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THE RESPONSES

Complementary practice at Phoenix Surgery: first steps in cooperative inquiry

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SUMMARY. **This paper reports briefly on a cooperative inquiry into collaboration between general and complementary practitioners at Phoenix Surgery in Cirencester. From the experience of the co-researchers it is clear complementary practices have a place in primary health care, and that time and energy need to be devoted to developing communication and understanding for a full benefit to be realized.**

INTRODUCTION

Phoenix Surgery† is a six-partner practice in Cirencester with some 9000 patients. The practice philosophy has been one of providing a generally holistic approach to medicine. To this end, and in response to patient requests, the practice has since 1990 provided osteopathy and acupuncture at a reduced private rate at its surgeries. In response to invitations from the Gloucester Health Authority the practice put forward plans for developing this service to explore alternatives for patients which would avoid secondary referral when more appropriate primary health care resources could be shown to be effective.

After much discussion a study focusing on conditions of the head, neck and spine was agreed. The research methodology included audit cycles and cooperative inquiry. It was thought that while a series of audit cycles would provide data that would help judge the therapeutic contribution of the complementary practices, cycles of cooperative inquiry[1–3] would provide a discipline through which questions of professional collaboration and mutual learning could be explored. Cooperative inquiry had already provided significant insights into the practice of holistic medicine, and into the processes of collaboration between general and complementary practitioners.[4–6] While neither the audit nor the cooperative inquiry were as rigourous as might ideally be wished – mainly because of insufficient funds and shortage of time – all involved felt they had made significant steps in learning to work together which were of benefit to patients.

The information on which this article is based comes from a tape-recorded conversation with most of the

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† Note: this paper is written with the collaboration of the general and complementary practitioners at Phoenix Surgery. General Practitioners Drs Hugh Coleridge, David Beales, Ian Simpson, Chris Goldie, Marina Bielenky, Rohit Sethi; Osteopaths Ms Meg McDonald and Dr Lawrence Fielder; Acupuncturist Mr Adrian Lyster; Homoeopath Dr Elfie Klinger.

general and complementary practitioners at the end of the inquiry project. The author, who also facilitated the inquiry sessions, invited the practitioners to discuss the questions. 'What have you learned about working together and what else do you need to learn?' and 'What has been helpful about working together and what has not worked?' The whole experience provides some useful insights into the possibilities and problems of integrating complementary practices within an NHS general practice.

INITIAL RESPONSES

The general practitioners' first response on being asked what they had learned from working with complementary practitioners was that they had become aware of a wider range of ways of treating people, and that this had also lead them to begin to think differently about approaches to helping people:

> **Hugh:** It's not conventional medicine is it?... I think that something I have learned about is that you have to look at all sorts of different approaches that are unrelated to our conventional medical way of looking at things, the conventional medical model...
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> I was rigidly brought up in a strictly reactionary medical school. Anything that wasn't absolutely right down the middle, a proper medical model, it wasn't true and it didn't work and it was nonsense and they were all charlatans and quacks, which is why the General Medical Council was set up. But they couldn't have been more wrong could they?

The complementary practitioners, on the other hand, said they had learned about how general practice works and had learned to feel more comfortable working with general practitioners.

> **Meg:** I suppose I've learned more how the general practitioner practice actually works and appreciate more... what you're up against from my perspective of seeing so many patients every day and having to deal with such a volume of work and make decisions about so many people.

Working in general practice had also influenced the complementary practitioners' style of working.

> **Adrian:** Working in general practice has influenced me to adapt my whole clinical style and to much more take on board a primary care model... I (ask) 'Is this something simple? Is it an acute primary care situation? Can I treat it on those lines?' I see a lot more patients for shorter periods...

As we explored these initial responses a range of issues arose, including questions of communication and understanding, of the proper role of complementary practitioners within general practice, and questions of how doctors assess the impact of the complementary practices on patients.

COMMUNICATION

One consequence for all involved was quite simply that they got to know and trust each other, so the referral became a personal as well as professional process.

> **Hugh:** ...we have a personal acquaintance with Meg and Lawrence and have a personal trust in them doing things that are sensible, and not doing things that are not sensible. We're much happier to say with great confidence 'You go see Meg or Lawrence. We know them well. They work with us' and so on... It's an explicit understanding, not only of what they do, but also the people they are.
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> **Ian:** It's also about learning to trust, isn't it, because people are tackling things in a different way, from a different angle, and you have just got to say 'I have confidence in that individual and I'm willing to trust that what they're doing is right'...
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> **Meg:** Working here has made me much more relaxed with doctors and general practitioners. They're actually human beings.

One of the things that most helped develop trust was being in the same building together, and so bumping into each other in corridors and between clinical sessions. Some of the practitioners' paths crossed frequently, and they found this most helpful; others never saw each other because their sessions didn't coincide, and so knew each other less well.

