Commissioning complementary medicine

Evaluations of efficacy of treatments should be consistent

EDITOR,—In his editorial Iain Smith calls for research to obtain evidence of the efficacy of complementary procedures, and we agree that “the burden of proof should be no greater, or less, than for mainstream medicine.”¹ In the next paragraph, however, he says that randomised controlled trials “may fail to allow for the holistic effect that is central to the philosophy of most complementary therapies” and that “the beneficial effects are often so obvious, the side effects so rare and mild, and the duration of effect so variable after even a single exposure that perhaps observational studies may be enough to prove benefit.” He then cites Black, who quotes defibrillation for ventricular fibrillation as an example of a treatment with an impact so large that observational data are sufficient to show it.²

We are unconvinced by this argument. In conventional medicine the mildness of side effects or variability in the duration of effects would not be accepted as an excuse for not using a randomised controlled trial to prove efficacy. We cannot think of any complementary treatment that has an impact comparable to that of defibrillation or in which holistic considerations prohibit the use of a randomised controlled trial to prove efficacy, but Smith says that this is “often” the case. Could he please suggest a few examples of complementary treatments that cannot be tested by such trials for the reasons he gives?

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Homoeopathic hospitals have unique skill

EDITOR,—Although Iain Smith’s editorial on the problems facing health authorities in commissioning complementary medicine mentions several providers of complementary medicine, all of which are either small and local or mostly private, it omits to mention the most important NHS providers of complementary medicine—the homoeopathic hospitals.¹ There are five such hospitals in the NHS; four are parts of larger trusts, while one, the Royal London Homoeopathic Hospital NHS Trust, is a “stand alone” trust.

The homoeopathic hospitals are unique pools of medical skill in complementary medicine with established research records in just the type of research that Smith advocates.^{2,4} They are the only dedicated complementary medicine hospitals in the public sector in Europe.⁵ Despite their name they do not provide only homoeopathy. The Royal London Homoeopathic Hospital NHS Trust has services covering a wide range of clinical areas, including women’s and children’s clinics, rheumatology, dermatology, complementary treatment for cancer, back pain, and chronic fatigue. Each service provides a range of complementary treatments for the problems encountered.

The Royal London Homoeopathic Hospital NHS Trust has contracts totalling £1.4m with 26 health authorities covering most of southeast England, has had extracontractual referrals from most health authorities in England and Wales, and has referral arrangements with over 400 general practice fundholders. This is the largest single body of evidence on NHS purchasing practices for

complementary treatments, and Smith’s opinions would carry more weight had they been based on such evidence. Our evidence, however, bears out the variability of commissioning authorities’ purchasing policies to which Smith alludes.

We welcome Smith’s call for research and his recognition of some of the problems facing research in complementary medicine, but the argument needs to be taken a step further. In our experience, NHS bodies are reluctant to support such research. Unless this attitude changes, the problems facing commissioning bodies in making purchasing decisions on complementary medicine will multiply.

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Structural adjustment and health

Mission hospitals are a useful model

EDITOR,—The excellent leading article in which Angela Wakhweya describes the results of socio-economic adjustment on the health of women and children rings true for Africa, but only one mention is made of mission hospitals.¹ No mention is made of district hospitals, which are centres from which community care reaches out and to which patients with more serious problems can be referred.

For over 100 years mission hospitals have provided this kind of district hospital service, in some countries offering a significant proportion of the total health care available. They have been staffed partly by expatriate nurses, doctors, and paramedics who often stay long term and therefore become familiar with the language and culture of the local community and the particular medical and surgical skills required. The Christian Medical Fellowship has around 280 members working as doctors in developing countries and many work in such hospitals. Some are employed by multilateral, bilateral, and non-government organisations,² but others are employed directly by national governments and churches.

Because mission and church related hospitals face particular economic constraints their staff become skilled at providing appropriate medical care in a cost effective way. Their team spirit means they are often well motivated to do so. They can achieve a high degree of accountability because their expatriate members are free from the pressures that nationals experience from their own communities and because the expatriates represent the donor countries. Those planning overseas aid should take a longer look at mission and church related hospitals.

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Financial institutions must let go

EDITOR,—Angela Wakhweya has asked us to “require those who wield economic power not to do so with total disregard for . . . mothers and children.”¹ Who actually wields economic power? Clearly, when the people of the developing nations paid \$100bn between 1986 and 1991 to private financial institutions, these institutions wield considerable power.

