

# Doctors and Complementary Therapists - Preparing for the Journey

by David Taylor Reilly

*We need to start planning the journey up the mountain towards an integrated medical system. To begin, therapists, professional therapists and doctors must define their starting points and arrange to meet on common ground. Our principal reference point should be patient care, not a more holistic than thou attitude. Earlier expeditions have often floundered, exposing unknown risks described here including high altitude holigenic diseases (such as the Homalium syndrome), and a breakdown in the team when specialist members failed to see the need for a general guide. The next step is a fresh travel plan.*

## **Which mountain?**

Which mountain do we want to climb?  
What do we hope to see from the summit?  
I see my role here as simply laying out issues in front of you. These are my first thoughts as we begin what may prove to be an historic journey for doctors, homœopaths and other therapists. Better to admit before we start, that the journey is fraught with difficulty, some sections may be barely passable. If I am a guide, I am a heretical one, who does not speak for any organisation that would have me as a member.

So where are we going? The symposium leaflet states that the goal of the day is to 'discuss the policy and action necessary to ensure the homœopathic profession's long-term development and security... without compromising ourselves or homœopathy.' It seems perhaps to be mainly about the issue of homœopaths and doctors. I think this is entirely wrong. The agenda should have been about ensuring good homœopathy, good doctoring and good medicine without compromising patient care. Before entering the political arena our reference points should be patients and achieving a better quality of care. These are more important than homœopathy or any particular form of therapy. So, I would encourage you to

identify what you want, then see if it is possible. Then the practical and political matters will flow in naturally behind it.

## **The explorers and their patients**

Too often, we don't hear about the patients, they become abstract entities, pawns in the game, as the futures of general medicine and natural medicine are discussed. If we must play games let's remember to use human rules. Professions: medical, homœopathic, complementary, whatever, are human communities not abstracts. Growing up seems to be learning that 'they' out there – parental, protective, domineering, remote – are a reflection of what is projected from inside. If we see or describe only the cynical, the power play, the self-protection of this Society or that Faculty then we are imbalanced. Equally, if we deny these negative aspects we are deluded. Either way we become dangerous. Or maybe we see only the good in everyone. If we want heaven on earth before the resurrection then I suggest we are waiting for infinity. I hope we will not waste energy denying our problems or throwing stones and let's focus on patient care.

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*See the diagram on the inside back cover*

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In 1985 he published work which first revealed the positive views which many young doctors had towards alternative medicine (BMJ 1983: 287). Following training in and clinical evaluation of hypnosis, acupuncture and homœopathy he conducted a research programme examining the placebo hypothesis as an explanation for homœopathy.

In his dual role as Research Fellow and Senior Registrar in Medicine he has explored the points of contact between orthodox and complementary medicine including clinical trials, experimental integrated clinics, and postgraduate teaching. For the first time in the UK discussion of this subject matter was included in the undergraduate curriculum. He sees medicine as moving towards an integration of the best of orthodox and alternative practices.

## **The purpose of the journey – to deliver the goods to patients**

It is doctors, nurses and others within the NHS who deliver most of the medical care in this country. As a recent academic working party pointed out, of the UK population of 55 millions perhaps 3% have unfettered access to homoeopathy, far less to good homœopathy (ref 1). So there's the mountain. How are you and I to change this, how is the Faculty and the Society to change this? How are we to create an integrated medical system, a healed medicine?

## **Planning directions**

If we agree that these are our aims then the key to achieving them is through communication. To talk to others we must learn to listen, to use their language, understand their fears and prejudices, and respect their standards. I believe the success of my personal journey along with my co-worker Morag Taylor through the RCCM Fellowship in Complementary Medicine at Glasgow University has proved the power of making human contact between apparently disconnected groups, and I would like to digress and describe our passage up that mountain as a travel guide for your consideration.

The aim was simple enough, simple to state at any rate to persuade the largest orthodox medical school in Europe to open its doors and its hearts and therefore its clinics to complementary medicine. If you think you have problems of exclusion, picture me knocking on the Professor of Medicine's door three and a half years ago, and asking if he would consider an examination of complementary medicine in his department. I did not begin by asking if I might treat patients in his wards with homoeopathy, or if I might discuss this and other complementary treatments with the medical students in the school as an official part of the curriculum. This would have been foolish at that time. Nevertheless I recognised that under every white coat beats a heart and the way to that heart is through patient care. I evolved a three part strategy, with patient care as the central pillar.

