help themselves move towards better health and wellbeing. Some people began to work with their bodies rather than feeling dissociated from them, were able to express more about themselves and their body to CTCs, and demonstrated an increasing connection and empathy with CTCs over a 10-week period.

An important criticism of the service was boundary-related. A few interviewees raised concerns about the need for therapeutic care workers to stay within the boundaries of what they had been taught. Although many users found it helpful that CTCs allowed them to speak about their worries and concerns, it was clear that CTCs are not trained counsellors. So as ordinary people (not 'professionals') conveying humanity and concern through trained touch, they sometimes responded too freely to what their clients were sharing, by telling them about their own experiences. This was not always perceived as 'professional' or helpful.

Given that personal factors proved so significant to perceived outcomes, and that a perception of dissonance between healthcare cultures ran through the findings, it is not surprising that when asked about the potential for integrating similar projects into mainstream settings, concerns were raised that non-mainstream practitioners might become oppressed in the mainstream health care environment, implying that it might therefore be best to keep practitioners with distinct philosophies apart from one another. In view of these findings, it might be that people perceive complementary healthcare as attending to health needs that are different from those that they believe (presumably on the basis of their experience) conventional health care is prepared to address. While CatchOn's clients might have appreciated the contribution made by the mainstream system, it was clear too that what they learned through CatchOn had allowed some of them to usefully reframe their understanding and experience of healthcare, and to move forward in ways that the mainstream provision had not allowed them to.

Illustration by Linda Kirkpatrick

Limitations of the research process and investigation

The study design was orientated by specific requirements of the CatchOn2us team and shaped by their comments. Though this might be considered to have biased its approach, analysis of clients' responses revealed that the key areas of focus were client health, wellbeing and transformation. Given the CatchOn2us model of care (which aims at optimising many factors that facilitate wellbeing), it is impossible to know whether it is the training of practitioners, the working environment, the philosophy and culture of the system in which they work, personal characteristics of the CTCs or their relationships with clients that determines the outcomes of patient care. At this point it is important to acknowledge that this study was not designed to understand causation, but the findings have helped generate a hypothesis about the therapeutic relationship which is in need of further exploration.

Our analysis provides a systematic unpicking of the CatchOn2us experience derived from one snapshot in time. Such snapshots cannot capture or express the richness and entirety of individual accounts, and are inevitably subject to the editorial forces that come into play in order to transform 'the text into a story for analysis'. [4]

As it stands this evaluation has provided insight into the therapeutic carer-client relationship based on stories which are not always explicit enough about key factors. For example, clients inform us of their having received love and care but provide no detail about what gave them that sense of love and care; or they relay information about finding new abilities to relax about life events, or to function with a new self-help mindset, or to establish control over their body. Yet they have not explained the process or mechanisms by which these gifts manifest themselves. We accept the limitations of the auto-ethnographic approach chosen. Further research in this field might produce a deeper and richer understanding of the therapeutic relationship by using interpretative phenomenological analysis or discourse analysis to pick up complexities of dialogue between CTCs and their clients .

Whole person care for the future: approaches, training and research

In the case of Catchon2us, practitioners received the kind of training and delivered care in a way which supported their clients engaging in a response shift that was associated with an appreciation of the humanity underlying the communication and behaviour of CTCs. This finding reinforces the notion that each client needs to feel that practitioners care about them as a whole person whatever the kind of intervention offered). [18] This highlights the importance of factoring into holistic clinical work an awareness of those subjective and individual perceptions that influence therapeutic outcomes; furthermore that clinical evaluations need to take individuality and difference into account, especially when considering interventions aimed at improving self-efficacy. [19] This evaluation provided strong support for of the approach developed by CatchOn2us.

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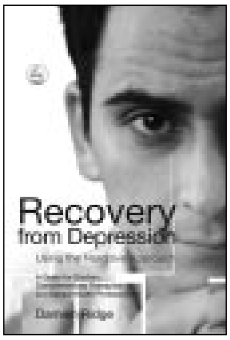
On becoming a ‘recovery ally’ for people with depression



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I am a sociologist and qualitative researcher and developed the depression and HIV DIPEx research projects and websites (www.healthtalkonline.org). Since late 2006 I have led the patient experience research group at the University of Westminster. I am now involved in studying the way men engage in mindfulness, as well as how men age successfully. I am a regular meditation and yoga practitioner, currently training as a psychotherapist.

Summary

Depression is unique in the way it attacks the mind and undermines the ‘voice’ and patient abilities to tell a life-giving story. So how then do patients actually go about organising their recovery from depression? What is the role of memory and narrative? And how can professionals best encourage revitalising narratives?

One in six people are affected by depression in their lifetime, while less than 50% of people access treatment for their condition. [1] And yet despite poor rates of treatment and the debilitating nature of moderate to severe depression, there is actually much patients and professionals can do to promote recovery. In my book *Recovery from Depression Using the Narrative Approach*, based on 38 in-depth interviews with people from all over the UK, the focus is on how people themselves overcome the debilitating effects of depression to tell stories of survival, recovery and prospering. Taking a narrative approach themselves, professionals can respect patient narratives; aid more helpful patient narratives to emerge; assist patients to select more life giving narratives; and learn about the narrative ‘tools’ (eg medication, exercise, therapy) that help patients to manage their depression and tell stories of recovery.

Narrative and memory

Telling and re-telling our personal stories is a key way people retrieve, attribute and transmit meanings about themselves and their lives, including about their health. [2] In personal storytelling, ‘truth’ is constructed as not only ‘what was experienced, but equally what becomes experience in the telling and its reception’. [3] As part of constructing a narrative of transition – like from depression to recovery – our memories are complex, and the past is selected and filtered according to the needs of the present: ‘The past structures the present through its legacy, but it is the present that selects this legacy, preserving some aspects and forgetting others’. [4] From concepts of memory and narrative as actively ‘constructed’, the actual ‘truth’ is not as important as the notion that people can constantly revise their interpretations as a way of better coping with their present circumstances. Regardless of how others may evaluate the ‘truth’ value of personal stories, the consequences of our life stories are real enough: Story telling can be healing when it is skilful, and detrimental when it is unskilful. [5]

In a whole range of chronic conditions, it is known that the stories we tell about ourselves can have considerable impact on our wellbeing. [5,6,7] Thus, if your story is not working for you, then tell a better story! But that is easier said than done. Our research with people who have experienced depression shows that the helpful stories we select need to resonate with us at a deeper level. [5] And this is the tricky bit: How do patients discover these helpful narrative threads that ring true? There are all kinds of complexities involved. For instance, depression involves feelings of 'voicelessness.' While voicelessness has been described in various health-related conditions [8] patients with depression can be particularly affected by the lack of ability to articulate their experience, not least because the mind is 'broken'. The articulation of interiority itself – like sadness, guilt, misery and hope – is also fraught with difficulties, such as the inadequacy of language to describe experience. So how do professionals help patients to articulate that which is silent, or things only said in coded ways?

> *I was hardly getting any sleep at all and I was becoming… walking around like a zombie really and I just went to her [GP] for some sleeping tablets… I was working shift work at the time, that's probably why. And she kind of started questioning my mood, she is very good, I have a very good GP… And she was kind of asking me questions about my social life and I said, 'I haven't got one at the moment. I just don't, I can't be bothered and…' I suppose my whole body language was telling her something as well. And maybe my voice and how I was generally but something told her, I think, to question me a bit more than just hand me over some sleeping tablets… And I think she said to me, 'I think you're suffering with depression'.*
> *(Belinda)*

Although patient narratives can be difficult terrain for professionals, time and time again, people's stories tell us that the simple ways in which professionals engage can make all the difference to their depression and recoveries. For example, Mathew, 16, talks about the comfort he felt when he realised that his GP – a man decades older than him – understood his particular kind of misery:

> *And he [GP] said, 'Well we're going to give you something just to stop your mind whizzing', I remember him saying that… He was like, he made me feel okay my mum was not there. This is you and me. You're an adult, this is between you and me, which I don't think I kind of understood that actually… And he was a kind of… I suppose before he'd always seemed a sort of, kind of rather you know, a figure of authority to go with all the other ones. Then when he starts to talk to you, then you sort of, you realise, God this man in his 50s knows what it's like to be 16, talks to a lot of 16-year-olds, knows what it feels like to feel shit. And lots of people have felt the way I feel, and that really helps. (Matthew)*

Recovery

The idea that people could actually recover from severe mental illnesses really only took off in the last century. [9] Today, the concept of 'recovery' is being championed by government and non-government organisations alike. An early and influential definition of recovery by Anthony [10] resonates well with the task as described by the participants in the book:

> *[Recovery is] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*

'Recovery' is a powerful concept in mental health, and patient discourses about recovery may well challenge pessimistic professional/academic accounts about mental illness. [11] But from a narrative perspective, it is assumed that recovery is anything but linear: it can feel like it is going backwards or running on the spot. Recovery is not perfect. Additionally, it is patients with mental health issues who are the expert storytellers, and indeed the only ones capable of telling their own story: Fortunately, the ways patients with chronic conditions like depression can develop expertise, self-manage their conditions, and become more active consumers of health care is being recognised more and more. [12] Thus, professionals can only *facilitate* recovery, it is patients who must 'recover': Professionals are best seen as allies in recovery.

