A Model of Integrated Primary Care: Anthroposophic Medicine

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Jane Ritchie

National Centre for Social Research

Jane Wilkinson
Madeleine Gantley
Gene Feder
Yvonne Carter
Juliet Formby

Department of General Practice and Primary Care
St Bartholomew's and the Royal London School of Medicine and Dentistry
Queen Mary, University of London

Participating practices:
Blackthorn Medical Centre, Maidstone
Camphill Medical Practice, Aberdeen
Helios Surgery and Therapy Centre, Bristol
Mytton Oak Foundation, Shrewsbury
Park Attwood Clinic, Bewdley
St Luke's Medical and Therapy Centre, Stroud
Wallis Avenue Surgery, Maidstone

Department of General Practice and Primary Care
St Bartholomew's and Royal London School of Medicine
Queen Mary, University of London
London E1 4NS

020 78827957 (telephone)
020 78826396 (fax)
g.s.feder@mds.qmw.ac.uk

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Project Team

The study was initially designed by Jane Ritchie and further developed with the collaboration of Yvonne Carter, Gene Feder and Madeleine Gantley. Jane Wilkinson was responsible for interviews, other data collection and initial analysis, supervised by Jane Ritchie with the support of Madeleine Gantley. Juliet Formby contributed to the medical records extraction and analysis, under the supervision of Gene Feder. All the members of the team participated in discussion of the results, as well as writing of this report.

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New Options in Primary Care: Anthroposophic Medicine

Research Summary

Background

Anthroposophic medicine is an extension of conventional medicine that aims to provide a means by which people can develop their own latent capacities to address physical, psychological and spiritual aspects of illness. It involves the use of a variety of therapies, including art, music, eurythmy (movement therapy), massage, and counselling as well as anthroposophic medicines. Opportunities for social rehabilitation and work may also be offered as part of the therapeutic process. Anthroposophic medicine is most widely developed in Germany, the Netherlands and Switzerland although there is now growing interest in many other countries, both in Europe and elsewhere.

Within the UK, there are six general practices (five NHS and one Primary Care Group based charity) and a 16 bedded residential unit offering anthroposophic treatments as an integrated part of the care they provide. In 1996, the practices wanted systematic answers to questions about the impact, effectiveness and durability of different treatments across a range of medical conditions. They also wanted to understand how the process of delivering anthroposophic medicine might be unified or enhanced, through collating learning from each of the practices.

Aims of the research

The research addressed three questions:

- What is anthroposophic medicine as understood and interpreted by doctors, nurses and therapists working within general practice?
- How is anthroposophic medicine organised and delivered within primary care settings in the UK?
- What impact does anthroposophic medicine have on patients, both in terms of clinical outcomes and patient responses?

The central issues explored by the study are ones which lie at the heart of much contemporary socio-medical research. There has been increasing interest in attempting to define different forms of general practice and the nature of the roles that GPs play within it. Similarly, there is now widespread interest in how to provide 'evidence' about plural and more delicate interventions.

The study also takes place against a background of extensive change in the organisation, delivery and governance of primary care services.

Study design

The study was largely qualitative in design in order to understand the nature of anthroposophic medicine in general practice and the outcomes that result from anthroposophic treatments. The research undertaken had three main components:

- A medical record analysis in which 492 records were analysed to provide a profile of patients receiving anthroposophic medicine in the study practices;
- In depth interviews with patients (30) and various professionals (40) involved in the delivery of anthroposophic medicine to provide documentary evidence of the approach;
- Case studies of patients currently undergoing treatment (20) in which patients and their GPs and therapists were interviewed to explore the impact and effects of the treatments received. Two patient centred outcome measures were also completed which use self generated symptom indices or effects of illness as the basis of assessment.

The study practices

The seven practices in which the research took place are:
Blackthorn Medical Centre (4 GPs) situated at the north-western edge of Maidstone, within a largely middle income community.
Wallis Avenue Surgery (Single handed) also in Maidstone, sited on a council estate.
Helios Surgery and Therapy Centre (3 GPs) located in a residential, high income area in the north west of Bristol.
St Luke's Medical and Therapy Centre (3 GPs) situated in Stroud in Gloucestershire, with a branch surgery in Gloucester.
Mytton Oak Foundation (1 GP) a charitable Foundation sited on the Western edge of Shrewsbury adjacent to a six-partner NHS general practice where the Foundation doctor is also a GP.
Camphill Medical Practice (1 GP) sited within one of the Camphill communities on the edge of the City of Aberdeen.

Park Attwood Clinic a 16-bedded residential unit situated on the outskirts of Bewdley in Worcestershire. Four doctors work at the clinic, two of whom are GPs.
All of the practices, except Wallis Avenue, accept referrals from outside of their lists for anthroposophic treatments.

The organisational structure of the centres is such that, technically, five of the six primary care practices are NHS general practices and one, Mytton Oak, is a charitable trust. All but one of the NHS practices also provide most of their anthroposophic treatments through a linked charitable trust. The residential clinic is a charitable company limited by guarantee attached to a 'general practice' with a small temporary list.

Anthroposophic treatments and therapies available

The practices had been providing anthroposophic treatments for between five and fifty years and, in all cases, key developments had taken place during that time. At least one GP in all the practices prescribes anthroposophic medicines for their patients. Massage is also available at every practice, largely because it is used for diagnostic as well as therapeutic purposes.

Most of the practices had widened the range of treatments available since anthroposophic medicine was first introduced. As a general pattern, art therapy, massage and counselling had been introduced at earlier stages than, for example, eurythmy, hydrotherapy, music or garden therapy, partly because the latter required special accommodation or equipment.

Some of the practices are developing specialist services or clinics for specific conditions, based on anthroposophic principles. All of the practices had experienced a significant growth in the demand for anthroposophic treatments, particularly in recent years.

Funding

In all the general practices other than Wallis Avenue, charitable Trusts have been established to manage and administer the anthroposophic work and to co-ordinate fund raising activities. Funding for patients either comes through Health Authorities, through the charitable foundations, or through patients themselves paying privately, or paying according to their resources.

Those with purpose-built premises have undertaken major fund-raising for this purpose. In these instances, the land and buildings are owned by the charitable foundations, and the NHS practice, where this is linked, rents space in the building, thus generating additional NHS funded income for the Trust.

Defining anthroposophic medical practice

All the practitioners were firmly committed to working within mainstream general practice. There was an equally universal view about the limitations of orthodox clinical practice and a desire to push the boundaries to include both psychological and spiritual dimensions. Most crucially there was felt to be value in 'having a foot in both camps', both for patient care and for professional development.

There are important philosophies and principles that define an anthroposophic approach. These are summarised very briefly in the report.

Referrals

A distinction is made between patients who are members of one of the anthroposophic general practice lists through local residency and are treated by an anthroposophically trained GP (local list patients); and patients who come to the practices specifically for anthroposophic treatments (referrals). List patients are treated anthroposophically by their GPs as a list patient at the practice although they will need to be referred for other therapies and treatments. Other patients need some mechanism of referral to begin their anthroposophic consultations and treatments with GPs. The majority of the latter referrals are made either by another GP in the practice or one belonging to the same Primary Care Groups.

Some basic reasons were identified as to why anthroposophic treatments may be more suitable for some patients on medical grounds than conventional treatments:

- avoidance of adverse side-effects associated with conventional treatment;
- conventional treatment alone cannot address the range of factors contributing to the condition;
- all orthodox treatment options have been exhausted without success;
- no conventional treatment options exist.

Medical Care

Patients are generally seen by one GP throughout their whole treatment programme and a key role played by the doctor is as 'overseer' of the treatment package. Being involved throughout, and having an overall sense of each stage of the treatment, allows both development and continuity of care.

Length and frequency of consultations
The length of the initial consultation with new patients averages between 45 minutes to one hour. Slightly less time is usually needed for in-depth consultations with patients known to the doctor where information has been built up over time. Subsequent follow up appointments are generally shorter than initial sessions, but also vary in length of time depending on knowledge of the patient, the condition(s) they have and the treatment programme they are following.

Medication
As all anthroposophic doctors are trained in conventional medicine, full use is made of the same spectrum of allopathic medicines as used by more orthodox colleagues. The degree and style of prescribing anthroposophic medicines varies amongst doctors according to the degree of experience and training.

There are a wide variety of anthroposophic medicines available which provide practitioners with a range of prescribing options in illness management. They may prescribe anthroposophic medicines before, or along side, allopathic medicines, or as an alternative. For some conditions (e.g. established diabetes, severe hypertension), often only allopathic medicines are used.

Three key benefits were felt to be gained through the use of anthroposophic medicines:

- Lowered prescribing rates for allopathic medicines and, hence, reduced prescription costs;
- Increased self medication for minor illnesses thus reducing GP time;
- Reduced referrals to secondary care.

Anthroposophic nursing
The roles of anthroposophic nurses are similar to those of orthodox nurses. All must have completed conventional training prior to learning an anthroposophic approach.

Anthroposophic general practice nurses, like other NHS practice nurses, run clinics, for example for blood tests, vaccinations, dressings etc. Where the nursing role differs is in the application of compresses, footbaths and massage. In some practices, anthroposophic principles are applied to antenatal care and midwifery.

Specialist medicinal treatments
Another key respect in which anthroposophic medicine differs from orthodox practice is in the use of oils, ointments, lotions, and infusions. These are administered in various forms such as teas, compresses, baths and water massage. They may be prescribed and applied both by nurses and by massage therapists. The substances used are made from mineral and plant extracts and, like the medicines already described, are applied using anthroposophic principles.

Massage

Rhythmical massage practised by anthroposophic massage therapists is a body massage where the focus is on generating a general balance to the 'system' as a whole, but also addresses specific problems through working with particular systems and areas of the body. Massage is often the first treatment prescribed for patients because it also provides valuable diagnostic information for the doctor.

Massage plays a key role in enhancing physical processes, such as circulation and muscle function. The skin, as one of the major sensory organs, is the obvious point of contact but the therapist is able to reach much deeper into the organism itself and affect other processes, such as liver, spleen and kidney functions. The physiological processes that may be facilitated by massage include increased mobility, lymph drainage, improved circulation, enhanced adrenal function, pain reduction, muscle tone, reduced tension, increased energy and general up-building of the system.

Eurythmy

Eurythmy is a form of movement unique to anthroposophy and has various therapeutic applications. Rhythm is key to this form of movement which also makes use of physical and symbolic space. Therapeutically, work begins with very simple exercises that facilitate assessment and diagnosis but which also begin

to address imbalances in the physical body. An important role of the movements is to increase awareness of the body, the self and ultimately the surrounding environment. As the diagnostic picture develops, therapy progresses with the use of various exercises which mostly centre around gestures. These are connected to sounds related to the letters of the alphabet, each of which has its own effects (e.g. calming or energising).

The combination of movements has a variety of roles, as well as being a gentle form of exercise. The functions of eurythmy include increasing mobility, promoting healthier breathing patterns, loosening and releasing tension, improving posture, strengthening muscle tone, stretching and relaxing of muscles, reducing pain, promoting more balanced forms of movement and generally enhancing physical vitality.

Eurythmy therapy is mostly done on a one-to-one basis but groups are run for specific conditions (e.g. asthma, back problems). It is available at four of the study centres.

Counselling

Counselling was available at four of the study practices. Other centres have access to statutory services. All of the counsellors operate, to a greater or lesser degree, within anthroposophic principles although only one had training in biographical counselling, which is specific to anthroposophy. Most work is done on a one-to-one basis but some group work is undertaken.

In biographical work, the phases of development are primarily explored within the principles of seven-year cycles. These stages allow insight not only into personal development but also provide a context for processes likely to occur at different stages in a person's life. The approach is described as being eclectic, humanistic and *'very much person centred'*.

Therapists have an integrative approach to their work and use 'working hypotheses'. These relate strongly to an anthroposophic approach. The role of the counsellor is seen as working alongside patients in helping them to 'manifest who they really are'.
To further this, each counsellor has developed techniques drawn from varied disciplines, as well as anthroposophy. A common approach is the use of visual imagery in developing more positive pictures of situations and responses to events.

In some circumstances, patients may be encouraged to extend this visual element artistically through painting or drawing.

The number of counselling sessions given varies with conditions but also across the practices. Sessions last between 50 minutes to an hour and are run on a weekly or fortnightly basis.

Art and sculpture therapy

The key activities in art therapy are drawing, painting (with both wet and dry mediums), and sculpting. Techniques and exercises, which are specific to anthroposophic art therapy, are tailored to the individual and the mediums used are watercolours, pigments made from natural plant colours, pastels, charcoals, pencils and clay. Sculpture therapy, which has developed as a separate therapy in recent years, works primarily with the medium of clay. Although a diagnostic element of art therapy exists, it is used primarily to inform treatment.

Art and sculpture exercises are designed to allow the patient to make small steps at the point at which they are ready so that progress is tailored to each patient. Initial exercises are designed to help patients to familiarise themselves with the medium and techniques and to build confidence in their artistic abilities.

The key emphasis in both art and sculpture therapy is more on the process than the finished product. The process of communication during therapy is derived from the use of colour and form and more subtle elements of light, dark, warmth, coolness, flow and movement. These often have direct parallels to the illness itself.

Therapy is conducted both on an individual basis and in group settings. Individual sessions last approximately forty-five minutes to an hour, but group sessions tend to be longer (one to one and a half hours on average). An average 'term' of therapy consists of ten or eleven sessions. Art therapy is available at all but one of the study practices.

Music Therapy

Music therapy, developed in two study centres relates closely to 'creative music therapy' and specifically to the work of Paul Nordoff and Clive Robbins who initially developed their work with children with physical and learning disabilities, later extended to other patient groups.

Patients are seen on either a one-to-one basis or as part of a group. The principal instruments used are the hand lyre (a hand-held stringed instrument), and a range of percussion instruments and small flutes. The therapist normally accompanies patients and the key method used in individual sessions is improvisation. This allows the patient to build up the range of musical expression and provides an immediate musical experience. The main focus in therapy is on the 'flow and meaning' of the music rather than the accuracy of playing.

There are three main principles that underpin the form music therapy might take: the relationship between music and emotion, achieving balance, and developing communication and personal/social contact. Music therapy principally relates to the development of the 'soul life'.

Sessions last approximately fifty minutes and are generally on a weekly basis. The average length of therapy is around twelve sessions over a period of few months.

Occupational and social therapies

Each organisation is at a different phase in the development of what are termed 'social' therapies. The occupational project at the Blackthorn Trust has the most fully developed services, made possible through statutory as well as voluntary funding.

The activities of the project are based on anthroposophic principles and include a garden and garden centre, a café and the production of crafts, oils and other products.

Approximately sixty patients (referred to as co-workers) were attending at the time of the research. Half are referred through local mental health services with which the Trust has built strong relationships. The remaining patients, who have a wide range of predominantly physical conditions, are referred to the services by GPs at the practice.

Individuals work a varying number of days within the project. They also stay in the project differing lengths of time depending on their condition and personal development.

The patients

The analysis of patient records shows that the demography of patients getting treatments, the consultation rates and the conditions of patients being treated were similar across practices.

- 72 % of patients receiving therapy within anthroposophic practices were women, compared to 51% of general practice consultations nationally.
- The largest group of patients attending for therapy in 1998 was aged between 35 and 54 years (42%).
- The data on occupation are limited but indicate that there are a disproportionate number of patients with professional and associated professional occupations amongst the patient population.
- Consultation rates tended to be higher than among the general patient population. This difference is not surprising: since patients referred to anthroposophic therapies are more likely to have chronic conditions and thus more likely to consult their general practitioner or practice nurse than other patients.
- The most frequently recorded diagnosis was connected with mental health (20% of all recorded diagnoses). Nine per cent of recorded diagnoses were associated with musculoskeletal problems. A variety of other medical conditions were recorded.

The patients divide between those who had knowledge or experience of anthroposophic or other complementary medicines prior to treatment and those who came from more orthodox medical traditions. Among the latter group, there was a degree of scepticism about the treatments prior to receiving them. Some also had misconceptions and apprehensions about what might be delivered.

Patients' experiences of anthroposophic medicine in general practice

Patients were overwhelmingly positive in their appraisals of the doctors, therapists and nurses who had treated them as well as other practice staff with whom they had come into contact. Those new to anthroposophic medicine were often pleasantly surprised by the approach taken by anthroposophic doctors finding it very different from previous experiences of orthodox care.

The key aspects of care from practitioners that were favourably mentioned include:

- ***Time*** given to consultations to discuss their concerns as well as the 'calm' and 'unrushed' nature of the practitioner, though time was related to quality rather than quantity.
- ***Technical care*** and thoroughness in exploring medical and biographical histories. A key element in appraising this thoroughness was the connections that could be made between physiological problems

and their underlying causes. Value was consistently placed on having both an orthodox and anthroposophic approach combined.

- ***Communication and information*** Patients consistently described communication with their doctors and therapists as more of a 'dialogue' or 'two way process'. The approachable and friendly manner of the doctors was frequently noted.
- ***Personal care and support*** Patients emphasised the levels of care and concern that the doctors and therapists showed in their consultations and the degree of personal encouragement they gave to individuals.

Key aspects of an anthroposophic approach that patients viewed very favourably included: its holistic nature; a person centred approach that was tailored to individual needs; the facilitation of personal learning and development; its ability to look at underlying causes; the use of natural treatments and remedies; and the involvement of patients in the management of their illness.

Around half the patients interviewed had paid in full or in part for their treatments and just under half were non fee-paying. There were no apparent differences between fee or non-fee paying patients with respect to the reported degree of engagement in their treatment. The cost of therapies to patients was, however, a significant factor in barriers to uptake of therapies for those with limited finances. A number of patients reported that they would have been unable to receive treatments without financial assistance for therapies. Payment plans made it easier for some patients with limited financial resources.

Clinical outcomes and their measurement

The data on outcomes were collected primarily through a series of case studies carried out with patients who were currently undergoing anthroposophic treatments. Patients were interviewed on two occasions - the first just as they began treatment and the second usually after it was complete. The patients were also asked to complete Measure Your Own Medical Outcome Profile (MYMOP) and Patient Generated Index of Quality of Life (PGI) questionnaires on both occasions. There were also interviews with the therapists that carried out the treatments and with the referring GPs.

The outcomes resulting from anthroposophic treatments that patients identify are mainly positive. They fall broadly into physiological, psychological, behavioural and spiritual effects. There is a general sequence to the way in which outcomes are described with movement from the physical to the psychological, the psychological to the behavioural and the behavioural to the spiritual. Because of this sequential pattern, the longer-term effects are more open to the influence of other factors and interventions. Nevertheless, as they are perceived, these deeper level outcomes are still attributed, at least in part, to the anthroposophic treatments received.

MYMOP and PGI were both found to be effective in identifying physical symptoms and in terms similar to the qualitative data. Although both identify a range of psychological factors, those characterised in the PGI are more specific than in MYMOP. The PGI identifies more behavioural features (consequences of illness) than MYMOP and, again, these are more specific to individual patients. Neither tool captured the spiritual elements that emerged from the in depth interviews.

Problems of outcome measures

The measurement of outcomes for patients with chronic conditions participating in complex treatment programmes poses significant methodological difficulties. These are discussed in detail in the report covering the varying nature of outcomes identified depending on the 'instrument' used for data collection; the time frame over which measurement should take place; and whether single treatments or clinical packages should be assessed. It is concluded that a combination of qualitative and quantitative data may be particularly useful in the study of any medical practice which aims to address illness beyond the physical level.

Further research

The report concludes with analysis of the need for further research and the forms this could take. In particular, it supports the widespread call for robust research into the effectiveness of complementary medicines, particularly in primary care. It also discusses issues surrounding the assessment of 'quality' in primary care for the development of national frameworks and the need for research on issues such as co-morbidity, training and development for partnership working. The final discussion surrounds the need for further evaluation of anthroposophic practice and the form that clinical trials or other research might take.

PREFACE

Anthroposophic medicine is an extension of conventional medicine that aims to provide a means by which people can develop their own latent capacities to address physical, psychological and spiritual aspects of illness. It involves the use of a variety of therapies, including art, music, eurythmy (movement therapy), massage, and counselling as well as anthroposophic medicines. Opportunities for social rehabilitation and work may also be offered as part of the therapeutic process. Anthroposophic medicine is most widely developed in Germany, the Netherlands and Switzerland although there is now growing interest in many other countries, both in Europe and elsewhere.[1]

Within the UK, there are six general practices (five NHS and one Primary Care Group based charity) and a 16 bedded residential and outpatient unit offering anthroposophic treatments as an integrated part of the care they provide. They differ in their location, their size, the communities they serve and each is at a different stage of development. But in 1996, the practices shared an ambition to undertake research that would provide some assessment of their approach, particularly in the treatment of chronic illness. They wanted systematic answers to questions about the impact, effectiveness and durability of different treatments across a range of medical conditions. They also wanted to understand how the process of delivering anthroposophic medicine might be unified or enhanced, through collating learning from each of the practices.

At this point, there began a long search to find the appropriate research methodologies to answer the central questions as well as to gain funding for such a study. It was evident that some kind of quantitative measurement of outcomes was needed but with, as yet, no clarity about what outcomes to measure. Since the interventions themselves were complex and the conditions to which they were targeted often compound, there was a need for some investigation of the key effects that needed to be captured. This suggested early qualitative research, in order to understand the nature of relevant outcomes, alongside some testing of existing instruments. The plan to document the delivery of anthroposophic medicine across the seven centres also required the flexibility and depth offered by a qualitative approach.

This report documents the results of the research undertaken in 1999 and 2000, and addresses three central questions:

- What is anthroposophic medicine, as understood and interpreted by doctors, nurses and therapists working within general practice?
- How is anthroposophic medicine organised and delivered within primary care settings in the UK?
- What impact does anthroposophic medicine have on patients, both in terms of clinical outcomes and patient responses?

The central questions with which the study is concerned are ones that are at the core of much contemporary socio-medical research. There has been increasing interest, for example, in attempting to define different forms of general practice and the nature of the roles that GPs play within it. Similarly, the measurement of outcomes from complex interventions is an issue with which both primary care and other medical research teams across the country are grappling. There is now widespread interest in how to provide 'evidence' about plural and multi-levelled interventions. The data collected are therefore expected to be of interest to those concerned with the increasing challenges to primary care and its development over the coming decades.

The report is divided in to three parts. The first provides some background to the research, describing first the medical and policy context in which the research is set and a brief summary of its design (Chapter 1). The second part is devoted to a description of anthroposophic medicine in general practice, exploring in turn the practices (Chapter 2), the practitioners (Chapter 3), referrals (Chapter 4) medical care and treatments (Chapters 5 to 7) and the patients (Chapter 8). The final part considers the clinical outcomes from anthroposophic medicine (Chapter 9), and how, if at all, these might be captured in some form of trial or quantitative investigation (Chapter 10).

The study was largely qualitative in design and this has made it possible to describe features of the delivery of anthroposophic medicine and the principles that underpin it from the perspectives of different practitioners and groups of patients. It has also been possible to identify the factors that have contributed to different outcomes. However, the qualitative study cannot provide any statistical data relating to *prevalence* of views, experiences or outcomes; nor does it seek to infer any general patterns relating to treatments across a wider population. Where any such conclusions are suggested by the data, they are presented only as hypotheses to be tested.