The World Health Organisation’s 1995 report, *Bridging the Gap*, described the “disproportionate flow of resources from the developing to the developed world—poor countries paying money to rich ones—because of debt servicing and repayment.”² But these resources did not just naturally “flow” from one country to another. The directors of the financial companies used their economic power to make sure that the \$100bn moved the way they did. This money did not go to “rich countries”; it did not go to the people of those countries. It went into the accounts of those companies and their shareholders.

The directors want the money—\$20bn a year—to keep on coming. So, through financial institutions like the International Monetary Fund, they impose structural adjustment policies, which always “adjust” welfare provision downwards. But, as the WHO report said, “Investing in health saves money as well as lives. It must be accepted that expenditure on health is not a drain on national resources but a pre-requisite for economic and social progress.”² Welfare spending is not a wasteful inefficient diversion from the real economy: it is part of a country’s necessary economic base.

These countries need to repudiate their debts, recapture their national independence, and control their own economies. Only thus can they reduce poverty and so reduce ill health. As for our role, we can require those who wield power to get off the backs of the people of the developing nations.

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Every extracontractual referral is a jewel

EDITOR,—Barbara Ghodse points out that extracontractual referrals are a cause of anxiety in purchasing authorities, mainly because they have the potential to generate unpredictable expenditure on top of major service contracts.¹ We suggest that instead of regarding extracontractual referrals as a labour intensive drain on finance, purchasers should recognise that they are a potentially rich and convenient source of clinical information. They can be used as a simple method of quality audit if they are viewed as an index of dissatisfaction with services available under current contracts.

In the County Durham Health Commission, identification of changes in the pattern of extracontractual referrals has resulted in active interventions aimed at improving the range, quality, or appropriateness of contracted services. For instance, a rising trend in referrals for bone mass densitometry was an indication of demand by general practitioners for an investigation which was being widely promoted in the area and which required guidance for use. The emergence and increase in the number of extracontractual referral requests for paclitaxel in the treatment of gynaecological cancer highlights the need for a purchasing policy on the handling of expensive new drugs.

Extracontractual referrals have recently exposed a growing interest among general practitioners, psychologists, and community psychiatric nurses for specialist counselling services.

In our experience accurate data on extracontractual referrals can be collected rapidly, are relatively simple to analyse, and give procedure specific details and the possibility of case by case validation. A crude statistic on extracontractual referrals can be interpreted in a variety of ways. It is most useful when regarded as one piece of a jigsaw of evidence concerning services and interpreted in a context that includes clinical advice. Extracontractual referrals offer purchasers an easy way to tap into the local general practitioners' and hospital consultants' "bush telegraph" concerning the range and quality of clinical services and the views of patients as interpreted by their doctors. Extracontractual referrals should therefore be recognised as valuable nuggets of audit information. Rather than being a foe to the accountant, each extracontractual referral can be a friend to the purchaser of better quality health services.

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1 Ghodse B. Extracontractual referrals: safety valve or administrative paperchase? *BMJ* 1995;310:1573-6. (17 June.)

Measles data are reliable

EDITOR,—Nigel Higson claims that the only source of data on measles cases which has remained consistent before and after the measles-rubella campaign is statutory notification and that numbers of notified cases have shown little decline.¹ As he admits, numbers of notifications are less reliable than cases confirmed by saliva testing, but this service was not widely available before the campaign. The saliva assay, however, was extensively piloted in 18 districts of the United Kingdom between October 1991 and October 1994.^{2,3} During this pilot 36-38% of patients with measles tested were IgM positive,^{2,3} suggesting recent infection, compared to only 4% of patients tested since the campaign. Since November 1994, saliva samples have been received in over 50% of notified cases and the proportion that is IgM positive has fallen with time (table).

In addition, measles cases confirmed by serology, isolation, or antigen detection have been reported to the Communicable Disease Surveillance Centre by laboratories in England and Wales for over 20 years. Unlike notifications, the number of laboratory reports has fallen dramatically, from 224 cases reported with sample dates between 1 January and 31 May in 1994 compared with only 52 in the same period of 1995. Many of the 1995 cases occurred during late 1994 and early 1995, when the full effect of the campaign had not been felt—only four cases have been reported with sample dates during May 1995.

