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Commentary – Alma Ata

Complementary therapies in the NHS: some thoughts and three cases

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Introduction

The umbrella term ‘complementary medicine’ is a misleading label for a cluster of diverse and unconnected ideas and methods, whose most obvious shared feature is their absence from the medical curriculum. So why have doctors – especially GPs – taken such an interest; sometimes recommending them to patients or even working alongside complementary medicine practitioners? In various surveys – admittedly the most recent of them ten years out of date – as many as 60% of GP responded positively when asked about complementary medicine. Some GPs practice a complementary therapy (e.g. medical acupuncture or even homeopathy) themselves, others have employed a nurse to provide them, or send patients to complementary therapists based in their own practice or elsewhere.¹ The Vauxhall Health Centre experience, described in this edition of *London Journal of Primary Care*, is one of many examples. In the 1990s fund-holding and its variants boosted complementary therapies’ availability in the NHS, and this access was largely maintained or expanded by the emerging PCTs in the early years of the decade that followed. About 25% of the public have paid to use them at some time, primarily because of chronic illness, stress-related and painful conditions; all of which conventional practitioners find challenging. The clients have usually received prior medical treatment (we might infer that it did not fully meet their need) and surveys suggest both high levels of satisfaction and useful outcomes.²

In 1987 as a GP recently trained in osteopathy I was recruited by a new Central London NHS health centre that eventually became well-known for working with practitioners of complementary medicine.³ In the 20 years I was there, the part-time complementary therapy personnel changed now and then; but the team itself – acupuncturist, massage practitioner, homeopath and osteopath – continues its work, nowadays with funding from the PMS budget. About six years ago Westminster PCT rolled out an expanded service making complementary therapies available to the

whole area through our centre and another local practice. Complementary medicine was on the rise in the NHS at that time: our own surveys of all England’s PCTs in 2002 estimated that 43% of them were spending significant sums on complementary therapy provision; in nearly half of them the provision was PCT-wide. The survey reported that 84% of Greater London PCTs had public sector CAM services: 67 services across 31 PCTs.⁴

Recently, cash-strapped PCTs, possibly persuaded by a few high profile critics of complementary medicine, have begun reining back on complementary therapies. This frustrates those of us who find complementary therapies helpful for patients who are caught in one of primary care’s many ‘effectiveness gaps’.⁵ Top of the list of common conditions where GPs feel their treatments are relatively unsatisfactory, are musculoskeletal pain and ‘soft tissue rheumatism’: problems where low-tech and high-touch approaches are (according to clinical experience, public testimony and pragmatic outcome studies) found to be highly effective.⁶ But far too little research has been done to establish the efficacy of complementary therapy; though it is a point of contention whether the research methods most acceptable to the medical community are suitable for complementary therapies. Their outcomes depend greatly on individual practitioners’ skill; rather than providing a direct, instrumental intervention, as ‘western’ medicine tends to, they aim to help the body to heal itself. and diagnosis and treatment evolve iteratively. These subtle and global elements which are fundamental to complementary therapies, are difficult to quantify and control for, so the standard randomised controlled trial can hardly account for them.

The popularity of complementary therapies with the public, particularly given the avowedly patient-centred focus of a primary care-led NHS, makes future integration of complementary therapies likely. Primary care commissioning, wellbeing services and orthopaedic service redesign should all create new opportunities to

investigate the public sector role of complementary therapies. It will be important to evaluate them in ways that are true to their nature.

Box 1 shows three examples from my own cases of women with atypical shoulder and arm pain, who were helped by complementary therapies. All three were seen in my private practice in Central London, but as an NHS osteopath I saw similar patients. Two

were referred by their NHS GPs and one patient's fees were reimbursed by private medical insurance. There are a number of common themes: disabling acute pain without gross neurological signs, high anxiety, a degree of over-breathing, myofascial trigger points, treatment involving acupuncture, osteopathy and relaxation techniques. Two had experienced significant past traumatic events ..

Box 1 Three women with atypical shoulder and arm pain

Patient 1

A married mother of two young children she had experienced a stiff right shoulder for about a year, though it had become much worse and more painful after suddenly straining it eight weeks before. Now she describes acute disabling poorly delineated pain in the back of her arm down to the wrist. Her GP's injection (near the supraspinatus) had initially helped her mobilise but left the pain unaffected. On the advice of a friend and with her GPs begrudging consent, she had sought me out.

At her first visit, she was near to tears, rating her morning MYMOP as 5, lunchtime 3–4, and in the evening 6 (i.e. as bad as she could possibly imagine). She couldn't sleep or wash properly under the arm, or actively abduct it much though I could passively abduct it to about 80 degrees. There were no anterior impingement signs and she could actively rotate in both directions. She had very sensitive trigger points in the trapezius and upper sternomastoid, and when I pressed on them pain spread into her arm, neck and head.

Clinically this was neither an acute capsulitis nor a 'frozen shoulder', but a supraspinatus dysfunction, and – judging by the absence of impingement – caused by tense, irritable local muscles rather than a tendonopathy. The barrier on passive elevation suggested a subacromial bursitis but I held back on giving a Kenalog injection because to my surprise, after some soft tissue stretching, massage and local acupuncture to various tender trigger points (trapezius, supraspinatus, infraspinatus plus a few point on her arm and hand) she was able to abduct half way. My assumption is that needling the body stimulates local circulation, produces bursts of mechanoreceptor nerve impulses, and releases endorphins. Whatever the mechanism, it seems a highly effective way of treating myofascial trigger point pain.