The report uses verbatim quotations and case studies throughout. Where necessary, details of the contributors or their subjects have been moderately changed to protect anonymity. Pseudonyms have been used in all case studies. However, because of the small size of the anthroposophic medical community, the views of certain key players are hard to disguise. Certain passages of verbatim text, therefore, have been cleared with their originators before inclusion for publication.

PART I

THE STUDY AND ITS CONTEXT

1 INTRODUCTION

This study of anthroposophic general practice takes places against a background of extensive change in the organisation and delivery of primary care services. This chapter first considers the recent and imminent changes that are taking place within the NHS, focusing particularly on those that have implications for delivering patient centred services in primary care. There is then a brief description of the design and conduct of the study from which the report evidence is derived.

1.1 NHS developments and their implications for primary care

A modernised NHS

In its December 1997 White Paper *The New NHS, Modern and Dependable*,[2] the Government stated that it would put quality at the heart of the NHS. It set out an ambitious and far reaching 10 year programme of modernisation, describing how the internal market would be replaced by a system of integrated care, based on partnership and driven by performance. The document promised early, visible improvements to the quality of service people experience in their own homes, at their GP surgery or health centre, and in hospital.

The White Paper focused particularly on structures, quality and efficiency. Six key principles underlie the changes set out:

- to renew the NHS as a genuinely national health service (set national standards);
- to devolve the responsibility for meeting these new standards to a local level (creation of primary care groups);
- to work in partnership (e.g. forging stronger links with other agencies);
- to improve efficiency so that all money is spent to maximise patient care;
- to shift the focus to quality of care ensuring excellence is guaranteed to <u>all</u> patients; and
- to make the NHS more open and accountable to the public.

Under the new arrangements, Health Authorities (HAs) take the lead in drawing up three year Health Improvement Programmes and have responsibility for improving overall health and reducing health inequalities. Following the publication of *Our Healthier Nation*,[3] the Government introduced legislation to place a new statutory duty on HAs to improve the health of their population.

In *A First Class Service: Quality in the New NHS*,[4] published in July 1998, the Government went on to set out in some detail how it intended to implement the changes in England and asked for views about how the objectives could best be met. The document emphasised the importance of the active participation of clinical professionals and patients throughout the NHS. The main elements of the proposals are:

- clear national standards for services and treatments, through evidence-based National Service Frameworks and a new National Institute for Clinical Excellence;
- local delivery of high quality health care, through clinical governance underpinned by modernised professional self-regulation and extended life long learning; and
- effective monitoring of progress through a new Commission of Health Improvement (CHI), a Framework for Assessing Performance in the NHS and a new national survey of patient and user experience.

The newly established Primary Care Groups (PCGs) and Trusts (PCTs) have responsibilities for high quality care, partnership and accountability. This provides an opportunity and framework for service innovations and research in primary care although affirmative action may be required if the necessary climate, infrastructure and skills are to take root in areas where research has been traditionally absent.

In March 2000, the Government announced extra investment for the NHS over the next four years.[5] In return it called for modernisation of the service and established five Modernisation Action Teams to consider problems in the areas of partnership, performance, professions and the wider NHS workforce, patient care and prevention. This Plan sets out how the NHS is to be modernised over the next four years. Its vision is to offer people fast and convenient care delivered to a consistently high standard.

The problems with the NHS are outlined: under-investment, a lack of national standards, demarcations between staff, a lack of clear incentives (the way in which GPs are remunerated are mentioned as a problem), barriers between services, a lack of support and intervention, over centralisation and disempowered patients. The additional investment will be used to get the basics right – the right number and the right type of beds, buildings, services and equipment – alongside the right number of staff.

To improve primary care premises, the Plan states that the NHS will enter into a new public private partnership within a new equity stake company – the NHS Local Improvement Finance Trust (NHS Lift). The priority will be investment in those parts of the country where primary care services are in most need of expansion. Up to £1b will be invested in primary care facilities and up to 3,000 family doctors' premises will be substantially refurbished or replaced by 2004. According to the document, this record investment will allow for a range of brand new types of NHS facilities, bringing primary and community services – and where possible social services – together under one roof to make access more convenient for patients. New one-stop primary care centres will include GPs, dentists, opticians, health visitor pharmacists and social workers. There will be 500 one-stop primary care centres by 2004.

The document states that between now and 2004, there will be 7,500 more consultants, 2,000 more GPs, 20,000 more nurses, and over 6,500 more therapists and other health professionals. There will also be more training places. The Plan states that the NHS needs a new pay system: one that rewards staff for what they do.

The Plan provides an extra £900m investment by 2003/04 in the new intermediate care and related services to promote independence and improve quality of care for older people. With the extra funding, HAs, PCG/Ts and local authorities will have to demonstrate that they will put in place various services. These include rapid response teams made up of nurses, care workers, social workers, therapists and GPs working to provide emergency care for people at home and help to prevent unnecessary hospital admissions; and integrated home care teams. CHI, the Audit Commission and the Social Services Inspectorate will jointly inspect health and social care organisations to see how well they are implementing these arrangements.

Quality and performance monitoring

The Plan states that standards will be set, performance monitored and a proper system of inspection put in place. There will be back up to assist modernisation of the service and to correct failure from the centre. As standards improve and modernisation takes hold, there will be a progressively less central control and progressively more devolution - a system of earned autonomy.

A new Modernisation Agency will be created to help local clinicians and managers redesign local services around the needs and convenience of patients. Its membership will include health professionals, patient and citizen representatives, and frontline managers drawn from 'green light' NHS organisations.

The Plan sets out changes to the way performance standards are set and information is collected and published. A complementary version of the Performance Assessment Framework (PAF) that specifically applies to all NHS trusts, as well as PCTs providing community services, will be established. This Framework will include relevant parts of the health authority PAF as well as trust specific information on patients' views, quality of care, the workforce and efficiency. Responsibility for publishing the results will be transferred to CHI who will work with the Audit Commission. The results will take the form of an annual 'report card' setting out how well each part of the NHS is performing. By April 2001, every GP practice and PCG/T must have in place systems to monitor referral rates from GP practices.

Depending on their performance against the PAF, all NHS organisations will annually and publicly be classified as 'green', 'yellow' or 'red'. Criteria will be set nationally but assessment will be by Regional Offices with independent verification by CHI. Red organisations will be those who are failing to meet a number of the core national targets. Green organisations will be meeting all core national targets and will score in the top 25% of organisations on the PAF. Yellow organisations will be meeting all or most national core targets, but will not be in the top 25% of PAF performance. The 25% threshold for green status will be reviewed periodically.

Green-light NHS organisations will be rewarded with greater autonomy and national recognition. From April 2001, a National Health Performance Fund building up to £500m a year by 2003/04 will be introduced. The fund will be held and distributed regionally and will allow incentives worth, on average, £5m for each HA. Green status organisations will have automatic access to the National Performance Fund without having to bid and the ability to take over persistent failure red light organisations. Yellow status organisations will be required to agree plans, signed off by the regional office, setting out how they will use their share of the fund to improve their services. Red organisations will have their share of the Fund held by the Modernisation Agency.

General practice

By April 2004, all PCGs are expected to have become Trusts. They will provide a suitable means for the commissioning of social care services, using the flexibilities of the Health Act for older people and those with mental health problems. A new level of PCTs, Care Trusts, will be established to commission and be responsible for all local health and social care for older people and other client groups. Social services would be delivered under delegated authority from local councils. The first wave of Care Trusts could be in place next year.

The Plan states that there will be 2,000 more GPs and 450 more GPs in training by 2004, but faster growth of the number of GPs will need to continue beyond 2004. Pressure on GP services will be eased as nurses and other community staff, together with a new generation of graduate primary care mental health workers, take on more tasks. GPs will be helped with their Continuing Professional Development (CPD) through earmarked funds.

The document states that the current GP contract – the 'red book' – has often worked well, but it gives greater emphasis to the number of patients on a GP's list and the quantity of services provided rather than the quality of them. The Government intends to encourage a major expansion of Personal Medical Services (PMS) contracts. The Personal Medical Services (PMS) pilots were set up in 1997 to address inequalities in health, and to provide more flexible employment opportunities in primary care. They comprise some 300 pilot projects specifically

targeting inequalities in health in vulnerable groups (homeless, IV drug users, HIV positive, minority ethnic groups, refugees, severely mentally ill cared for in community). The pilots, which are being evaluated, are intended to be responsive to local needs in order to improve access to health and social care and to reduce morbidity and mortality amongst target groups.

All current pilot schemes that are successful will become permanent. By April 2002, it is expected that nearly a third of GPs will be working to PMS contracts and the number is expected to grow steadily over the next four years to form a majority of GPs. The Plan states that salaried GPs will come to form a growing number of GPs if that is what they choose to do.

A standard core contract will be introduced to make it easier to switch to a PMS contract. The Government will work with GPs and their representatives to amend the national 'red book' contract. The Plan states that a revised national contract should reflect the emphasis on quality and improved outcomes inherent in the PMS approach. By 2004, both local PMS and national arrangements are set to operate within a single contractual framework.

The Plan states that by 2004 the majority of NHS staff will be working under agreed protocols identifying how common conditions should be handled and which staff can best handle them. NHS employers will be required to empower appropriately qualified nurses, midwives and therapists to undertake a wider range of clinical tasks including the right to make and receive referrals, order investigations and diagnostic tests, run clinics and prescribe drugs. The range of medicines that nurses can prescribe will be extended after 2001. Proposals will be invited for PMS-type schemes for pharmacists. There will be new joint training across professions in communication skills and in NHS principles and organisation. A new common foundation programme will be put in place to enable students and staff to switch careers and training paths more easily.

Information for, and accountability to, patients

The 'Expert Patient' Programme will be extended. NICE will publish patient-friendly versions of all its guidelines. Letters between clinicians about an individual patient's care will be copied to the patient; smart cards for patients will be introduced.

A wider range of information will be published about each GP practice including: list size; accessibility; performance against standards in NSFs; and figures on the number of patients each practice removes from their list. By 2005, all patients will be able to book every hospital appointment and elective admission giving them a choice of a convenient date and time. PCGs will be able to act on published information about patients' views of hospital services by moving service agreements from one hospital to another.

All NHS Trusts and PCG/Ts will have to ask patients and carers for their views on the services they received. All local NHS organisations will be required to publish, in a new Patient Prospectus, an annual account of the views received from patients – and the action taken as a result. A Patient's Forum will be established in every NHS trust and PCT to provide direct input from patients. The Forum will have half of its members drawn from local patients' groups and voluntary organisations. The other half of members will be randomly drawn from respondents to the Trust's annual patient survey. The Forum will have the right to visit and inspect any aspect of the Trust's care at any time.

Clinical priorities

The clinical priorities are cancer, coronary heart disease and mental health. Action to be taken in each area is outlined in the Plan. In the area of mental health, the Plan accepts that most mental

health problems are managed in primary care and that one in four GP consultations are with people with mental health problems. In order to improve primary care services, 1,000 new graduate primary care mental health workers and 500 more community mental health staff will be employed.

Healthy Living Centres

A parallel initiative, funded by the New Opportunities Fund resulting from the National Lottery, is supporting some 300 projects by the end of 2002. Healthy Living Centres (HLCs) are intended to take a proactive approach to promoting health, through referrals across a range of options including fitness clinics, physiotherapy, chiropody or arts projects. The key features of HLCs are local support; access, particularly for disadvantages groups; responsive to local needs; aim to influence wider determinants of health (social exclusion, poor access to services, and deprivation); and the principle of 'additionality'. They are expected to proliferate in areas of multiple deprivation, particularly Health Action Zones. Community involvement in the design, planning and operation of the centres is essential. Healthy Living Centres thus provide a model for creative partnerships across the voluntary, public and private sectors.

All of these developments and initiatives have a bearing on the ways in which primary care might develop in future and on how newly created models of general practice might be helped to fruition. It is precisely in this context that a review of the delivery and anthroposophic medicine in primary care is so timely.

1.2 The study

1.2.1 Aims of the study

The study was conceived as having two stages. The first, which is reported here, aimed to provide exploratory and descriptive evidence about the role, delivery and impact of anthroposophic medicine in primary care. More specifically, the central objectives were:

- to document the use of anthroposophic medicine in general practice and its expected developments;
- to identify conditions and symptoms for which anthroposophic treatments are regularly prescribed;
- to identify the nature of outcomes resulting from anthroposophic treatments; and
- to consider how outcomes from treatments might be statistically measured and the scale and nature of any trials required.

At the outset of the study, it was thought that the second part of the study would attempt some quantitative measurement of the outcomes identified in the present study. This plan has been revised in the light of evidence from this work and is further discussed in Chapter 10.

1.2.2 Study design

The research undertaken had three main components:

- A medical record analysis;
- Interviews with patients and various professional groups involved in the delivery of anthroposophic medicine to provide documentary evidence of the approach; and
- Case studies of patients currently undergoing treatment.

Medical record analysis

It was important to gain some understanding of the patients for whom anthroposophic treatments had been prescribed and to locate their characteristics within the wider patient population of the practices. To do this, information was extracted from case notes of half the patients (randomly selected) referred for anthroposophic treatments in 1998.[i] The information recorded included:

- Socio-demographic characteristics;
- Nature and length of main diagnoses;
- Rates of primary care and specialist referrals; and
- Referral source.

A total of 492 records were analysed and the profile of patient characteristics is discussed in Chapter eight. Evidence from the initial case notes extraction was also used as a basis for purposive sampling for the later stages of the research.

Documentation of the approach

Before the study was undertaken there had been only limited documentation of the anthroposophic approach and how it was being operated in general practice.[6, 7] Investigative research was therefore undertaken to explore how the approach is being implemented in the different practices, the principles and objectives to which the different practitioners aspire and how the approach is viewed by patients.

In devising a sample for this part of the work, the aim was to acquire maximum diversity in terms of the groups of professionals and patients covered. Purposive sampling was used to achieve this within certain criteria. For patients, these criteria ensured range in terms of age, primary condition and clinical history, route of referral and type of treatment. The composition of the sample achieved is shown in Appendix I.

A series of exploratory and interactive interviews was carried out in each practice covering:

GPs (9);
Therapists (18);
Practice/clinic nurses (2);
Practice/project managers (7);
Patients (30); and
Other administrative and fundraising staff (4).

The interviews were based on a topic guide which outlined the key areas for discussion (see Appendix II). All the interviews were tape recorded and transcribed verbatim for analysis. A systematic content analysis was then carried out using *Framework*, a qualitative analytic technique.[8] A more detailed description of the interviews and analysis is also given in Appendix I.

Case studies

Although the documentary interviews provided some general information about the outcomes from anthroposophic treatments, more specific evidence is required, related to particular conditions. A series of case studies was therefore undertaken which involved patients being interviewed on two occasions; the first as soon after the start of treatment as possible and the second after the treatment had ended. In addition, the doctors responsible for the patients' care and the therapists that undertook the treatments were also interviewed about the treatment given and its clinical effects.

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[i] The period of referral was September 1997 to August 1998 for Blackthorn Medical Centre.

The sample for the case study interviews was selected from within four categories of diagnoses covering musculoskeletal, mental health, neurological and multiple conditions. The sample was also selected to ensure diversity across other key variables using a purposive basis of selection. Such diversity was required because the study aimed to map as fully as possible the range of outcomes that result from anthroposophic treatments. The key variables were gender, age, type of treatment and referral route. The characteristics of the case study sample are shown in Appendix I

The interviews with patients, GPs and therapists were exploratory using the method described above. In addition, the patients were asked to complete two questionnaires about their health, both of which use self-generated descriptions of symptoms or effects of illness as the basis of assessment. The instruments involved were:

> ***Measure Yourself Medical Outcome Profile (MYMOP)*** which identifies aspects and effects of illness that patients decide are most important and measures how these change over time.[9]
>
> ***Patient Generated Index of Quality of Life (PGI)*** which identifies important areas of the patient's life that are affected by their condition and measures how badly affected they have been in the last month. This again can be used to look at changes in effects over time.[10]

Both outcome measures were used on two occasions: MYMOP at the initial and follow up interviews and PGI shortly after the initial interview and at the follow up interviews.[ii]

The analysis of the qualitative case study interviews was carried out using *Framework* as described above. The results of MYMOP and PGI were used primarily to identify the outcomes described as important to patients and to compare these with the outcomes derived from the qualitative analysis. Further details are given in Chapter nine and in Appendix I.

[ii] Three patients completed the first PGI at the initial interviews, the remaining 17 were administered by phone shortly after initial interviews.

PART II

ANTHROPOSOPHIC MEDICINE AND ITS DELIVERY

2 THE PRACTICES

The research took place in seven practices that provide anthroposophic medical care and treatments. This chapter provides a profile of these practices in terms of the services they offer, their organisation and funding. It opens a series of six chapters that will describe the form and delivery of anthroposophic medicine within primary care settings in the UK.

2.1 A profile of the practices

The seven centres comprise six practices offering anthroposophic medicine as part of primary care and a clinic that offers short term residential care. They are as follows:

Blackthorn Medical Centre is situated at the north-western edge of Maidstone and serves a predominantly urban population. The patients are mixed in terms of socio-economic characteristics, although it is a largely middle-income community. There are four full time partners in this teaching practice, with a list size of 7200 patients. One GP leads in all aspects of anthroposophic work but all the doctors prescribe anthroposophic medicines and refer to therapies. There is also a horticultural centre, a bakery and a café on site, all of which provide rehabilitative and therapeutic work.

Blackthorn Trust was founded in 1985 as a charitable organisation, which manages the administration and funding of the anthroposophic facilities and treatments. It also co-ordinates fundraising activities.

Wallis Avenue Surgery is also in Maidstone, sited on a council estate. It serves a largely disadvantaged population amongst whom unemployment and lone parenthood are high. It is a single-handed practice with 1860 registered patients and still growing in size.

Helios Surgery and Therapy Centre is located in a residential, high income area in the north west of Bristol. Patients come from all parts of the city with only around twenty per cent (of the 2400 list) living in the immediate vicinity of the practice. There are three doctors in the practice, all of whom practice anthroposophic medicine.

The building and anthroposophic treatments are managed and co-ordinated by a charitable Trust, founded in 1995.

St Luke's Medical and Therapy Centre is situated in Stroud in Gloucestershire, with a branch surgery in Gloucester. It has three part-time GPs with a list size of 2800. Patients are drawn from a wide catchment area covering the Stroud valleys and parts of the city of Gloucester.

Anthroposophic facilities and treatments are administered by a charitable Trust founded in 1998. There is also now a café that is open and run by volunteers.

Mytton Oak Foundation is sited on the Western edge of Shrewsbury adjacent to a six-partner NHS general practice where the Foundation doctor is also a GP. It is a registered charity and, since 1994, offers anthroposophic therapies to people with long term and severe illness who are referred by GPs in the Shrewsbury Primary Care Group and beyond.

Park Attwood Clinic is a 16-bedded residential unit which is situated on the outskirts of Bewdley in Worcestershire. It also offers out patient treatments. It was set up in 1979. Four doctors work at the clinic, two of whom are GPs. There are also resident nursing staff and a

matron. In 1988, the GPs formed a practice based at the clinic with a temporary list. The clinic is run by a charitable company, limited by guarantee, and takes patients from all over the UK. There are also regular referrals from the six anthroposophic practices.

Camphill Medical Practice is sited within one of the Camphill communities[iii] on the edge of the City of Aberdeen. It is a single handed GP practice with two part-time sessional doctors, and a list of 800 patients. Around two thirds of the patients are from the Camphill communities themselves, many of who have physical disabilities or learning difficulties. The remaining third are NHS patients from Aberdeen and its surrounds and this component of the list is growing. The practice also has a charitable Trust, which administers and part-funds the anthroposophic treatments.

All of the practices, with the exception of Wallis Avenue, accept referrals from outside of their lists for anthroposophic treatments. The extent to which they do so is more fully discussed in Chapter Six.

2.1.1 Organisational structure

The organisational structure of the centres is such that, technically, five of the six primary care practices are NHS general practices and one, Mytton Oak, is a charitable trust. However, as has been shown, all but one of the NHS practices also provide most of their anthroposophic treatments through a linked charitable trust and Mytton Oak grew from the work of the lead GP at a NHS practice alongside sharing its name. Meanwhile, the residential clinic is a company limited by guarantee attached to a 'general practice' with a small temporary list.

For ease of presentation, we will refer to the centres as the six primary care or general practices and the residential unit or clinic. Despite their complex organisational status, this more accurately reflects the services they provide. All six general practices, for example, offer anthroposophic medicine as an integrated part of NHS primary care to some or all of their patients. The fact that they do so within different administrative arrangements is secondary to the form of care provided.

There is nevertheless an important divide between the seven centres, which concerns the ways in which anthroposophic medicine is combined with other care or services available within the practice. In these terms, it is possible to divide them into three main groups:

- ***Synchronised*** practices where an anthroposophic approach has been merged with conventional approaches to provide a compound model of primary care;
- ***Unified*** practices where an anthroposophic approach is dominant across the services provided;
- ***Dedicated*** practices that have been developed as specialist anthroposophic services.

It is important to stress that the distinction here is not one of integration of anthroposophic and orthodox medicine since that lies at the heart of an anthroposophic approach (see Chapter three). The key difference between the three groups concerns the *degree* of specialism in anthroposophic medicine across the practice as a whole. In these terms the seven centres divide as follows:

Synchronised **practices -** Blackthorn and Wallis Avenue;
Unified **practices –** Camphill, Helios and St Luke's;
Dedicated **practices –** Mytton Oak and Park Attwood.

[iii] The Camphill Movement was founded in Aberdeen in 1940 and has over 80 centres in 17 countries. Its principal aim is to found and develop communities in which those with special needs, and of different ages and abilities, can share life in a setting created to serve the wellbeing of each individual.

As will become evident through out the following sections, this taxonomy helps to explain many of the differences that occur between the practices in the way that anthroposophic medicine has been developed and is now delivered.

2.1.2 Anthroposophic treatments and therapies

Chart 2.1 shows details of the treatments and therapies that were on offer at the seven centres. At least one GP in all the practices prescribes anthroposophic medicines for their patients. The conditions for which they do so are wide ranging but certain medicines are almost always used for some conditions. For example hypericum (St. John's Wort) is regularly prescribed for depression, viscum for cancer. Medicines and their applications are described in detail in Chapter 5.

Apart from the prescription of medicines, massage was the only treatment available at every practice, largely because it is used for diagnostic as well as therapeutic purposes (see Chapter six). Art therapy too is offered at all but Wallis Avenue and had often been one of the first anthroposophic treatments on offer. Art therapy is also used for a wide range of purposes in anthroposophic medicine. Again, a discussion of all the different treatments, their properties and their applications is given in Chapters six and seven.