To achieve the goal of integrated care I saw a strategy beginning with a case-presentation. I use this concept very broadly whether it's applies to an educational case, clinical care or research. Any of these can be seen as a case model. If you want to take the mountain to Muhammad, as it says in this symposium's brochure, the onus is upon you to present the case, "to be proactive".

Having first met the need to establish my credibility as a physician, twelve months into the fellowship I presented to my colleagues a single case history of a patient with cluster headaches who had clearly benefited from homœopathic medicine (ref 2). After a three month period of stunned silence I was sent a referral for complementary medicine. After successfully treating him there began a trickle of referrals which in time grew into a modest flow. Bear in mind

what is happening here. These doctors don't know or understand this therapy, and accept that it's not scientifically proved yet, they are seeing with their own eyes and hearing in language which is showing respect to them that it is helping patients. Two years on, there are now two shared integrated clinics each week in the hospital where patients are assessed to see if a complementary treatment will ease their distress. Increasing numbers of patients are being referred from consultants, specialists and general practitioners. Two and half years in I was invited to join the pain clinic to work with the anaesthetists using complementary techniques. More recently, three and a half years in, I am now occasionally asked to see patients for complementary treatment. These are patients, not political dreams and slogans: it involves 'them', their 'allopathy' and 'suppression': and success. One group of patients that particularly interests me in the studies we are doing are those for whom orthodox medicine and complementary medicine may be failing. We must not lose sight of these patients. In a medical care system you need continuity of care, you do not need a network of therapists. Such a network is useless to a person who is trying to cope with ongoing incurable difficulties.

The second leg of the strategy involved education. It began with case presentation through introductory lectures to sceptical medical audiences. Believe me, these lectures have got to be good or don't do them. Don't blow it at that first contact. Suffice it to say that discussion of complementary medicine is now included in the Masters of Public Health degree course and the undergraduate teaching in Glasgow – the largest medical school in Europe. Meantime, with the Faculty of Homoeopathy, the Fellowship developed a postgraduate education course which has grown into one of the most vigorous medical courses in Scotland and is included in the official Postgraduate Education Allowance Scheme. We are attracting 80–90 health professionals onto these courses. They are mixed professionals including doctors, vets, pharmacists and dentists. The people on the course report 70–80% success rate in their applications of homœopathy which are highly targeted applications. The main things they are told on the course are the things that they cannot do, that is the philosophy of the course. Right from the introductory level, videos of Vithoulkas, Jonathon Shore, Frederick Schroyens and other advanced teachers are shown to these students to say, "This is a homœopathic specialist and you are not a homœopath, but you don't need to be a brain surgeon to be remove a wart". The net result has been many thousands of patients who have had homœopathic care who would not otherwise have received it. We have done some audit research on this and two years after attending such a course 70% of all attenders are continuing to integrate some element of homœopathy into NHS general practice. I think that's a surprisingly high suc-

cess rate. These educational courses have had great impact on the doctors who do them and many of them have spoken of a 'broadened outlook' and a 're-kindling of an interest in medical practice', a more holistic attitude and so-on. I find this very encouraging and see the effect of this work as planting seeds in the medical system. I would commend to you Jeremy Swayne's recent paper in the *Journal of The Royal College of General Practitioners* describing the scope and depth of homœopathy within NHS general practice (ref.3).

There is no future for complementary medicine in any model unless the trainee doctor has an adequate awareness in this field. The goodwill and credibility we have built up in Glasgow has led to the official inclusion of the discussion of complementary medicine in the medical school curriculum. The Dean of Faculty and Professors of Medicine and Surgery are strongly behind this. We are not teaching therapeutics- that would be premature. We are simply raising the awareness of the trainee doctor to the issues that are relevant here.

I wonder as professional homœopaths, are you pleased about this integration of homœopathy into academic education of doctors and the National Health Service? (ref 3).

The third part of the strategy is research, which I see as primarily a very effective form of communication for 'talking to the neighbours'. Without research activity the Fellowship would not have been established in the University. A willingness to participate in enquiry and self-criticism has been a critical element in this success. Research is indivisible from the other two strategies and indeed they actually nourish one another. I do not however equate evidence only with controlled clinical trials. Research is enquiry and there are many valid methods of enquiry. I hope to publish soon, with Morag Taylor, evidence from our work that, in practice doctors, take a broad and flexible view when considering the validation of unorthodox treatments, as well as being open to the exploration of the working links between doctors and complementary therapists. Perhaps it is now or never – the climate is favourable, it's time to go for it – we should run out into the sunshine before the clouds return.