I asked her to pay attention to her breathing (she had been hyperventilating when she came in) pointing out how her whole shoulder girdle was tensing up when she breathed with her upper chest, and I showed her a simple relaxation technique. As she relaxed, and with her arm at least eligible to leave her side, she reported her pain was much reduced. Two days later she returned, more comfortable still: MYMOP 3 at worst, 1 at best, and she could sleep. No doubt this progress had been anxiolytic in itself; anyway she looked and said she felt much calmer. I treated her several times more at increasing intervals until she was pain free, instructing her along the way in how to restore the strength her disused muscles had lost, and always reminding her to be aware of the link between her bodily tension and her response to stress.

Patient 2

A woman in her early 40s presented with severe left arm pain that had spread into her hand. She was not from the UK and lived here alone, separated from her ex-husband and two children who still lived abroad. Though not exertional, her pain got worse when she tried to lift her arm to brush her hair and she feared she was having a heart attack. She found the pain frightening and said that she was becoming very anxious. Since her sister visited recently her tendency to be anxious had turned into episodes of near panic, and an all too familiar melancholy has descended on her.

Her heart rate was up to 110; respiratory rate 20 a minute; BP 160/90. The story did not suggest cardiac ischaemia, the movement-related elements, and the extremely tender point I found in her left trapezius gave me a clue to what was going on. I noted her 'fear posture' (shoulders up, head slightly extended, rapid upper chest breathing), how she braced her body as though expecting a blow; how she recruited her scalene and sterno-mastoid muscles for upper chest-breaths; how little her belly moved with each rapid breath. I explained to her what was happening in her anxious body (though I expected she would not have much free attention available to take my words in), that the pain was from muscle spasm in her shoulder and that her panic and pain were reinforcing one another. I let her know that the pain was neither a heart attack nor some

disembodied psychic illusion, but trapezius trigger point pain which I would try to reduce. When I pressed on the point it reproduced her pain and spread down her arm. At this she visibly relaxed then burst into tears. I suggested we try acupuncture, which she had experienced years before and which she knew had helped the friend who had sent her to me. Fortunately she was a 'strong responder', so her body visibly quietened down after I inserted some needles locally and into traditional calming points. I also massaged the muscles of her neck which had become very stiff and I manipulated her cervical spine. With the return of more normal neck movement her arm pain reduced and her face registered relief.

Her anxiety had been so extreme that I asked her to take 2 mg of diazepam TID for three days as a muscle relaxant and to help her sleep. Three days later she seemed more in control but during this session she had a sudden memory of a time when she was fleeing a war-zone with her children and ex-husband, who had punched her and dragged her by her left arm. The sudden intrusion of this post-traumatic recollection shocked us both. Subsequently, however, our conversations about this event, her life since and her unexpected feelings about her sister became an important part of her recovery process. Her friend had paid for three sessions and so I urged her to find herself a GP who could help her find a counsellor locally.

I often find trigger points in anxious people, though they often don't realise they are the source of their diffuse referred pain. Sometimes I am the first to make the connection, and this can be highly reassuring in someone who feels a crucial diagnosis has been missed.

Patient 3

A woman of 70 was brought by her daughter because of right sided chest and arm pain and disabling headaches. Her GP had referred her to me 'to see if CAM will help'. Over the previous three years – dating back to a knee replacement closely followed by a hernia repair which had broken down – her episodic chest pains had been extensively investigated. Though she was hypertensive the pain was not cardiac, and the provisional diagnosis was GORD. She was on three antihypertensives, a statin and a proton pump inhibitor and (though she had no appetite and was waking early) she had weaned herself off her longterm dothiepin some months before.

She felt short of breath, dizzy, unable to concentrate and frightened; her voice was squeaky and unsteady: all suggesting hyperventilation. When I inquired about any severe shocks she burst into tears and looked even more terrified. With some difficulty I was able to calm her down and pull her back from dissociation. Only then could I set about identifying the myofascial component of her pain, deal with her over-breathing, and show her the connection between the pain and her upper chest and neck tension. As I explained that the pain was from tense muscles and 'not all in her mind', she slowly relaxed and was able to use her diaphragm. Soon the pain reduced a little and (to her surprise) her voice returned to normal, and we agreed to try using acupuncture for pain and tension control. Her homework involved diaphragmatic exercises and slow 7/11 breathing. I suggested she start her dothiepin again.

Her depression meant that progress was slow despite seeing her weekly; but she was sure she felt better after every treatment: the positive transference may have been an important factor in her recovery! Other factors might have been her (eventual) increase of dothiepin to 75 mg a day, and homeopathy. I recognised in her a pattern of characteristics known to be helped by a certain homeopathic medicine: anxious, obsessively tidy, sleepless and so restless that she must get up at night, plus dyspepsia improved by hot drinks. I gave her the matching homeopathic remedy and she felt it made a difference. In addition – because an unspeakable, shameful traumatic event appeared so significant – she agreed to see a Human Givens CBT practitioner to try their 'Rewind' technique. Fortunately her GP knew someone using HG approach locally in the NHS, two sessions with whom made the trauma less overwhelming: which seems incredible but is not an uncommon outcome of the HG 'Fast Trauma Cure'.

My assumption was that peri-operative trauma three years before had rekindled old deeply repressed but increasingly, embodied feelings. The consequences included physical anxiety and depression, as well as gut and myofascial dysfunction. Whether or not it contributed to her rising blood pressure is more speculative. It took six months to pull her out of the mind-body tailspin she had fallen into; but would a purely talking approach have been as successful? I think not: osteopathy and acupuncture entail touching and feeling the suffering body, a manual approach which obliges one to take the patient's embodied experience at face value, to explore what the body is actually doing, and try to make narrative sense of it. This is talk-and-touch therapy but it also involves doing things to the body that produce relaxation and pain-relief. These moments also create opportunities for breaking out of the prison constructed by habitual pain-tension-misattribution cycles.

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