Chart 2.1 Anthroposophic treatments available at the centres

	Blackthorn	Wallis Avenue	Camphill	Helios	St Luke's	Mytton Oak	Park Attwood
Anthroposophic medicines	✓	✓	✓	✓	✓	✓	✓
Eurythmy therapy	*		*	*	*		*
Massage therapy	~	~	~	~	~	~	~
Art therapy	†		†	†	†	†	†
Sculpture therapy							Ψ
Music therapy	♫		♫				
Garden therapy	•			•	•		
Counselling	⁂	(not anthrop)	⁂	⁂		⁂	
Hydrotherapy			β	β	β		β
Nurse massage and compresses			( )	( )	( )		( )
Other therapies	Occupational (bakery, café)		Therapeutic speech		Occupational (café)	Counselling group	

Although there is variation in the number of treatments available at the different centres, this is partly a result of the stage of development that anthroposophic medicine had reached. The practices that had more recently started to offer anthroposophic treatments, like Mytton Oak and Wallis Avenue, had fewer therapies on offer. For Wallis Avenue, this was likely to remain the case as the patients could, if necessary, be referred to Blackthorn in the same town. For Mytton Oak there were restrictions because of the existing premises (see section 2.2.4).

Some of the practices are developing specialist services or clinics for specific conditions, based on anthroposophic principles. For example, at the Helios Centre, one of the doctors is specialising in the treatment of chronic fatigue syndrome, another in the treatment of autism amongst children. Similarly, a number of the centres are receiving local referrals for anthroposophic treatments of cancer.

2.1.3 NHS primary care services

The *synchronised* and *unified* practices offer a wide range of NHS primary care services to their patients. These include contraceptive, antenatal and baby clinics, child health, asthma and diabetes clinics, minor surgery and general nursing services. There are also midwives, health visitors and district nurses attached to each of the practices. In the main, the practitioners involved in providing these services are not anthroposophic specialists although they may have an interest in the subject as a result of working in the practice. However, the Camphill practice has nursing services that are anthroposophically based because of the particular specialisms of the practice nurse. For example, she provides massage, compresses and baths, based on anthroposophic clinical principles, for a range of conditions including treatments for babies and small children.

The integration with other primary care services is rather different in the two *dedicated* centres. Mytton Oak, which offers primary care services, has a developmental link with a relatively large general practice that offers the full range of primary care services. The Mytton Oak Trust provides anthroposophic treatments but does not itself have other NHS services. Park Attwood does not offer primary care services because of its primarily residential status.

2.2 The development of anthroposophic medicine within the practices

As may be evident, the practices are at very different stages in their development of anthroposophic medicine in general practice. Blackthorn, Helios, St Luke's and Park Attwood have been offering anthroposophic treatments for many years and, in individual ways, have pioneered the development of a range of services and specialisms within the approach. Mytton Oak and Wallis Avenue have more recently begun to offer anthroposophic medical care and are applying the approach in new settings. Camphill has always offered anthroposophic medicine but has only recently extended this to patients outside the Camphill communities. All of the practices have plans to extend their activities and to develop their activities within their local primary care services communities.

2.2.1 The origins of an anthroposophic approach

In each of the seven centres, one or more individuals had been highly influential in introducing anthroposophic medicine to the work. The people concerned were usually either the current lead GP, or a medical predecessor, although therapists and other staff members had played key roles. Where the current lead GP had not been the originator, they had always been very instrumental in later developments.

In the *dedicated* and *unified* practices, the introduction of anthroposophic medicine had usually occurred at the time the practice was established, (see Chart 2.2). At Park Attwood, for example, the origins of the clinic lay in a residential home for people who needed long term care that was set up by an anthroposophic (non medical) practitioner. The home closed and Park Attwood was opened, partly to house some of the residents but also to widen the service to provide medical care. Similarly, at St Luke's, an anthroposophic doctor had set up a single-handed practice in the early 1940s, a few years before the NHS was established. He then passed the practice to another anthroposophic GP and the anthroposophic tradition has continued ever since.

Conversely, in the two *synchronised* practices, the lead GPs had brought anthroposophy to the practice, in both cases helped by the inspiration and support of others. At Blackthorn, the art therapist had been highly influential in first demonstrating a crucial role for anthroposophic treatments; at Wallis Avenue, anthroposophic colleagues had acted as important mentors and supporters in moving into such work.

Chart 2.2 Key stages in the delivery of anthroposophic medicine

	Blackthorn	Wallis Avenue	Camphill	Helios	St. Luke's	Mytton Oak	Park Attwood
Practice / Clinic established	**Early 1960s**	**Early 1990's**	**1965**	**1977**	**Early 1940's**	**1994**	**1979 (1988 general practice estab.)**
Lead GP joined establ* or took-over ^ practice	**1997**	**1994^**	**1997^**	**1977^**	**1991**	**1994***	**1984-6^ 1988***
Anthroposophic Medicine introduced	**1983**	**1994**	**1940s (by visiting doctors)**	**1971**	**Early 1940s**	**1994**	**1979**
Trust established	**1985**	**N/A**	**1989**	**1995**	**1998**	**1994**	**1979**
Moved to purpose built / dedicated premises	**1990**	**N/A**	**1988**	**1997**	**1998**	**1999**	**1979**

All the existing lead GPs had developed an interest in anthroposophic medicine at an early stage of their medical careers. In some cases, this interest had grown from a previous exposure to anthroposophy, through, for example, attending Steiner schools, or through their parents' engagement with it. For others, the seeds of interest were sown at medical school often through a quest to find to find a more holistic approach to medicine.

There were other features of anthroposophic medicine that inspired the GPs in the early stages of their interest. High amongst these was the concept of a medical practice that was patient led, and one that took account of the 'place' the patient had reached in their lives. There was also a concern to practice a form of complementary medicine that utilised, rather than ignored, the well-founded knowledge of conventional methods. Chapter 3 explores in more depth the influences of anthroposophy on the current work of the GPs.

For all the lead GPs, some years of specialised education and training in anthroposophic medicine followed their initial acquaintance. In some cases this took place in formalised courses at centres outside of the UK. In others the training took place in this country, either through placements at one of the seven practices or through attending lectures and private study. Several of the GPs talked about the importance of gaining a full understanding of the concepts of anthroposophy and 'making sense' of it for general medicine. This it, was agreed, took a significant amount of time:

> *In terms of actually getting to the point of feeling 'right, I'm in a position to actually make some of this happen through me as opposed to just soaking it up or using it for personal development….it took a long time…it's not a skill or an attitude that arrives overnight either….you've got to feel pretty acquainted with or immersed in it or to have made some sense of it, if you like, before I think one can then use it sensibly, particularly in the context of trying to use it in an orthodox setting….* (Lead GP)

The practices had been providing anthroposophic treatments for between five and fifty years and, in all cases, key developments had taken place during that time. These varied depending on the rate of growth of anthroposophic medicine and the extent to which the practice, as a whole, specialised in such an approach. There were, however, some significant events in common.

2.2.2 Expansion of services

All the practices, except perhaps Wallis Avenue, had experienced a significant growth in the demand for anthroposophic treatments, particularly in recent years. This was felt to be a result of better communication about their work on the part of the practices; a widening interest in anthroposophic medicine, both amongst patients and amongst other local medical practitioners; and a more general increase in the use of complementary medicine for certain conditions. All of this was underpinned by the perceived limitations of conventional medicine for treating more complex or chronic conditions.

Most of the practices had widened the range of treatments available since anthroposophic medicine was first introduced. As a general pattern, art therapy, massage and counselling had been introduced at earlier stages than, for example, eurythmy, hydrotherapy, music or garden therapy, partly because the latter required special accommodation or equipment. But there were important exceptions to this where a key individual had become involved in the anthroposophic work of a particular practice. For example, at the Helios Centre, eurythmy had been available since the mid-eighties, before other treatments became available.

The move to a purpose built building (see 2.2.4) had a notable effect on the provision of the treatments available. At St Luke's and the Helios Centre, for example, garden therapy became available once the practice moved into new premises with suitable land. Similarly, all the purpose built buildings had specially designed art studios that provided appropriate conditions for creative work.

Wallis Avenue was the only centre where the treatments available at the practice had lessened, although opportunities to receive others are provided through links with Blackthorn. Art therapy, anthroposophic counselling and massage were available at one time but art therapy and counselling are no longer provided. In both cases, this was because the lead GP was finding insufficient short-term value in having the services on site. He had a preference for group rather than individual work for his patients and eventually decided to let both therapists go. In the case of art therapy, this is not without some regret:

> *And the art therapy, I also felt that it wasn't moving things… I think there were patients who benefited from it and since then occasionally have felt regret because I felt that some particular children they could have gone on. And I have also learned that art therapy is a long haul sort of therapy….*(Lead GP)

2.2.3 The establishment of a charitable Trust

In all the general practices other than Wallis Avenue, charitable trusts have been established to manage and administer the anthroposophic work and to co-ordinate fund raising activities. Blackthorn was one of the first practices to set up such a trust, largely because the practice itself could not financially sustain the provision of anthroposophic treatments:

> *Gradually the debt grew…. We didn't charge anybody for treatment…we didn't want to charge because we knew it would make a private practice population. And, gradually the debt grew and grew and then we took on another chap for counselling …. By then, we had quite a number of patients who were actually able to stand up and say, you know, this is what happened and we'd got some ground to stand on. And so we decided, on -----' s advice, he's still a Trustee, that we would start a charity. We didn't*

know what we were doing – or anything about it – but we found a solicitor friend who drew up a thing, we took advice from another anthropop practice which had a charity and we went to the charity commissioners and did all you have to do…. (Lead GP)

The establishment of the Trust greatly helped the financial problems, although not without some initial teething problems. Two of the three *unified* practices had set up trusts at much later stages of their anthroposophic development. In each case this was to help raise money for planned developments or buildings but also to ease the financial administration of anthroposophic treatments for patients outside of the practice.

Camphill was in a rather different position because all the work of the community was funded and administered by a Trust and the medical practice came later. However, the Trust still continues to administer anthroposophic treatments alongside the NHS practice now established.

The origins of the Trust in Mytton Oak were similar to that of Blackthorn but there was also an added dimension. This was to ensure that the anthroposophic practice was administratively and financially separate from the NHS practice. This was for a variety of reasons but also reflected a high rate of referrals from other practices (see Chapter Four).

2.2.4 The move to a purpose built building

The three *unified* practices and Blackthorn all have buildings that are specifically designed for anthroposophic medical work. In each case these were designed by architects who specialise in buildings based on anthroposophic principles. These principles are complex but result in buildings that are notable for their soft interior lines and curved walls and for colours that carry a particular symbolism through their lightness and specific tones. Within the purpose built buildings, facilities are available for a range of different treatments including, for example, rooms that are sufficiently large for eurythmy, studios with appropriate light for art therapy and baths for hydrotherapy.

Mytton Oak is also now in dedicated premises that have been adapted, rather than purpose built, to accommodate consultation and treatment rooms, a reception and an office. The Trust moved towards the end of the research from a portacabin in the grounds of the Mytton Oak general practice. This was a temporary arrangement while funds for a building were raised. This did, however, restrict the treatments that could be made available.

The Park Attwood premises are also not purpose built for anthroposophic medical work but comprise a large building in several acres of ground, formerly operating as a hotel. Adaptations for anthroposophic treatments have been made to the building.

2.3 Funding

Fundraising is a core activity for all the practices and many of the individuals involved have diverse roles. They may combine roles in fundraising with organisational duties, such as practice management, and with therapeutic roles such as counselling. For instance, practice management spanned the well-documented duties of a non-anthroposophic practice, but includes a range of additional funding and organisational activities that are particular to anthroposophic practices. Being a GP also involves being an advocate for anthroposophic practice, responding to requests for information from both professional peers and potential patients. This has a real cost in terms of managing professional role boundaries in a range of different professional and personal contexts.

As already noted, all the practices have seen a rapid increase in interest in, and requests for, anthroposophic treatment, and the funding and organisational activities have had to expand in parallel. This has entailed balancing a need for continuity among professionals and patients, with meeting the demand for additional capacity. Practitioners also spoke of the need to remain true to anthroposophic principles in management and organisation, as well as in-patient care.

2.3.1 Buildings and staff

All the practices except Wallis Avenue have established mechanisms for bringing in additional funding through local charitable foundations established to support anthroposophic practice. Each of the charitable foundations has trustees, who meet regularly, and have a broad overview of medium and long-term development, and are ultimately accountable for financial aspects.

Those with purpose-built premises have undertaken major fund-raising for this purpose. In these instances, the land and buildings are owned by the charitable foundations, and the NHS practice, where this is linked, rents space in the building, thus generating additional NHS funded income for the Trust.

The cost of constructing buildings is a constant theme: they are more costly than a surgery for non-anthroposophic practitioners for three reasons. They are designed in line with anthroposophic principles, they need to accommodate a wider range of therapists, and, in most cases, they need sufficient grounds to support community and garden based activities.

Therapists are paid, in part or in full, by the charitable foundation, and vary in their employment status, which in part relates to the degree of funding available. The subsidising of therapies is regarded as particularly important in order to ensure that limited income does not restrict patient access to therapies.

2.3.2 Formal and Informal fund-raising

Fundraising is undertaken both formally and informally. Formal fundraising, and financial management, is the responsibility of finance and/or management groups, some of which have formally appointed workers with a specific remit for raising funds. Informal fundraising is taken on by Friends or volunteer groups, who initiate and run a series of activities (described more fully in Section 2.4.3). The links between formal and informal activities are maintained through specific appointments, for instance a creative communication co-ordinator or an Outreach Co-ordinator and Outreach Committee, or in-reach groups. All practices reported a conscious attempt to maintain communication between practitioners and formal and informal fundraisers through regular meetings.

Formal fund-raising entails the submission of applications to national and local bodies. Funds have been obtained from diverse sources, including the National Lottery, J. Paul Getty Foundation, Shropshire Wildlife Trust, King's Fund, SmithKline Beecham, and various charitable trusts.

Funding for patients comes either through health authorities, through the charitable foundations, or through patients themselves paying privately, or paying according to their resources. Thus practices, and particularly practice managers, effectively run two organisations, the NHS practice and the Trust practice. Former patients and their families are also a source of donations and legacies.

2.4 External liaison

2.4.1 Health authority liaison and support

Health authority liaison and support has taken a range of forms, including funding of patient care and research. The ways in which particular practices have received health authority funding are linked to the ways in which changes in legislation have affected the history of the individual practices. For example, Park Attwood had originally been a residential home, with DHSS funding, providing residential, nursing and later medical care. With the introduction of the Community Care Act, DHSS funding was withdrawn and the focus shifted to medical care. Similarly, at Blackthorn, when an adjacent hospital was closed following the introduction of the Community Care Act, the anthroposophic practitioner was approached and asked to develop an employment project for people with long term mental health problems; the practice agreed, but wished also to include people with long-term physical health problems.

Some health authorities had provided funding for research and had supported research on benefits of treatment for patients referred to anthroposophic practitioners.

Health authority support relies on a number of factors:

- Individual personal links between anthroposophic practitioners and individuals within the health authority;
- Continuity of personnel within the health authority;
- The nature of evidence used by the health authority to support decisions over funding. During the period of the research the emphasis on evidence-based medicine - and on ensuring decision making was supported by evidence - was receiving considerable public attention and influencing policy makers at all levels.

2.4.2 Primary health care groups/trusts

At the time of data collection (1999), Primary Care Groups (PCGs) were in their infancy, and Primary Care Trusts (PCTs) had yet to be formed. Thus the data refers to potential rather than actual issues in relation to the functioning of PCG/Ts.

The introduction of PCGs and PCTs will entail practices developing more links with other non-anthroposophic practices. The representation of anthroposophic medicine on PCG/T boards varies from area to area, and in some areas it is clear that other local GPs have little knowledge of anthroposophic practice. Practices have therefore started to invite local GPs to visit the practice, either through individual contacts or through the organisation of a practice 'open day' to allow visitors to see the range of therapies available.

Both negative and positive potentials were recognised in the shift to PCG/Ts. These included possible restrictions on staff, funding and prescribing budgets on the one hand; on the other, possible increases in activity as other GPs became aware of, and started to use, anthroposophic practitioners as an additional local resource. In the same way as links with local health authorities rested on individual contacts and the interests of the officials concerned, so links with PCG/Ts will be influenced by the particular priorities of local GPs serving on their boards.

It was anticipated that the management of funding for referrals will become more formalised with the introduction of PCGs. At present, only patients from fundholding practices bring funding with them. Patients from non-fundholding practices may be seen without a referral letter since there are no funding implications. In future, all patients will bring funding with them, which will

entail additional financial administration. Such patients will be viewed as patients of the charitable trust, rather than of the NHS practice.

2.4.3 Community activities

Community activities are initiated by practitioners and staff and are assisted by an informal but committed network of friends and family. They may be characterised in a variety of ways:

- social rehabilitation and work (e.g. garden, bakery, café);
- socially therapeutic activities; for people with long-term physical and mental health problems;
- activities designed to encourage participation.

They include:

- charity shops;
- garden work;
- cookery;
- running a café;
- groups of various kinds: craft, story telling, music;
- discussions and workshops on health related topics; and
- outings, celebrations, cultural events.

In addition, it was felt important to see the surgery as community resource and to build links with local schools, residential communities (particularly for adults and younger people with learning difficulties or mental illness), local charities and initiatives such as good neighbours' schemes.

Funding may be augmented by the sale of products of community activities, such as gardening, cookery, and craft groups through various events and stalls or shops based on site or near to the practice.

3 THE PRACTITIONERS

This chapter describes the anthroposophic practitioners that work in the seven centres and the routes, interests and orientations that brought them to anthroposophic medicine. As a context for this, we consider first where anthroposophic medicine might be placed in relation to other movements and initiatives occurring in contemporary general practice.

3.1 New options for primary care – where does anthroposophic medicine lie?

The definition and evaluation of anthroposophic primary care is taking place within the broader context of a reassessment of the nature of general practice. While there is great diversity among general practitioners, there is a clear a shift – in both practice and education – towards recognising the expertise of general practice as a speciality with its own knowledge base, rather than being defined in terms of its working practices.

A report from the Royal College of GPs (2000) suggests that general practitioners have prided themselves in offering high quality technical medicine combined with a personal service. The elements of this personal service are identified as continuity of care within a long-term doctor-patient relationship, with a shared understanding of the needs and best care of the individual patient. The broad services to which the public requires access are information, advice, triage and treatment, continuity of care, and personal care. The emphasis on continuity of care spans both continuity over time, and continuity over a range of conditions. Both of these elements are shared with anthroposophic practitioners.

There have been a number of attempts at defining general practice, and recent conclusions have emphasised the shift from a focus on working methods to attempts to identify the core content and specific expertise of the discipline (Olesen *et al.*[11]). Olesen and colleagues cite a 1974 definition from Leeuwenhorst:

> *[T]he general practitioner is a licensed medical graduate who gives personal, primary and continuing care to individuals, families and a practice population irrespective of age, sex and illness. It is the synthesis of these functions which is unique.*

Olesen and colleagues follow with their own definition:

> *[T]he general practitioner is a specialist trained to work in the front line of a healthcare system and to take the initial steps to provide care for any health problem(s) that patients may have. The general practitioner takes care of individuals in a society, irrespective of the patient's type of disease or other personal and social characteristics, and organises the resources available in the healthcare system to the best advantage of the patients. The general practitioner engages with autonomous individuals across the fields of biomedicine, medical psychology and medical sociology.*

The debate surrounding the recognition and legitimisation of general practice as an academic discipline - and as, in some senses, a speciality - has focused on the expertise of primary care practitioners in incorporating psychological and sociological perspectives within a biomedical model. GPs are described as specialising in the complexity of medical care in the patient's context, drawing together biomedical explanations and broader social contexts.[12]

Such definitions, however, do not make explicit how general practitioners attempt to understand their patients' broad concerns. Two commentators provide more detailed attempts to do so. Iona

Heath suggests that the 'current crisis in general practice' results from a number of developments that are undermining and distracting attention from the essential nature of general practice.[13]

These are:

- market values and the destruction of vocation;
- the conflict between advocacy and distributive justice;
- the specious separation of health care and social care;
- health promotion instead of health protection.

Her discussion of the nature of medicine focuses on the human need to seek explanations for misfortune; ill health juxtaposes the power of scientific medicine with the individual experience of sickness.

> *The story of medicine is one of striving to make sense of the human experience of illness. Patients who perceive themselves to be ill have always asked questions of the doctor: 'Am I indeed ill?', 'Can I be cured?', 'Can my suffering be relieved?', 'Why has this happened to me?', 'What will happen to me now?', 'Will I die?' The enormous advances of scientific medicine over the last century have meant affirmative answers to the second question, 'Can I be cured?', in more and more cases with much relief of suffering and prevention of premature death. However this has been at the cost of avoiding the other questions and the human need is for all the questions to be answered. Medicine is diminished by too narrow a definition of the discipline, in terms both of the nature of illness and disease, and of their causes.*

Peter Toon, asking 'what is good general practice?' distinguishes between the bio-mechanical doctor; the doctor using teleological, hermeneutic or humanist models, including the Balint movement, cognitive and behavioural approaches, and holistic approaches; and the anticipatory care doctor focusing on the whole population as well as the individual, within a public health framework.[14] The biomechanical doctor is characterised as disease centred, understanding symptoms in terms of associated pathophysiology, and maintaining a strong division between mental and physical, with an emphasis on the physical. Such an approach reveals a moral vacuum in dealing with patients with untreatable disease. By contrast, the general practitioner operating within teleological or hermeneutic models focuses on the purpose of life, and the development of patients' understanding of their illness and its symptoms. Medicine is seen from both perspectives as a humanistic activity, concerned essentially with human relationships.

One of the challenges of evaluating anthroposophic practice lies in distinguishing between the approaches of anthroposophic practitioners and other practitioners espousing a humanistic approach to general practice. This is a challenge for both anthroposophic practitioners and researchers, given that many practitioners work within conventional general practices. The remaining parts of this chapter provide a brief overview of some of the general features that define anthroposophic practice and the key concepts that underpin this approach to health care.

3.2 General features and philosophies of practice

Although the term 'anthroposophic doctor' is used in this report to refer to the GPs practicing anthroposophic medicine, some of the doctors were reluctant to define themselves as such. In part this was due to the view that anthroposophic practice is a continuous process of learning and self-development, rather than a once and for all attainment of a specialised qualification. There was also the view that anthroposophic practice is an extension of, not an alternative to, orthodox medicine and thus not a defining characteristic. In contrast, the masseuses, nurses and therapists were very clear in referring to their practice as anthroposophic. This was to a large extent a reflection of their training which was often exclusive to the anthroposophic approach.

3.2.1 Defining practice

All the practitioners were firmly committed to working within mainstream general practice. There was an equally universal view about the limitations of orthodox clinical practice and a desire to push the boundaries to include both psychological and spiritual dimensions. But most crucially, value was placed in 'having a foot in both camps' both for patient care and for professional development.