But as intimated earlier, being an ally in someone's recovery is not always a straightforward task for a professional, as it involves adopting particular approaches that may not seem intuitive or may need to be learned. Nevertheless, the people I interviewed agreed that highly regarded allies in recovery had certain key qualities or approaches. The good news is that many of these things could be relatively easy adopted. For example, being able to imagine the existential crisis of depression, helping patients to feel like their suffering matters and promoting hope in recovery. Other things require more skill – like helping patients to select more useful narratives out of a confusion of narrative threads. Yet, sensitive professionals can learn such approaches as I outline in detail in my book. Below, I discuss a small number of examples from the book on how professionals can support patients: recognising depression existentially, empathy and non-judgment, making connections with clients, listening and responding, and conveying a recovery attitude.

Recognising depression existentially

Patients who have had depression may describe in great detail their existential misery and isolation after the event. Yet they can find it very difficult to articulate their interior world of thoughts and feelings at the time. [13] They are also likely to lack self confidence and may feel fraudulent, and so they can struggle to overcome the perceived asymmetry of encounters with professionals.

> *You've just got to feel confident [going to the GP]. You just have to prepare yourself that it's OK to feel like this. I'm not being a fraud. It really is that self belief. And it's really, really hard because if you are depressed anyway you have got such low self esteem that you feel a complete fool. (Julie)*

People may also feel they have to present as good patients, and establishing this 'deal' with professionals can also work against a frank discussion of difficulties. [14,15]. Patients also described the invisible and 'locked in' nature of depression which added to problems in diagnosis. As one man pointed out, 'You can see a broken arm, you can see a broken leg, you can't necessarily see a broken mind.' Professionals too may have good reasons for not wanting to rush to label patient suffering as to do with depression. [16,17]. But when professionals fail to identify the patient crisis – and the seriousness of the suffering involved – the 'voicelessness' of depressed patients can be reinforced. Thus a sensitivity to the issues facing people with depression can be most useful.

> *… I knew that I could talk to him [psychiatrist] about anything. And everything. And he was patient, and quite a gentle man. But … I would think very knowledgeable. Yeh so I had a great deal of faith in him. Yeh. So he was the most influential person… He never criticised. He never made judgements…And he was terribly sensitive, or he made me feel that he was. And I'm sure he was, and I had great confidence in his skill. (John)*

Empathy and non-judgement

It is long known that conveying empathy and non-judgement towards patients is important in patient-centred health care. [18,19] Putting in the effort (including patience), to understand patients, convey empathy, not rush to judgement and stick with them throughout their experiences of depression and recovery is key. For instance, Rosey expected harsh judgement as part of her depression, but instead a congruent and non-judgemental approach was what she really needed!

> *She [psychotherapist] doesn't push me to do things I don't want to do. She may suggest things but if I don't do them I don't feel that I'm in the wrong for not doing them. She's very accepting. She is completely non-judgemental, quite frustratingly so… Because I'm a 'bad' person and it would help me enormously if she did judge me! [laughs] (Rosey)*

Connecting with patients

There is an art to reading patient narratives, selecting what is salient (said or unsaid) and finding a way to connect to patients through narrative. Professionals have varying abilities to connect with patients in a way that inspires. The onus is very much on the professional to connect with what depressed patients are experiencing and trying to say. As already mentioned, patients with depression will have difficulties connecting to others themselves:

> *One of the most important things is having people there for you. I mean it's a bit of a… I can't think what the word would be for it, but it's a bit of an unfortunate thing that when you need people, is when you feel least able to ask for people's help or relate to people. (Heather)*

So in a sense, a lot is asked of the professional. However, in another way, little more is being asked of the professional other than attempting to demonstrate certain very human qualities. Participants felt more confidence in – and connection to – professionals who were obviously trying, even if they did not always get it right.

> *She's [GP] good because she is human. She listens and she responds to me as a human being, not as a professional. She gives me time, as much time as I want sometimes… You know, she is a human being, she has made mistakes and that's fine because she is a human being and I know she's a human being because she talks to me like, like I'm a human being… She's never standoffish or looking at her watch and thinking, you know, about the next patient. Never. (Belinda)*

Listening to the patient narrative

Many participants had lived much of their lives without feeling heard. In these circumstances, professional consultations can be an opportunity for patients to feel listened to for the first time. An attitude of curiosity about what patients are voicing, and the narratives they are trying to convey, can open up important narrative spaces for patients.

> *I think I went over the course of about three terms, over a couple of academic years, seeing that counsellor… It was, it was quite good in a way, because it was the first time somebody had sat and listened to me, listened to my concerns, exclusively, and that worked quite well. (Rosey)*

Responding appropriately

The patient narrative that resonates is the one that helps patients to feel like things are dropping into place. Such a narratives allow meaning to be retrieved from the crisis of depression. [16] Here, practitioners demonstrate that they are listening by sifting through the fragments of patient narratives, and finding ways to respond to the information that feels authentic for patients.

> *He [psychiatrist] had an expression that every time I went to see him, he would say, 'How are you in your spirits today?' So I would feel free to say, 'I've… I've had a terrible time', or 'feels*

> *bad'. And he would say, oh, that's probably because of something I'd mentioned was happening…So he was able to put a label on it to a certain extent, which made it drop into its place… (John)*

As previously noted, listening also involves monitoring what is left unsaid. In the quotation below, a health professional acquaintance picks up on the real undercurrent in Peter's narrative: that he somehow felt to blame for having had depression. By responding with a 'no-blame' chemical imbalance narrative in a supportive way, the professional was able to get to the heart of Peter's concern.

> *You see somebody said something to me, and one of the things that really helped me… It was that somebody at church said 'It's not your fault Peter. It's not your fault, it's probably the serotonin in the brain has been knocked out, and therefore it was a chemical cause …' I think this is what she said, it's some time ago. But it was such a relief, I don't know if I was bearing a sort of a hidden guilt for getting this illness, I don't know but it was such a relief to be told that, it was marvellous… [Being told it was not my fault] was a major episode, that. I remember we were outside the Baptist church, and she got chatting to me, she was in the medical profession herself… (Peter)*

Promoting a 'recovery attitude'

Even when a person has trouble believing they will ever recover during the depression, the key difference between an ally and someone with depression is that the ally can always believe that the person will recover. In the book, I outline the complex tasks and phases involved in recovery from the patient perspective. At a simple level though, what is clear is that people can adopt a recovery attitude at any age – or stage – of depression and recovery, as this man in his seventies proved by his thinking in the depths of depression.

> *I always try to think that there's a sort of beneficial flip side to these problems. And I tell myself that if you don't hit the bottom, you don't really know what the good things are. So when I felt absolutely as if I'd hit the rock bottom, it was starting then to feel quite joyful because I knew it was going to get better, and gradually it did. (John)*

The kinds of professional statements (used sensitively, and appropriately within patient narratives) that participants found helpful included ones like: 'I believe you can get through this', 'You will recover in time, but not immediately,' 'Depression is only part of you, not all of you', 'What does not kill you can make you stronger.'

In summary, there is much professionals can do to help patients write a better story about their depression and recovery. Regardless of where patients are on the depression-recovery spectrum, patients can always discover or re-write a narrative to help improve – or even revitalise – life.

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Nursing in partnership with patients means embracing integrated healthcare

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I have nursed and supported patients with cancer and long term conditions who have used an integrated approach to managing their health. I feel that one of the most important aspects of care is respecting patient autonomy and providing information for them to be able to make an informed decision.

Summary

Improving the quality of care for patients will require nurses to understand how patients integrate complementary therapies into their self-care. If nurses are to work in partnership effectively they will have to learn to facilitate integration effectively, and that will mean understanding more about these ideas and practices.

The Prince's Foundation for Integrated Health intends to support nurses to ensure that patient's receive the best care that they can when engaging with health professionals. Hence we are working hard to ensure that current national policies to help patients receive a quality service are implemented and are of benefit.

Perhaps one of the most important principles we seek to support is the patient's right to make decisions about the care that they receive. This is not always straightforward: while some patients simply expect to exercise their right to self-determination and are clear about what they require from health professionals, others lack this focus of control, are less assertive, perhaps more dependent on the health professionals to whom they look for guidance in their decision-making processes. The majority of patients operate somewhere between these two extremes, so it is essential that in our nursing practice we know who, and how, to facilitate and even deliver more integrated care in ways that are appropriately personalised.

The quality of care hinges on three components which have been ably described by Lord Darzi in *High Quality Care for All: NHS Next Stage Review* .[1] The components are:

- ensuring the safety of patients
- the clinical effectiveness of treatment
- the importance of the patient experience.

