

### **Why we need integrated health care**

**David Peters**

Public sector health care, anguishing about its spiralling costs and the demographic explosion, has concluded that it cannot carry on in the same old biomedical way. The biomedical model, effective though it can be in confronting single-cause pathology, is shot full of holes where chronic, lifestyle- and environmentally mediated diseases are concerned. At the same time, many practitioners and NHS users feel fragmented, disempowered and unheard. Throwing drugs at their problems fails to satisfy patients or their doctors, so **we** want something different, something less disintegrated. In short, **we** are experiencing a crisis of theory and practice.

**Integrated** health care has become shorthand for better medicine, but there is more to it than just bolting CAM onto conventional health care, although that might seem like an obvious way of augmenting the ‘magic bullet’ approach. For patients and GPs, as well as managers and policy-makers, CAM perhaps represents approaches that involve greater patient participation, approaches based on mind–body interaction, low-tech treatments and relatively low-cost time. These are seductive conclusions, supported to a degree by the impression that these therapies meet needs, for the complementary therapist’s stock in trade is chronic illness, stress-related and painful conditions, all of which conventional practitioners find problematic. Even if in most instances pooled evidence from RCTs tells patients that their feeling better has little to do with the techniques used, surveys of CAM clients suggest high levels of satisfaction and useful outcomes. Those who can afford to, therefore, already vote with their feet and seek out practitioners with the time to take a different view of their chronic health problems. They shop around for massage, homoeopathy, counselling, hypnotherapy or perhaps they take life by the scruff of the neck and change their diet or lifestyle, job or relationship. Yet although something changes when people take action (something that RCTs don’t necessarily catch in their experimental net) this consumerist pick-and-mix pluralism does not add up to **integrated** health care. If holistic health care is the aim, this will require integrating a mesh of multidisciplinary and inter-agency activities, and those who engage in it will **need** to view clinical problems from diverse perspectives in order to work together.

Inter-professional misunderstanding and uncertainty are part of the healthcare landscape, struggle as **we** do to hem them in. Nor should **we** try too hard: biomedical primary care based only on what is meta-analytically validated would be impoverished, robotic and alienating. **We** must therefore be prepared to turn our research methods upside down: to research individuality, patient preference, empowerment, therapeutic relationship, the patient journey. Primary care research trusts will not be appropriate for these tasks; the paradigm of **integrated** care is new and it will **need** new methods to evaluate it, but is there already enough evidence to justify integrating a wider range of treatments? I believe so, and by waiting for ever more RCT evidence **we** deprive people of potentially useful cost-effective treatments. Such strategic integration should be exploratory although, for instance, appropriate new approaches could be tried in pilot care pathways, National Service Frameworks and local guidelines. While aspects of CAM have a place in this picture, I don’t only mean CAM, but also dietary approaches and an extended range of physical and exercise therapies, and cognitive-behavioural therapy approaches that could re-empower people with chronic disease, dysfunctional and undifferentiated illness, and problems of daily living. People in these groups are often dissatisfied, high service users who flummox carers and cost the system dear, while stressing health professionals at least as much as they do themselves. Our experience of **integrated** primary health care has convinced us that it can spread this load and boost everyone’s satisfaction when a better job is done.

I believe that, in general, a more pluralistic primary care-centred NHS, concerned with long-term prevention, if strategically developed and properly organised, could manage the health care of an aging chronically needy population more effectively. However, **integrated** health care is a process and a signpost rather than a destination and if exploring the role of CAM is part of the process, then in current NHS-speak integration will **need** quality frameworks, performance indicators and appropriate ways of researching the process and its outcomes. This will be no easy undertaking, no bolt-on quick-fix prescription for the ills of the NHS, for in these terms integration is less like a medicine and more a lifestyle change, a regime designed to transform the way **we** think about health care and make it work. Yet the NHS modernisation project is radical enough to embrace the kinds of development needed. Integration and NHS modernisation sit well together – patient choice and participation, health promotion, clinical governance, a seamless service, expert patients, are all essential pieces in the puzzle of how to manage 21st century health care and a necessary recognition that health care is something more than biotechnology.