A conceptual framework

It is it is beyond this report to attempt a thesis on the philosophies and concepts that lie behind an anthroposophic approach to medicine. Instead, we have summarised very briefly some of the key elements and principles that help to define an anthroposophic approach:

- *An integrative view of the human being* recognising the complex inter-relationships between the physical, psychological and spiritual aspects of each person. These relationships are elucidated by observing each patient from the perspective of a number of different organisational sub-systems. Two of these are:
    i) the four-fold system which identifies the physical body, the system of life forces (etheric body), consciousness and its physical basis (astral body) and self-consciousness (ego). These four bodies' each have a complex but consistent relationship with the different 'kingdoms of nature': the physical body with the mineral kingdom, the etheric body with plants, the astral body with animals and the ego with the exclusively human realm;
    ii) the three-fold system which defines another series of physical and functional inter-relationships: the 'nerve sense system' centred in the brain, nervous system and sense organs whose activity is mainly catabolic (breaking down); the 'metabolic-limb system' centred in the intra-abdominal organs, the limbs and some elements of the blood and lymph whose activity is mainly anabolic (up-building); and the 'rhythmic system' comprising the heart and lungs together with their rhythmical signatures throughout the body whose activity is mainly modulating and integrating between the opposing tendencies of the other two systems. There is also a corresponding psychological activity subsumed by each system: the nerve-sense – thinking; the rhythmical – feeling; and the metabolic-limb – willing (volition).

  All the sub-systems within the three and four-fold systems interpenetrate each other in their activities and cannot be viewed as anatomically or functionally separate from each other. In addition, no one sub-system can be seen exclusively as either physical (body) or psychological (soul) in their structure or function. Along with other sub-systems (e.g. one, two, seven and twelve-folded) they should be regarded as a series of complex and dynamic forms which characterise not only those aspects of the human being that are essentially distinct and separate from his/her environment but also simultaneously reveal the social, environmental, earthly and cosmic connections that exist at every level of the human organisation.[iv]
- *Biographical detail*. Clearly defined and differentiated developmental stages are identified within anthroposophic practice. The basic stages are 'archetypal' seven-year cycles which relate to childhood development, adolescence, adult development and the transition into middle and old age.

[iv] A more detailed account of these elements and others can be found in Evans and Rodger, 2000. [1]

- *Constitution*. The elements of a person's constitution relate to inherent tendencies which operate at physical, psychological or temperamental levels. The type of information used in assessing these factors relates closely to the principles employed in homeopathy where constitutional pictures are built from physical attributes, habits and patterns of behaviour, temperament and so on.
- *Social and environmental factors* also form a key aspect to the work in placing the individual within the context of their lives as a whole. In practice this means ensuring that adequate support networks exist for the patient which to allow healthy development and self-determination.
- *Concepts of illness and well-being* are seen in terms of the dynamic relationships between the various sub-systems or 'bodies' of each person within the context of their constitutional tendencies and environmental and social situations. Illness may result from a disturbance in this dynamic interplay and will manifest in highly individual ways according to each person's inherited qualities, constitution, life phase and biography.
- *The search for meaning in illness* which can provide the potential for positive development within a person's life which can be facilitated by a person-centred approach and by focusing on the positive, healthy aspects of the person as well as the area of disease.
- *Interrelationship of the systems*. There is an interplay between the elements described above which is elucidated in intellectual, imaginative and intuitive ways. Flexible working 'pictures' of patients are held by the practitioner, rather than simply assigning patients to simple and abstract categories.

A practical framework

- *The use of self as a means of facilitating the healing process.* Engaging the patient in their own healing process is considered fundamental to an anthroposophic approach.
- *Imagination and intuition.* Although systematic in their approach to patients, practitioners emphasised the importance of developing their observational, imaginative and intuitive faculties in building diagnostic 'pictures' and developing treatment strategies [v]. For many practitioners, the development of these skills was not only central to the team approach professionally but was also the subject of personal study and meditative practice.
- *Stimulating the body's capacity to heal*. As the body is seen as inherently capable of self-healing the key function and aim of any intervention, medicinal or therapeutic, is to stimulate those forces in a manner that balances them within the system as a whole.

Influencing practice

- Making a *personal connection to patients*.
- *Accompanying patients*. The role of practitioner and therapist is very much seen as in partnership with patients.
- *Team working* within a multidisciplinary approach allows practitioners to draw on a range of skills and appropriate techniques to address the patient's illness.
- *Facilitating learning and experience between practitioners*. Key to the approach is the emphasis on development, not only of the patient but also for the practitioners themselves. Working and meeting regularly as part of a team enhances understanding between doctors, therapists and nursing staff.
- *Treatment options*. Referral to therapies and anthroposophic remedies.
- *Holistic treatment*. Illness is very much seen in context of the above social, psychological, biological (and inherent) and spiritual factors. The therapies and medicines are seen to work not in isolation but as an interconnected holistic system capable of addressing the many fold aspects of the patient's lives.

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[v] The definition of 'intuition' was seen to closely resemble the concept referred to by the phenomenological psychologist Merleau-Ponty. [15]

- *Individually tailored treatment*. Treatment is tailored to the individual's constitution, background, and in relation to the three and four fold elements. The complexity of the system allows for specific treatment programs that are very highly tailored.
- Less reflex, *more enjoyment*.
- *Continuity of care.*

3.3 The general practitioners

The lead GPs share a commitment to the practice of anthroposophic medicine and to developing its application within the healthcare system in the UK. They are all currently working to increase co-ordination and co-operation with their orthodox peers within both their PCGs and in secondary health care settings.

All the lead GPs have been key figures in the integration and development of anthroposophic medical practice in their respective organisations. They have, however, developed their practices in unique ways, with specialist work on chronic illness, cancer, physical and mental disabilities, chronic pain, mental health and the efficacy and legislation of anthroposophic medicines. Each also has a very individual connection to anthroposophy and thus vary in the degree to which they operate within an anthroposophic approach in every day general practice.

Four practitioners were born and educated in central Europe. All but one qualified as general practitioners at orthodox training practices in the United Kingdom.

3.3.1 Routes to anthroposophic practice

All the lead practitioners had at least some knowledge of anthroposophy prior to, or during their medical training. For some this was through parents and Steiner education, for others through a general interest in different philosophies and religions. They all shared an early interest in integrative approaches to healthcare.

Two different types of path had been followed in the development of the doctors' anthroposophic work. Some started medical life with a strong orientation towards anthroposophic medicine and had continued its application in primary care. Others had evolved an anthroposophic approach over a longer period and gradually integrated this into orthodox practice. Several factors were influential in the way the development of anthroposophic medicine occurred but the availability of training in anthroposophy was crucial. Some had had opportunities to study in central Europe, where anthroposophic medical care is more widely known and training more easily available. It was also evident that other individuals had played a key role, acting as significant mentors in the development of the doctors' anthroposophic work.

All the GPs described the process of understanding the concepts related to anthroposophic medicine as one which is very much developed through practical experience over a long period and not without incidences of doubt. They had all, in different ways, put the principles of anthroposophic practice 'to the test' and placed it under scrutiny with some of their most problematic patients.

Those who were trained in other European countries had had opportunities for learning in anthroposophic general hospitals as well as in specialist areas, such mental health. T hose who had developed an anthroposophic approach during general practice had acquired it throughout their medical careers, supplemented by lectures, courses and conferences run in the UK and overseas. There was also variation in the extent to which individual practitioners had been trained in therapeutic work, such as eurythmy or art therapy, and in the preparation of anthroposophic medicines.

3.3.2 Medical training and continuing education

The process of becoming an 'anthroposophic doctor' is not explicit but rather a case of acceptance within the anthroposophic medical community through peer recognition. The doctors all belong to the Anthroposophic Medical Association (AMA) for which the key requirement for full membership is a qualification to practice medicine in the United Kingdom. Practitioners are encouraged to participate in the various events and courses organised by the association and are directed towards a minimum of a four-week basic medical course in Switzerland. Other courses are available in Central Europe for German speaking doctors.

The opportunities to study anthroposophic medicine are growing in the United Kingdom, as is the development of a clear definition of the requirements for becoming an anthroposophic practitioner in accordance with European guidelines. Full training opportunities are expected to be available in the UK within the next few years. Practitioners regularly attend lectures and conferences held in the UK and abroad on anthroposophic medicine, as well as updating knowledge and skills in orthodox medicine.

3.4 Therapeutic teams

The therapists and nurses at each centre had very varied backgrounds although there was generally a long-standing interest in anthroposophy. In many cases practitioners had moved from formal studies in related professions and areas such as pastoral counselling, Art or Music Degrees, physiotherapy, general and psychiatric nursing. Some had made career changes from professions such as banking, teaching, social work or orthodox nursing practice.

Work and study abroad was notable, especially in relation to anthroposophic training and practice. For those practitioners from central Europe, the introduction to anthroposophy and formal anthroposophic training establishments had usually occurred relatively early in life.

3.4.1 Training

Nurses

Nursing staff had orthodox qualifications in general nursing practice often with additional qualifications in specialist areas such as psychiatric nursing or midwifery. Anthroposophic nursing had mostly been learned through in-service training and various short courses. Camphill Medical Practice in Scotland offers a two year courses whilst Park Attwood Clinic runs an in-service training.

Massage therapists

The massage therapists were all trained in both conventional Swedish massage and rhythmical massage (as indicated by Dr Ita Wegman). For those who had initial state training in Germany, courses included aspects of physiotherapy, hydrotherapy and compresses. One therapist had separate training in nutrition and another type of physical therapy, the Bowen Technique. Only one therapist was employed full-time by Park Attwood Clinic, the rest worked on a part-time basis. Some worked at more than one centre and more senior practitioners were also involved in teaching and supervising training in rhythmical massage.

Training in rhythmical massage is only possible after a relevant qualification in remedial massage has been accomplished. The academic elements of the course are largely provided through correspondence with intensive blocks of practical tuition and supervised practice throughout the year. Courses can be taken over varying periods of time, between one and half to five years. At

present, the courses are run in Germany and America but are expected to develop in the United Kingdom in the near future.

Art and Sculpture Therapists

Therapists were employed on a part-time basis at the centres and worked either as therapists at other anthroposophic centres or as supervisors and teachers of art therapy in other settings. Training in anthroposophic art therapy has developed quite rapidly in the United Kingdom whereas sculpture therapy is less widely practised and separate training is not currently available in the UK. Courses in art therapy are full time and lead to a diploma on successful completion of three years study and at least a six months placement in a clinical setting. To become a full member of the Association of Anthroposophic Art Therapists, practitioners must have practised for a further two years under supervision.

Eurythmy Therapy

Eurythmy therapists had lengthy courses of four years basic training with between one and a half to three years practical training in the therapeutic application of eurythmy. Basic training continues to be four years, which includes movement, music theory, anthroposophy, art and performance. Most students go on to teach or practice as therapists. The therapeutic components, which include medical elements, can take between one and three years to complete depending on the amount of practical experience.

Music therapists

A few courses in music therapy exist in the United Kingdom but the only training available in anthroposophic music therapy is in Germany. Therapists can also train through apprenticeship placements with practising music therapists in blocks of several months.

Counsellors

The counsellors interviewed were all employed by the practice on a part-time basis. Each had been involved in counselling for between ten and fifteen years. Most had increased their work at the centres not only as counsellors but also in other areas such as music therapy or project management and development. All at some point had also had private clients outside of the centre, which have generally reduced due to increased work commitments at the centres.

The counsellors' professional backgrounds were very varied and spanned training in biographical counselling (specific to anthroposophy), pastoral counselling, psychosynthesis and psychodynamic therapy. All these approaches acknowledge a spiritual dimension to personal development and were described as compatible with an anthroposophic approach. Training in biographical counselling is carried out over a three and a half-years with practical and academic components. At present only one course is run in Canada.

Gardening and occupational co-workers

Not all staff involved in the garden and occupational projects were trained as therapists but had had training carried out in-house about therapeutic and practical aspects of the work. Some key members of the team had relevant qualifications in, for example agriculture or bakery. At two centres therapists had training in horticultural therapy. There are no anthroposophic courses available and training continues to be in-house.

3.4.2 Continuing education and professional development

The majority of therapists are involved in continuing to develop their own education, both individually and collectively. All have the opportunity to attend regular lectures on aspects of anthroposophic medicine as well as in their individual fields. Various practical refresher courses and workshops are organised by the separate associations for nurses, massage therapists, art and eurythmy therapists as well as general conferences in anthroposophic medicine. At Park Attwood and Camphill Medical Practice, nurses have regular in house training mostly in the form of seminars with some practical training in Einreibung massage (a technique specific to anthroposophic nursing).

3.5 Teamwork, supervision and support

During training, doctors are supervised by colleagues experienced in anthroposophic practice. Practitioners learn how to manage themselves within the guidelines for orthodox practice although more recently there have been plans to develop a more formalised anthroposophic version of 'clinical governance' via the AMA. Practitioners had several close connections with other doctors practicing anthroposophic medicine from whom they could rely for advice and support in developing their work.

Nursing and the key therapies of art, counselling, eurythmy and massage are supervised quite intensively during first years of practice and all have Associations to which therapists belong. Some associations require a minimum of two years supervised work post-training. Although much of the training still continues to be in central Europe, each has a group of recognised supervisors across the country and informal support is provided between groups of therapists. Regular training courses are also run by the relevant associations.

Counsellors were the only practitioners receiving external supervision, which was considered by most as essential to the nature of the work and degree of confidentiality required of them. For those members of the British Association of Counsellors, supervision is required as part of the Association's code of ethics. Many of the training organisations stipulate regular refresher courses as a form of monitoring the work of qualified counsellors or therapists.

The main source of supervision and support is gained through the therapeutic teams at the centres. Each centre has both formal meetings as well as informal opportunities for advice and support from colleagues. All the centres had, or were in the process of developing, formal strategies for team working and greater support was provided on both personal and professional levels. At Park Attwood Clinic, regular peer review provides constructive input and support for professional development.

The centres that provide training opportunities in anthroposophic medicine, Blackthorn, Camphill and Park Attwood, had developed more formal structures for team meetings. The content of meetings had also become more differentiated in terms of subject matter as it was considered more productive to focus on specific elements of the work. The content of meetings falls into several categories:

- therapeutic work
- professional development
- organisational development
- administration and management
- financial matters

Therapeutic team meetings are generally run on a weekly or fortnightly basis and are attended by therapists, nurses and doctors. These meetings provide an opportunity for the doctors, therapists and nurses to introduce patients to the team and share 'first impressions' with practitioners involved directly in individual patient care. Further to this, diagnostic pictures and therapeutic programmes can be developed amongst team members. The meetings also provide the opportunity to exchange information and advice on patients' progress and future treatments.

Case conferences on individual patients, which are very focused therapeutic team meetings on individual patients, involve an in-depth process of detailed reporting on aspects of the patient's biography, constitutional information, medical background, and 'first impressions'. Because of the intensive nature of the work at Park Attwood, where most team members are involved in patient care on a frequent basis, there are weekly case conferences. In other centres less opportunity for such in-depth work exists but patients are usually only seen by one therapist at a time. Patients sometimes attend part of the case conference.

Therapists also meet individually with the doctors responsible for each patient, preferably on a set regular basis. Some practices had developed a strategy of rotating the attendance of doctors and therapists to maximise the opportunity to review patients.

Team members were generally very enthusiastic about working as a group. It provided a means of regularly reviewing patient's progress and offered opportunities to develop treatment programmes for patients more sensitively. A cautionary note was sounded, however, to ensure that the case conferences did not become overly rigid and intellectual since this could breach a central tenet of anthroposophic practice to provide patient centred care. Overall, therapeutic team members found meetings to be a good form of peer supervision, professional development and support and were keen for further developments in team working. The increased number of meetings, however, had expanded the workload of part-time staff quite significantly. At some centres, there was not yet funding for these elements of the work.

All the centres ran educational sessions on various aspects of anthroposophic medicine and therapies. In some cases, these were open to trainees, visiting professionals and orthodox practitioners interested in the approach. Other administrative staff may also take part in some of these events. Some practices run regular 'study groups' which take a more active and hands on approach to learning about elements such as specific medicines, illnesses, anthroposophic first aid or observational and artistic exercises.

More general staff meetings are held to discuss the administration and organisation of the practices (other than at the smallest practice, Wallis Avenue). Similarly, smaller groups of core team members had begun to deal more specifically with aspects of financial and organisational development. At Park Attwood and Blackthorn, the development of a 'college' structure has developed with sub-groups that deal with different elements of the work e.g. personnel, training, fundraising and so on.

3.6 Professional networks

Several forms of formal and informal networks were identified, both for specialised fields of work and for the development of anthroposophic medicine more generally. The associations representative of specialist disciplines within anthroposophic medicine provide a forum for practitioners to regularly make contact and further develop skills and knowledge.

Supporting the development of anthroposophic medical work in the UK is the Anthroposophical Medical Trust, (AMT), an independent organisation with a board of non-medical trustees. The AMT was formed to support initiatives in anthroposophic medicine and it provides funding for training in medicine and therapies, supports trainee placements and work on medical legislation. Regular seminars, study groups and working conferences for doctors, therapists and nurses are held which provide an opportunity for networking amongst practitioners.

The Anthroposophical Medical Association (AMA) is the professional body though which doctors primarily have contact. Membership is open to doctors, students, pharmacists and dentists. The AMA is based at Park Attwood Clinic but co-ordinated by several members across the UK. It forms a branch of an international organisation, based in Switzerland, dedicated to the study and research of anthroposophic work. A regular newsletter and journal keep members informed of research and development in both the UK and abroad. There are frequent training events for members.

Doctors practicing in anthroposophic medicine have the opportunity to network primarily through the activities of the AMA in the UK and Europe. The lead GP's have regular contact with one another and with other anthroposophic doctors in the UK and abroad. They also have increasingly strong connections with orthodox colleagues. In most cases the GPs had made efforts to make their work transparent to other members of their local PCG in the form of presentations and open days.

The nurses and massage, art and eurythmy therapists are represented by separate associations, which are at different stages of development regarding membership requirements, protocol and codes of ethics. The associations form a central point for networking as well as training opportunities for members. Each association organises annual conferences and short courses for updating and developing practical skills. Some have regular newsletters to keep members up to date. Membership varies relative to the number of practitioners in the United Kingdom – for example, around 20 massage therapists regularly attend the annual conference whereas around 60 nurses attended their last meeting. As the groups tend to be quite small, they also form quite close-knit networks, who are in regular contact and provide additional support and advice outside the local therapeutic teams. Some meet regularly with others to develop specific aspects of their work or anthroposophic medicine in general. These networks also extend to colleagues working in the rest of Europe and many practitioners had close links with colleagues abroad.

At the time of the research, there were no plans to establish an association of anthroposophic counsellors. Approximately twenty practitioners, who work in primary care settings and who have some training in anthroposophic counselling, meet informally to develop their work. The group would like to develop the meetings further in a way that is not exclusive to other disciplines. Alongside this, counsellors have specific training backgrounds and may already hold membership with Associations linked to that field or to counselling more generally, such as the British Association of Counsellors (BAC).

Staff from the seven centres meet on a regular basis to co-ordinate elements of their work and to exchange information about treatments and therapeutic programmes as well as research and development.

4 REFERRALS

This chapter describes how patients come to be referred for anthroposophic treatments. It focuses first on the different methods of referral and the nature of the referral process. It then goes on to explore the criteria used to assess patients' suitability for anthroposophic treatments and the factors affecting their effective up take-up.

4.1 Sources of referral to anthroposophic practices and practitioners

A distinction needs to be made between patients who are registered with one of the anthroposophic GPs and who are referred either within the practice by another GP or from outside the practice. Although, for patients registered in the practice, this distinction can become blurred, it makes an important initial difference in how patients start anthroposophic treatments. Registered patients will be treated anthroposophically by their GPs as an ongoing patient at the practice, although they will need to be referred for other therapies and treatments. Other patients need some mechanism of referral to begin their anthroposophic consultations and treatments with GPs. It is this latter group with whom we are principally concerned in this section.

The analysis of medical records show that the majority of patients are referred either by another GP within the general practice or belonging to the same PCG. Once referred, the anthroposophic practitioners will take responsibility for patient care, either generally or for the specific condition for which they are referred. This is often negotiated with the patient's own GP with whom they are encouraged to remain registered.

Medical and professional referrals

Other doctors or health professionals may refer patients to anthroposophic practices. This can occur through:

- *External GP referrals:* These most often come from general practitioners belonging to the same Primary Care Group. External referrals often occur with patients who have chronic illnesses or conditions, particularly where orthodox treatments have been ineffective in the past. In some cases, patients are referred for specific conditions, in other cases for more general assessment.

- *Consultant referrals:* Orthodox consultants who are aware of specialist treatments offered by anthroposophic practices may also refer patients for treatment (for example referrals from consultant oncologists for mistletoe treatment).

- *Professional referrals:* Other types of health professionals such as community psychiatric teams and psychologists may also refer patients to anthroposophic medicine. Again, this is usually to treat specific conditions such as schizophrenia or acute depression.

In broad terms, patterns of referral differ with the three types of practice identified earlier (i.e. *synchronised*, *unified* and *dedicated*) but also because of the stage of development the practice has reached. In the case of Blackthorn, a *synchronised* practice, patients receiving anthroposophic medical care are divided between local list patients and external referrals in the ratio of about 3:1. In two of the three *unified* practices, the majority of anthroposophically treated patients are on the local list. In the two *dedicated* practices, all referrals are external.

The two exceptions are Camphill and Wallis Avenue. Camphill, a *unified* practice, is now beginning to have a high rate of external referrals through other GPs as well as self-referrals from Aberdeen and the surrounding area (see Chapter One). Wallis Avenue, a *synchronised* practice, has no external referrals because the practice devotes its scarce anthroposophic resources to the local list.

Chart 4.1 shows the percentage of external referrals, as identified from the medical records examined at each practice. The column showing the type of external referrals is based on qualitative data from the interviews with professionals in each practice.

Chart 4.1: Sources and extent of external of referrals to each practice

PRACTICE	TYPE OF ORGANISATION	PERCENTAGE OF EXTERNAL REFERRALS	TYPE OF EXTERNAL REFERRALS
PARK ATTWOOD	*Dedicated*	100	GPs, SELF, MEDICAL
MYTTON OAK	*Dedicated*	100	SELF, MEDICAL, PROFESSIONAL
BLACKTHORN	*Synchronised*	25	SELF, MEDICAL, PROFESSIONAL
WALLIS AVENUE	*Synchronised*	0	
HELIOS	*Unified*	0 *	SELF (rare)
ST LUKE'S	*Unified*	2	SELF
CAMPHILL	*Unified*	31	MEDICAL, SELF

** The figure relating to external referrals to Helios does not account for patients who are seen separately in clinics run at the practice specifically for cancer, Autism and ME.*

Self-referral

General practice patients may request specific therapies or treatments, including anthroposophic treatments. Patients interested in particular anthroposophic treatments may therefore refer themselves to a trust or foundation that provides these services. People who come to anthroposophic practices via this route usually hear of the services informally via word of mouth and contact the practices directly to enquire about the referral process.

4.2 Process of referral to anthroposophic practices and treatments

4.2.1 Methods of introduction

Medical and professional referrals

When an external referral comes directly from another health professional, a letter of referral is usually required. This may simply set out information and issues raised during some initial contact, such as a telephone conversation between professionals:

Having a referral letter and the notes is…a good reference point. I think asking them to write a referral letter also focuses their thoughts helpfully on why they're making the referral so it's…quite a useful process. It also gives me something to respond to…I can try and marshal my reply in the context of the way they've made the referral, so it's quite an important document really. (Lead GP)

In the *synchronised* practices, patients of non-anthroposophic practitioners may either be referred directly to the appropriate therapist or to the anthroposophic GP for assessment (depending on the degree of familiarity the referring GP has with specific treatments). These types of referrals within practices are generally less formal and rely upon a discussion or a brief note between colleagues.

