Holistic health care?

In recent years, 'holistic health centres' have mushroomed. Such establishments, which sometimes also use the term 'integrated' or 'integrative' instead of holistic, offer a range of 'alternative' therapies and promise to treat not just the patients' somatic problems but to also address their psychological and spiritual needs. Patients normally pay out of their own pockets. Here I discuss two (partly hypothetical and necessarily simplified) scenarios in order to critically analyse this practice.

Our patient is a 56-year-old male carpenter, Mr Nash, who has always been physically active, is not overweight, has smoked about 20 cigarettes per day for the last 30 years, and last consulted his GP 1.5 years ago. He enjoys 1–2 pints of beer per day, takes no prescription medicines and states that he has no relevant medical history; both his parents suffer from cardiovascular problems. Mr Nash seeks medical help because he has not felt well for about 4 weeks. In particular, he suffers from insomnia, fatigue and pain in his left-upper arm and shoulder. He believes that these symptoms started when, together with a friend, he carried a fridge-freezer to his fourth floor flat.

THE 'HOLISTIC' APPROACH

Mr Nash decides to follow his wife's advice and visits a local holistic health centre. He initially sees a practitioner who takes a brief history and refers him to the centre's homeopath, chiropractor and healer. The homeopath takes a detailed homeopathic history which lasts 90 minutes but does not examine him in any other way. Eventually the homeopath prescribes a homeopathic medicine explaining that it is individually tailored for the patient and should improve his insomnia and fatigue. Mr Nash is given a follow-up appointment 2 weeks later. The chiropractor conducts a manual examination of the spine, takes several X-rays and diagnoses subluxation of several vertebrae. He explains that, in his view, these abnormalities are the likely cause of the patient's pain and proposes a series of 10 spinal manipulations. The healer asks Mr Nash to sit in a chair and gently moves her hands over his body. She explains that this sends out healing energy enabling his body to heal itself. The session, which Mr Nash finds agreeably relaxing, is repeated on a weekly basis.

Both the homeopaths and the chiropractor also give lifestyle advice regarding a well-balanced diet, smoking cessation (which, they claim, could be helped by acupuncture), regular physical activity and sleep hygiene. Both practitioners suspect that Mr Nash suffers from psychological problems and recommend counselling. The patient (who indeed has considerable family problems) does, however, not want to talk about 'such things'.

Despite good compliance, Mr Nash continues to feel ill. In particular, he finds physical exercise increasingly difficult and has the impression that it aggravates his pain and leads to breathlessness. Two weeks later (at this stage the out of pocket costs for the treatments exceed £600), he experiences sharp chest pain and collapses while walking up to his 4th floor flat. In hospital, he is diagnosed with a massive myocardial infarction and treated conventionally. Eventually Mr Nash undergoes double-bypass surgery and subsequently makes a good recovery.

THE CONVENTIONAL APPROACH

Mr Nash rejects his wife's advice to 'go holistic' and consults his GP who takes a medical history, conducts a physical examination, measures his blood pressure (165/100 mmHg), and finds ischaemic changes on the resting ECG. A subsequent ECG on a bicycle ergometer is discontinued because of chest pain and overt ischaemic ECG changes. Mr Nash is admitted to hospital where coronary heart disease with two stenosed coronaries is confirmed. He undergoes angioplasty the next day. The medical team also identify the following risk factors: hypertension, diabetes, hypocholesterolaemia, smoking and distress. After returning home on β-blockers, statins and aspirin, Mr Nash finds it difficult to control his diabetes with diet alone; antidiabetic drugs are therefore added to his list of medications. A supervised smoking cessation programme seems to have the desired effect. The medical team urges him to see a clinical psychologist, but he refuses to discuss the causes of his stress on the grounds that it relates to very private family matters.

COMMENT

Hypothetical scenarios such as those above may seem somewhat contrived. They are, however, not unrealistic and make a number of points clearly. Holism is currently used by many as an attractive label to recruit customers. The claim to treat mind, body and spirit certainly sounds good and agrees with today's 'Zeitgeist'. However, this claim can be misleading, particularly if the treatments do not address the most urgent problem effectively. Clinicians must have sufficient diagnostic skills to identify life-threatening conditions and their risk factors regardless of whether they are doctors or complementary practitioners. Unless this precondition is fulfiled, their interventions can put patients at risk. Arguably the 'holistic approach' is fragmented and the 'conventional approach' can prove to be more holistic than the naïve holism displayed by some complementary practitioners.