This informal contact is extremely important, given the problem, in a busy general practice, of arranging regular clinical meetings. This difficulty was increased by the different relationship of the general practitioners and the complementary practitioners to the practice: while the former as partners are in effect paid for all the time spent in the practice, the latter are part-time and paid by the session and would need a fee for attending additional meetings.

Thus one of the realizations from the project was that more time was needed sharing perspectives.

> **Hugh:** Part of the downside for me is the feeling that really I'm not significantly wiser about what exactly Meg and Lawrence actually do to make patients better. The fact that I've never actually been a fly on the wall at their clinic and seen what they actually get up to. I know I get all sorts of positive feedback from patients... but I still haven't the faintest idea what actually they do... and how it relates to my perceptions of manipulation in what I try doing in

a very crude sort of way. For me, that's a considerable downside. Similarly I have very little idea of what actually Adrian does.

Adrian: It's mutual, because I only ever meet you in the corridors and at meetings and I'm very intrigued as to what goes on behind closed doors.

These questions of knowing each other's work were important for building trust, but also in order to learn how best to use the different skills that were now in the practice and how to respond to the different needs of patients.

David: I think something we haven't properly addressed is... what kind of patients – for work reasons or simple pain reasons – really do need a quick channel of response... Those are the kinds of things I think would continue to come up in cooperative inquiry and regular discussions. We would gradually develop some of the criteria for fast-tracking and selection.

It was felt that in order to develop this understanding a refined audit cycle was needed, plus more time set aside for reflection and clinical discussion together.

Another area which was identified as important was what information was required on referral. The complementary practitioners generally did not want complex referral notes but to know why the patient has been referred in quite general terms. Most important is the information that the general practitioner can provide about the patient's circumstances, and personal comment or insight: 'This is an anxious patient', or 'We've tried six different forms of treatment and they haven't worked', and also information about how long the problem has been going on and whether it is recurrent. Other information they prefer to hear direct from the patient. The general practitioners greatly appreciated notes from the complementary practitioner at the end of treatment, partly technical explanation of what has been done, and partly suggesting what might be tried next. All involved agreed that such communication between practitioners was really helpful, but that it often was omitted because of pressure of time. Filling in the audit forms was experienced as an extra burden which did not help improve communication.

ROLE OF COMPLEMENTARY PRACTITIONER IN GENERAL PRACTICE

The complementary practitioners experienced the pressure of working in general practice, and this influenced how they adapted their own clinical style:

Meg: On a negative side... I feel a pressure to give people the minimum number of treatments. I also feel (concerned) about chronic patients who are really going to need to be seen over a longer period of time; also with people I feel I can get say 20% or 30% better. I feel in this situation that maybe that's not appropriate, whereas in my private practice I would – if they were happy to look for that kind of improvement – work on that smaller level of improvement.

Meg felt the pressure of general practice was different from private practice, 'a sense of going toward that bigger result or shorter treatments'. This raised an interesting reaction from the general practitioners, who pointed out that general practice is not so much about acute treatment:

Chris: I can understand why you say that, but I'm not actually sure that's the culture of general practice. I think we spend quite a lot of time on long term, ongoing treatment with patients without necessarily much expectation of dramatic improvements... ongoing care, over the generations even.

So while the experience of general practice, and probably the pressure of proving that complementary practice had something to offer in the short term, influenced the complementary practitioners to concentrate on acute cases where they might have an immediate effect, their role in helping to contain long-term conditions emerged as potentially equally important.

Hugh: ... it actually increases your options in terms of containing patients with long term chronic problems. Meg has said to me on a number of occasions that there are areas where osteopathy can help a bit and often it's a question of drip drip, water on the rock. If you do it long enough the rock wears away...

In caring for an elderly person or one with multiple problems, making them more comfortable might be important.

... if there are muscular skeletal things with which they can be helped, but with no expectation of cure, then it gives you a wider option in terms of helping them in that process.

Ian: I think... in general practice that we understand there is a chronicity about this and you can't get every patient better every time. I think that's something you appreciate, but I'm not sure that all the practitioners see that and I'm sure that every patient sees it. I think sometimes our role is to say to patients 'Actually, this is something you've got to learn to live with and you've got to adapt your life to'.

The general practitioners were curious that the complementary practitioners had not perceived this aspect of general practice. Part of the problem was that demand – particularly for osteopathy – had built up, the general practitioners had used the osteopaths for acute cases, and so there was no longer space for helping to support long-term problems, or even for maintenance and top-ups which might reduce the need for NSAID or long-term analgesics. And part of the problem was the pressure to 'prove' that the complementary therapies 'worked'.

This definition of the complementary practitioner role in the practice – dealing with acute cases where there would probably be a short-term benefit – had emerged without a conscious decision by anyone. As Meg said:

> **Meg:** I feel very much that I've been allowed to practice as I see fit and not in any way dictated to. (But) demand outstrips supply, there's a waiting list and the receptionist will say, 'Oh, if you could fit this person in today because they've got a lot of pain'. And there's a feeling that you have to get people better and out the other end so you can deal with the waiting list.

