

Herbal medicine in primary care

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I graduated with a degree in herbal medicine from the University of Westminster in 2004, having spent many years previously as a manufacturer of herbal medicines. I have since been establishing my clinical practice in Bristol. The theory and practice of western herbal medicine is still not that well understood in orthodox primary care, and as we western herbalists head towards statutory regulation, I feel it is essential to foster a deeper understanding of what we do and just how useful we can be in the NHS.

Summary

As the practice of herbal medicine (HM) moves towards statutory regulation, many herbalists in the UK are hoping this could allow them to form closer ties with the NHS. This, they believe, would make HM more accessible to those most likely to benefit from it. A unique herbalism service working within the NHS is described here.

Introduction

There are very few examples of herbalists working in NHS primary and secondary care settings, and only one (that I could find) where the service is paid for by the practice, and where the only cost to the patient is the standard prescription charge for the medicines.

Having managed to locate this very rare example of a medical herbalist practising in an NHS primary care centre – The Glastonbury Health Centre – I was interested to find out how this had come about, and how the collaboration actually works.

So when I was studying herbal medicine at the University of Westminster three years ago I decided to take a close look at how my single identified herbalist working in the NHS had managed to achieve this unique position. I ended up doing several hours of clinical observation with him, and this resulted in my making a case study (which became my BSc dissertation) of how his practice integrated into the primary care centre where he works. I talked to other people working there too, including GPs and staff, and then formally interviewed the herbalist and the senior partner in the practice. My intention was to get a 'ground level' view of what actually happens, compared to theoretical notions of what ought to be

happening according to the prevailing literature on the subject.

The key issues I was keen to explore included:

- reasons for specifically including herbal medicine in their CAM service – what needs were being met?
- the inter-professional relationships and communication channels – how to work collaboratively?
- clinical issues – including referral criteria, length and periodicity of referrals, and clinical responsibility
- dispensary management, autonomy, and quality assurance.

There were few studies on the provision of CAM in primary care that seemed relevant. And, though one in particular (from the Somerset Trust for Integrated Healthcare¹) focused on the kind of primary care centre I was looking for, I could find little in the literature that talked specifically about herbal medicine in the NHS. In fact, whenever herbal medicine was mentioned, the key issue seemed to be whether an evidence base would allow GPs to blend herbal medicine seamlessly into their own practice; as though herbal medicine could be merely an extension of ordinary prescribing. Looking at articles of a more general nature on CAM therapies in primary care was useful to a certain

extent, but there was still a missing chunk of information, because none of the other CAM therapies that had been widely written about involved phyto-pharmacological interventions.

I have extracted snippets of my conversations with both the herbalist and the senior partner at the practice to try and answer some of my own questions.

Why choose herbal medicine?

Dr Roy Welford, of The Glastonbury Health Centre, has expressed the opinion that 'all formal healthcare systems are trying to catch up with patient-led interest in and demand for complementary medicine'.² In an article in *Complementary Therapies in Medicine*,³ the main positive influences on the development of CAM services within NHS funded primary care organisations were identified as:

- existing services
- local enthusiasm and expertise
- patient demand
- a willingness to consider the wider evidence base
- a perception that complementary therapies could help primary care organisations to meet national NHS targets.

At this particular practice, the decision to include HM was made because there was a thriving local HM service in the private sector, and a consequent need to create equality of access.

Herbalist: 'I had quite a well-established practice, so lots of patients were obviously using herbal medicine anyway... so I don't think it was necessarily herbal medicine above all others, but they (the GPs) wanted a complete range of the major complementary therapies.'

There were three partners in the practice, all with some level of interest in complementary therapies, or at least willing to take a pluralistic view of health and illness. The senior GP expressed the view that HM is a commonly used, well-established clinical practice, with its own formal system of training and accreditation. Therefore he felt that: 'You're not trying to introduce something that isn't understood'.

This attitude contrasts sharply with a widely held notion that most GPs are unaware that a distinct stream of HM representing a western tradition exists in the UK.⁴ This is perhaps less so in this part of the UK, where people are generally more conscious of alternative lifestyles. As the herbalist explained: '*Because of the nature of the demography of this area... Glastonbury is a New Age centre... there is an unusually high demand for complementary medicine.*'

In terms of the perceived need for a complementary health service *per se*, the GP cited:

'A huge cohort of patients in primary care whose needs are not met by conventional medicine' and 'a huge number of patients who don't want conventional medicine.'



The inter-professional relationship and communication channels

I felt it important to understand the professional relationship between the two practitioners (GP and herbalist) involved. I therefore selected views and opinions gleaned from general discussions, alongside their descriptions of their customary patterns of communication. My aim was to build up a picture illustrating the nature of their relationship, but I acknowledge that the practitioners' descriptions of what they do can only be regarded as anecdotal. Further research would be needed to develop a more rigorous description of their clinical co-operation and how they have learned from one another: obviously structured clinical audit and a detailed observational study would reveal more. In order to begin clarifying how they worked together and what they might have learned inter-professionally, my interviews focused on particular themes.