Holistic practitioners claim to treat the causes rather than the symptoms of a disease and argue that the cause–effect relationships of conventional medicine often do not apply to the complex situation of whole human beings. The above scenarios suggest that such views can be simplistic. Underlying causes of illness often exist on many levels. Mr Nash's symptoms were caused by myocardial ischaemia, which was caused by coronary stenoses, which was caused by arteriosclerosis, which was caused by a multitude of risk factors, which were caused by a complex mix of genetic and environmental factors. These interrelationships need to be first understood and subsequently acted upon; the most

urgently treatable problem (coronary stenoses) must be solved without delay. Other causative levels (that is, risk factors) can be addressed later. In this and many other situations, the spiritual needs of the patient may require addressing but are not a priority.

The hypothetical scenarios also imply that holism can have its limits, for example, when the patient does not cooperate. In real life, this frequently seems to be the case. Mr Nash was not fully compliant with dietary measures and did not want to talk about his family problems. Holistic health care is an ideal that many clinicians subscribe to, but it does not work if patients do not want it.

It could, of course, be argued that the scenarios I have created here are exaggerated caricatures of reality and that the conventional approach is a rather optimistic description of what might happen to a patient in the current NHS. This may well be true. My aim was not to depict 'real life' but to tease out potential problems with the current misuse of holism. Caricatures can make certain features more obvious than reality. If nothing else, my approach implies that naïve holism may be attractive to many patients, but that it can be a dangerous distraction from the most important issues in health care. Yet I do believe that holism is important — too important to be delegated to alternative practitioners! Those who agree with this view should consider ways of reintroducing it into modern medicine where it may have gone missing.

In conclusion, good health care is likely to be holistic but holistic health care, as it is marketed at present, is not necessarily good. The term 'holistic' may even be a 'red herring' which misleads patients. What matters most is whether or not any given approach optimally benefits the patient. This goal is best achieved with effective and safe interventions administered humanely — regardless of what label we put on them.

Edzard Ernst

Personal profile on pain

Living with constant pain is a problem not only for the sufferer, but also for their family, friends and indeed everyone who touches their life. We all have a threshold of pain where one can endure no more without medication, or any of a variety of treatments. With the assistance of these it is hoped that one can enjoy life as near normal as is possible. Beyond that level is the great unknown, of side effects from increased medication, and in some cases mood swings on a daily basis. These side effects vary greatly depending upon pain threshold, specific case history, and medication prescribed solely for the individual; in extreme circumstances there can be dramatic consequences.

It was while at the limit of my personal pain threshold, and a resulting discussion with my GP, that my quest for knowledge about the long-term use of opioid medication began. Put simply I have a desire to know what lies ahead of me, with regard to quality of life and how best to assist my ailing body in order to cope as best I can in the future.

I have led a full and varied life for 56 years. Occupations have spanned professional football, civil service scientific work and hard manual labour. From a very young age, sport of all kinds, competition and a desire to be the best, with along the way injury, wear and tear, as well as broken and damaged bones, have all contrived to place me in my current condition. Mine is either a case of bad luck or inevitability, but deal with matters I must, as there is no alternative. Hence my discussion with my GP, which followed many years of excellent care from the NHS.

With the Honiton Surgery being a Research Practice, the idea of tackling my circumstances and fears through the mechanism of a fully accredited research project for the community appealed to my GP, because as well as being of benefit to me personally, it could also be a worthy subject to apply for funding to see if my situation was common among others taking strong opioid medication for chronic non-cancer pain. With the guidance and help of my GP I was invited to attend a course on research methodology in Exeter with the assistance of the Folk.us organisation. On the course I studied grounded theory, qualitative and quantitative research, phenomenological study, as well as the basics of research in the wider community. It was necessary to do this to satisfy the stringent requirements of the ethics committee in order to be granted an honourary research contract to assist the research team at the Honiton surgery under the guidance of the Exeter Primary Care Trust. The whole process was of great interest, reward and fulfilment to be among professional dedicated people and be allowed to take a small part in their never ending efforts for the community.

The project took the form of compiling knowledge in a qualitative approach from interviews with people suffering and coping, on a daily basis, with pain management in their own individual circumstances to try and determine, by thematic analysis, any recurring details or patterns common to all sufferers of pain who are taking strong medication. The interviews were transcribed and the research team met periodically to discuss and evaluate the relative merits of the individual interviews. The overall results produced really interesting and in some cases surprising points of similarity, which could be grounds for further professional investigation on a wider basis.

Brian Ruel

The results of this study are presented on pages 101–108.