I have in mind examples from my early days in nursing several patients who typified different sorts of needs and wishes and who had differing expectations of me as a nurse. Take Brian for instance, a frightened terminally ill 18-year-old whose eyes seemed to follow me around the ward as I set about settling other patients down and administering medication. Was Brian, I remember wondering, one of those patients who had given up his fight for life and become too frightened to enter into any dialogue about his care and his wants? He seemed to me too passive, merely an inert recipient of care. And so my conversations with him were light-hearted and superficial, never entering into any kind of deeper meaningful talk about what he felt or needed or expected of me. For my part I was too frightened that his only true desire might be to live longer; and I knew of course that this was something I could not give him. So I wasn't about to enter into a conversation that might make me feel cornered into offering something I was unable to deliver. Consequently I did something nurses sometime do to defend themselves: I separated Brian's body and mind, and I looked after his body (which was undeniably in bad shape and rapidly deteriorating further) but neither I nor anyone else involved in his care made any attempt to care for his mental wellbeing. It wasn't that as a young newly qualified nurse I hadn't been taught about a patient's right to a peaceful death; I just didn't know how to help him achieve it.

Mary made a huge impression on me. In my whole time as a student nurse on the haematology ward she was the only person I ever remember going into remission from leukaemia. I recall vividly seeing her eating avocados (something I intend to do too should I ever get leukaemia) and her explaining to me that as well as taking her conventional drugs she was changing her diet, and doing all she could to improve her health. Mary had decided to take a lot of responsibility for her health, and to this day I wonder how big a part her sense of self-determination and control over her own health played in her eventual recovery.

> ‘Rosa had upset the balance of power by refusing the experts' advice.’

Rosa was another patient with cancer, who on learning that her carcinoma breast had spread into her bones, decided that she didn't want chemotherapy. Instead she agreed to a mastectomy and went on to manage her own care using alternative therapies. The medical reaction to this was at first to refuse her any access to diagnostics for monitoring the disease. Because Rosa had upset the balance of power by refusing the experts' advice her punishment was to be denied important components of care until she complied. Some 10 years on I can report that Rosa still manages her cancer using a combination of conventional medicine and diet, and that in those 10 years she has managed to work, live creatively, see her family grow up and even to hear her consultant describe her as ‘the one who chose to go alternative… …which is probably why she is still here today’. Rosa had realised there was no outright cure for her condition, so she chose to work on developing a positive way of living with cancer. As things worked out her approach wasn't alternative; it was integrative, and she used complementary as well as conventional approaches having researched and understood the potential impact that nutrition (and chemotherapy) might have on her cancer.

It is becoming ever more common for people to seek out information about their health problems and to try out remedies that most conventional healthcare professionals know nothing about; for we are neither taught about them in conventional medical and nursing schools nor are they made available in our hospitals. Personalisation of care will call for a better understanding of our patients' beliefs, wishes and self-care plans so that we can help support their ability to lead the lives they want to lead, at the same time offering them our professional knowledge and clinical expertise. How useful it could be to provide patients with relevant test results and other pertinent diagnostic information *before* they meet with health professionals to explore options for changes to their care. This sort of two-way exchange of information would support real working in partnership.

The ultimate goal of integrated self-care is not to supplant modern medicines, but rather to make appropriate use of validated non-conventional approaches alongside the best of current conventional medical practices. The art of nursing understands that any illness is more than just the presence of a disease; it is also a struggle with the human experience of suffering and of the consequences of disease. Because nurses are so near to these experiences we have unique opportunities for working in partnership to address the uniqueness of patients' experiences, to hear of their needs and beliefs, to inform and help shape appropriate choices. If we are to achieve this we will have to employ whatever approaches are likely to facilitate self-care and health improvement, and in order to do so we have to gain a much broader understanding of the range of possibilities available.

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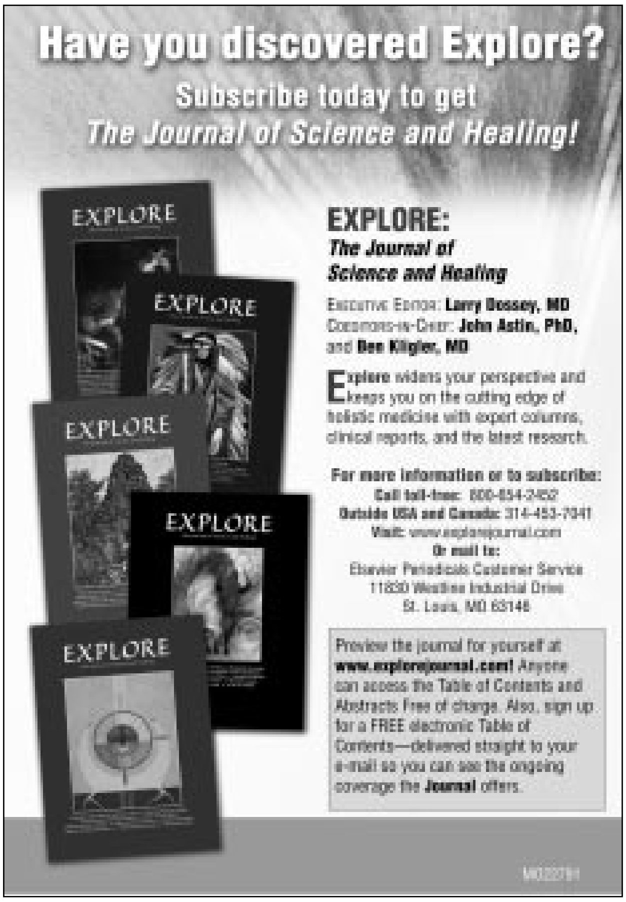

An integrated approach to gynaecology

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Having been born and trained in London I am now a consultant obstetrician and gynaecologist at Dorset County Hospital in Dorchester and medical director of The Poundbury Clinic. I have always believed in an integrated approach to healthcare and I have travelled to India on many occasions to study different aspects. These include yoga, Yunani medicine, acupuncture, homeopathy and Ayruvedic medicine.

Summary

Gynaecology and women's health is ideally suited for an integrated approach. Women must be offered a choice with a team approach. It is essential to have good communication between different practitioners. The problems with developing evidence base is raised and a systematic approach to the integrated management of patients using the acronym DR AID is discussed. The problems of infertility, menopause and premenstrual syndrome are also addressed.

Finished files are the re-
sult of many years of scientif-
ic study combined with the experience of many years.

I would like you to look at the sentence above and count in 30 seconds the number of fs. Have you found three, four, five or six? When I present this to different audiences I am surprised by the results. The average count is three although the real figure is 6!

The reason I have started with this little mind game is to introduce integrated medicine: the idea being that when there is a lot going on, we have to look carefully beyond our expectations and assumptions to understand what is really there. The same can be said about integrated medicine. There is nothing particularly new about it and a lot of practitioners are probably involved with doing their own versions of it without being much aware of how many others are doing similar things. And why are so many doctors exploring this sort of integration for themselves? Surely because in a health system such as ours, faced with so many problems and far too few solutions, it must make sense to look beyond our assumptions, to widen our horizons and, in order to see what's really there, consider the ways different medical cultures have developed around the world. I suggest it is time for mainstream medicine to study their strengths and weaknesses and to work towards combining what is best from all systems of healthcare.

Synergy

As Peter Hain, Leader of the House of Commons 2003-05, once said 'we need to end the Berlin wall between complementary and conventional medicine and integrate it. It is not that one is better than the other – it is that there can be a synergy between them both'.

In this article I want to demonstrate how gynaecology and women's health is ideally suited for an integrated approach. I believe that managing patients is like being a conductor of an orchestra: the music is what the patient hears and the different members of the orchestra are there to create the music. One must remember that some individuals prefer one type of music while others prefer a different type of music. Thus it is not 'one size fits all' but we have to develop a holistic individual approach and give patients choice as to the care they require.

So integrated medicine entails understanding the many factors that contribute to an individual's wellbeing and perhaps having to balance a number of interventions that might help them attain their full potential for health and wellbeing.

Using the orchestra analogy I believe an integrated practitioner needs to have the knowledge of all the different components of the orchestra rather than be an expert in everything. This is why we need a team approach to the management of the patient. For when various practitioners can work together to address a patient's needs from the different perspectives of their particular expertise, then the sum will be far greater than the individual components involved. The team approach is essential. In order to have a well structured team one needs role clarity and role acceptance before one actually moves on to role performance. Indeed, Sir John Harvey-Jones once stated 'to create success everyone's nose must be pointed in the same direction'.

Communication

Writing in the BMJ back in 2001, reference Simon Mills pointed out that 'many patients consult complementary practitioners without telling their doctor; with possible detrimental effects on their healthcare. Greater cooperation and respect between orthodox and complementary practitioners would improve communication with patients'[1]. When building a house, if the plumber did not speak to the electrician and the electrician did not speak to the plasterer, complete disaster would occur and a badly structured building would develop. Similarly, without good communication between individual practitioners inadequate patient care will occur. Communication can be via many routes, and at The Poundbury Clinic we use all channels of communication – letters, phone calls and email – and we have developed a very a simple and cost-effective co-operation card.