Self-referral

Patients not registered with the practice who enquire directly about services are commonly asked to obtain a letter of referral from their own GP. The purpose of this is to gather information, facilitate liaison and clarify responsibility for treatment with other professionals involved in the patient's care. However, in some cases, patients may simply be requested to write a letter referring themselves to the anthroposophic practitioners. Whichever the approach, patients remain registered with own general practitioner throughout treatment.

The situation is somewhat different for patients registered with the practice. They may approach an anthroposophic practitioner directly regarding specific treatments or, in some practices, are able to re- refer themselves directly to therapies which they have had previously.

4.2.2 Initial consultation with the anthroposophic practitioner

After a patient has been referred to an anthroposophic practitioner, their suitability for anthroposophic treatment must then be assessed. This assessment is usually made after a long and detailed consultation between the patient and the anthroposophic GP.

Externally referred patients generally have a lengthy initial consultation with the anthroposophic practitioner lasting anywhere from forty minutes to over an hour. With internally referred patients from other partners, practitioners may feel they already have sufficiently detailed information about the patient gained during their previous encounters with them. However, they may still feel that more in-depth consultation is necessary. Anthroposophic GPs would also normally require this sort of consultation with patients who are new to the practice.

The aim of the consultation is to gain a more holistic understanding of the patient and their circumstances and how this relates to their physical state. The practitioner is therefore interested in the patient's overall constitution (i.e., physical, mental, spiritual), their life history and their medical history:

The anthroposophic method tries to develop a picture of what that constitution is first of all at a physical level then at a temperament level and then beyond that in terms of the spiritual nature of that human being. What's unique about them? What's their adulthood beginning to look like? What's the golden thread of their life, is it visible? ….. the attempt is then to have a comprehensive and integrated picture of those various levels….(Lead GP)

As might be anticipated, the way this information is gathered varies to some degree between practitioners depending on their background, training and personal style. However, patients are typically invited to begin by telling their 'story', guided by appropriate questioning. The practitioner then asks about their medical history, biography and constitution. Some practitioners also use a pro-forma designed at Park Attwood, for recording information from this initial session.

Medical information

In addition to a letter of referral that provides basic medical information about the individual, patients may also be asked to give their own account of their health and any previous treatment they have had. This is an important means of acknowledging and understanding the patient's thoughts and feelings about their health and medical history:

> *If it's a referral letter I'll often read it to the patient when they arrive which is not a common thing to do in the NHS……I do it because I want… to get a response out of them in respect of their relationship with the referrer ....Are they on first name terms with them…or [do] the bristles rise and there's clearly some disagreement around?…With contentious diagnoses,..... there often isn't complete agreement between the patient and the previous doctors as to what the problem is. So I'll get a pretty quick view on whether there is agreement or not by reading the referral letter out.* (Lead GP)

Biographical information

Information is always sought from the patient on their 'life story', possibly starting from birth onwards. Practitioners are interested in a range of different issues such as the patient's earliest memories, their perspectives on their family life and upbringing, major life events, and their relationships with others. This information is then considered in the light of the medical information available about the patient to enable a more holistic overview:

> *I'm absolutely convinced that if I don't hear the story in a biographical context then I'm not doing anything above what anybody else has previously done. So the first step which I think makes me potentially somewhat different from their point of view, from a consultant or a GP, is making the time to hear their life story with their illness embedded in it rather than separating the two out. So I try to hear it put together.* (Lead GP)

Constitution

Similar to homeopaths, anthroposophic practitioners adhere to the belief that people are born with certain innate tendencies, be they physical, physiological or temperamental. As a package, these innate tendencies comprise the individual's 'constitution'. In attempting to understand more about the patient's constitution, practitioners may ask about a variety of different issues such as: the patient's preferences regarding food and temperature; their bodily functions; their eyesight; their sleep patterns; their dreams; their health as a child; their relationships with others; their perceptions of what others think of them; their particular skills and talents. Using this information, the practitioner attempts to situate the patient in relation to a number of anthroposophic concepts such as the 'disposition of the 'soul' or how the patient exists in relation to the various 'realms' or 'super-sensible bodies'. These ideas are discussed in greater detail in Chapter Five.

4.3 Process and criteria for assessing the suitability of patients for anthroposophic treatment

After obtaining information about the patient from the various sources described above, the GP makes a judgement as to whether the individual is a suitable patient for anthroposophic treatments. Although the GPs identify a complex range of factors in assessing suitability, they can be distilled down to two key questions:

(1) Is there a medical case for pursuing anthroposophic rather than conventional treatment?
(2) Is the patient psychologically able and prepared to engage in anthroposophic treatment?
Given the holistic nature of anthroposophic medicine, focusing on the mind as well as the body, the answers to both of these questions are considered equally important in determining the suitability of the patient for treatments.

4.3.1 The medical case for anthroposophic treatment

Overall, there were basic reasons why GPs felt that anthroposophic treatment may be more suitable for some patients on medical grounds than conventional treatment. These were:

- avoidance of adverse side-effects associated with conventional treatment;
- conventional treatment alone cannot address the range of factors contributing to the condition;
- all orthodox treatment options have been exhausted without success;
- no conventional treatment options exist.

Avoidance of adverse side effects

GPs noted that there are occasions when it is preferable to avoid orthodox medication because adverse side effects are deemed to outweigh the potential benefits to the patient. For example, in the case of mild depression, the use of anthroposophic remedies may mean that conventional anti-depressants can be avoided.

Conventional treatment cannot address the factors contributing to the condition

The GP may feel that anthroposophic treatment is more suitable than conventional medicine if they suspect that the underlying causes of a patient's condition will not be addressed adequately through orthodox methods. Failure to address the underlying causes of illness was viewed as potentially leading to more severe, long-term problems and effectively, storing up problems for the future. The use of anthroposophic treatment, by contrast, was thought to be potentially more effective at addressing both causes and symptoms of illness and thereby provided a more durable remedy:

> *[There are] situations where… if they take a more orthodox approach, a sort of 'fix me quick' approach, then they may be heading for lifelong problems….There may be a sense of them looking to paper over the cracks of say a problem with anxiety or depression,... multiple symptoms, .. of pain or irritable bowel or combinations that are I think trying to tell them something. You know the body's fighting back and…it's probably taken years to get to the point where they're beginning to get physical symptoms…* (Lead GP)

Anthroposophic medicine may also have an important role to play in preventing a further deterioration in health. An example of this is postnatal depression, which may not require conventional treatment if dealt with early on through anthroposophic methods.

> *If you give them one or two massages or three at the most when it's a mild thing you set them off. If it's left and…they go through anti-depressants and psychiatrists and admissions and so on, then of course you've begun to in a way to add another burden to this person's problem.* (Lead GP)

No conventional treatment options exist

In some cases, GPs felt that anthroposophic medicine was medically justified specifically because it appeared to be the only route available to the patient. This was either because they were at the point of having exhausted all orthodox options or because there were no conventional treatment options available for their condition.

Patients for whom the former was the case tended to be suffering from chronic conditions. They had often been referred to the practitioners by external orthodox professionals who had fully investigated the condition but treated it without success. Such patients were sometimes referred to as 'heartsink' or 'stuck' patients and anthroposophic medicine was viewed as a potential means of making progress in cases that had not responded fully to conventional treatment:

He's referred to us specifically because he felt that he was...getting nowhere…despite as much orthodox input as (he – the referring GP) knew how to engage…his scans and orthopaedic opinions and physio and so on had all been to no avail and he was left not only without being helped but really not even with a proper diagnosis…. It was the intractable and severe nature of his pain [that] didn't fit with the investigation findings…. That's a common one that leaves the orthodox fraternity in a bit of disarray because that leaves them wondering where to go next…. You know, a young man who cannot work and is looking at long term disability unless something can be turned round. (Lead GP)

Or Parkinson's disease where it's maybe in a stage where they…don't feel that medication treatment is yet…warranted, and yet they don't have anything else to offer the patient…. And so you get somebody with Parkinson's who's not yet on medication for example [but for whom you will] still be able to do things. (Lead GP)

For externally referred patients, if there are any doubts regarding diagnosis or if the anthroposophic practitioner feels that the condition could be addressed more appropriately with orthodox treatments, they may refer back to the patient's own GP:

I would hesitate to offer people with...middle of the road asthma, for example, intensive treatment here unless they told me a very good reason [that they cannot use] the orthodox inhalers and what have you which are pretty effective in controlling it if not curing it. I'd need to hear from them a major motivation as to why they wanted to go beyond that or indeed why they wanted avoid the orthodox treatment in the first place. Diabetics … who haven't yet learned what to do with their diet and haven't explored the more orthodox mechanisms of treatment..., it would be unprofessional to imagine that they ought to come in this direction before they've explored all of that. So have they done a thorough trawl of what's available already? Not that we're the last line but with certain diseases I would say, as an orthodox doctor, that the orthodox treatments are really rather good and it would be foolish for them (patients) not to hear me say that. (Lead GP)

4.3.2 The patient's ability and preparedness to engage in anthroposophic treatment

Although the active and positive involvement of patients in their own health care may be sought in both conventional and anthroposophic medicine, this is a key issue in assessing whether patients are suitable candidates for anthroposophic treatment. The doctors noted a range of factors that they look for in order to determine whether a patient is 'ripe' for an anthroposophic approach, of which three were seen as central:

- psychologically able to address their health problems
- motivated to actively engage in their treatment and willing to take responsibility for addressing their health problems
- receptive to alternatives to conventional medicine

Ability to address health problems

The patient's ability to engage in their healthcare and to work actively with the GP and their team is viewed as essential to the success of anthroposophic treatment. Where patients are assessed as psychologically unable to participate in their healthcare, they may be deemed to be inappropriate candidates for anthroposophic treatment. Examples of this include patients with active psychosis or sociopathic tendencies.

Patients' motivation to engage in treatment

Anthroposophic GPs tended to look for indications of the patient's degree of motivation to engage actively in anthroposophic treatments. If patients are not thought to be clearly motivated to undertake the treatment, GPs generally felt that anthroposophic treatment was inappropriate for them at that point.

> *My first question is, is a patient having come to the point where he or she asks as a basic question 'What can I do I to get better? How can I understand my illness'… instead of saying or feeling or thinking, 'doctor make me well, doctor give me a prescription to make me well.* (Lead GP)

The degree to which patients are prepared to involve themselves actively in therapies was thought to relate to a number of factors. This included patients' perceptions of the causes of their illness and the degree of control and responsibility they wish to take over their own health care.

Receptiveness to alternatives to conventional medicine

A number of factors were identified as contributing to the degree to which prospective patients are receptive to alternative approaches to healthcare. These included: the patient's prior medical history and their satisfaction with previous medical interventions; their previous exposure to alternative medicine and satisfaction with this; the views of family, friends and trusted health professionals; and the desire for change and impetus to try something new.

Anthroposophic practitioners considered the timing of a referral to be important not only in relation to the patient's medical condition, but also in relation to their motivation, openness to alternatives and willingness to engage in more intensive treatments. GPs felt that there were in effect 'critical moments' at which people were more receptive to actively engaging in alternatives such as anthroposophic treatment:

> *I get a stronger and stronger feeling that the timing issue is very important when you meet people with chronic conditions. There are times in their lives when it's inappropriate to do anything intensive at all and there are some moments, windows of opportunity if you like, where the timing is very good...for them to engage.* (Lead GP)

A desire to find a 'natural' form of treatment that does not involve drugs was cited as another key reason why some patients are particularly receptive to anthroposophic treatment.

> *Or having an antithesis to orthodox medicine, that's actually more frequent: 'I don't like orthodox medicine, I don't like drugs'. It's not that they actually have a sympathy towards anything else they just have an antipathy to things orthodox….* (Lead GP)

Chart 4.3 provides an overview of the factors that the GPs consider in assessing the suitability of prospective patients for anthroposophic treatment. This assessment process acts as a means of filtering out prospective patients who could benefit more from conventional health care, on medical, psychological or motivational grounds, and moving them back in the direction of orthodox medicine. The remaining patients who are expected to be able to derive some benefit from anthroposophic medicine then move forward to treatment.

Although these principles relate quite specifically to externally referred patients, the same is generally applicable to local list patients.

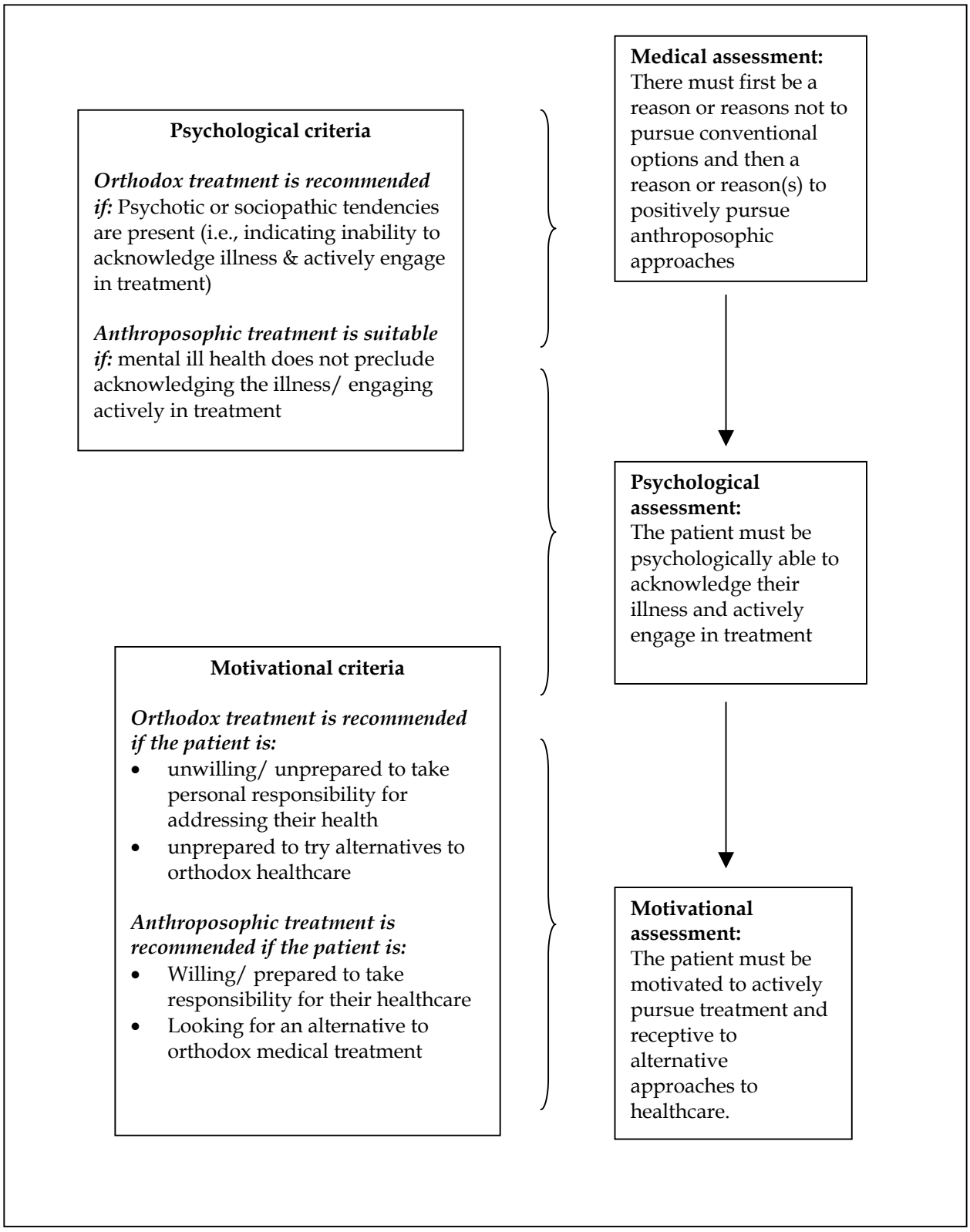
4.4 Strategies for encouraging the take-up of anthroposophic treatment

Anthroposophic practitioners described a range of strategies that they use to encourage patients to consider anthroposophic treatment. This is not so much about ensuring that they accept and respond to an externally imposed prescription, but that they understand and are ready and willing to engage in the treatment being offered.

Gradual introduction to anthroposophic medicine

Depending on the degree of familiarity the patient has with anthroposophic medicine, it may be necessary to slowly introduce them to anthroposophic concepts. Some practitioners described the need to build a trusting relationship with the patient and to assess their state of readiness to engage in treatments before suggesting any specific treatment options. This may be the case particularly with patients who have not sought out anthroposophic treatment themselves.

Chart 4.3 Assessment process and criteria used to determine the suitability of patients for anthroposophic treatment



Making the case for anthroposophic treatment

Patients may also need to be encouraged to see that there may not be a simple solution to their health problems and that conventional medicine alone may not provide a cure. This is especially so for patients presenting with multiple conditions who have not sought anthroposophic treatment themselves. Helping patients to acknowledge the complexity of their situation and the need for a deeper and more comprehensive look at the causes of their symptoms may provide a means to introduce the possibility of anthroposophic treatment:

> *I talk to them about how asthma has to do with breathing and not only with breathing of the lungs but with this whole process of learning to let go…. There are usually also sleep problems. It's also letting go [to go] to sleep…. Once we talk about these kind of things and they begin to understand that there is something which is you know not just a chest problem, they are more open to see that it [anthroposophic treatment] could help them to do something.* (Lead GP)

Exploring the patient's preparedness to engage in treatment

By exploring a patient's expectations and motivations during initial consultations, the practitioner can assess whether the patient is prepared to embark on the treatment being offered. For some patients, the value of anthroposophic treatment may have to be suggested several times before they feel ready or willing to take a non-traditional approach to addressing their health problems. This reflects the point made earlier that there may be particular moments at which individuals are more receptive to the possibility of an alternative approach to their healthcare:

> *For people for whom it's a completely novel idea, and they're quite resistant to it, it might only be after the third visit that they actually then take up the suggestion positively…. People…do sort of move on and become open if one doesn't try to sort of force the issue.* (Lead GP)

Making anthroposophic treatment more accessible

There are various ways in which practitioners described making anthroposophic medicine more accessible to patients. This involved providing further information and reassurances about treatment options as well as suggesting that financial help may be available to those for whom the costs of treatment might be a barrier:

> *I think counselling is very accessible to most of the patients, [but with] some of the other therapies you have to warm them up and explain what it's about….* (Practice partner)

> *And one can encourage saying, well [in art therapy] they won't ask for exhibition pieces from you and so on.* (Practice partner)

Incremental introduction of anthroposophic treatments

Some practitioners also described an incremental process whereby either: (1) trust in the approach is built through the success of initial treatment with remedies or massage, which can encourage engagement in more active therapies; or (2) where one form of treatment is suggested and if that is unsuccessful, an alternative is tried. In this way, patients may become more receptive to new and less conventional forms of treatment as they move through different types of therapy:

> *It's often an evolving process. It may be that initially a patient will come with a problem and expect either a conventional or an anthroposophic sort of medical treatment,.. but if the problem is going on, and isn't something that can be cleared up in one session or something, then I think they're much more open then to feeling that massage or movement therapy or something other of a more on-going nature could be helpful, and I think that they are then very open to the idea.* (Lead GP)

Respecting patients' wishes

Although they identified a variety of ways in which they encourage patients to take up therapy, the GPs nonetheless acknowledged the importance of respecting patients' own wishes with regard to treatment. This involves a careful balance between offering treatment choices and indicating the potential value of the treatment but allowing the individual the right to decide for themselves whether the treatment is right for them. This principle of respecting patients' wishes also means that people must be given time to think about the options they have been offered and possibly to discuss them with others:

> *In conventional treatment you would very often end up saying well you have to…have this particular treatment now because…the clock is ticking. I would much rather say to patients well think about it for two weeks and, you know, if you've got questions come back and I won't start before you're happy about it and you feel you're okay with it. That time is very well spent….*
> (Lead GP)

5 MEDICAL CARE

This chapter describes the various forms of treatment provided by the anthroposophic doctors and nurses. The primary aim throughout is to consider key features of the treatments provided and the main principles that guide the clinical practice.

5.1 Provision of medical care

The medical care provided by anthroposophic doctors in general practice shares many features of orthodox practice. As Chapter Three highlighted, the degree to which orthodox practice is extended by anthroposophic principles is affected by factors such as the practice population, the GP's training and experience and perhaps most importantly the individual doctors themselves. There were nevertheless key factors in common to the approach taken in the provision of medical care.

5.1.1 Medical direction

Although anthroposophic medicine operates from a team based approach, the anthroposophic doctor works as the central figure, directing the therapeutic process. This is seen as providing a more consistent and holistic approach to patient care.

Patients are generally seen by one GP throughout their whole treatment programme and a fundamental role played by the doctor is as 'overseer' of the treatment package. Being involved throughout, and having an overall sense of each stage of the treatment, allows both development and continuity of care:

> *… the buck always stops with the doctor, and quite rightly so. They need to have the overall view…have all the reins in their hands to…responsibly have an overview of that person's therapy package.* (Therapist)

5.1.2 Treatment rationale

Diagnostic pictures are initially built up within orthodox and anthroposophic medical frameworks through detailed biographies of the patient and some investigation of the patient's constitution. As treatment progresses, feedback from the patients and the therapeutic team is used, sometimes accompanied by looking at the paintings, drawings or sculptures of patients in therapies. Based on this information, the practitioner makes decisions as to appropriate medications, therapies or other therapeutic activities and, crucially, how these individual treatments link into an overall package of care. The anthroposophic framework helps to determine a form of treatment that is highly tailored to individual needs and which should be very responsive to change.

Funding considerations and the availability of services may have some impact on the treatment recommended. An example of this is where anthroposophic injections, (available on the NHS), are used in the treatment of sciatica, where a preference *may* have been to offer one of the therapies (which are not funded).

Reviewing existing medical care is more appropriate to patients who are either externally referred or new to the practice. Doctors will look carefully at any orthodox medication the patient is taking and, if appropriate, liase with the patients general practitioner or consultant.
It was noted that patients with chronic conditions often present with a long list of supplements of vitamins and minerals, which the doctors will seek to rationalise. Other complementary

interventions, such as acupuncture or osteopathy, will also be reviewed and doctors will discuss the suitability of continuation alongside anthroposophic treatments. Doctors and therapists vary in their attitudes to other forms of complementary therapies but in general are supportive of patients' wishes to continue other treatments. Nevertheless, it is important to ensure that other factors that may have an impact on the condition remain as constant as possible to allow a full understanding of the efficacy of the anthroposophic treatments.

5.1.3 Length and frequency of consultations

The length of the initial consultation with new patients averages between 45 minutes to one hour. Slightly less time is usually needed for in-depth consultations with patients known to the doctor where information has been built up over time. Either way, the doctors, as the first point of contact for treatment, play a significant role in introducing and explaining the treatment and/or the concepts of anthroposophic medicine in a way that is accessible to individual patients. This is especially important with new or referred patients.