On the principle of delegated care and ultimate clinical responsibility both participants cited safety as being the primary issue. In this matter, and from a medico-legal point of view, the herbalist stated: 'There are no clear parameters for that but generally the GP referring the patient to the herbalist retains full responsibility'.

The GP's comments included:

'I have a lot of respect for (the herbalist's) skills and integrity.'

'I rely on people like (the herbalist) and his professionalism to provide a safe service.'

'I'm reassured by working with someone like (the herbalist), who I know and trust, and I know isn't cranky and isn't going to be cavalier in the management of people.'

'If something did go wrong, we'd have to be able to justify it.'

'So it goes on trust – like most other clinical referrals I suppose, but perhaps we're maybe a bit more in the dark than with other treatments.'

This last statement implied a comparison with referrals to other parts of the NHS (outside the practice, especially hospitals), where it is essential for the GP to receive feedback from the referred service after every patient visit. The GP noted: 'We don't get that with (the herbalist)'.

So there was no loss of autonomy on the herbalist's part, because the GP felt confident in his management of patients. To a degree this trust was backed up formally through systematic communication entailing a written referral sheet sent by a GP when a patient was referred to the herbalist. The herbalist can also access the patient's computerised medical records, although he cannot input information into these records. Alongside the referral sheet he also receives two Measure Yourself Medical Outcome Profile (MYMOP – patient-centred self-assessment) forms:

The herbalist: 'We have MYMOP forms for the patient's feedback both at the beginning of the treatment and at the end of the treatment. Also at the back of the referral sheet we have a form, where I outline my views and describe the treatment, offer a prognosis and whether I feel the patient will benefit from the treatment.'

He stated that the MYMOP forms are generally used for research purposes rather than as part of a standard communication protocol feeding progress reports back to the referring GP. So the MYMOPs tend to be used only when there is an ongoing research project, whereas use of the handwritten referral sheet is standard practice.

When asked about why the herbalist was barred from inputting data into the computerised records the GP said: 'It should work the other way as well. We have talked about it, and then life carries on at its own pace'.

However, this apparently missed opportunity to use the computerised system for communicating progress is tempered by the herbalist's observation that the computerised records he has access to 'are probably of lower quality than when I first started. Basically it's their own stuff and tends to be diagnoses. You've got access to all the tests that are going – blood tests, x-rays, things like that, which is useful. But in terms of the quality of

the information, medical history, personal information – they are lacking'.

In the meantime there is very little in the way of formal communication about the clinical progress of patient referrals. The herbalist's patient notes are handwritten and kept in the consulting room, although the referring GP does have access to them if the need arises. The GP acknowledged: 'We could tighten up, so when a patient is prescribed a herbal medicine then we get information like that back so it goes on their clinical record – as this doesn't happen now'.

However, in reality, both practitioners seemed relatively comfortable with the level and quality of less formal communication channels.

Herbalist: 'Face to face, or by internal email or by whatever means necessary if there are any queries or problems arising'.

GP: 'Getting feedback from the patients about what's going on'.

Although the interview itself prompted the GP to reflect on what advice he might pass on to other practices regarding setting up a CAM service, he suggested they should 'probably have better communications than we've got with (the herbalist), as ours are so informal'.

In the early days of the CAM service there were formal meetings attended by all the practitioners involved, but these were logistically difficult to maintain as complementary practitioners worked on different days. I suspect this must be a common problem in organisations where CAM practitioners work part-time.

Clinical issues, including length and frequency of referrals, clinical responsibility

A patient referred to the herbalist is allocated a maximum of six half-hour appointments. These are generally spread out, with three to four week gaps between appointments, or as the herbalist deems appropriate. If the treatment needs to continue beyond six appointments the patient may seek re-referral from the GP and might then have to go back on to the waiting list, at the GP's discretion. In the meantime the herbalist can 'let the treatment keep ticking over, if possible, with repeat prescriptions'.

There is an underlying assumption here that if the herbalist deems it appropriate for the patient to be re-referred, then it is likely to happen. Again, the GP, in respecting the clinical judgement of the herbalist, is effectively granting the herbalist autonomy.

Compared with the herbalist's private practice, where the first appointment is at least one hour long, there are time constraints. This is an aspect herbalists

are most likely to compromise on: financial constraints in the NHS dictate that as many patients as possible should be squeezed into the available time slots. This means an NHS herbal consultation will not be the same as a private herbal consultation. However, the herbalist in this practice felt it did not adversely affect the treatment. The real issue here is one of pragmatism, given that time constraints exist everywhere in the NHS. And therefore as the herbalist put it 'one really has to focus on essential information'.

Referral criteria

In terms of types of patients and conditions that tend to get referred the herbalist listed:

'Those who would prefer not to use conventional drugs.'

'Where conventional medicine isn't very successful.'

'A lot of irritable bowel syndrome, perimenopausal and menopausal symptoms, PMT.'

'Often patients with hypertension who just don't get on with conventional drugs.'