Rather like the co-operation cards that GPs, obstetricians and midwives and health visitors use when caring for a pregnant woman in the community, patients carry our card and individual practitioners write in a note of their management so that good lines of communication are maintained. To address concerns about confidentiality patients fill out a consent form at their first visit indicating with whom direct communication can take place and by what means. We have also encouraged multi-disciplinary team meetings so that different practitioners can discuss shared cases in a confidential environment.

Evidence

One of the main concerns is the need for evidence based integrated medicine. Indeed Julie Stone warned in 2002 that 'the absence of a credible research base within complementary and alternative medicine has been used as a political stick to hamper attempts at integration'. [2]
The sceptic might observe that 'the purpose of those who are in, is to keep those that are out, out'! But in reality some of our most revered physicians are far from closed-minded about integration. For example as Sir David Weatherell put it, 'though I believe passionately in scientific medicine, I have not got to the state of being so blinkered that I cannot believe that at least some aspects of a complementary approach may have a lot to offer. I think they could be put to scientific tests, and should be, but whether this will happen is far from clear. But one of the things I am sure of, regardless of what a patient is suffering from, the
reaction to their situation and their state of mind are of critical importance and to ignore them in the face of high technology and medical practice is to court disaster'.

Several concerns have been expressed lately about randomised controlled studies, for they were designed to test drugs, not skill-base person-to-person individualised treatments. Consequently they may not be the best way of finding out about individual outcomes. Moreover they aim to bracket off the practitioner's effect on the outcome of treatment. Sadly, the research budget for complementary and alternative medicine is very limited but without the resources to do the sorts of research needed, how are we ever to discover what integrated medicine can achieve in everyday practice? Catch 22: provide the evidence about integrated healthcare but don't practice integrated healthcare until you have the evidence.

DR AID is my acronym for the systematic integrated management of patients.

D = Diagnosis
In my practice, when patients present with a particular problem, before deciding on the best management protocol we need to make a good diagnosis. This tends to be based on a clear and thorough history, appropriate examination and investigations. Different practitioners will use different skills including the triple pulse in Ayruvedic medicine, the iridologist will add their component, and in Western practice we plump for scanning and blood investigations. Communication between individual practitioners is essential, because although it may not always be possible to add these bits of information together they can sometimes create an extended and more useful diagnosis.

R = Review
Once an appropriate diagnosis has been reached I review with the patient all the possible options for treatment. They might include self-help, over the counter products, CAM therapies, medical therapy and surgical treatment. Once we have considered all the different options for treatment and as much evidence as we can muster on risks and benefits we can move on to A for agreement.

A = Agreement
At this stage we need to formulate with the patient a plan of therapy for their particular complaint. I make it clear to her that I totally respect that we all have different preferences for treatment and that I won't get upset if she decides to go for a different treatment option that may not be my own preferred option.

I = Implement
Once we have an agreement on a treatment plan or journey we need to implement it and monitor it over a period of time.

D = Demonstrate
Obviously, progress needs to be kept under review in order to demonstrate whether the treatment plan has the hoped for beneficial effect.

Integrated care plans – three examples from Poundbury

Fit for fertility

Using the above as the basis for planning, The Poundbury Clinic has introduced a *Fit for Fertility* programme for patients presenting with fertility problems.[3] The programme addresses several issues including:

- **Positive thought**
  There is no doubt that positive thoughts lead to positive results. This is as true in infertility management as in elite athletes trying to win a gold medal. I have always felt that whatever the outcome it can be outcome-positive. In some ways, the management of an infertile couple is similar to that of an individual undergoing cancer treatment. The role of a cancer specialist is twofold. One is to try to help treat and cure the disease and the other is to help the individual live with the disease. The same can be said for infertility. Obviously, the preferred outcome is to have a healthy baby born to a healthy mother. Sadly, this is not always what happens but as long as the individuals involved feel they have done everything they can in order to conceive, it may allow them to move on to look at other options, including adoption, in a more positive light.
- **Planning the journey**
  It is essential in infertility to plan a journey over a 9–12 month period rather than planning from month to month. This may appear obvious but it is often not done and this can add unnecessarily to the stress that individuals and couples experience.
- **Diet**
  Good nutrition is essential. Simple advice can lead to good results. Indeed, it is my basic premise to make things simple rather than giving unachievable targets that create more stress.
  Excessive caffeine and alcohol are known to be detrimental to fertility in both men and women. Both will upset the hypothalamic pituitary gonadotrophic axis and lead to anovulation and amenorrhea.
  NICE guidelines have shown that smoking can have a negative effect and females who smoke decrease both conception and the risk of spontaneous miscarriage. There is also evidence that it has a detrimental effect on assisted conception.[4,5]
  There is no doubt that being overweight (BMI >30) or underweight (BMI<18) has a significant negative effect on fertility.[4]
- **Stress**
  Stress management is essential. There is plenty of evidence demonstrating that stress can have a negative effect on the hypothalamic pituitary gonadal axis as well as on immunological response. A study by Arck PT *et al* published in 2001 demonstrated that stress had a negative effect on the cells associated with the immune response in the uterine cavity.[6]

So the programme aims to approaching patients with fertility problems in an integrated way, addressing diet, lifestyle and stress management. All are essential. Different techniques we might suggest include aromatherapy, reflexology and yoga. Hypnotherapy can also have a positive effect on reducing smoking. In deciding on the most appropriate form of treatment including lifestyle advice, ovulation induction and assisted conception one needs to address several areas including medical, ethical, emotional and financial.

When we look at the role of assisted conception there is increasing evidence, particularly in the work of Stener-Victorin, about the role of acupuncture. This has demonstrated that acupuncture can improve endometrial circulation. Paulus *et al* [7] have also demonstrated a beneficial effect of acupuncture on the outcomes of embryo transfer.[8]

In summary, when addressing infertility you can see with the above approach looking at the Fit for Fertility programme one can manage infertile couples in an integrated way. By keeping things simple and keeping realistic goals which are achievable is essential. Planning a journey with appropriate practitioners is ideal.

Premenstrual syndrome

In gynaecology, the effect of fluctuating hormones on women's quality of life has been a longstanding concern. The President of the American College of Obstetricians & Gynaecologists, in his 1900 address, waxed lyrical about this, saying that 'many a young life is battered and forever crippled in the breakers of puberty; if it crosses these unharmed and is not dashed to pieces on the rock of childbirth it is still ground on the ever recurring shallows of menstruation blasted upon the final bar of the menopause for protection from the unruffled waters of the harbour beyond the reach of sexual storms'. (!).

Premenstrual syndrome involves a series of distressing physical and/or psychological symptoms that interfere with social or work related activities, which are not caused by any recognisable organic or psychiatric disease, which occur in the luteal phase of the menstrual cycle, improving with the menses and remaining significantly reduced until the next cycle of premenstrual symptoms begins.

Premenstrual syndrome is often difficult to diagnose and the role of a careful history and a diary card is important. I use a simple diary card as following.

Date							
Bleeding							
Anxiety							
Nervousness							
Sad Feeling							
Tearful							

0 (nothing) 1 (mild) 2 (moderate) 3 (severe)

Treatment can include changes in lifestyle, and the use of over-the-counter products, as well as alternative treatments and conventional therapies. Explanation and reassurance is essential, because there is no doubt that initiating a positive thought process helps and that for some women it is essential to organising life so that predictable important or stressful occasions don't fall on the premenstrual days. Exercise, and relaxation techniques including yoga and reflexology have been shown to have a positive effect on PMS, as indeed have certain supplements including Vitamin B6, magnesium and gamma-linolenic acid. If more aggressive forms of treatment are required there can be a role for the oral contraceptive pill as well as LHRH analogues.

Menopause

I believe that in the management of the menopause a women's integrated health team should advance towards a precise regime involving lifestyle changes, diet and appropriate therapeutic agents aimed at safely promoting a robust and thoughtful older age. Surely all women should be able to expect this. Although hormone replacement therapy obviously does have a role, this should not be the only solution. Indeed, I think we should be working towards something we might call integrated menopause therapy (IMT). An IMT, by offering women a range of choices for self-help plus professional expertise, both conventional and complementary, would help them manage their menopause in a way that is best for them and their way of life. For instance there is increasing evidence about the role of different techniques to help peri-menopausal hot flushes including yoga, meditation and visualisation techniques, and on the beneficial effect of exercise on post-menopausal breast cancer. (See *Your Change, Your Choice*).[9]

In summary, I have no doubt that the way forward in women's health is an integrated approach to healthcare and the three examples that I presented including fertility, menopause and premenstrual syndrome are ideally suited to this approach.