Subsequent follow up appointments are generally shorter than initial sessions, but also vary in length of time and frequency according to several factors:

Patient factors

Where patients are well known to the practitioner, fewer reviews may be needed. Conversely, new patients generally need more time to familiarise themselves with the practitioner and his or her approach. The frequency of consultations may also increase when patients are in periods of quite intensive therapy. Information from therapists themselves is important in highlighting the need for fewer or additional reviews depending on the patient's response to the therapy.

Condition factors

As in all forms of general practice, the nature, severity and recency of the condition will have an impact on the frequency of GP consultations. Hence patients in an acute phase of illness, those with severe symptoms or those with newly acquired conditions are likely to be most closely monitored. A common example is severe depression where doctors may step up the number of reviews, even if they can see the patient only briefly, (i.e. for ten minutes per week).

Organisation of services

The development of *dedicated* services has allowed for a more structured appointments system for medical reviews. Patients of the Mytton Oak Foundation are generally seen four times, at any stage, throughout their treatment programme. At Park Attwood Clinic, residential patients are seen approximately three times a week. In *compound* and *unified* practices, medical reviews tend to be less structured.

Follow-up interviews

Follow up generally takes place after 'blocks' of therapy, which can be anywhere from 3-12 weeks. The desire to incorporate systematic recall varies amongst doctors, as the value of monitoring progress has to be carefully weighed against the demands of a busy general practice. Often the opportunity to review therapies may be taken during general practice consultations when problems are ongoing, or when other illnesses or symptoms arise. One of the *unified* practices has now adopted a system where therapists remind their patients to return to the GP to increase their involvement in the therapeutic process.

5.1.4 The functions of regular assessment

Review sessions provide the opportunity for the practitioner to check on progress and adjust treatments and also to provide an element of care and support for patients.

Clarifying therapeutic goals with patients.

Doctors are able to discuss with patients what is and is not achievable within the treatment programme. This is particularly important, for example, for patients with cancer where doctors are very clear about not offering a 'miracle' cure and the focus of treatment is more geared towards enhancing the quality of life. Patients may take some time to accept such conclusions and doctors need time with their patients to ensure that their expectations are realistic. Review sessions also provide time for doctors to discuss with patients any areas which they are unsure or unclear about relating to their treatment.

Medical assessment and treatment

Doctors monitor the progress of patients through feedback from them and from other members of the team involved in their care. Based on this information, the practitioner will assess whether treatments need to be adjusted or whether there is a need to introduce something new into the programme.

Focus on specific areas/topics

A review session may be planned specifically to focus on particular issues. For example, at Mytton Oak, the practitioner works in close co-ordination with the massage therapist over their shared interest in diet and nutrition. The underlying principle here is that if patients are nutritionally depleted this will limit the efficacy of any treatments they receive.

Facilitating patient engagement

Building trust with patients is important in heightening the patient's engagement in, and uptake of, therapies. Consultations provide an opportunity for the practitioner to establish if the patient enjoys, and can relate to, the therapy and whether they are finding a way of working with the therapist. Doctors will actively encourage the uptake and continuation of therapies and will make every effort to get patients 'onboard' with their treatment.

The doctors also utilise a variety of techniques to enhance awareness or facilitate the process of change. Some of these have been learned through orthodox training but several are quite specific to anthroposophic medicine and stem directly from the work of Rudolf Steiner. The most frequently cited examples were observational exercises, which are detailed in the description of art therapy later in this section. In brief, these encourage patients in the observation of plants and nature to become *'more conscious of colour, growth, death and reality'* and how this relates to the *'natural'* cycles in their own life.

Patient support and facilitation of the therapeutic process

Although the restoration of health is of primary concern, the doctors play a key role in helping patients to cope with their illnesses in the context of their lives. This is most essential with chronic and terminal conditions:

> *And if that person has got cancer and I can see they've got six months and they're going to die that is a very valuable six months for me to be working with them. …It is an exciting time because things can be achieved in six months in terms of inner development which then one has in one's rucksack when one continues which cannot be developed without this…this limitation, this sort of deadline.* (Lead GP)

The doctor plays a key role in helping patients make sense of changes experienced whilst engaging in therapies. These may well be of great significance to the patient and need careful nurturing.

Facilitating patient development

Doctors need a certain firmness and directness in dealing with patients and placing the onus of responsibility for health care and personal development with the patients themselves. By speaking to the patient directly and honestly, the doctor aims to *'re-educate patients in becoming their own 'managing directors" or "captains of the ship."'* This process is considered as a major therapeutic aim: *'It's their body after all'*. The use of metaphors was quite evident in GPs' descriptions of their approach to patients and was confirmed by patients as useful to their development.

Health promotion

During consultations, GPs may educate patients in methods of self-care, as well as preventative and 'first-aid' measure with anthroposophic treatments. This is thought to reduce GP time and prescribing rates etc. The doctors may also encourage patients to attend events, organised by the practice, about general healthcare or those related specifically to their conditions.

Input to content of therapy

Historically, anthroposophic doctors were responsible for giving specific indications to therapists in the treatment of their patients. In more recent times, due to the changing nature of general practice and the development of the therapies themselves, the degree to which a practitioner directs the therapists' programme of treatment is often limited. The doctors demonstrated a great deal of trust in the capabilities of the therapists and therapists felt this to be so.

The content of therapeutic sessions will be a synthesis of what the practitioner and the therapist believe to be the best way to work with the patient. Some doctors have trained in the therapies and are quite keen to give precise indications to achieve specific therapeutic goals, for example, certain movements in eurythmy, or for specific activities in art therapy. Others may not be so specific, but instead point to aspects such as the 'breathing' or the 'uprightness' of the patient.

Liaison with referring practitioners

The GPs are keen to establish a good relationship with other professionals who share responsibility for their patients' care. Where appropriate, doctors will provide the patients' own GPs with regular updates on treatment progress and, if necessary, make recommendations for further investigations or changes to orthodox treatments.

5.2 Medication

5.2.1 The use of anthroposophic medicines

As all anthroposophic doctors are trained in conventional medicine, full use is made of the same spectrum of allopathic medicines prescribed by more orthodox colleagues. The degree and style of prescribing anthroposophic medicines varies amongst doctors according to the degree of experience and training. Similarly, the structure and type of service and patient population influence the extent to which these remedies are prescribed. The percentage of anthroposophic medicines used in the general practices studied was variable, between ten and fifty per cent of all prescriptions. This may be as much related to the degree to which individual doctors make use of anthroposophic medicines as to any differences between patient populations.

There are a wide variety of anthroposophic medicines available which provide practitioners with a range of prescribing options in illness management. Five different modes are summarised in Chart 5.1. Other options could be added as therapeutic activities can be prescribed with or without medication.

Chart 5.1 Modes of prescribing.

Orthodox medicines only	Combination of orthodox and anthroposophic medicines in parallel	Orthodox medicine as an initial form of treatment	Anthroposophic medicine as an initial form of treatment	Anthroposophic medicines only

Orthodox medication only

In anthroposophic general practice, there are many situations where the management of an illness will follow the same pattern as an orthodox approach. Where patients have a preference for orthodox treatment this is respected by the anthroposophic GP. Similarly, where patients are referred externally, it may not be possible to change treatments that have already been recommended by the patient's own physician. In such circumstances, the practitioner may chose to prescribe a therapy to complement the treatment although certain potent orthodox medicines, such as steroids, can impair the efficacy of anthroposophic remedies. Where it is felt that orthodox medications need to be changed, the patient's own doctor will be contacted. If the practitioner is unsure of the patient's motivations for seeking treatment, the decision to prescribe anthroposophic medicines will be deferred until the practitioner better knows the patient.

Where there is a clear medical need, such as in the case of established diabetes, severe blood pressure, or other life threatening conditions, orthodox medication will be prescribed. Similarly, conventional anti-psychotic drugs are used in cases of acute schizophrenia, manic depression or psychoses, whilst conventional antidepressants are used in severe cases of depression, especially where the patient exhibits suicidal tendencies.

Combined medicines

A good example of where orthodox medicines are used in combination with anthroposophic remedies is in the treatment of acute lower back pain. The condition is usually initially treated by conventional medicine with analgesics. Likewise, with sciatica and lumbago, non-steroidal anti-inflammatory drugs and paracetamol are prescribed with advice on appropriate activity or rest, depending on the severity of the condition. However, these may be supplemented with the prescription of arnica lotion to be added to hot baths. If the conditions become more long-term, anthroposophic injections, (made of a compound of remedies called DISCI), can be introduced alongside conventional painkillers to make life comfortable until the remedies take effect.

Orthodox medicine as an initial form of treatment

There are circumstances where allopathic medicines are initially prescribed, gradually reduced and then eliminated with the introduction of anthroposophic remedies. This will often occur with externally referred patients, or those new to the practice, who are already receiving allopathic medicines for a condition.

Sleeping problems, for example, may be treated for a short period with a strong medication, such as temazepam. This will be followed by anthroposophic remedies to treat the underlying cause of the problem. Particularly in cases of externally referred patients, many of whom may be on many different medications for complex and chronic conditions, the GP will often reduce the number of medications if at all possible, prior to prescribing new remedies. Anthroposophic medicines may also follow orthodox options for preventative as well as curative purposes.

Anthroposophic medicine as an initial form of treatment

For many reasons, there is a preference for prescribing natural medicines as a first line of treatment using conventional drugs only at the point where symptoms are recurrent and a more vigorous approach is needed. Prescribing of antibiotics by anthroposophic doctors is usually reserved for serious problems which it is not possible to treat with anthroposophic remedies and where there is need to address the pathology. An example of this is in the treatment of tonsillitis, where a herbal gargle, combined with anthroposophic remedies, is used to provide symptomatic relief and support immune function to fight the infection. The practitioner will monitor progress, and may resort to antibiotics where no resolution has been achieved. One practitioner felt that having 'a foot in both camps' put him in a good position to advise patients, who may be averse to conventional medicines, to accept the times when a more orthodox approach was necessary.

Anthroposophic medicine only

Why not, if costs the same, it works and it's got no side effects? (Lead GP)

A preference for natural alternatives is based on the principle of addressing the cause of illness, rather than merely the symptoms. An example is in the treatment of rheumatism and osteoarthritis where symptoms increase over time and where orthodox treatment, whilst providing temporary relief, may adversely affect the progression of the illness.

Doctors reported that a considerable number of minor ailments could be treated without the use of antibiotics or powerful drugs. Examples include middle ear infection, menstrual problems, allergies, depression and anxiety. The fact that there are many anthroposophic remedies available often makes it unnecessary to prescribe allopathic medication. There are also possibilities to treat acute infections, such as pneumonia, although this would need the back up of a nurse to administer treatment, which may not be possible when resources are limited.

Anthroposophic remedies are particularly appropriate in situations where patients experience adverse reaction to allopathic medication. Furthermore, there are anthroposophic remedies for conditions where conventionally few treatment options are available or may be damaging on a long-term basis – e.g. high dosage steroids for children.

Both doctors and patients reported that a degree of patience was needed with some remedies, where as with others relief can be instantaneous.

5.2.2 Primary factors involved in prescribing anthroposophic medicines

The key principles underlying the medicines themselves and their relation to the higher processes are considered fundamental. These principles are applied at a very individual level and take account of the factors gathered during consultation but may also relate to certain illness 'pictures' and associated conditions. The degree to which practitioners have trained in anthroposophic medicine and their level of confidence in specific remedies are also important factors, as are prior successes or failures with particular medicines. Practical considerations regarding suitable facilities also enhance or restrict treatment possibilities.

Underlying principles

The substances used in anthroposophic preparations are mainly derived from natural plant and mineral substances. Herbal remedies are prepared through specific processes and relate to more traditional herbalism. Others are made up in a diluted form, through a process of potentisation, in the same manner as homeopathy. For homeopathic, herbal and anthroposophic remedies, the aim is to prescribe substances that enable the body's innate healing capacities to work more effectively.

Anthroposophic preparations differ from classical homeopathy in that a wide spectrum of potencies is utilised. Furthermore, practitioners have explored the use of natural substances in a wide variety of ways so as to find their most optimal use, a concept that is also contrary to classical homeopathy and herbalism. An ongoing process of exploring different preparations and seeking an understanding of why each substance works leads doctors to use either different substances, or the same substances prepared in entirely different ways, in their prescriptions.

The underlying principles of classical homeopathy and anthroposophy differ quite substantially from principles of allopathy, where substances are used to produce changes in the chemicals and functions of the physical body. Homeopathy, in contrast, works with the basic principle of treating 'like with like', i.e. a substance can be used to treat symptoms that are produced in healthy patients. Prescribing is based upon matching the symptom pictures of the remedy to symptoms associated with particular conditions.

Plant and mineral substances are diluted in a very specific way through a process of potentisation where the dilutions, in the form of tinctures, are 'sucussed' or agitated between dilutions. The tenet of homeopathy is that, through this process, substances take on a more 'dynamic nature' than simple dilutions.

Whilst anthroposophic medicine adheres to the same principles as homeopathy, there are several quite distinct differences in the way they are applied in practice:

> *… one of the few basis tenets of homeopathy is that you can treat with high dilutions that which causes the same symptoms in low dilutions…. In anthroposophic medicine we try to understand why that is, first of all, and secondly what other consequences that would have….in anthroposophic medicine we use high dilutions in a totally different way than in homeopathy, we use it for totally different purposes and we use totally different substances.* (Lead GP)

Preparations are understood in the light of how they relate to the organism as understood within an anthroposophic framework. The underlying principle of the medicines is that of restoring the natural balance of the physical and super-sensible bodies, as described in Chapter three. This process relates to the mineral, plant, animal and human realms, and the way in which the remedies work to facilitate their interaction, bringing harmony to the system as a whole.

Anthroposophic doctors make extremely detailed observations of a plant or mineral examining appearance, shape, texture, and growth patterns in exploring their potential uses. This has parallels to the 'doctrine of signatures' whereby the physical appearance of a plant influences its use in a physical disease. For example willow bark (a natural form of aspirin), which grows in damp conditions was originally used for problems worsened by damp, such as rheumatism. This concept is extended further in that it is then related to the 'invisible' forces operating within the human being according to anthroposophic principles, such as the three and four fold systems, discussed in Chapter Three. The following explains how these principles apply with use of antimony for helping the individual 'take up' their physical bodies:

Antimony is a real poison just like arsenic...but used in a potency as a homeopath would use it it can be used for all manner of different things…but we in anthroposophy use it for its capacity to draw in the spiritual, the invisible into material and if you look…at antimony the metal it's a very striking, very futurist looking, architecturally built, …it's sort of silver and it points up to the sky in columns which radiate out and it has been built-up, that structure we would say has been built up by particular forces which relate to that metal, that mineral, each metal, each substance has to be built up in a particular way…. It is a really big step of the imagination to think of genes actually sort of managing the shape of things but in modern science we're not really interested in the shape or maintaining the shape…in anthroposophy the shape also has, as everything has, a significance, everything has a significance you can't just leave out blocks because you can't find an explanation. (Lead GP)

What further separates this perspective from classical homeopathy, is that an anthroposophic perspective widens its view to include the influence of other forces, such as cosmological influences and relationships:

Also…the whole picture, the relationship of the metal to the human being, that's all anthroposophic. Practical homeopathy uses metals but they use them in a different way, in a very empirical way, that you give somebody the substance and then you see what effect it has on them whereas perhaps Steiner's way is coming more from a bigger cosmic picture of man and how the metals relate to the human being. (Lead GP)

Thus, rather than matching signs and symptoms to remedies as in classical homeopathy, a more dynamic picture is built in relating remedies to these elements of the human being:

… if you see this, this and this, this group of signs or symptoms, they will prescribe that whereas ours is more, it involves the feelings and the will, the whole human being. (Lead GP)

As with homeopathy, there are typologies that apply to each remedy in relation to the person's constitution and condition. But practitioners also describe holding a more dynamic picture of each remedy to which they relate on a more intuitive level. Doctors emphasised the need to experience what processes are occurring in the person and to have '*a certain feeling of reverence for them of being a unique being*.'

Preparation and administration of medicines

As a result of this diverse approach to the possible uses of plant, mineral, and some animal substances, the ways in which preparations can be made up and administered are vastly increased:

… contrary to, for instance, homeopathy and herbalism we use every possible way that we can think of. So not only orally but also we have a range of external applications of eye drops, of suppositories and an enormous amount of injections. (Lead GP)

Decisions about which types of preparation are used relate heavily to the individual but again rest on the principles relating to anthroposophic medicine:

… to some extent it depends on who we are dealing with, which application we choose and the Noddy's version is that where somebody is obviously well at home in his metabolic system you would primarily…orally. For somebody who's obviously more a nerve sense oriented person you…perhaps go more for potentised or external applications. (Lead GP)

Two of the organisations that manufacture anthroposophic remedies, Weleda and Wala, have close links to the anthroposophic doctors. For some conditions, remedies are made up in specific combinations. Examples of this are 'Menodoron', used for a variety of menstrual problems, and 'Disci' injections used for chronic lower back pain and sciatica type problems.

Conditions treated by anthroposophic medicines

Anthroposophic remedies are prescribed across the full spectrum of conditions and are suitable for acute, chronic or terminal situations. Although not yet widely used in this country, anthroposophic remedies are more extensively prescribed in other countries. The types of conditions for which anthroposophic medicines are felt to be very effective[vi] include:

- *musculoskeletal problems;*
- *immunological conditions;*
- *neurological conditions*
- *chronic pain;*
- *chronic fatigue syndromes*
- *heart conditions*
- *blood pressure*
- *common colds, flu, nasal congestion*
- *arthritic conditions*
- *skin conditions*
- *gastrointestinal problems*
- *mental health problems*
- *menstrual problems*
- *sleep disturbance*
- *post operative care*

Doctors gave quite detailed accounts of the rationale behind the medications applied to these categories of conditions. However, for the purpose of this report, three conditions, which were frequently referred to, have been selected for illustration: cancer, depression and back pain.

Viscum for the treatment of cancer

Viscum is an anthroposophic remedy derived from mistletoe and is a key medicine used for a number of conditions. It is an immune stimulant and is often used in the treatment of cancer. It is also beginning to be used for pre-malignant conditions such as myelodysplasia. It improves energy levels and it is used for conditions like chronic fatigue syndrome. In recent years there has been an increase in studies investigating the efficacy of mistletoe preparations.

In the treatment of cancer, Viscum is used to build up the immune system, unlike chemotherapy, which has a well-documented destructive effect. However, Viscum is most often given in conjunction with the patient's orthodox treatment such as operations, chemotherapy or radiotherapy and it is rare for a patient to have this form of treatment by itself. Other anthroposophic medications and therapies are also sometimes used to address the different individual nuances and symptoms of the disease which results in highly tailored treatments.

The main function of mistletoe, as understood in anthroposophy, is that it brings order and balance between the opposing 'threefold' members of the organism detailed in chapter three, namely sensory, rhythmic and metabolic activities. Disturbances in the opposing effects of these activities, which are both anabolic and catabolic, are understood to be directly related to physiological changes. For this reason it has also been used in the treatment of rheumatoid arthritis.

St. John's Wort and gold for the treatment of depression

Anthroposophic medicines are often used as a first line of treatment for depression. Anthroposophic doctors and their patients are highly motivated to avoid the prescription of orthodox anti-depressants because of the adverse side effects and problems with dependency. Patients with mild depression are prescribed a combined remedy, made up from St. Johns Wort (hypericum) and gold (aurum). Doctors reported a high degree of success in stabilising depression with such treatment with few patients progressing to more orthodox treatments. The doctors explain to patients that the remedy works on a physical level to alleviate the symptoms, that it is by no means a 'miracle cure' and that it needs time to have some effect.

St. John's Wort, as a herbal remedy, has been shown in trials to be as effective as antidepressants. Anthroposophically, it is given in liquid form and includes a potentised remedy of gold. Gold is one of the main metals used in the treatment of depression in both homeopathic and anthroposophic treatment. Its influences are directed towards the heart.

As with all anthroposophic medicines, other remedies and therapies may accompany the treatment. Prescribing is tailored to suit the full range of symptoms and the varied causes of depression.

Back problems

Acute back pain is commonly approached by anthroposophic doctors in the same way as in orthodox medicine, although often with the addition of arnica lotion for symptomatic relief.

Chronic back problems, which include lower back pain, sciatica, muscle and joint pains, are conditions where anthroposophic medications provide increased possibilities for hard to treat complaints. One key remedy, referred to frequently during interviews with patients and doctors, is Disci Comp. Stannum, which is used in the treatment of long-term chronic lower back pain, and sciatica type problems. This is a combination of remedies made up in the form of injections, manufactured by Wala, which are given subcutaneously at the point where the problem is believed to be originating. Injections tend to be twice weekly and can be administered either by a nurse or by a lay person.

Another combination injection, used in the treatment of back pain is Apis and Levisticum. This more specifically addresses inflammatory elements of the condition. Again, this may be prescribed alongside massage.

Practitioner differences

Although doctors train in the prescribing of anthroposophic medicines, much of their knowledge is developed through practice. Practitioners start with remedies that are clearly indicated, such as gold (aurum) and St. John's Wort (hypericum) for the treatment of depression. After that, patterns and levels of prescribing develop through patient and team feedback.

The prescribing of anthroposophic medicines was described as an intuitive process, which is developed over years of training, underpinned by knowledge of the principles of anthroposophy. Some doctors were more willing to experiment and try out various remedies whereas others were content to prescribe those with which they had previous success or that they were relatively confident that they would work.

For other practitioners, learning about the remedies had been a frustrating process and had led to staying either with conventional medicines or remedies that were very familiar.

5.2.3 Other factors affecting prescription of anthroposophic medicines

Availability of appropriate facilities

The degree to which some remedies, such as compresses and oils through dispersion baths, are prescribed is affected by the facilities available to the practitioner. Park Attwood has the advantage of a range of facilities, which enable a broader range of treatments to be offered. In common with the Camphill medical practice, the clinic employs anthroposophically-trained nurses who are able to administer treatments specific to anthroposophic medicine. In other practices, some nurses have started to pick up elements of treatment but this is limited and less a part of general practice culture.

Prescribing alongside therapies

Anthroposophic remedies are often used to complement other therapies with the aim of working on the same problem or symptom but at different levels. For some doctors, it is rare not to prescribe alongside the use of therapies. It was felt that working through two different media served to increase each other's effectiveness. An example of this is the use of injections of Apis and Levisticum alongside massage to reduce inflammation, which increases the amount of work the therapist is able to do.

Breaks in treatment

Breaks in treatment are often given to allow the effects of the medicines to be absorbed. Often the response to treatment diminishes over an extended period and by stopping and later resuming medicines, an enhanced outcome can be achieved.

Side effects and dependency

Anthroposophic remedies are unlikely to have serious side effects and do not create physical dependency. As with allopathic medication, any obvious contra indications such as known allergies or over-sensitivities to specific substances are always taken into account. If a patient reports that they feel worse on any remedy the practitioner will usually respond to this experience and not continue treatment. This was felt to be a preferable strategy to questioning such adverse reactions just because certain effects have not been previously documented.