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***Why integrated medicine should be treated with great suspicion***  
**Peter H Canter**

I understand integrated health care to be the provision of complementary therapies as part of routine NHS treatment. Unfortunately, the integration agenda appears to be side-stepping the necessity of demonstrating safety and efficacy before new therapies are provided as part of mainstream services.

There is very little convincing evidence that many CATs have any specific therapeutic effect over and above that of placebo. Non-specific treatment effects are a combination of those causally related to the treatment (setting, time spent with the patient, therapist charisma, care, empathy and interest shown by the therapist, patient's beliefs and expectations<sup>1</sup>) and those not causally related to the treatment (natural course of the disease and statistical or measuring artefacts). Thomas<sup>2</sup> asserts that 'The placebo effect can be produced by any action intending to heal; by a consultation in which no treatment is given, by a procedure, such as admission to a hospital ward, or by any contact, between doctor and patient, even a few words exchanged in the street.' For this reason, there is rightly great interest in increasing our understanding of how the placebo effect works and how it can be maximised during routine medical practice.

Medical practitioners could use 'pure' placebos, treatments in which there is no proven, or in some cases not even any plausible, mechanism of action, but Thomas surmises that deliberate use of placebos is resisted by doctors because it involves them in deceit.<sup>2</sup> It is also paternalistic and inconsistent with treatment with informed consent. Nor can it be squared with a holistic and respectful approach to patients that treats them as intelligent and active participants in their own pursuit of health and well-being. If the placebo effect accompanies any therapeutic intervention, then the logical and ethical course of action is to choose treatments where there is a demonstrable specific effect, and to take steps to maximise the accompanying placebo response. Although patients may have exceptionally high expectations of CATs, Kaptchuk concluded that there is little empirical evidence that any particular type of CM for any particular condition has an augmented placebo effect.<sup>3</sup> It is my impression that practitioners of CATs are as deeply troubled as mainstream practitioners by the idea of deliberately using treatments with no proven specific effect. It opens them up to the charge of charlatanism, and challenges their core

beliefs about health, disease and their particular treatment modality.

Proponents of integration frequently rationalise that patients are already using CATs on a large scale, which indicates dissatisfaction with mainstream medicine and somehow demonstrates the worth of such therapies. This conveniently side-steps the important issues of whether people are purchasing placebos and being exploited, whether it is ethically acceptable for the NHS to endorse the deceit of patients and whether such treatments are safe. It also raises the question of what services the NHS should stop providing in order to fund CATs: one person's aromatherapy is another's hip replacement.

Because even the most prevalent treatment, the prescription of a pharmaceutical, is accompanied by a powerful placebo effect, even when mistakenly prescribed or prescribed on the basis of a wrong diagnosis,<sup>2</sup> medicine is a fertile field for the growth of superstition among both patients and doctors. The disagreeable but necessary corollary of this is that the opinions of patients, doctors and complementary therapists about efficacy will frequently be very unreliable. Only the most rigorously controlled clinical trials can determine whether a therapy, mainstream or alternative, has any specific effect.

The absence of a convincing evidence base for most CATs, combined with what is rapidly becoming the politically correct agenda of integration, is leading to a proliferation of poorly designed, inconclusive and biased scientific studies of CATs using the softest of data. A further consequence of the growth in low-quality research around '**integrated**' medicine is that research funds are being usurped to pay for the actual provision of CATs under the guise of doing research. As the agenda from the outset is to attract future funding for continuing provision of CATs, the research sets out to demonstrate that **integrated** provision is efficacious and cost-effective, and chooses the weakest of research designs, which is most likely to prove just that.

Without proof of efficacy, mainstream medicine risks embracing therapies that are based entirely on a placebo effect, leading it into the realms of superstition and a serious ethical dilemma, and risks wasting public money. Given the present state of research evidence, doctors serve their patients best by resisting integration, remaining sceptical about complementary therapies, advising their patients about the efficacy and safety of privately purchased therapy with great caution, and by making sure they get involved in only the most rigorous research.

## References

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