The Prince of Wales, as president of the BMA in 1982-1983, said: 'Today's unorthodoxy is probably going to be tomorrow's convention.' Women patients are wanting an integrated approach with the knowledge that 10 million people see a CAM practitioner each year and it is now our duty to promote an integrated approach in a positive way.

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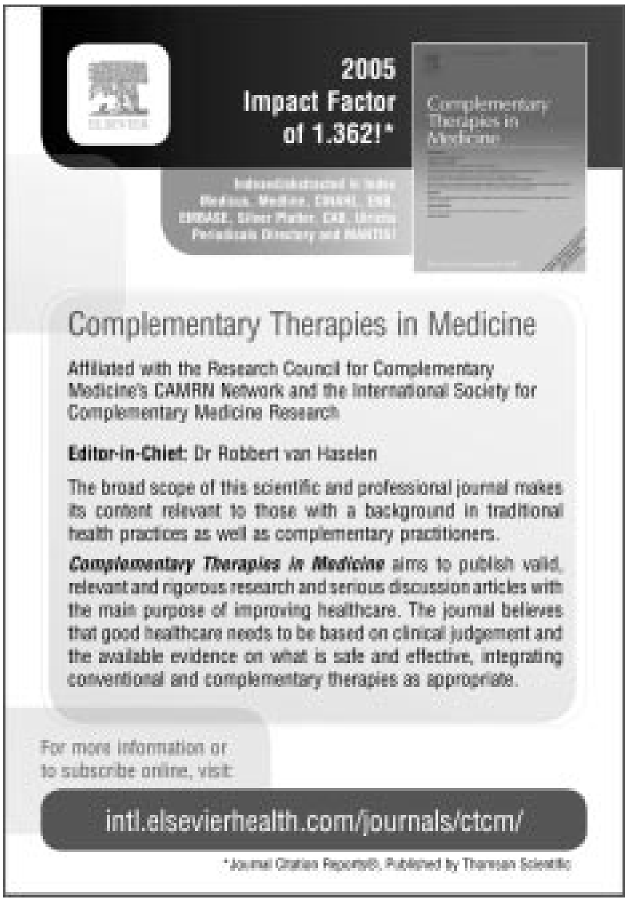

The challenge of obesity

Chris Drinkwater

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Summary

Knowledge and information about the management of obesity remains firmly located within a disease-based medical model. This model is inherently paternalistic and tends to undermine both collective and individual responsibility for our behaviours.

We need to shift to a model that is about fully engaging the public as co-producers of health. Challenging the prevailing orthodoxy of the medical/pharmaceutical industrial complex will not be easy, but sustainable long-term solutions will only be achieved if we are serious about devolving responsibility, power and funds to local communities.

The challenges of inner city general practice and the creation of a healthy living centre in Newcastle in the early 1990s have fostered and developed my continuing interest in partnership working, public health and the wider agenda of engaging patients and the public. I now sit on far too many groups and committees but remain convinced that the only way forward is through a model in which the public and frontline professionals work more closely together to develop and implement local solutions for local problems.

The amount that has been written about obesity over the last 10 years is staggering. If you type obesity into Google it provides a list of results under sub-headings.

Sub-headings	Results (5 April 2009)
Obesity statistics	486,000
Obesity in children	1,410,000
Obesity in the UK	5,220,000
Obesity facts	402,000
Obesity more causes/risk factors	1,130,000
Obesity more condition treatment	1,320,000
Obesity definition	3,500,000
Obesity pill	317,000
Obesity virus	427,000
Obesity surgery	3,660,000

Three questions arise from looking at this list:

1. Is there anything more that can be usefully said about obesity?
2. Why does all this information seem to have so little effect?
3. Why is there so much focus in this list on possible causes such as a virus and on technical solutions such as pills and surgery? ?

The current paradigm is that obesity is primarily a medical problem. The Department of Health is the lead for obesity; most of the research and information is medically generated; and much of the annual cost of obesity for England [1], reckoned at nearly £7 billion in 2002, is largely born by the NHS. The NHS is struggling to shift from a hierarchical, paternalistic model in which people are given information and told what to do, to a model in which the public are fully engaged as co-producers of health. [2] The reality, however, is still dominated by an approach that believes that provision of yet more information and development of quick fix technical solutions will solve all of our problems.

This brief paper will use NICE guidelines on behaviour change [3] and on community engagement [4] to argue that a disempowering deterministic model that is predicated on specific causes and individual bio-medical responses is unlikely to deal with the epidemic of obesity. Obesity is a social phenomenon with medical consequences and this complex issue requires a primarily social response.

Behaviour change

The NICE guidelines on behaviour change explicitly differentiate between interventions designed to change the behaviour of individuals, communities and populations. Dealing with these in reverse order, at population level interventions could include fiscal and legal measures and national campaigns. For obesity this would include enforcement of food traffic light systems proposed by the Food Standards Agency and campaigns such as *Change 4 Life*. At local community level interventions need to identify and build on the strengths of individuals and communities and the relationships within communities. For service commissioners keen to address obesity this means a shift away from a focus on provision of professional services to an approach which is about mapping out social networks and support that currently exists and looking at maintaining and enhancing these networks. Community activists and the local voluntary and community sector are well placed to engage with and influence local behaviours and their energies need to be harnessed to work through peer support models to produce change. Finally, at an individual level, there needs to be a change in professional behaviour that shifts consultation and engagement with people to a much more positive, motivating approach that encourages co-production through the explicit planning of ‘if–then’ coping strategies as part of action plans. Too many patients who are overweight or obese still feel put-down and demoralised by their contacts with healthcare professionals.

Community engagement

The NICE guidelines on community engagement add substance to the 2002 Wanless Review of NHS spending, which indicated that the NHS would be unsustainable from general taxation by 2022 unless we moved to a ‘fully engaged’ scenario with high levels of public engagement in health. Building sustainable engagement that delivers outcomes is difficult. The guidelines provide a practical way forward but to be successful it is essential that the NHS sees community engagement as a high priority.

The recommendations in the guidelines are divided into four areas:

- the prerequisites for engagement
- the infrastructure required to support engagement
- the approaches that can be used
- evaluation.

They are directed at three different groups:

- people involved in planning and designing national regional and local policy initiatives, commissioners and providers in public sector organisations
- members of community organisations and group and community representatives.

Key messages about the prerequisites required is that planners need to involve the community at an early stage and that they need to take account of existing activities and previous experience. One of the failings of obesity services is that they often do not involve people who are overweight and obese at the planning stage. This means that the ideas, concerns and expectations of patients are not incorporated, resulting in high non-attendance rates.

The need to understand the gradual, incremental and long-term nature of community engagement is also stressed, alongside the need for mechanisms to ensure that learning from these processes takes place on a continuing systematic basis. This will require a change in the culture and values of public sector organisations with a much greater sharing of power and influence than is currently the case. Part of developing effective engagement is about building mutual respect and trust between service providers and the communities they serve.

This requires continuity and pro-active feedback of information. It is still too often the case that agencies only consult when it is required by statute, so meetings are poorly planned and attended, and communities feel that even when they have had their say, nothing changes.

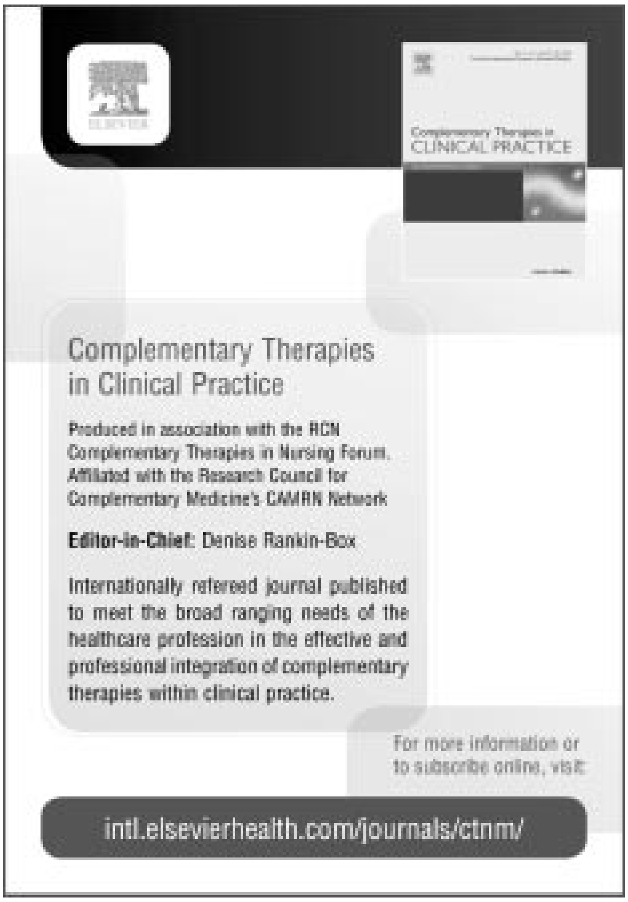
Meeting the prerequisites leads naturally to a focus on the infrastructure required to deliver effective practice. Here attention needs to be paid to the provision of appropriate training and development, mechanisms to endorse partnership working and support for the implementation of area-based initiatives. Training needs to involve frontline staff and community members. Joint rather than separate training can often enhance mutual understanding. For staff involved in providing obesity services, hearing directly what it is like to be overweight and how individuals often feel blamed and guilt-ridden, can help to enhance empathy and improve consultation styles. Providing training in participatory research and evaluation skills for service users and members of local communities can take this a step further by providing structured feedback about services and how they can be improved. These sort of approaches need to be incorporated into neighbourhood and area-based initiatives and they should be developed into agreements about local partnership working. At the highest level this might involve participatory budgeting with local communities having a real say in how budgets are spent to meet locally identified needs.