### **The visa application: Occupation?**

And now to the heart of the matter-the relationship between doctors and other therapists. I'd like to grasp the nettle at this point really. We must ask – What is a therapist, what is a doctor? Can we reach any common ground on this? Let me make it clear that I see them as very different roles. If you are unsure ask a mother, one with a sick child, maybe your own and see what intuitive response comes back. In a way my opinion is irrelevant because these things are decided on a broader stage. What do you see yourself as being? Who decides and do they agree

with you? Can we find common ground on this? – for it will determine the future. Let me begin by offering some definitions. At the centre of the model in the diagram I have placed the therapist. Perhaps they could best be defined as someone with specialist knowledge of a therapy, sufficient to apply it effectively. The specialist is a heat-seeking missile, absolutely deadly if accurate, they may need to be pointed in the rough direction of the target, but they may also need to be disarmed at times.

Broader than that is a professional therapist. They are all the above, but with additions such as: adequate and demonstrable standards of safety, ethics, self-regulation etc. Strangely enough, perhaps less important is evidence of efficacy. One could be a professional iridologist for example – but with effectiveness unknown (ref 4). Professionalism could be achieved in the UK without official recognition or academic development, however desirable these are. You could achieve the standards worthy of a Royal Charter in medicine, reaching the standard before it's offered you. Professional therapists need not involve themselves in academic endeavour, though it would be better if they did so. It could be possible for so-called classical homœopathy to continue into the next century unchanging, unenquiring but continuing up to a professional standard.

Beyond this level we come to the more difficult issue of What is a Doctor? I will avoid The Ideal and Desirable – this may come within vision when we have started our climb, and tackle The Pragmatic. I am not talking about doctoring here either. We can all doctor and should do. I'm speaking more here in terms of professional structures. The doctor requires all the qualities described so far for the professional therapist and an additional layer. The additional layer as far as I can see is largely culturally determined and we have to accept that. The simplest definition perhaps is that the doctor is a graduate of a medical school. The culture has determined such things as legal structure, academic structures and professional structures and it is expected that a doctor meets these ideals. Also it is expected that they have tested and demonstrated levels of clinical skill and experience. Obviously a lot of these things blend in a grey area with the previous definitions of a professional therapist and it's interesting to try and explore these boundaries. But perhaps what differentiates the doctor is the broad-based nature of the perspective which the training is expected to offer and the graduate is expected to display. Most of all a knowledge of their own ignorance within the broad field of medicine, a knowledge of when it is necessary to act or not to act in the broad field of patient care. I think that is a vital ingredient.

Another aspect which perhaps makes up as much as 50% is the culturally and human-determined emotional and non-rational aspect. We are the servants of the culture and the many and deep currents which

flow when people consider the role of their doctors. Echoing the human mind, and our needs when unwell, at least half of these demands are not analysable in a rational way. They are linked to emotion, to the art of medicine, to the spirit of ancient healing rituals, to magic. These things are difficult to talk about but often easy to recognise. When someone asks you as they do me at times, 'Are you a real doctor?', it's not the intellectual part of that person's mind that is asking that question. (Anyone who still clings to the latter day illusion that medicine can be reduced to a science should ponder the uncomfortable scientific discrepancies described in Payer's book *Medicine and Culture* (ref5): why do American women have twice the chance of having their uterus removed, or German citizens six times the chance of receiving digitalis?) Within the more visible and laid-down cultural requirements are included all those of a professional therapist as previously defined plus legislative and academic demands. Certain practical procedures and defined experiences must be met – a mixture of tribal initiation ceremonies and apprenticeship. In addition the public approaching a doctor has certain expectations which they are entitled to take for granted will be met. There must be a general knowledge and awareness of the processes of illness and health according to the dominant cultural models: presently including physiology, pathology, psychology and so on. Further it is expected that the doctor will have in addition at least one special area of skill – be it general practice or a narrow more specialised field. Certain guarantees are expected, based on the principle of the guaranteed minimum, rather than one of excellence, a sort of British kite standard, in particular for ethics, safety and discipline. The doctor is expected to distinguish the seriously ill from the not-so-seriously-ill; when to act; when to call on help; and when not to act.