'Some chronic musculo-skeletal pain. Migraines.'

'Quite a lot of eczema, some psoriasis.'

The GP listed:

'People with metabolic disturbance, hormonal things.'

'People who have got general malaise or who are chronically unwell.'

'Chronic fatigue.'

'People with depression.'

'Prostate problems or bladder dysfunction problems.'

'Dysfunctional problems in general.'

'Cardiac problems, but they happen less.'

'Blood pressure, asthma, and things like that. If people request.'

'There are some people who don't want to go on to medication – then I would suggest it perhaps.'

'I suppose I tend to gravitate towards referring where I feel someone needs building up; you know, vitalising.'

'Arthritis type complaints'

And areas where he tended not to refer included:

'If someone's going to go on long term therapy then referral to a herbal practitioner is not appropriate – they would need longer than any treatment they're going to get from (the herbalist).'

'Psoriasis – a difficult thing to treat.'

'Chronic inflammatory conditions that are quite major and people are on quite heavy medication – I feel that they've moved on from herbal medicine intervention.'

Both of these lists suggest strongly that referral indicators tend to be based primarily on clinical experience rather than any set protocol or evidence-base. Indeed, when asked about how reliant the practice is on evidence the GP replied: 'Evidence changes. All the evidence there is in herbal medicine doesn't really correlate with the real clinical situation; we all know it works, we just don't know how it works.'



The information gathered reflects the referring GP's perspective on the value of HM as a therapeutic modality. The absence of clearly defined protocols and referral criteria encourages referral as and when the participants (including patients themselves) deem it appropriate and according to their own judgement.

The GP admitted that he did not have a great understanding of what the herbalist actually does. This raised the question of how the GP describes HM treatment to patients he is referring, particularly if it has been his decision to refer them rather than their own request. On this matter he stated: 'I don't really tell them what it is, what to expect.'

Although he always sought their consent, it was on the basis that he regarded the therapy as being more appropriate to their needs than conventional drugs.

He was, however, aware that herbal medicine could involve 'introducing harmful substances'. Nonetheless he entirely trusted that the herbalist would make correct and well-informed decisions about any possible interactions with conventional medicines, or any other adverse events that might arise from taking pharmacologically active herbs.

On the question of patients actually requesting HM, the herbalist expressed the view that:

'The problem is that the more patients request referrals, the fewer slots there are available for patients ... referred by the GP, so they (GPs) might not be referring as many as they could.'

And the GP, estimating the proportion of patients requesting HM said that 'about 30% would be my feeling. I think more come from me than come from patient request.'



The herbalist interestingly noted that among patients who the GP had suggested should try HM 'if anything the compliance amongst that group is probably better than those who

request a referral. Perhaps in some instances because it is suggested by the GP, (these patients) are highly compliant and accepting.'

This points to an interesting hypothesis: might the provision of HM on the NHS, by implicitly validating it, increase not only compliance, but HM's effectiveness? The degree to which this occurs could be the subject of future outcome studies, and could have some bearing on the development of more formalised referral criteria.

Dispensary management, autonomy, and quality assurance

The herbal dispensary in this practice consists of around 40 different tinctures kept in a locked cupboard in the consulting room. The herbalist is entirely responsible for the management of the dispensary, the selection and purchasing of its contents, quality assurance, and their prescribing and dispensing to patients. The practice reimburses him the cost of all medicines, without a fixed budget, so it is up to the herbalist to interpret what is acceptable in terms of expenditure, and stay within his own defined limits. According to the GP the annual bill for herbal medicines 'seems to run at about the same every year'.

This level of autonomy on the part of the herbalist has evolved from a situation, described by the GP:

'When we were originally setting up (the herbalist) was issuing his medications on a prescription via a GP – actually prescribing them. The local pharmacist would then get the prescription, who would then ring up (the herbalist) and (the herbalist) would do us a special order and then sell the prescription to the chemist, who would then dispense it. But that seemed to get so complicated,

and the other thing was a legal concern, because we were actually prescribing stuff and we didn't know what it was, and we shouldn't have been doing that, (because it's) really not professional. So now we're just referring to a professional who is trained and competent at what he is doing.'

Conclusion

It is clear that in this practice, the principle of delegated care has translated into a complete delegation of clinical responsibility. The herbalist enjoys virtual autonomy over his patients whilst they are under his treatment. This arrangement relies on the considerable respect, trust, and mutual understanding that has grown during a 12-year collaboration between GP and herbalist. In this setting, HM is regarded as a complete therapeutic modality, distinct from conventional medicine, and there has been no attempt to absorb it into the mainstream, or treat it as merely an adjunct to conventional medicine. The apparent dismissal of the need for a formal

evidence base to inform decisions on referral and prescribing is interesting. It seems the evidence-base for herbal medicine, such as it is – pharmacological studies and clinical



trials – does not count for as much in this NHS setting as clinical experience. Instead there was a notable emphasis on exercising personal judgement and the strong wish to match patients' preferences with acceptable and appropriate care.

References

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