The section on approaches in the NICE community engagement guidelines concentrates on community members as agents of change, community workshops and resident consultancy. Recruiting and training local people as health trainers responsible for working with individuals and groups, to tackle local health problems, is a very obvious way forward. The value and visibility of these roles will be enhanced if these individuals become part of a wider local network working with neighbourhood managers, community forums and community representatives. They could, for instance, be involved in running community workshops on food, nutrition and physical activity, where the focus could be on the local food supply chain and access to healthy foods rather than on obesity as a medical condition. They could also focus on barriers to physical activity, including the built environment and lack of access to green spaces. Finally there is the potential to draw on the skills and experience of local individuals and groups to run resident consultancy initiatives. Arguably this might be a much better use of the money the NHS currently spends on expensive external consultants who are financially motivated and have little continuing interest about what happens once they have delivered their agreed contract and left.

Implications for tackling obesity

This brief piece suggests that if we are to tackle obesity we need to re-balance an approach that at present focuses on the evidence of what works for individuals – medically prescribed diets, drugs and surgery – with an emphasis on supporting local people and communities to get involved and to take responsibility.

Local Joint Strategic Needs Assessments [5] that bring together local data about the prevalence of obesity and map what is already being done in local authority areas are a key initial building block in this process. In Newcastle upon Tyne, for instance, the prevalence of obesity varies from 8.8% – 20% in the best Super Output Areas to 26% – 31.5% in the worst areas. Previous consultation events around the development of the Newcastle upon Tyne Health Improvement Strategy identified the following outcomes and actions to tackle the growing rate of obesity.



Outcome measures suggested:

- obesity levels in adults
- physical activity levels in adults
- levels of social isolation
- levels of expectation about good diet and nutrition
- access and utilization of green open spaces
- consumption of quality food products.

Action points suggested:

- deployment of community nutrition assistants
- community cooking skills/course
- more funding for green spaces
- ensure facilities do not provide unhealthy snacks
- proactive support for local shops
- encourage activity as part of life – not as separate activity
- more lobbying about food marketing and about successful promotion of health messages
- pricing policies that encourage healthy choices.

Translating this into action in an economic recession against a rising trend of NHS spending on drugs and surgery for obesity is more difficult. The radical approach would be to look at those Super Output Areas with the highest levels of obesity and to model the costs for these areas on the basis of postcoded obesity drug costs and obesity referral costs together with projections of longer term costs resulting from obesity. A community workshop should then be convened to share the information and to develop local priorities and solutions. As already happens with participatory budgeting, solutions should then be developed into business cases with costs which can be included in annual operating plans and funding proposals. Ultimately if local communities can demonstrate that they have made savings in both immediate costs for drugs and surgery and in potential long term costs by reductions in levels of obesity, at least some of the money saved should come back to the community for re-investment in other community ventures.

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Students' health matters

Krisna Steedhar
Medical Student, Imperial College London

Summary

This is the last year of the BHMA David Cobbold essay competition for medical students which has awarded £250 annually for the best student essay. Here we print an edited version of this year's winning entry. The runner up, Daniel Kelly, will be published in a future issue.

For a full version with references please visit www.bhma.org

> *Healthy medical students are likely to become healthy doctors who can then model and promote healthy lifestyles with their patients.*
>
> *Dr Thomas M. Wolf*

Harking back to the days of Hippocrates, medicine has long been regarded as a gratifying and honourable career. Healthcare students, as a whole, start their education with a sense of commitment, enthusiasm and the noblest of beneficent intentions.

Medical students enter the above process; the emergent doctor is expected to be humanistic, caring and dedicated to their patients. However, the pursuit of a medical career can exact a heavy toll on the student's health and well-being, since there is a great emphasis on technical excellence and amassing information with little regard for students' social and emotional development. Despite starting off filled with idealism and optimism, there is often a noticeable shift to a more cynical and hedonistic orientation during medical school.

Increasing attention has been devoted to the problems affecting the medical population with somewhat startling statistics that describe increased rates of drug and alcohol abuse, depression, deleterious effects of sleep deprivation, medical student abuse and suicide. These statistics are particularly worrisome because they represent those individuals entrusted with our collective well-being. Altogether, if a future physician's potential is reduced or destroyed by these factors, the results will inevitably be impaired healthcare delivery. Thus, it is imperative that those charged with directing medical students' education as well as students themselves assume responsibility for their physical, mental and spiritual wellbeing. This short essay will provide an overview of the more pertinent issues in student well-being, elucidate sequelae of its dysfunction and in a nod to the oft-recanted, 'Prevention is better than cure', discuss possible solutions.

Manifestations of impacted student wellbeing

Stress

While stress is 'normal' and universal, medical students experience substantial levels from the beginning of the training process. Stress is a common motivator, however not all students find stress constructive.

Depression

Separate studies have shown that medical students share similar mental health to their non-medical peers. Taking into account medical education's aim to produce graduates capable of promoting health, one might reasonably surmise that an apprenticeship in such a profession would be a period of personal growth and improved health. Disappointingly, evidence points to the contrary.

When tested against the General Health Questionnaire, which measures anxiety and depression, one third of first year British medical students were designated as being of poor mental health. Subsequent investigation on the same study population reported a doubling of students by the end of the first year suffering from quantifiably poor mental health.

Burnout

Burnout is best described as a syndrome of emotional exhaustion, depersonalisation and low personal accomplishment culminating in decreased efficiency at work. Studies report high rates of burnout among junior doctors, prompting speculation that the origins of this process lie in medical school.

Consequences

Academic performance
Stress and performance are inextricably linked. Examinations can be sources of intense stress and anxiety. Although these states may reciprocally affect grades, the degree of this influence may be subtle and dependent upon personality. Pre-medical academic attainment is correlated with academic performance during medical school, however rather surprisingly, psychosocial characteristics (such as anxiety, depression, neuroticism) are equally efficient at predicting written examination scores.

Cynicism
Medical school interview panellists often joke of a ringing in their ears, 'I want to help people'. However, as alluded to earlier, these benevolent intentions often give way to cynicism during medical school. Despite medical education's drive to promote empathy and humanism, these two traits show a marked decline during the process. Cynicism and loss of compassion appear to affect specialty choices, and can translate into an unwillingness to care for the chronically or terminally ill and elderly populations.

Dishonesty
The perceived integrity of doctors is commonly cited as a prime facilitator of productive patient-doctor communication.[30] Set against such a backdrop, widely described dishonesty amongst students as well as practicing physicians is even greater cause for concern. Students often blame their conduct on illness, workload and the perceived 'waste' of committing medical minutiae to memory outside of exams.

Substance abuse
Although the overall pattern of alcohol consumption is similar in medical students and age-matched peers, problematic or binge-drinking is common among the medical student population. Students commonly attribute this reckless behaviour to anxiety, stress and examination pressures. Lending credence to the proposed deleterious effects of medical training, 29% of medical students noted an increase in alcohol intake during the course. These are not recent phenomena, however; medical historian Stuart Garner writes that the heavy drinking culture in British medical schools dates back at least as far as World War I.

Suicide
Work has shown an increased rate of suicide amongst a Birmingham cohort. Although the prevalence of suicidal ideation has not been studied, an estimated 8 to 25 attempted suicides occur for each death, reflecting the concern that suicide statistics reflect but a fraction of the extent of severe psychiatric morbidity in medical schools.

Proposed solutions

Understanding the aetiology and manifestations of poor student health is of undeniable worth. However, pursuit of well-rounded humanistic physicians requires a more dynamic approach. Well-being should be differentiated from the mere absence of distress; it is more aptly characterised by verifiably high attainment in multiple domains – physical health, mental health, emotional and spiritual health. By producing medical school graduates of this ilk, we can be confident that they are equipped to recognise distress of self, laying the foundations for resilient, professional careers.

Learning environment
Creating a 'nurturing' learning environment is an admirable goal. Mentoring programs between teachers and students, when implemented correctly, can have a profoundly beneficial influence on student well-being. Perhaps owing to the greater intimacy shared between medical students, student-led mentoring programs are possibly even more effective.