I have tried to put in diagrammatic form how I would see medical care in some way. Lying at the top is this heat-seeking missile, the pure blooded therapist that you just point and hit with, more broadly – based below this is the professional therapist and below this again the broadest base of medical care in a community, in what the community defines and decides as being a doctor. You'll notice the triangle defining therapeutic skills is to a degree getting smaller not least just because of the capacity of the human brain. Also you will notice a line between the first and second level which represents the next principle I'd like to introduce – the difference between a generalist and a specialist. It also introduces in a way another subject which is *The Myth of Holism* in alternative medicine – something I'm tired of, and the attitude of "I'm more holistic than thou".

As a general practitioner I learned that one of my main roles was to protect the patient from specialists. You view the cardiologist like the brain scanner, and you bring in this expert's powerful mind to seek out

an opinion while you and the patient keep the broader picture. You may choose in fact to completely reject the advice of this second line specialist that you chose to involve in the case. Specialists can be powerful, but they are narrow in view and therefore if misapplied, dangerous. Without the broad base of the generalist's perspective, things can go haywire. I put it to you that an acupuncturist or a homoeopath is a specialist: viewing the patient through the tinted glasses of their training and therapeutic orientation. So that if you go along to see a homoeopath, don't believe the whole-patient perception too much – it's part of it. As a homoeopath you are thinking homoeopathy, looking homoeopathy, and the more effectively you can do that the better the homoeopath you are going to be, the more powerful you are going to be and the more potential you have for an effective outcome from the homoeopathy. But the danger is this, and I've seen it, that homoeopathy becomes the new Supervalium. You used to go along to a GP and say you are anxious and not coping and he would say, 'Yes, yes take some valium', now you go along to the homoeopath and he says, 'Yes and at what time of the day?' and 'How do you feel in relation to company?' whereas to my mind someone, sometime in the care of the patient has got to put down the pen and simply ask 'Look, what's the problem, what's going on?' instead of this obsessional pursuit of therapy and intervention.

This specialisation has led on occasions to new holigenic diseases (my term for certain types of new-age holistic iatrogenesis, some forms of which begin as a 'high attitude sickness' in the therapist). The Homalium Syndrome causes the therapist to perceive every human experience as a symptom. This is transmitted to the patient who then develops a craving for lactose. This is why I use the word 'drugs' in relation to homoeopathy, not remedies but drugs. To me a drug is an externally administered agent which will alter the physiology of the patient. It's an intervention and we intervene at our peril. George Bernard Shaw once said 'All doctors are damned' and in bringing our communities together I'd like to include the homoeopaths in that.

So what I am touching on here is the difference between what is called in classical medical structure primary care and secondary care; the difference between the generalist and the specialist. As I see it, the training of the homoeopath, the non-doctor homoeopath, at the moment is rendering them increasingly safe at the secondary-care level. The specialist homoeopath will be essential and effective at the secondary care level but at the primary care level the training currently renders the person potentially dangerous. I would not send my mother to such a specialist for a diagnosis and management plan, I might send her for a homoeopathic prescription. I'm sorry if I offend anyone, in all genuineness I'm not trying to do so. I think we're dealing with people

here, we are dealing with ethics and we can't avoid anything other than the highest standards. So I do not accept what is said in the symposium leaflet that the old criticism about inadequate training in terms of diagnosis has now been answered by modern education.

The doctor who graduates at five years is seen only as fit to spend another year working 120 hours a week, as part of a team constantly supervised and at that point is only allowed to register. As a registered medical practitioner the only thing you are then allowed to do is to start training further. In order to train to be a GP you then start what is going to be at least another four years training. To become a principal in general practice is now taking a minimum of ten years training and at this point whether you become a principal in general practice or a registrar you are only seen fit to be a supporting member of a team network and your diagnostic skills are seen as minimal. To go on to be a consultant diagnostician in a particular specialty is probably going to take another six to eight years. So the average consultant physician often achieves this position at about the age of 38 having entered medical school at around the age of twenty.

So in terms of primary and secondary care where are you going as a Society and a profession? Decisions on how you see yourself now and your role in the future are critical first steps in determining the possibility of future creative dialogue between us. Do you want the pain and pleasure, the power and pressure of achieving a position that the culture would call a doctor? Do you want to pay the cost involved? More importantly, what elements of these first draft thoughts (admittedly flawed by my doctrocentric view) do you accept or reject? What fresh models and points of reference would you propose?