A patient's diary:
episode 2 — a swollen leg

20 JANUARY

My liver has felt a good deal better this week — thanks largely to some herbal tablets from the health food shop and no thanks at all to 'Gastrocalm Intensive Care' which is more useful for killing slugs in the garden, as I told Dr Grimes once, in a moment of brutal frankness. I'm afraid he is totally unaware of the latest NICE guidelines and his prescribing leaves much to be desired when it comes to clearing impurities from delicate structures like the bile ducts. However, things in that department are greatly improved, as I said, and I would have been entirely free from health problems this week had it not been for the swelling in my left leg which developed early yesterday morning. As soon as I woke up I could feel the whole of my calf tugging and pulsating as the blood tried desperately to force its way through. The skin was a nasty purplish colour and the whole limb obviously swollen. Of course I knew at once what was wrong. I was reading a piece only a few days ago on one of the excellent internet health sites (dangers of long haul flights) that undue stasis in the calf vein from prolonged sitting can cause deep vein thrombosis (or DVT). Of course I hadn't been on any long haul flights but I did fall asleep in front of the television last night during a rather tedious nature watch live programme in which there seemed to be nothing to watch. When I woke up the programme was over and Hilda had gone up to bed. That must have been when it happened.

Over the next few months readers will be privileged to have access to the Diary of Mr Norman Gland, an ordinary NHS patient whose indifferent health necessitates frequent visits to his local GP surgery. This month our second extract relates how the doctors dealt with Mr Gland's calf pain of sudden onset. Deep vein thrombosis? Baker's cyst in a man who never baked anything in his life? Read on…

Over breakfast I showed her my thrombosed leg and, to my amazement, she said it looked completely normal to her. I had to remind her that her judgement is notoriously weak when it comes to clinical matters. There was no question of going to work so I rang the surgery to ask for an urgent home visit. As usual, I found myself up against Mrs Flagg who wanted to know what my symptoms were. When I told her, she asked with her usual lack of empathy why I couldn't come down to the surgery? With one leg completely useless? I said. Would she like me to crawl there on my knees or should I hop all the way? But irony is wasted on Ivy Flagg. She merely said it didn't sound like an emergency to her but if I liked to come down to the surgery, she would ask the new nurse to 'triage' me. This is some new system they've got for cutting down appointments and I didn't like the sound of it. TRI-AGE. What does it mean? Obviously it has something to do with AGE and no doubt means that if you are over 50 like me you are regarded as past it with one foot in the grave (one thrombosed leg in the grave, I said to Hilda with bitter irony, but it was wasted on her too).

Anyway I had to get help of some kind, so after breakfast I rang for a cab and got myself round to the surgery. When I went up to the desk I found I'd been fitted in with Dr Teacher, so Flagg must have relented a little with her harshness. Dr Teacher wouldn't be my first choice but as it was an emergency I was willing to be adaptable. The waiting room was full, as it usually is on Monday mornings and there wasn't a seat available. However, when they saw me limping painfully down the corridor, several people offered me a place. Very decent of them I thought. I explained that as an emergency I would probably be called first and apologised for the inconvenience I was causing to those with booked appointments. They were all most understanding. So I was quite puzzled and upset to find that several people were called in ahead of me. I tried to point this out to Mrs Flagg but she pretended not to hear as she swept past on her way to the kitchen for her coffee. Eventually Dr Teacher called me in. At first I thought he had a patient with him but it turned out to be young Sally Greengage, the trainee doctor (they are called registrars for some mysterious reason). He went on about her being fully qualified and so forth, as if I didn't know. I pointed out that I had already helped Dr Greengage with one of her videos that they have to do for the Membership Examination. In our taped consultation she had forgotten to ascertain whether I had fully understood her Management Plan, thus depriving herself of the chance to win Merit points. I always try to be as helpful as I can with these young doctors on the threshold of their careers. Anyway, I explained the problem and showed them my swollen leg, and Dr Teacher said where was the swelling? So I showed him again and he said he couldn't see any swelling. Dr Greengage very sensibly asked me to roll up the other trouser leg so we could compare it with the normal side. Dr Teacher said they looked more or less the same to him and I was rather dismayed when Dr Greengage agreed with him. Of course most of the swelling was internal and therefore not very obvious to a casual inspection.

Feel it, I said. At that, Dr Teacher seized my swollen calf and I gave a great cry of pain as his icy fingers closed like a vice on the most sensitive place.

Then they began to take me seriously.