Availability of medicines

Some anthroposophic medicines are available over the counter from pharmacies and health stores. Others are strictly prescription only and are listed in a section dedicated to anthroposophic remedies in the National Homeopathic Pharmacopoeia. Historically all homeopathic, herbal and anthroposophic medications are available on the NHS in the UK and most of the remedies prescribed continue to be. Attempts to limit prescribing of such substances through European Union directives have been made, which could have considerable implications for the practice of anthroposophic medicine. In the UK, since 1968 some 1600 anthroposophic medicines have been licensed by the MCA (Medicines Control Agency) as PLR's (Product Licences of Right). Considerable work is being undertaken to ensure that the availability of these medicine with PLR's can be accommodated within the European licensing framework.

5.3 The perceived benefits of anthroposophic prescribing

In addition to increased prescribing options, other benefits were felt to be gained through the use of anthroposophic medicines. The most important of these were felt to be:

- lowered prescribing rates for allopathic medicines and hence reduced prescription costs
- increased self medication for minor illnesses thus reducing GP time
- reduced referrals to secondary care

5.3.1 Reduced prescribing rates

Certain orthodox medicines are prescribed less often when anthroposophic medicines are used. Antibiotics are one such example. One *unified* practice reported 90% lower prescribing figures for antibiotics compared with both local and national statistics. Anthroposophic doctors are perhaps less likely to be under pressure from patients to prescribe antibiotics due to the type of patients registered or referred to services, but the doctors also have the advantage of being able to provide an alternative. In one *unified* practice, for example, the GP prescribes antibiotics to less than five per cent of patients with bacterial ear infections (otitis media). Similarly the prescription of analgesics is significantly reduced.

Related to this, one GP reported that the anthroposophic practices may have substantially lowered budgets for prescribing as a whole. The cost of anthroposophic remedies is equivalent to conventional medicines, but the former are generally prescribed for shorter periods. In one of the established *unified* general practices prescribing patterns have been monitored. It has been inferred from health authority figures that the prescribing of orthodox medication is around half the amount prescribed in more conventional general practices. Overall rates are 20% below the local and national rates yet anthroposophic remedies only account for 30% of total prescriptions and overall cost.

5.3.2 Increased self medication for minor illnesses thus reducing GP time

Anthroposophic doctors try to play an educational role in teaching patients how to observe symptoms correctly and appropriately treat straightforward conditions. This is especially so for parents where 'home' medication can increase confidence in future care and promote parent-child bonding:

> *Through contact, through applications, through old traditional forms of applying something which comforts and is helpful…just to say 'go home, it's a viral infect and it'll sort itself out' is very frustrating for everybody involved. So if you can give them hands on experience how to do that.* (Lead GP)

Certain treatments are easily administered and can be quickly learned. Doctors particularly appreciate self-medication during the winter months when surgeries are crowded with colds, flu, sore throats and ear infections. An increase in self-medication was evident in patient interviews. Patients of more established *unified* practices reported that, for minor conditions, they often took over the counter remedies or medication 'left over' from previous prescriptions. A few examples are 'Infludo' taken when symptoms of flu are first apparent, which is especially useful for patients who are susceptible to bronchitis. Arnica was also frequently mentioned by patients in self medicating, such as arnica lotion added to baths for back and rheumatic pain, arnica tincture or cream for sprains and bruises, and a few patients reported taking arnica tablets pre and post operatively to optimise recovery.

Patients or their relatives/friends can be taught to administer anthroposophic injections. Similarly patients can be taught how to prepare and apply compresses:

> *I had someone over the weekend that was worried about their seven year old who suddenly developed severe abdominal pain, I just prescribed over the phone how to do a camomile compress and mix some camomile tea to drink as well and two hours later it was all over….* (Lead GP)

5.3.3 Reduced referrals to secondary care

One of the *unified* practices had monitored their rates of referral to secondary care services and number of hospital beds taken up in comparisons with other local practices were reported to be 35% lower. A specific example of this is in relation to orthopaedic services where referral rates from the practice are said to be one of the lowest in the county.

5.4 Anthroposophic nursing

The roles of anthroposophic nurses are similar to those of orthodox nurses. All must have completed conventional training prior to learning an anthroposophic approach.

5.4.1 Residential care at Park Attwood

The nurses at Park Attwood have responsibility for the day to day care of residential patients at the clinic. An initial session is conducted on the first day to help settle the patients into the clinic and gather information appropriate to their treatment and stay. Physical observations of temperature and pulse are taken and regularly checked throughout treatment. Responsibility for promoting healthy rhythmical function are key to the nurses role as, according to anthroposophic principles, this provides the most optimum climate for healing to occur. Thus, patients are also monitored regarding the regularity of, or problems with, bodily functions, such as urine, bowels and menstruation. Mobility is discussed with specific reference to any problems getting in and out of baths, or if the patient has any special needs concerning the type of mattress, warmth or dietary requirements.

Medications are administered at set times throughout the day, as in orthodox nursing practice, but may also include treatments specific to anthroposophic medicine such as compresses, massage, baths, foot-baths, anthroposophic injections, herbal preparations or teas, as discussed in the next section. These are prepared in the on-site dispensary.

All such treatments are prescribed by the doctors although nurses are trained to take their own initiative in some cases, e.g. when patients are unable to sleep and where a foot-bath or back massage with a therapeutic oil such as lavender can be beneficial. The nurses have usually many years of training with the various medicines and therapeutic treatments and have an understanding of the underlying principles of their use.

Nurses are available 24 hours a day. In addition to the rounds of treatments at set times during the day, patient care involves making patients feel comfortable, checking how therapies are progressing and offering support where necessary. The nurses have a great deal of personal contact with patients not only providing support on physical, mental and emotional levels, but also socially in encouraging patients to take part in the numerous activities that are held at Park Attwood.

5.4.2 Anthroposophic nursing in general practice

Anthroposophic general practice nurses run clinics, like other NHS practice nurses, with the usual functions (blood tests, vaccinations, dressings). Where the nursing role differs considerably is in the application of compresses, foot baths and massage as described below. Where massage and baths are concerned, the role of the nurse was described as been more akin to that of a therapist than nurse. In one *unified* practice, anthroposophic principles are applied to antenatal care and midwifery.

In those practices where an anthroposophic nurse was not available, conventional nurses have generally begun to employ such treatments such as using tinctures, creams, and ointments for cuts, bruises, sprains and so on as well as various teas made from herbal infusions. Many of these treatments involve injections, most commonly for back problems, which can be a major part of the practice nurses work. Although more prominent where anthroposophic training has been acquired, the practice nurse also plays a key role in educating patients in self care or medication for minor conditions such as colds, sore throats and flu and for various 'first aid' treatments common to the anthroposophic approach.

5.5 Specialist medicinal treatments

Another key respect in which anthroposophic medicine differs from orthodox practice is in the use of oils, ointments, lotions, and infusions. These are administered in various forms such as teas, compresses, baths and massage. They may be prescribed and applied both by nurses and by massage therapists. The substances used are made from mineral and plant extracts and, like the medicines already described, are applied using anthroposophic principles.

Teas and compresses

A variety of herbal infusions are made up as teas or as stronger infusions in the form of compresses, oils or juices. They are applied to specific areas of the body depending on the condition. The compresses are prepared by adding the substance to boiling water in which a cloth is soaked and directly applied to the appropriate area. For other compresses a layer of wool and towelling are wrapped over the cloth and a hot water bottle applied to keep the area hot and thus facilitate the uptake of substances.

Hydrotherapy

A variety of specialised baths are used for quite differing effects, administered by either nurses or massage therapists. These include oil dispersion baths, brush baths, 'pyrogenic' baths and limb or footbaths. Additionally, massage therapists with state training in Germany have a specialist training in hydrotherapy. Although none of the sites has a therapy pool the therapists can nonetheless employ techniques specific to this training. Examples are hot and cold treatments to stimulate circulation and leg or arm baths with exercises for broken bones.

Oil dispersion baths

Oil dispersion baths are particularly appropriate for conditions where an element of physical depletion is present. This is because they offer a passive means of applying substances and may be given with the patient either sitting or lying down. The bath itself can last anything between five and twenty-five minutes depending on the patient's energy levels and variations in temperature. Both the temperature and pulse are monitored before, during and after treatment.

The baths are made of wood in order to retain the temperature for extended periods of time. The baths are also quite large so that the patient floats, thus eliminating the forces of gravity which serves immediately to settle postural muscles. The choice of oil, as in massage, varies depending on the desired effect, such as a warming or enlivening and stimulating. Various combination lotions are also used in the baths.

The whole process can last up to over an hour and a half as patients are not dried off but wrapped in towels and large flannelette sheets and rest in bed for at lease twenty minutes to one hour in order that the oils have a chance to be absorbed.

Brush baths and 'water massage'

Brush baths involve the use soft brushes which help to stimulate circulation. For water massage, no touch is involved but particular movement is created in the water by the nurse or massage therapist. This is beneficial for patients with conditions such as high blood pressure or the inflammatory stages of rheumatoid arthritis where massage would be contra indicated. The movement of water allows a diversion of fluid, reducing the areas that are inflamed and congested and providing relief to the patient.

Pyrogenic baths

For conditions where anomalies may be found in the body temperature, such as some cancers (especially of the reproductive system) and immune deficiency problems, there is often an aim to raise the body temperature. The process is quite lengthy and challenging for the patients, with baths lasting up to one hour. The temperature of the bath is gradually increased to above normal to produce a fever by external means, thus attempting to stimulate the immune system. The therapist or nurse constantly monitors the temperature of the bath and the pulse of the patient.

Foot-baths

Footbaths have a variety of uses in anthroposophic nursing and are a convenient means of treatment as they can be carried out anywhere. Either the feet, or the lower part of the legs up to the calves, are emerged in water with various solutions added to the water. A widely used treatment involves the use of mustard which can be used to alleviate headaches, catarrh and coughs.

The oils used by the therapists and nurses are provided by the practices or clinic. Most are manufactured by Weleda or Wala. In the case of Blackthorn, some are prepared from plants from the on site gardens, where the specific substances are infused into a base oil. Normally the nurse has between 10 to 12 pre-prepared combinations of oils, which are regularly prescribed.

6 MASSAGE, EURYTHMY AND COUNSELLING

6.1 Massage

There are two types of anthroposophic massage that have been developed over the last century: 'rhythmical massage' (as indicated by Dr. Ita Wegman) practised by the massage therapists; and 'einreibung' which is a lighter form of massage, based along similar principles, and practised by clinic and practice nurses.

Rhythmical massage is a body massage, where the focus is on generating a general balance to the 'system' as a whole, but also addresses specific problems through working with particular systems and areas of the body. Massage is often the first treatment prescribed for patients because it also provides valuable diagnostic information to the doctor for further treatment. The massage therapist is able to provide important information, not only about the physical condition but also how this relates to the 'higher' dimensions operating within the individual.

Therapeutic processes are highly individualised and based on many factors. A wide range of conditions can be treated with specific techniques for each. The massage therapists vary in the degree to which they utilise techniques from other schools of thought, relating to their own training backgrounds and interests developed throughout their careers.

6.1.1 Diagnosis

Information is obtained from a variety of sources to inform diagnosis and treatment. Prior information from doctors, other therapists and patient records is used together with discussion and observation of the patient and a detailed examination of the physical condition. This information is then reviewed within an anthroposophic medical framework to provide a full picture of the patient on differing levels.

Diagnostic session

The initial element of all massage sessions consists of a brief discussion with the patient but more time (up to 30 minutes) is generally given up during the first diagnostic session to get to know the patient and to gain 'first impressions'. Massage therapists are keen to listen to the patients' own perspectives, experiences and feelings about their condition.

The following provides a summary of the kind of information collected from patients in the early stages of massage therapy:

- ***Medical***
  - medical history, including the length of time the patient has had the illness
  - presenting symptoms including the source, nature and intensity of pain or discomfort
  - how symptoms interact and trigger other effects (especially relevant in chronic conditions)
  - condition of overall well-being
  - function of digestive and nervous systems and cyclical processes (e.g. menstruation)
  - other concerns not necessarily related to the condition for which they were referred

- ***Timing***
  - the stage of an illness in relation to acute, chronic or terminal conditions

- ***Lifestyle***
  - eating and drinking habits
  - sleep patterns
  - physical activities
  - social life
  - relationships between the above factors and subsequent effects on bodily systems and symptoms

- ***Beneficial activities***
  - what helps in combating problems experienced relating to the condition?

- ***Psychological elements***
  - emotional and behavioural aspects
  - connections drawn between patient's emotional responses to their physical condition
  - expectations of treatment

Apart from gathering information, the time spent listening and communicating with patients was reported as beneficial to patients by having 'shared something' with the massage therapist. This may, in turn, facilitate the patient's engagement or willingness to participate in the therapeutic process.

Contraindications

Practitioners are trained to recognise conditions and other patient factors where certain techniques or oils are contraindicated. With some conditions, prior information is essential. An example of this is with cancer where over stimulation of the lymphatic system may adversely influence the spread of disease. Similarly, problems identified by the doctor, such as a bad reaction to previous massage therapy or an aversion to physical touch, will be taken into account by the massage therapists. Therapists are keen to gather other important diagnostic information such as x-rays and scans that would influence the choice of technique or intensity of treatment.

Diagnostic massage

The first treatment consists of a light massage that is more a general assessment and treatment of the whole back, abdomen, legs, arms and extremities. Approximately thirty minutes is taken for the massage, which is ideally followed by a twenty-minute rest period. Throughout the massage the patient is kept as warm as possible, with only the parts of the body being massaged exposed and blankets wrapped around the patient after treatment. This allows a healthy distribution of warmth throughout the body.

Information is gained from a number of observations which take account of the appearance, form, texture, fluidity and differentiation throughout the body of the following elements:

- skeletal proportions and functioning
- 'fluid' systems
- quality of skin, soft tissue and muscle tone
- lymphatic system
- major organs
- warmth organisation, (distribution and type of heat, relates also to circulation)
- rhythmic system (e.g. breathing)

These factors are merged with the information already gained and developed into an overall picture. It is not uncommon for the therapist to discover a fresh 'angle' on the patient's condition, which is especially valuable in chronic conditions. By the end of the first session, the massage therapist most often has a good idea of a diagnosis and therapeutic direction.

Although the main aim of the initial treatment is diagnostic in nature, the massage therapist usually has time for a light form of treatment which itself can be extremely effective. The initial massage is always done lightly, especially with long-term chronic conditions, to avoid too great an impact.

6.1.2 Therapeutic rationale: aims and processes

As with other treatments the therapeutic process differs widely between patients and thus therapeutic goals are set accordingly:

> *I think the most general (aim)… is enabling the individual to be more at home in their body…. So you're trying to create a balancing out of what has, as it were, fallen out of balance. … so something that might be as a symptom of over tight here (upper body)…and losing…access to one's legs…you would try and create more form and vitality (in the lower body) and loosen and warm up here.* (Massage therapist)

Two key elements are directly related to overall therapeutic aims, *encouraging the body's own natural healing capacities,* and *promoting healthy rhythms in cyclical processes (e.g. breathing, menstruation)*. The massage therapist utilises various techniques to facilitate the process of bringing balance to particular functions and the system as a whole.

Physical processes

Massage plays a key role in enhancing physical processes, such as circulation and muscle function. The skin, as one of the major sensory organs, is the obvious point of contact, yet the skills of the therapist enables them to reach much deeper into the organism itself and affect other processes, such as liver, spleen and kidney functions. The following list gives a brief overview of some of the key physiological processes that therapists claim are facilitated by massage:

- increased mobility
- lymph drainage
- improving circulation, relating to the 'warmth organism'
- promoting adrenal function through supporting the kidney function
- pain reduction
- balancing muscle tone
- structural realignment
- reduced tension and promotion of relaxation
- general up-building of the system
- increased energy levels

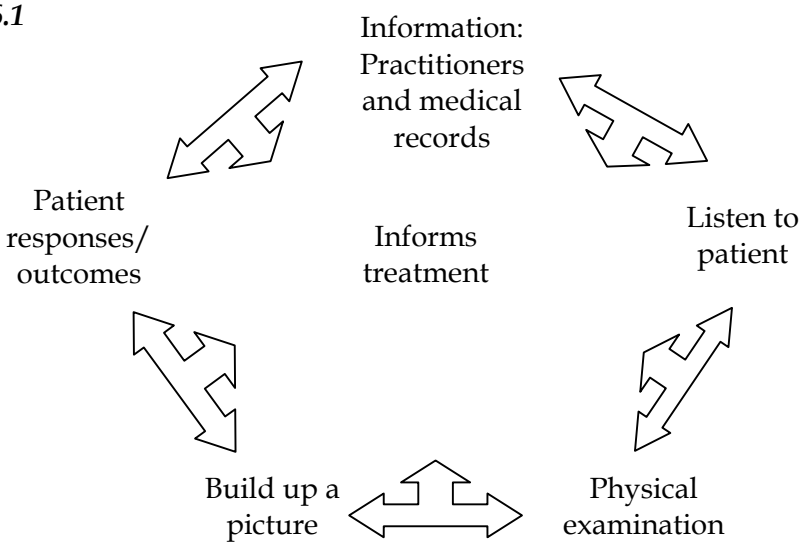
Higher processes

Through achieving balance in physical functions, the therapist is able to influence and connect with the other 'higher' levels to promote greater balance and connection between them. Massage mainly works through the physical and etheric (or life forces) level which can then strengthen the soul (emotional) and spiritual levels (ego organisation.) The treatment of specific organs and functions is reported to be capable of influencing these higher levels.

6.1.3 Therapeutic massage

The massages that follow the initial session continue to be diagnostic to a degree, but the main emphasis is on therapeutic activity. By the third session, at the latest, a well-developed picture has usually been formed and the treatment enters a more cyclical process where feedback from the patient, other staff members as well as the massage therapists' own findings, inform further treatment. Figure 6.1 exemplifies this interplay between information gathered, treatment decisions and patient responses and outcomes.

Figure 6.1



The format of therapeutic sessions is similar to the first, although the time spent talking with patients is shorter, where the therapist asks the patient about their general well being and whether there have been any noticeable changes or any new symptoms since the last appointment. The massage lasts approximately twenty to thirty minutes, depending on various patient and condition factors and the degree to which the therapist is able to 'work' on the patient's body.

Following the massage, patients are wrapped in towels and blankets and left in a darkened room to rest for 15-20 minutes. This part is considered to be an integral part of the therapy, which allows the body time to 'accept' and assimilate the changes that have occurred through treatment. Most practices set a guideline of six to eight weekly sessions, with subsequent follow up sessions where appropriate. The length of treatment can vary significantly and depends on the therapeutic aims and, sometimes, financial restrictions.

6.1.4 Specific techniques employed

Various techniques are applied to address different imbalances that relate to both physical and non physical processes. These are not detailed here but are based around a primary technique of rhythmical kneading where the quality of grip and emphasis of movement are altered to promote differing effects.

Effleurage is also employed and although it is a method common to most forms of massage, it is the direction of movement which is key in rhythmical massage. For example, working with the legs upwards can create a greater sense of vitality and 'awakeness'. Working with the legs downwards is used to 'anchor' patients back into their bodies, as are movements in a figure of eight, referred to as 'lemniscates'.

The part of the hand used by the massage therapist also is alternated according to the desired effect. The fingertips are used to induce a breaking down process to hardened parts of the body. This is employed to knotty areas in the muscles to break down and dissolve the affected area and loosen the muscle fibres. Conversely the palms of the hands are used for more localised treatment to lift the tissue in a sucking motion to induce a more soothing, warming and centring effect. Often the massage therapist will work on one part of the body to create an effect in another. The underlying principle here is common to other forms of natural medicine, that the body is essentially an interrelated system.

Advice and information

When appropriate, therapists will highlight patterns which may exacerbate the patients illness and which can be altered by making patients more aware. Lifestyle changes such as drinking, smoking, eating and exercise may be recommended which are supported and encouraged throughout the treatment programme.

Prescribed exercises and activities

Exercises or activities outside of treatment time are often recommended to patients and are often guided by activities or elements to which the patient has previously related well. These may include footbaths or perhaps limb washes with particular oils to which the patient feels some affinity. The therapist may also encourage patients to carry out observation exercises, such as a walk in nature, or plant observations connected to the oils applied during treatment. The therapists see these additional techniques as important to the patient's development in maintaining the effects of the treatment. With children, parents are often encouraged to continue treatment at home and the therapist will teach parents the techniques and indicate appropriate oils.

6.1.5 Factors affecting treatment

Various patient and condition factors can influence the therapeutic process, both positively and negatively:

- **Medication.** Heavy doses of orthodox medication can 'impede flow and movement' within the system. Conversely anthroposophic medicines were reported to facilitate treatment.
- **Patient responsiveness.** Very ill patients may sometimes be quicker to respond than other patients who have acute but very 'hardened' physical conditions.
- **Energy levels.** Patients who require more energy either thermal or attention wise may require longer treatments.
- **Access to other diagnostic information** (e.g. MRI) can affect progress.
- **Potential to change.** Some patients have very weak constitutions or are very stuck thus limiting the degree of improvement which can be expected.
- **Children** are reported to be particularly responsive, especially asthma sufferers.

Very few cases are excluded from massage and some centres send the majority of patients for massage for diagnostic information. There are, however, several categories of conditions that are considered to be particularly suited to anthroposophic massage. These include:

- **Orthopaedic or musculoskeletal problems** including joint and back pain, broken bones, rheumatic and arthritic conditions
- **Neurological conditions** such as fibromialgia, multiple sclerosis, ME, migraines
- **Gastrointestinal problems** such as irritable bowel, indigestion
- **Circulatory problems**
- **Mental health** such as psychosomatic problems, post natal depression, depression
- **Respiratory problems** particularly asthma
- **Gender specific problems** relating to menstruation or prostate problems

6.2 Eurythmy

Eurythmy is a form of movement unique to anthroposophy and has various therapeutic applications. As the Greek name suggests: (eu) well and (rhythmos) rhythm/motion, rhythm is key to this form of movement, which also makes use of physical and symbolic space. To this end the movements also consist of sequences of gestures that are related to the sounds created in speech. It is thus referred to as a 'visible form of speech.' The type of eurythmy therapy practised in the centres is done mainly with speech. It was consistently described by patients as being most similar to the eastern form of movement, Tai Chi.

6.2.1 Eurythmy therapy

Work begins with very simple exercises that facilitate assessment and diagnosis but which also begin to address imbalances in the physical body. A fundamental role of the movements is to increase awareness of the body, the self and ultimately the surrounding environment. As the diagnostic picture develops, therapy progresses with the use of various exercises which mostly centre around gestures. These are connected to sounds related to the letters of the alphabet, each of which has its own effects (e.g. calming or energising).

The eurythmist selects sounds and movements suited to individual patients and which relate to patient and condition factors. These movements are gradually built up into a sequence, over a number of sessions, resulting in a 'composition', which the patient is encouraged to practice on a regular basis. The movements can be adapted to the patients' own capacities – for example, physically depleted or elderly patients can do exercises whilst lying or sitting.

Eurythmy therapy is mostly done on a one-to-one basis as the treatment is tailored specifically to the individual. However, as certain sequences of movements were indicated by Steiner and developed over the years for conditions such as asthma, cancer and back problems, groups are run for certain conditions. The therapist works with the whole group but still tailors the therapy to individual needs.