### **The Future**

There is no standing still. Patient pressure and the EEC will see to that. We've got to act and preferably in concert. I would suggest your immediate goal is one of becoming professional therapists. To achieve this you are going to need external examination and external examiners, which is one of the principles of professional training. Perhaps you would even see a role for the Faculty in this, or the Faculty may see a role – I don't know, I'm not speaking for the Faculty. It's a possibility. What relationship do you want with the Faculty of Homoeopathy, would you accept it as a regulatory or examining body? Whilst moving towards professional, registerable and accreditable qualifications and to an accountable regulation of ethics, and discipline, equally important will be the development of a capacity for self-questioning, and self-criticism, things which I think whilst not perhaps being essential, are desirable for a good profession.

You need to research, within your own community, attitudes towards issues such as specialist or generalist

status. The role of a secondary care specialist would allow you to focus on your chosen therapy, while advising your primary colleagues on suitable applications of your speciality. The GP does not have to train in brain surgery to remove a wart, how much training do they need to give Arnica in injury, or Chamomilla to an angry teething baby?

What words would you want me to use? How would you like me to address you? What language do we want? How would you like to be addressed in relation to your role to doctors? Do you see yourselves as complementary, supplementary to or independent of the medical profession? How will you relate to the existing healthcare system – the National Health Service? Are you prepared to see yourselves as being 'subservient' to the GP as hospital consultants now are. Do you realise that the GP always has control of the case and can withdraw the case from the consultant at any point and choose to send the patient elsewhere? The consultant is only entitled to see the patient with the GP's blessing. 'Subservient', I'm deliberately using a word which would not normally be used in practice; I've used it just to get our emotions going.

I see the need for a primary care generalist who coordinates the patient's care, you can see that's my point of view. Perhaps we have a model already in psychologist and psychiatrist, both overlap in knowledge but have defined strengths. Or are you still thinking of a new, parallel primary care? The principal of a UK homoeopathic college once explained to me that its graduates would replace GPS, and, in passing, added that homoeopathy would remove disease from the population after two generations of miasmatic treatment. How wonderful! We've finally found the answer to the human condition – homoeopathy! 'Oh' I said, 'and would your graduates be visiting the old lady found at twoam behind the door of her eighteenth floor flat?' 'Well I guess we will still need some allopathic systems' was the reply. An interesting definition of allopathy don't you think! So do you want to be in primary care?

Will you offer 24 hour cover and continuing care for the incurable? If you do, you will have to accept that your view of homoeopathy will diminish and will become a lesser component because you will; have to develop a broader medical skill; community care is not the same thing as a network of therapists.

And what of the doctors? It remains to be seen if they can adapt to the changes within your profession. As I said earlier, there is no future for complementary medicine in any integrated model unless the trainee doctor has an adequate awareness in this field. In relation to homoeopathy, the doctors on the Faculty courses are taught to use targeted applications of the therapy in a limited way, and then a small self-selected group go on to develop specialist training. I can foresee a front line homoeopathy likely to be practised by the GPs with a certain level of defined knowledge and very aware of their own ignorance.

Beyond their front-line homœopathy they would refer the patient on for a specialist's opinion/therapy. That opinion/therapy could be in the hands of the psychologist equivalent of the homœopath within the medical structure, that's how I would see it. Just as some doctors are motivated to become psychiatrists and develop overlapping skills, we would have second-line doctor specialist homœopaths as well as the pure homœopath. The advantage to this is the power and capacity to help to bring to patients a standard of homœopathy that is unobtainable to the GP, perhaps even unobtainable to the second-line specialist doctor homœopath whom the patient still expects to be functioning as a doctor. The homœopath is able in this role to study and practise exclusively homœopathy and raise it to an artform previously not even thought about.

Now I'd like to come to the end of the beginning of today and maybe, as Robin Pinsent said the end of the beginning for homœopathy (ref. 6). Robin Pinsent was the man who seeded one of the revolutions in medicine that led to the transformation of general practice from 1950 to present day and led to the founding of the Royal College of General Practitioners. We would do well to listen to the spirit

of his vision on our path to try and find homœopathy's place within a better medicine. I look forward to studying your travel plan. Climbing mountains is very difficult, there is no doubt about it, and I think it would be a lot easier if we did it together. Thank you very much.

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