Dr Teacher said: 'Sally, would you like to examine Mr Gland? What do you think it might be?' Sally said it could be a DVT or

maybe a ruptured Baker's cyst. Personally I thought the latter was a bit of a wild guess as I've never done any baking but I didn't want to dampen her enthusiasm. Then Dr Teacher said he didn't think it was a DVT but you could never tell and perhaps I should be sent up to the hospital for a Doppler. I said I would rather avoid the knife if possible and Dr Greengage explained that this was just a non-invasive method of detecting blood flow in the deep vein. I asked if they could do some detective work on my liver circulation at the same time, but Dr Teacher just groaned softly and shook his head. He's not very good at coping with 'multi-tasking'. My leg pain suddenly came on again and I started to sweat. At that very moment there was a knock at the door and in came Dr Brenda Phillips. She wanted to borrow a tongue depressor but the others said while she was here would she care to have a look at my leg? I like Dr Brenda — she's so much more sympathetic than the other doctors. I sometimes imagine that I'm resting my head on that motherly bosom of hers and she's stroking my hair (I wouldn't tell her that of course as it might embarrass her). Anyway, she asked me all about the leg and nodded compassionately as I told her about the pain and the swelling. She knew at once what the trouble was.

All it needed, she said was a little massage and with a few deft strokes of her capable fingers she smoothed out the knotted muscles. I felt the obstruction clear and the blood begin to flow again. She gave me a prescription for some quinine tablets and said if I took those every night I shouldn't have any more trouble. All the same I think I should let her have another look at it to be on the safe side. If Mrs Flagg will grant me one of her precious pre-booked appointments.

We are grateful to John Salinsky for these extracts from Norman Gland's diary.

Mike Fitzpatrick

The alternative regression

Although cancer specialists have recently challenged the corporate opportunism of the world of alternative health care, many GPs remain sympathetic to the drive to integrate these anachronistic methods within primary health care.[1]

While advocates of alternative medicine claim that it offers a more compassionate mode of health care, scientific medicine's claim to be more humane rests on its unparalleled record of achievement in the treatment of disease and the relief of suffering. Alternative healers raise unrealistic expectations and provide therapies whose effectiveness (and safety) have rarely been objectively confirmed. The worst medical doctor can cure diseases and save lives; the best alternative healer can only offer false hopes.

Alternative practitioners proclaim a 'holistic' approach, which takes account of the patient's body, mind, and spirit. They condemn orthodox medicine for its mechanistic conception of the body, for its reductionist attempts to understand its function (and malfunction) in biochemical terms and for its interventionist style of therapy. By contrast, alternative therapists regard disease as a disturbance of the harmony between the individual, nature and the cosmos; their treatment aims to assist the purposeful attempts of the body to restore its natural balance.

If the fundamental principles of the alternative health movement sound familiar, this is because they are the same as those of the Hippocratic tradition, which dominated orthodox medicine from antiquity until the beginnings of scientific medicine in the 17th century (a period in which almost all treatments were useless, if not dangerous).

Alternative health schools claim three sources of wisdom. Some are based on revelation, either divine or secular. Others rely on speculation, theorising human health and disease in terms of elements or humours, or energy flows. Others still use empirical methods, observing patients and classifying the clinical features of disease.

Although empiricism proved the most productive approach, the activities of pre-scientific doctors were constrained by the speculative theories that guided their selection of data. As Louis Pasteur observed, 'without theory, practice is but a routine born of habit. Theory alone can bring forth and develop the spirit of invention'.[2] Scientific medicine emerged out of the empiricist tradition, but crucially advanced through the methods of induction and experimentation, developing theory by arguing from the particular to the general, elaborating hypotheses and testing them in practice.

Traditional healers turn ancient insights into laws of nature with eternal validity. For scientific medicine what was previously thought to be true has often been superseded by new discoveries. Whereas traditional healers express humility in the face of nature and deference towards authority, practitioners of scientific medicine are sceptical and insubordinate, challenging divine and secular authority, questioning the evidence of the senses and the passive reflections of the human mind. 'Why think?', surgeon John Hunter famous challenged GP Edward Jenner, 'why not try the experiment?'[3] The historic innovation of scientific medicine was that it was open to critical evaluation and revision. Whereas alternative systems arrive in the world fully formed, medical science is in a constant state of flux.

Just as reason cannot be reconciled with irrationality, so orthodox medicine cannot be integrated with alternative medicine. For Bruce Charlton, 'fringe therapies are a kind of cultural fossil, preserving a pre-scientific and pre-critical mode of reasoning about medicine'.[4] Furthermore, 'their survival depends upon either ignorance or double-think (a deliberate bracketing off of skepticism) — which explains why such practices can never be disproved'. This is why the project of subjecting alternative therapies to randomised controlled trials and other scientific methods is doomed.

Given that the general trend of medicine up to the late 20th century was to move away from superstition, it is sad that the new millennium has brought a return to mysticism. Given the backward-looking character of the vogue for alternative medicine it is remarkable that an openness towards such practices is today regarded as a progressive, even radical, outlook.

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