Clinical education is administered largely at the bedside, by house officers, registrars and consultants. Burnout and cynicism is rife among graduates which can adversely affect professional modelling. Thus, in order to achieve this 'nurturing' program, we need to focus on the source of clinical education: the same house officers, registrars and consultants. Faculty development programmes need to simultaneously address staff satisfaction and confront problem behaviour, which is all too often ignored.

Struggling students
Poor academic performance during medical school as well as maladaptive coping strategies place the emergent graduate at increased risk. Pastoral care programs can provide an individualised approach to struggling students' problems.

Stress management
Formal instruction in stress management has been shown to reduce psychological morbidity. Peer discussion groups can help students process conflict, develop empathy and unmask the realisation that their plight is not unique.

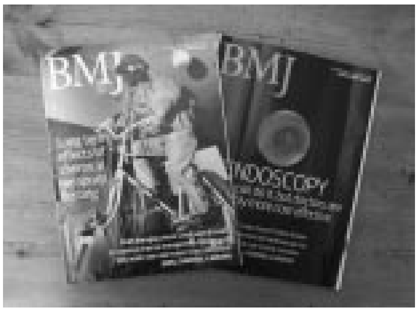
Health promotion
British undergraduate education is punctuated by Wednesday afternoons allocated to sport. This is helpful, although greater emphasis must be placed on regular physical activity for medical students. Programs that promote this message as well as responsible sleeping patterns have noted benefits.

Summary

Medical school is a stressful period, culminating in the crescendo to finals. Many students experience significant levels of distress, which can impair academic performance, erode integrity and lead to substance abuse. Medical educators need to be able to recognise the manifestations, causes and consequences of student distress. Medical schools can then evaluate and develop informed strategies to promote well-being of the student body.

For as Dr Thomas Wolf recognised, healthy doctors benefit us all.

William House
GP



Holism with a new face?

Notwithstanding my regular diatribes in this column against the excesses of reductionist healthcare I think the tide may be turning in the NHS and internationally. Something has changed in the zeitgeist. Would-be banner carriers for holism are coming out of the woodwork. These are not yet the heady days of the 1980s when the BHMA was born, but the new holism is recognisably holistic. My evidence for this? I looked at two recent issues of the British Medical Journal chosen at random from a pile in my study: 28 February 2009 and 28 March 2009. The BMJ is published weekly, has an enormous circulation as a paper journal, and a vast internet readership – about 420,000 users per week. It is one of the most prestigious international medical journals. It accepts only a tiny proportion of articles submitted – so the editor, Fiona Godlee, has real choice. It is also heavily reliant on pharmaceutical advertising.

Each issue starts with the Editor's Choice. In the February issue the editor devotes half of this to a systematic review of studies on the effectiveness of influenza vaccine. The investigators found that those reporting positive effects over placebo were of poorer quality than those that do not, that the 'overwhelmingly positive' conclusions were not supported by the data when closely scrutinised, and that publication in the more prestigious journals was associated with funding of the study by industry. Among the letters in the same vein are some of the readers' responses to a previous issue (7 Feb 09) themed on reframing relations with the pharmaceutical industry (big pharma). There are many more responses through the website, showing widespread concern about the antics of big pharma and the ethics of doctors who accept their money: 'It takes two to tango'. While on the issue of big pharma, the March journal I chose reviews a book Drug Truths written by a research chemist who spent his career with Pfizer. The reviewer (professor of public health and family medicine in Boston, USA) writes: '…the factual and logical holes ….are large enough to drive a truck through' and the author writes with 'unabashed..pride and naivety'. All credit to the BMJ for publishing criticism of its funders.

The March issue also covers two more prominent holistic issues. The Editor's Choice is devoted entirely to carbon strategy and sustainable development. She quotes WHO's director general Margaret Chan, calling climate change 'the biggest public health challenge facing the 21st century'. There are four items on this topic in the journal, including two substantial features about recycling in the NHS – or lack of it. The other prominent issue is treatment of depression in primary care. The context is that GPs are almost forced (by linking practice income to toeing the line) to manage depression according to the medical model, using validated questionnaires to score severity, and then either antidepressants or talking therapy (mostly CBT) or both. Two studies from a collaboration of British universities and an editorial from Nijmegen in Holland question the validity of this protocol-driven management, cast doubt on the validity of the questionnaires and call for a 'holistic patient-centred approach' that respects professional judgement.

Finally, the careers sections of both BMJ issues deal with doctors' health. One focuses on the continuing problems following the 'modernising medical careers' debacle in 2005, and the other on the importance of practitioner health programmes.

There are other items in these two issues of the journal that I would call holistic but by now you may be wondering what is holistic about all this! There is no mention of mind/body/spirit or CAM therapy or spirituality in medicine. However, there is a growing acceptance that the corporate and reductionist edifice is crumbling and there is a sense of groping for something else: professional judgement, ecology and systems thinking, a focus on the person and context not just the disease, and renewed concern for the health of doctors. This new holism has the same heart but a different face. Perhaps we should take note and go with it.

Research Summaries

The research page is compiled with the help of Greenfiles (www.greenfilesjournal.com) and James Hawkins.

Happiness is good for you

Is happiness good for your health? This common notion was tested in a synthetic analysis of 30 follow-up studies on happiness and longevity. It appears that happiness does not predict longevity in sick populations, but that it does predict longevity among healthy populations. So, happiness does not cure illness but it does protect against becoming ill. The effect of happiness on longevity in healthy populations is remarkably strong. The size of the effect is comparable to that of smoking or not, so public health can also be promoted by policies that aim at greater happiness of a greater number.

Veenhoven R. *Journal of Happiness Studies 2008*; 9 (3): 449–469

Disinfectants that don't kill

Chemicals used to kill bacteria could be making them stronger. Low levels of biocides, which are used in disinfectants and antiseptics to kill microbes, can make the potentially lethal bacterium *Staphylococcus aureus* remove toxic chemicals more efficiently, potentially making it resistant to being killed by some antibiotics.

Biocides are commonly used in cleaning hospitals and home environments, sterilising medical equipment and decontaminating skin before surgery. At the correct strength, biocides kill bacteria and other microbes. But if lower levels are used, the bacteria can survive and become resistant to treatment.

Researchers exposed *S. aureus* taken from the blood of patients to low concentrations of several biocides. Exposure to low concentrations of a variety of biocides resulted in the appearance of resistant mutants.

Huet A *et al. Microbiology October 2008*, 154

Blueberries might reverse memory loss

Eating blueberries can reverse memory loss and may have implications in the treatment of diseases like Alzheimer's, University of Reading scientists claim. The important ingredients are flavonoids, historically believed to act as antioxidants in human bodies. But the study indicates they also activate the part of the brain which controls learning and memory.

Williams C *et al. Free Radical Biology and Medicine 2008*; 45 (3)

Ignoring a weighty question…

Despite media and health campaigns aiming to raise awareness of healthy weight, increasing numbers of overweight people fail to recognise that their weight is a cause for concern. This makes it less likely that they will see calls for weight control as personally relevant.

This study examined changes in public perceptions of overweight in Great Britain over an eight-year period surveying 853 men and 944 women in 1999, and 847 men and 989 women in 2007. Participants were asked to report their weight and height and classify their body size on a scale from 'very underweight' to 'obese'. Self reported weights increased dramatically over time, but the weight at which people perceived themselves to be overweight also rose significantly. In 1999, 81% of overweight participants correctly identified themselves as overweight compared with 75% in 2007, demonstrating a decrease in sensitivity in the self diagnosis of overweight.

Johnson F *et al. BMJ 2008*; 337

…but community programmes can help

Building community capacity to promote healthy eating and physical activity can be a safe and effective way to reduce unhealthy weight gain in children without increasing health inequalities. Be Active Eat Well (BAEW) was a community programme promoting healthy eating and physical activity for children (aged 4–12 years) in the Australian town of Colac. When compared over time with a random selection of schoolchildren from other towns, Colac children had significantly lower increases in body weight than comparison children, adjusted for baseline variable, age, height, gender, duration between measurements and clustering by school.

Sanigorski,AM *et al. Int J Obes 2008*; 32 (7)

Mental illness and debt

The association between poor mental health and poverty is well known, but what do we know about the mechanism? This study tested the hypothesis that the association between low income and mental disorder is mediated by debt and its attendant financial hardship. The study looked at private households in England, Scotland and Wales. Psychosis, neurosis, alcohol abuse and drug abuse were identified using a number of schedules and test and detailed questions were asked about income, debt and financial hardship. Those with low income were found to be more likely to have mental disorder but this relationship was attenuated after adjustment for debt and vanished when other socio-demographic variables were also controlled. Of those with mental disorder, 23% were in debt (compared with 8% of those without disorder), and 10% had had a utility disconnected (compared with 3%). The more debts people had, the more likely they were to have some form of mental disorder, even after adjustment for income and other socio-demographic variables. People with six or more separate debts had a six-fold increase in mental disorder after adjustment for income. The researchers concluded that both low income and debt are associated with mental illness, but the effect of income appears to be mediated largely by debt.