Both data sources clearly indicate that measles transmission has been substantially reduced by the vaccination campaign, in particular in 5-16 year

Saliva tests performed in notified measles cases from England and Wales

Year/week of notification	Notifications (provisional data)	No (%) of samples received	No (%) of samples positive for IgM
94/44 to 94/51	2585	1356 (52)	117 (8.6)
94/51 to 95/07	1672	1002 (60)	27 (2.7)
95/08 to 95/11	1568	910 (58)	10 (1.0)
95/16 to 95/23	1188	658 (55)	5 (0.8)
Total	7013	3926 (56)	159 (4.0)

olds—the age group targeted.⁴ Small numbers of measles cases are still being confirmed in preschool children and unvaccinated adults, and at least four recent infections seem to have been contracted abroad. A comprehensive surveillance programme for measles is now established and will allow us to monitor the longer term effects of the measles-rubella campaign and to define future vaccination policy in England and Wales.

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Treatment of children with asthma

Entrust parents with "crisis pack" of steroids

EDITOR,—In their excellent and comprehensive account of treating asthmatic children John Rees and John Price rightly emphasise the importance of "partnership in management" and "self management plans," including "an agreed action plan of what to do...if the child has an acute asthma attack."¹ However, in the subsequent part of the article dealing with acute severe asthma, the principle of partnership with parents seems to extend only as far as giving four hourly relief medication (dose not specified) and calling a doctor if there is no improvement. The adjacent paragraph refers to the need for a large dose of a β stimulant bronchodilator and considering starting oral prednisolone, treatment that most readers will interpret as restricted to a doctor rather than a parent.

Surely any parent who is fit to be entrusted with the overall care of a child is also fit to be entrusted with these forms of treatment, which can be started early in an attack and can often obviate the need for any medical involvement. There are often difficulties and delays in seeing a doctor, even in Britain, and the increasing number of families taking holidays abroad and in remote places is a strong argument for us trying to increase families' self reliance and reduce dependence on doctors.

For the past 10 years I have given a "crisis pack" of steroids to all the parents of asthmatic children on my list. If sufficient time is taken to supplement good written information, most families develop the confidence to use short courses of oral prednisolone very judiciously. Obviously, the concept of self reliance could be taken too far, and parents need to be told to seek medical help if the crisis pack is not working. In these circumstances, I prefer to give parents free access to our paediatric ward, as calling the general practitioner is unnecessary and only leads to delay in admission.

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1 Rees J, Price J. Asthma in children: treatment. *BMJ* 1995;310:1522-7. (10 June.)

Author's reply

EDITOR,—We thank Nigel Speight for highlighting an important issue relating to the management at home of acute asthma in children. In this section of our article we say that consideration should be given to starting oral prednisolone. It was certainly not our intention to imply that parents were excluded from making this decision. We completely agree that many families, given adequate guidance and explanation, will know when to give their child a course of oral steroid. On the other hand some families would be apprehensive about taking this responsibility, and we must continue to provide them with the support they need.

Short courses of oral prednisolone given at home increase rates of recovery and may prevent hospital admissions.¹ We agree that initiation by parents is appropriate and quicker than waiting for a doctor.

Occasional short courses of prednisolone are safe. There is transient suppression of hypothalamic-pituitary-adrenal axis function but this returns to normal within 10 days.² However, function of the hypothalamic-pituitary-adrenal axis remains subnormal in children receiving more than four short courses of prednisolone per year.³ Frequent courses of prednisolone indicate poor asthma control, so the total number given to the child, whether started by the family or the doctor, should be recorded. Parents should be advised to tell their doctor if their child is having asthma attacks sufficiently severe to require repeated courses of oral corticosteroids. This is an indication for a general review of the asthma, including reassessment of the home environment and the need for and adherence with regular inhaled anti-inflammatory medication.

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1 Despinande A, McKenzie SA. Short course of steroids in home treatment of children with acute asthma. *BMJ* 1986;293:169-71.
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Managing the complications of childhood arthritis

EDITOR,—I agree with Aileen Landers that the recommendations for ocular slit lamp screening are confusing.¹ The most important points to emphasise are that children with juvenile chronic arthritis are at greater risk of developing asymptomatic chronic anterior uveitis than the normal population and that irreversible complications may be prevented if the uveitis is detected early by slit lamp examination and treated effectively. Landers cited the guidelines for slit lamp screening issued by a joint working party of the Royal College of Ophthalmologists and the British Paediatric Association,² but unfortunately these guidelines do not seem to take into account two key questions.

Firstly, how quickly can irreversible visual impairment follow the onset of chronic anterior uveitis? This should determine the frequency of screening for at risk children. Irreversible complications are likely to occur if the chronic anterior uveitis is untreated for longer than six months (this is based on anecdotal evidence only). Annual screening would not seem sensible for any child with arthritis.