This experience of pressure had also meant that there had been no opportunity to teach the general practitioners the simpler aspects of manipulation, which has been hoped for by some of the doctors.

> **David:** ...what hasn't happened is you teaching us more effectively. Since you've been here, I have gone back to manipulating more patients. I did the British Association of Manipulative Medicine course. During this year I've been reminded that it is effective if you get it right and do your 'million dollar roll' and the patient is fine and it's good. But I imagine that that is at a very simple level and is effective and could be taught. You and Lawrence could hand over the simpler general practice skills which we could do in the surgery and that would leave you with more of the complex, difficult manoeuvres and so on.

One thing that has not changed at Phoenix is the role of the general practitioner as the first point of contact for the patient, and the pressures that this brings.

> **Hugh:** There's the permanent black hole for every general practitioner, the feeling that we have to deal with the problem there and then, but for the vast majority of things, unless it's an acute, crashing emergency, there's a waiting list of some sort for everything. This is something that bugs me. I'm expected to deal with everything there and then, but nobody else is, if you see what I mean. At the point of primary referral I have to cope with everything according to the patient's perception of urgency, not anything else, whereas everyone else... Nothing's going to alter that. It's part of the position we put ourselves in.

IT WORKS!... AND IT DOESN'T SEEM TO

The general practitioners made many appreciative comments about the contribution that some of the complementary treatment has made to the work of the Phoenix practice; at the same time they were less sure about some of the practices. They were generally enthusiastic about the contribution of osteopathy, felt they were learning a lot about the potential of acupuncture, but far less convinced that homoeopathy had established its case in their practice.

One thing that clearly helped was having short cycles of treatment, in which the impact or lack of it could be seen fairly immediately. This was the case with osteopathy and acupuncture (especially in the area of problems of the head, neck and back); whereas homoeopathy seemed to the general practitioners to involve a longer term process with less immediate feedback.

> **Ian:** It is about contact and it's a number of short, sharp referrals. You refer, they do well, they come back and they say 'He's wonderful' and therefore you start to think 'Yes, actually this works. It's pretty good'. And when you have patients coming back from the homoeopathy saying 'I've seen her three times and I'm actually worse. Do I carry on or do I come back to your conventional medicine?' I feel myself thinking I don't know, what do I do? I haven't got the trust in homoeopathy that says 'Stick with it, it's going to be alright'.

When pushed to explain how they could be so sure that some complementary treatments were effective, without the evidence of the clinical trials to which their education would have directed them, the general practitioners stressed the immediacy of the results:

> **Ian:** People are getting better and coming back happier and symptom-free.

While it was commented that maybe there was a bias in this impression, because 'It's the ones who get better who actually come back and tell us about it', it was also thought likely that the bias would be the other way 'It's the ones who don't get better that come and say so'. However, it was the immediacy of patients' response to acupuncture treatment for migraine that the general practitioners regarded as the clearest evidence of the potential impact of complementary therapies:

> **Ian:** I think the migraine thing was the thing that really swung it... the relief of migraine with acupuncture. People whose lives were devastated by their weekend migraines (changed) to people who don't have migraines. Something I've been unable to do with conventional medicine... The proof is... startling.

Hugh: I would echo that. Startling transformation in people, without anything else apparently being altered at all.

Beyond this immediacy of response, the general practitioners argued that they make the same kind of overall judgements about the efficacy of complementary practice as they do about other contributions to general practice: they make informed judgements based partly on what they see as outcomes, partly on their trust in the practitioners, and partly on what they describe as a 'validating experience': the whole treatment hangs together and makes an intuitive common sense. And again of particular importance was that by working closely with the complementary practitioners, cycles of feedback could be built up:

Marina: I'm very aware that Meg, Lawrence and Adrian, if they've seen a patient three or four times and there's no difference, say 'Well it's obviously not working'.

This immediate feedback could alert the general practitioner to other potential problems and initiate other lines of investigation.

CONCLUSION

It is clear from this small study that it is not simply a question of what complementary therapies might contribute to primary care – whether they 'work' – but also how such therapies and their practitioners can be effectively integrated within an NHS general practice. It is clear that the relationships between the different practitioners, and the nature of the trust, communications and feedback between them is of supreme importance. Getting to know one another as people, working in the same premises, quick cycles of feedback, open discussion in clinical meetings and, if possible, mutual training will all help to make the contribution of complementary practice not only more significant but easier to assess. Phoenix Surgery has taken some initial steps, and as a result of the early work, the practitioners are quite enthusiastic about what they have achieved. At the same time there is clearly much work to be done in deepening understanding and thinking through the nature of the complementary practitioner role in relation to acute and chronic conditions and, in particular, further work in exploring the contribution of homoeopathy.

However, the time appears to be well spent:

Hugh: I should feel very cramped now not having Meg and Lawrence and Adrian to refer the patients to, because I should feel that a whole chunk of area of potentially effective ways of helping patients had been removed.

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