Jenkins R *et al. Psychol Med 2008*; 38(10)

Reviews

I welcome readers' contributions. If you're reading something you want to share, please let me know.
You can also contact me if you think there is something – book, DVD, CD, video – that we should be reviewing.

Richard James, Reviews Editor (richard@integrativehealthcare.co.uk)

The art of dying

Peter and Elizabeth Fenwick

Continuum International Publishing Group, 2008

ISBN 978 0 82649 923 3 £9.99

In the bad old days, writers would delay putting pen to paper by brewing endless cups of coffee. Now they ration their caffeine intake but have taken to serendipitous Googling as a procrastination substitute. And this is how I discovered a bizarre website called derelictlondon.com. About to tap out a review of this excellent, compact but wide-ranging and very readable book, I began thinking of the two deathbeds I have so far sat at and of how I wish I had known then what I know now about the privilege of having been present at these occasions.

My parents died within a year of each other in the dilapidated and carelessly run Croydon General Hospital in the early '80s. Unhappy and unwell people for much of their lives, they were both ready to go, so these were not scenes of great grief and distress. But today I would not have engaged in a conversation with my sister over my mother's apparently comatose body – a conversation about family secrets and lies. Neither of us was aware that someone in our Mum's condition could possibly hear and follow what we were talking about and might, therefore, be distressed by it ("they can't hear a thing"). After many hours of waiting for the final breath, my sister and I were very hungry and, since the only food I could find to sustain us was fish and chips from a nearby chippie, my mother's dying moments owed more to Jo Orton than The Tibetan Book of the Dead. My Dad died across the grubby corridor a few months later, having been determined to leave his home "feet first" and having failed in this simple wish. Another unremarkable, general kind of death in a general ward of a general hospital. My abiding memory of my mother's death is the smell of vinegar and of my father's another smell, that of the mince in a feeding cup with which I was told to get food down him ("you've got to get him to eat"). I gave up the unseemly struggle to follow this patently ridiculous order pretty soon and left an angry, disturbed old man to (decide to?) die alone an hour or so after my visit. I had left the hospital feeling ashamed of my deference to doctors and nurses who were incapable of reading the need to be allowed to die in peace on a patient's gaunt, grey face. Not particularly good deaths I regret to say, but banal and unlovely and not uncommon.

Soon after this year of death, the BHMA was born and I began a journey towards understanding these matters more deeply and helpfully. In its first year, I remember Patrick Pietroni banging on (insofar as Patrick could ever be said to bang on) about the need for a Paradigm Shift in the teaching and practice of medicine – a phrase that was new to me then and intriguing. And here is that concept again, all these years later, still being called for in The Art of Dying by Peter and Elizabeth Fenwick. I'm pretty sure we are nearer to that shift now but nowhere near enough.

Dr Fenwick will be familiar to many not only as a distinguished neuropsychiatrist but as an authority on end-of-life experiences. In this book the Fenwicks focus on deathbed visions. Searching Pub Med for articles on this subject, they found only three mentions. "It seemed that it was one of the few areas in which you could become a world expert on the literature after reading two or three papers." There was plenty on palliative care and pain control but on mental states during the process of dying or on the visions that dying people and other deathbed witnesses frequently report, hardly anything. They speculate that this may be due to the widespread assumption that death is no more than the shutting down of the brain, an area of little interest to medics who feel that at this point they have no part to play in a process that they may also interpret as some kind of professional failure.

The first part of the book details the multifarious myths and writings featuring the final journey of the soul, and the universality of the deathbed vision phenomenon. And a fascinating melange it is, featuring: ravens; guardian angels; Hermes; the precise instructions in the Egyptian and Tibetan books for the soul's journey to the next life; phosphorescent lights (known in North Wales as 'corpse candles', said to hover over the roofs of houses where a death is imminent and believed to accompany the souls of the dead to the point at which they leave the earth) and much more. As for deathbed visions, these ubiquitous events have shown changes, as have near death experiences, reflecting various cultural shifts. In the earlier days of Christianity, Christ or the Virgin Mary or perhaps some holy man might have been expected to appear at the bedside to guide the soul onwards. Latterly, these visitors are more likely to be dead friends or family members. But the Fenwicks are in no doubt: 'so universal is the assumption that something does happen next that the reductionist scientific culture of the West is almost alone in its unshakeable belief in the finality of death'.

What further proof could a Professor Dawkins possibly need than the imprimatur of Richard and Judy? In 2007 they received an overwhelming response to a programme about end-of-life experiences, as a result of which the Fenwicks in their turn received hundreds of emails and letters detailing deathbed stories. Three themes began to emerge from these responses: that these experiences had been deeply comforting to both the dying person and those who witnessed them; the conviction that what had happened was neither a dream, wishful-thinking nor a figment of the imagination nor a drug-induced hallucination; and a sense of relief at being able to talk freely about such powerful events for, very often, the first time.

Should these experiences be 'explained', the authors ask, or simply accepted for the source of comfort they so clearly are? The Fenwicks took their gentle curiosity further by talking to forty carers from nursing homes and hospices, and detailing in this book, their experiences and views of end of life phenomena. A consensus emerged that it was not easy for staff to give the dying what they needed at this time. In fact, it was easier to deal with the pain and vomiting than with the perceived expectation to be, as one put it, the new priest at the bedside. There was insufficient training in pastoral care and many "lacked the therapeutic skills and understanding of spirituality which would enable them to identify the basic characteristics and range of end of life experiences that occurred and their significance to the patient." Carers wanted help recognising the language of the dying and on how to create a safe place where patients could talk openly about their approaching death.

A later chapter attempts to address that hot potato 'The Last Frontier: the unsolved problem of consciousness' in which my friend Paradigm Shift makes an appearance in an appeal for the establishment of a different kind of science that would take account of subjective evidence and ask the awkward questions necessary if we are ever to understand the nature of consciousness. This kind of thinking, of course, has long had an Eastern perspective but, in the West, the Fenwicks believe our tendency for rigid thinking is beginning to give way, pointing to the extent to which Physics, a far purer science than Medicine, has opened its mind to the seemingly impossible. Advances in neuroimaging show the interconnectedness of mind suggesting to these writers that emotionally close people are somehow linked by a field which may illustrate 'as spiritual masters have suggested, that love is the structure that connects people together'. Apart from deathbed visions, the dying seem to be able to reach out and interconnect with people they love to offer reassurance that all is well. These interconnections at the point of death can involve the strange behaviour of pet animals; clocks stopping; bells ringing; lights switching on or off … But now we must pause while Prof Dawkins hurls this book from the top of his ivory tower in utter disgust. Let us, meanwhile, heed the words of the nineteenth century's AR Wallace, so good they're quoted twice in this book: 'The first great lesson in the enquiry into these obscure fields of knowledge, [is] never to accept the disbelief of great men or their accusations of imposture or of imbecility as of any weight when opposed to the repeated observation of facts by other men, admittedly sane and honest'. Wow.

My criticism of this movingly detailed and scholarly work is a smallish but nagging one. This book, like those of Dr Raymond Moody on NDEs and the recently published "Is There An Afterlife: a comprehensive overview of the evidence" by Professor David Fontana (a very good companion piece to this one), seems to skim over, if not ignore, any notion that these experiences may sometimes, perhaps often for all I know, be negative, frightening, even hellish for some. Sorry to rain on a parade of hopeful, optimistic and positive academics – God knows, we need them. But there it is.

As for derelict.com, well, it tells me that Croydon General, (born 1867) died in 1996 when it was condemned and demolished to make way for an eco-friendly community centre with a green roof 'expected to be a habitat for wildlife and plants'. A slightly contrived but irresistible metaphor with which to end this appreciation of an engrossing book which chronicles experiences that do not simply herald the end of a life but the possibility of travelling hopefully onwards.

Maggie Winkworth

The happiness training plan

Dr Chris Johnstone and Miriam Akhtar
Gaiabeat Productions 2008
www.happinesstrainingplan.com

This audio CD is a practical plan for working towards greater personal happiness, based on the new science of positive psychology. This discipline approaches our human predicament from the point of view of enhancing wellness rather than tackling illness. It is structured as 12 'easy to use' strategies with about five minutes devoted to each. It is recorded in the form of a scripted conversation between the two presenters. The strategies include 'express gratitude', 'use your strengths', 'living with purpose', 'get physical' and 'improving relationships'. It suggests simple exercises such as keeping a journal, listing positive experiences, challenging negative thinking. It calls heavily on the authority science to reinforce the messages.

For those who respond to a highly structured method and also believe in the value of science in human thought and behaviour, it should be a very useful tool for combating depression, or periods of low mood. It is very clear and accessible without any prior knowledge of psychology and could be understood by those with basic education. Some may find the conversational presentation a little contrived, and the music may be thought too computer-generated, although there are welcome snatches of Chris Johnstone's delightful playing on the hammer dulcimer.

William House

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