Diagnostic session

As with other therapies, the therapist may take up to half of the first session to introduce the therapy and some of the general principles on which it works. Mostly it provides an opportunity for the eurythmy therapist to talk to patients and hear first hand about their background, interests, some medical history, what help they need and their hopes and expectations of the therapy. From this, the therapist will also assess the degree of anxiety surrounding the therapy itself. Ultimately the therapist's goal is to put the patient at ease, reassure them about any concerns, build up rapport and '*get a feel'* for how the session will proceed.

The therapist then assesses the degree of mobility, posture and the way in which a patient moves through initial exercises. These are always designed at a level which the patient is able to perform and are tailored to the patient's degree of mobility. Examples of these exercises are:

- straightforward stretching exercises aimed to give an experience of a sense of uprightness
- breathing exercise accompanied by very simple contracting and expanding movements using the imagination to bring in energy, holding and then releasing in order to gain awareness of movements
- 'three-fold' walking - a basic walking exercise which entails walking back and forth in a concentrated manner

What we call the threefold or the three part walking…which is very rhythmical…I often do it also to see which part of the step is more emphasised. And it's in some ways quite a tool to see if someone is going too fast or never gets off the ground, or goes too far with the step or can't step out. (Eurythmy therapist)

Observations of the patient's posture, breathing patterns, the way they move and discrepancies between the upper and lower body enable the therapist to get a picture of their constitution and functioning. The eurythmy therapist can detect important information through movement and appearance.

6.2.2 Therapeutic sessions

Subsequent sessions are very much a continuation of the initial session, where initial exercises are repeated and built upon, as is the diagnostic picture. The content of eurythmy sessions is individually tailored to each patient and there are quite distinct techniques applicable to specific conditions. Deciding on therapeutic input is not a simple case of matching conditions to exercises but is an ongoing process of getting to know the patient, prescribing a set of movements and then reassessing in the light of changes observed in the patient. Thus treatments are tailored to both condition and patient factors.

The eurythmy therapist paces the sessions to the patient's capabilities and is sensitive to gauging when patients have had enough. Sessions generally last between 30-45 minutes but vary according to individual patient conditions. Both therapists and patients noted that although eurythmy may appear externally to be quite a gentle form of movement it can have quite profound effects on an emotional level. As with massage, patients are encouraged to lie down and relax in a separate room, wrapped in blankets, for a short period following 'treatment'.

Generally, at least eight sessions are recommended which provides enough time for patients to learn a routine that they can practice for short periods on a regular basis. This is seen as crucial to the outcomes achieved and is obviously very much dependent on the capacity of the patient.

6.2.3 Therapeutic rationale: aims and processes

As with all treatments, the overall therapeutic rationale and subsequent processes are very much dependent on the individual patient and relates to a key principle of developing the *potential* of the person.

Physical processes

The combination of movements has a variety of roles, as well as being a gentle form of exercise. These include:

- developing freedom of movement in limbs and torso
- increasing mobility
- promoting healthier breathing patterns
- loosening and releasing tension
- improving posture
- strengthening muscle tone
- gentle stretching, relaxing and movement of unused muscles
- reducing pain
- promoting more balanced ways of movement
- increasing physical strength
- increasing physical vitality

Higher processes

One of the core principles of eurythmy is that movement is a form of self-expression. There is thus a direct relationship between movement patterns, physiology (linking also to the major organs) and the vitality forces of body. In a state of health, a balance between these elements is thought to be maintained regarding the three and four fold systems previously described.

- ***Life forces***
  As well as benefits deriving from gentle exercise, which contribute to improved physical strength, the impact of the movements on the 'life' or 'etheric forces' may facilitate a balance that contributes to maintaining physical and psychological well-being.

- ***Awareness***
  Most people can relate, at least, to the idea of 'inner feelings' such as happiness or being weighted down, hurried or lethargic all of which are visible in posture, non-verbal communication and movement. Activities require patients to focus internally on what their body is doing and feeling which serves to engage them not only physically, but mentally and emotionally too. It was described as *'movement with an inner activity.'* :

  … all the movements are always done with feelings and that's also quite a difficulty for patients to do a movement with a feeling and not just do it like you're doing gym or you're doing some sort of like digging the garden or painting the house where there's no feeling in the movement. (Lead GP)

Increasing the awareness of body and self was reported to facilitate the process of increased inner control and sensitivity to the surrounding environment. In chronic conditions especially, movement can often become quite mechanical and rigid with a loss of awareness and fear of movement, particularly with musculoskeletal problems.

It's a question of being prepared to move, prepared to also think about something and to translate a picture into how you might feel a movement could be, you have to be active. (Eurythmy therapist)

- ***Spatial orientation***
  Eurythmy therapists also stress the importance of the relationship between the self and space. This is further developed to incorporate the meaning and 'quality' of space.

6.2.4 Factors affecting treatment

Degree of patient engagement

Uptake of the therapies is dependent largely on the patient's motivation and willingness to actively engage in the therapy. Similarly, practitioners are aware that the patient's progress will be influenced by the extent to which they participate in the therapy. This most specifically applies to practising the eurythmy routines outside the sessions, which is encouraged by the practitioners and doctors involved in treatment.

Patient's ability and circumstances

Limiting factors that relate to the patients condition and current capacities are taken into account at each session, as practitioners are aware that they can vary significantly from week to week. Movements are thus tailored to the individuals' physical capacity to move whether it is due to limited mobility, tension and fear of movement or fatigue and tiredness. This is always assessed and checked by therapists at the beginning of each session.

Breaks and interruptions to treatment

Breaks in treatment also have beneficial effects, providing that the patient has had sufficient sessions to learn the routines. To this end, most programmes are geared to blocks of eight weeks. Practitioners emphasised, particularly in eurythmy therapy, the need for continuity during these treatment programmes. If circumstances arise where patients miss sessions this can disrupt the process, especially at the beginning of treatment.

Conditions

Eurythmy can be effective with virtually any condition but particularly so with the following:

- heart related conditions including high and low blood pressure
- arthritic/rheumatoid conditions
- respiratory problems, especially asthma
- digestive problems, especially constipation, chronic irritable bowel syndrome
- stress and anxiety related conditions
- depression
- eye problems such as squints, myopia
- diabetes
- neurological conditions such as multiple sclerosis
- sciatica
- musculoskeletal problems, e.g. back and shoulder problems
- migraines
- bed wetting
- drug misuse

6.3 Counselling

Counselling was available from five therapists, employed at four of the practices taking part in this research. Other centres have access to statutory services. All four counsellors interviewed operated, to a greater or lesser degree, within anthroposophic principles although only one had training in biographical counselling, which is specific to anthroposophy. The remaining three, had differing training backgrounds, (see Chapter Three) which include psychosynthesis (transpersonal), pastoral counselling and psychodynamic therapy.

The focus of this chapter is mainly on biographical counselling and the anthroposophic and other principles shared by the different approaches.

6.3.1 Biographical counselling

In biographical work, the phases of development are primarily worked within the principles of the seven-year cycles (as described in chapter three). These stages provide insight not only into personal development but also provide a context for processes likely to occur at particular stages in a person's life. The approach was described as being eclectic, humanistic and *'very much person centred'*.

Most work is done on a one-to-one basis though work with couples and groups is also undertaken. At some centres, 'counselling' groups have been run on a regular basis.

6.3.2 Therapeutic sessions

Initial sessions

Counsellors rarely access patients' notes prior to their first meeting. They prefer instead to talk to the patients without prior knowledge, other than a brief profile from the referring doctor. This then forms a starting point for the initial session in which attention is paid to the patients' perspectives and their requirements of counselling. The content of individual sessions is specific to each patient although there are common features of assessment and information:

- to observe the patients and the subtle and obvious elements of body language and responses
- to meet the person, hear their expectations and issues
- to allow the counsellor to describe their role and the therapeutic process
- to discuss aspects of confidentiality and supervision
- to reflect the main issues back to the patient, the aims of counselling and possible outcomes

Therapeutic sessions

The number of sessions varies significantly between practices and patients. Counsellors also differ in their preference to work in short blocks or within a set time frame, although all offer the possibility of continued sessions. Some patients resolve issues within a very short period of just three to four sessions, others have up to ten sessions, and a minority has more than ten. Patients are rarely seen on a long-term basis, although these are exceptions to this in some of the *unified* practices. Sessions last between 50 minutes to an hour and run on either a weekly or fortnightly basis.

Reviewing the progress of the counselling is often done briefly at the end of sessions, but more systematically at midpoints in therapy or at the final stage of the process. A continuation of sessions is always punctuated by a break of some months. One of the advantages of working in a primary care setting is the potential for informal follow-up through patients other visits to the surgery.

6.3.3 Therapeutic rationale: aims and processes

Anthroposophic framework

The diagnostic framework employed by anthroposophic practitioners is also utilised to a greater or lesser degree by counsellors. This relates to the three and four fold aspects, constitutional and biographical elements and views on illness and well-being.

In biographical counselling, therapists are trained to work at the level of the 'ego' and 'higher ego', and to explore how the illness is affecting the 'soul life' and practical elements of day to day living. One key therapeutic goal is to 'create a vehicle where a conversation between the two can begin.' Emphasis is paid to 'engaging the ego' and 'awakening' something within the 'healthy part' of the person to effect change.

Often the focus of therapy is very much in the present and biographical work is not considered appropriate in all cases. Exploration into a patient's biography may be avoided in certain situations where the patient is 'not ready' to explore events, such as with patients who had previously unexplored issues resulting from abuse.

Detailed biographical work entails an examination of past events in a way which provides a sense of continuity and a way in which patients can come to terms with the difficulties encountered in their lives:

> *… because they have a chance to actually look at the whole…story book for themselves in a new way because it's a long story and not just segments and actually having to speak out a number of these very difficult moments which before are unspeakable…and therefore it makes them less scary.* (Counsellor)

The point of examining background information was described as a process of acknowledging past experiences as a *'building stone for further development'*.

The developmental stages provide a framework for counsellors to assess the patient with regards to the quality and nature of issues the patient faces:

> *… you're focusing in terms of that person developing and if something major happens then that's more like a part of us that's a bit wiser and has a bit more clue about the plan, our sort of blueprint with which we come to life and say, "Okay, you're not .. on the right track,…let's put that illness…, or that meeting or that redundancy…as meeting resistance and how you're going to grow through that, like grass comes through the tarmac." So you're looking more for where some development has been stunted and maybe can be done at a later stage…and where development maybe shot too far out and you're saying, "Hang on a minute", you know, "you've become so intellectual, how about developing other forces?"* (Counsellor)

Within an anthroposophic perspective, illness is seen to relate to constitutional factors which may offer insight into other influences. Ill health can also be seen positively within an anthroposophic framework, for example as a means to 'stop us in our tracks' to facilitate a change on some level. Patients are encouraged to look at the meaning behind events, illnesses, deaths and so on and to look at the more positive gains from such experiences.

Active counselling role

An important feature of anthroposophic counselling is that of active listening and 'being fully present'. This involves reflecting back issues to patients, whilst avoiding interpretations which are influenced by the counsellor's own values, attitudes or beliefs.

A common element, which was described by one practitioner as 'an underdeveloped aspect of counselling', is the active role taken by the therapist in the process. This relates to features of approaches such as cognitive behavioural therapy (CBT). An example of this is in presenting patients with alternative and more positive perspectives:

> *I feel it's sometimes my task to put quite particular views down so they get a different perspective on the whole thing. I think in a lot of counselling people say "It all has to come out of the purse",…and it all has to be self reflective but I think sometimes it's very healthy…to actually take whatever is going on and showing it from a different angle…that very thing that often is tremendously helpful for people, so that's quite an active role.* (Counsellor)

Technical eclecticism and integrative theory

Each therapist has taken an integrative approach to their work and common to all are the basic concepts or 'working hypotheses'. These relate strongly to an anthroposophic approach. Key to this is supporting something inherent in the patient rather than 'picking things apart'. The role of the counsellor is seen as working alongside patients in helping them to 'manifest who they really are'. To further this, each counsellor has developed techniques drawn from varied disciplines, such as

NLP as well as anthroposophy. One quite striking commonality was the use of visual imagery in developing more positive pictures of situations and responses to events. In some circumstances, patients may be encouraged to extend this visual element artistically through painting or drawing.

Other more diverse approaches include introducing patients to others with similar conditions, plant observations, keeping a journal, setting a different rhythm in one aspect of the patients' life (such as brushing their teeth), writing with the other hand, meditation, thinking and memory exercises.

As with other therapies, exercises outside of therapeutic time may be given to counterbalance the problems encountered by the patient:

> *… when people feel totally overwhelmed by life I might say "Okay now take just one area in your house, just one windowsill and make that nice every day as a sort of…reminder of a feeling good"…it feels good to have one beautiful thing in a total mess and it takes a lot of effort to actually make that windowsill nice when you think your life is a mess and you are a mess. … when you actually work with a different habit to shift something that's totally stuck.* (Counsellor)

Therapeutic process and aims

Therapeutic goals are very much bound up in the needs of individual patients and these influence the direction and pace of the therapeutic process. Overall aims were referred to as a process of facilitation, attempting to increase patient's awareness of their behaviour, in order to make sense of, and accept, experiences that have influenced their lives. This in turn helped form connections with present circumstances and develop the strength needed for future situations and events. Fundamental to an anthroposophic approach, and shared by all counsellors, was the emphasis on examining and developing the existing qualities and potential of each patient and developing congruence in perception.

Counselling was described as a 'process of integration' i.e. of integrating events and circumstances into the patients life as a whole. Often these experiences are linked to the patients' conditions and the ramifications of ill health on other aspects of their lives.

The patient's outlook and approach to life was reported as key to the therapeutic process and goals. For example, for those patients who are referred to as 'copers' the therapeutic goals may relate more to issues of accepting vulnerability and developing the ability to cry. Thus work would be very different in cases where the patient is not so strong or confident and for whom the therapeutic goals would be more about finding inner strength:

> *… some people have a stronger inner strength than others…. Others you have to, it's like a little pilot flame and you have to take the bellows and…like a little boy scout fire, blow and then a bit more wood and a bit more.* (Counsellor)

Factors relating to the condition similarly influence the therapeutic rationale. The counsellor can, for example, look for triggers that worsen depression and identify patterns of illness so as to work towards prevention or delay of onset.

6.3.4 Therapeutic applications

Counselling was reported as appropriate to a wide variety of physical conditions, especially with chronic and terminal illnesses where issues are raised relating to aspects of the patient's life. Helping patients to deal with illness, associated symptoms and aspects of death and dying are

commonly dealt with in counselling. Counselling may be especially appropriate where a connection can be drawn between physical conditions and psychological issues such as pre-depressive symptoms of migraines.

As counselling works on a conscious level it requires a certain degree of awareness on the part of the patient. Within the anthroposophic concept of developmental stages, twenty-one marks the age at which an aspect of the self is able to take 'command' and be developed to full maturity:

> *There's no point in giving counselling to a child…they still need to be led in a way. I mean you might to a teenager but it's very, it's very clever counselling with teenagers because they also are not in their own command. Twenty-one is the time when the captain really has command of the ship and needs to leave the harbour and then can begin to make decisions properly about what they're going to do and you can counsel at that level*. (Lead GP)

> *… people who are in deep crisis but who have a sense that this is what life's led me to, you know. Yes this is a crisis but I can kind of already see where it's come from, I'm in the depths of despair here, can't really see out of this pit. They're often wonderful to counsel because it's a turning point, you know, you're actually meeting them at one of the biggest crises of their life and in a sense that's one of the biggest opportunities for change.* (Counsellor)

The types of conditions or problems that were considered inappropriate to counselling were those which required quite specific input, such as psycho-sexual counselling, family therapy, alcohol abuse and behavioural problems. In such cases patients are likely to be referred to specialist counselling services.

7 ART, MUSIC AND OCCUPATIONAL THERAPIES

7. 1 Art and sculpture therapy

The key activities in art therapy are drawing, painting (with both wet and dry mediums), and sculpting. Techniques and exercises which are specific to anthroposophic art therapy are tailored to the individual and the mediums used are watercolours, pigments made from natural plant colours, pastels, charcoals, pencils and clay. Although a diagnostic element of art therapy exists, it is used primarily to inform treatment.

Therapy is conducted both on an individual basis and in group settings. This is dependent on organisational, condition and patient related factors. Art therapy was described as being an active therapy in the sense that the patients are active participants in the therapeutic process.

Sculpture therapy is a branch of art therapy that has been developed as a separate therapy in more recent years. Only Park Attwood Clinic has its own sculpture therapist. Therapy works primarily with the medium of clay but has a great deal of overlap with art therapy as both use breathing and formative exercises. However, art therapy works primarily with colour and movement while the key focus of sculpture therapy relates more to form.

7.1.1 Diagnosis

Diagnostic session

Patients are initially seen on a one-to-one basis. For those patients joining a group, a half an hour introductory meeting prior to the session is arranged. As patients are often quite apprehensive, the primary aim of initial sessions is to allow patients to feel at ease and familiarise themselves with the therapist and the therapy itself. Some general features are:

- a basic introduction to the therapy and the various mediums and techniques used
- an explanation of therapy format, frequency, review sessions
- obtaining patient preferences or difficulties in working with specific mediums
- collecting information on symptoms and factors related to the condition
- hearing what the patient feels *their* problems are; physical, psychological, social
- establishing what the patient would like to achieve
- building trust and rapport
- gaining 'first impressions' through observations; hear what the patient's voice is like, how walk, move, present selves, e.g. confident or shy
- gaining a sense of whether a patient 'needs to unload' story
- gathering relevant biographical information
- assessing the degree of patients motivation
- checking shared confidentiality is acceptable

Therapists also have leaflets produced by the Art Therapists Association, which offer a general introduction to the therapy. However, they were keen to point out that rather than explaining the therapy too much, they prefer the patient to explore the therapies themselves rather than overly intellectualise the process.

The majority of patients are able to start initial exercises quickly. Where a preference is shown for a particular medium the therapist will take this as an initial starting point or will avoid mediums to which a patient has a particular aversion. Therapists reported that it was less common for patient to have specific requests and generally prefer more direction from the therapist.

Initially, the therapist will select a straightforward exercise designed to familiarise the patient with a particular medium and basic technique and to provide further diagnostic information. An example in art therapy would be the use of watercolours on wetted paper (wet on wet) with either free exercises or simple themes such as portraying rainbow sequences. This medium is easier to handle and more playful thus allowing the patient to experiment with colour and to see how colours relate and blend. Alternatively clay may be used in both art and sculpture therapy to form a simple geometric shape such as a rounded ball. This helps to increase awareness and concentration in the patient through a focused activity.

The key principle underlying these initial exercises is to obtain biographical, constitutional or medical information with which the patient will engage in the therapeutic process. The therapist is able to assess the degree of engagement via body language, degree of concentration, amount of conversation they try and engage in, amount of concentrated effort the patient puts into the picture or clay work. How patients carry out these initial tasks, i.e. how they apply the paint, how well blended the colours are whether the lines are thin and heavy and so on, provide the therapist with information that contribute towards a more complete diagnostic picture:

> *… whether you do a completely free painting or whether you do a rainbow sequence you still see whether they blend the colours well or whether they're in tram lines like thick divisions, whether they put the colour on lightly or heavily…, how they apply the brush to even the palette, do they stick it straight in a colour or do they tickle the edge of the palette…and sort of hardly dare go in the colour and you know you can hardly see it on the page and they've put more and more water on and [say] "doesn't seem to be very colourful you know".* (Art therapist)

> *… you can see a lot how this person approaches the task or if you do a free painting you've got swirls and whirls and snake like forms all over the paper endlessly with no idea about whether this colour looks nice with that colour and its all muddy and then you see lots of action, energy but completely undirected.* (Art therapist)

The initial diagnostic picture is not a static one, but informed by feedback from the patient on their reactions to the activities.

7.1.2 Therapeutic sessions

As therapy progresses, the therapist is able to enhance and develop the diagnostic picture through observation and understanding of the patient's responses to treatment. Often the therapeutic aims are apparent early on in treatment although there are exceptions where more time and greater detail are required. Therapy is very responsive to change and open to alternate directions that need to be taken if necessary.

Patients are always offered a choice of exercises although sessions are most often guided at the outset to achieve greater independence as the therapy progresses. Therapists listen for comments from the patient to suggest something that interests or inspires them and then utilise relevant themes to maximise the patient's engagement.

The exercises are designed to allow the patient to make small steps at the point at which they are ready to take so that progress is tailored to each patient. Initial exercises are designed to help patients to familiarise themselves with the medium and techniques and to build confidence in their artistic abilities. The key emphasis in both art and sculpture therapy is more on the process than the finished product.

Group sessions

Individual sessions permit greater privacy, personal attention and guidance but in group settings the focus remains very much on individually tailored exercises. Whether patients join groups or continue with individual sessions is dependent upon several factors, as is the point at which a patient moves into a group setting. These include:

- intensity of treatment needed
- degree of personal attention required
- length of treatment programme (at Park Attwood patients stay only a few weeks on average, which is not conducive to group setting)
- amount of privacy needed
- whether the patient is able to, or would benefit from, work in a social setting
- level of sensitivity or vulnerability of the patient
- severity of illness
- extent of personal problems that patient may which to discuss

Sessions may be run for very specific groups of patients, such as adults with learning difficulties involved in a local arts initiative. But, mostly the groups involve quite diverse groups of patients drawn from the general practice population.

The number of patients in groups is generally small and in some cases restricted by the size of the room available for therapy. Therapists preferred groups to be no more than five or six people with an optimum of four to ensure that sufficient attention can be paid to individuals and the therapeutic process of each.

Duration of sessions

Individual sessions last approximately forty-five minutes to an hour but group sessions tend to be longer (one to one and a half hours on average). This allows time for patients to arrive, prepare and pack up prior to leaving the session. For those patients who are physically quite weak the sessions may be shorter.

An average 'term' of therapy consists of ten or eleven sessions. Some patients are seen less and others on a longer-term basis. Variations tend to be linked to both patient and condition factors. Group sessions are slightly longer on average, spanning an average of fifteen weeks.

Some patients attend for a longer period, of anything up to a year. Stricter time-scales are employed in those practices where resources are limited. In one centre for example the number of sessions was cut from twelve to ten partly due to finances and partly due to better management of the inflow of patients in relation to other therapies.

Sessions are generally held on a weekly basis although some therapists who hold group sessions encourage twice-weekly sessions. Out-patients at Park Attwood Clinic are also seen on a weekly basis but in-patients tend to have approximately four sessions per week. If a patient is having both art and sculpture therapy the number of sessions for each will be reduced to two or three per week each.

7.1.3 Therapeutic rationale: aims and processes

As in all therapies, art therapy exercises are designed to effect the activity of one or more of the four fold systems and to create balance within the person's whole being. Art therapy was described as providing a means of accessing the emotional life of patients in an indirect way, where the patient can be met on '*neutral ground in the artistic realm*':

> *… as another possible therapy that doesn't need to have words in and which doesn't suck the therapist automatically into a very intense conversation about symptomology or problems.* (Lead GP)

The key principles on which anthroposophic art and sculpture therapy are based include:

- each illness has its own characteristics and different exercises work well with different conditions
- the patients own character and constitution determine how the therapeutic process operates
- responses to therapy or to specific exercises relate closely to responses and patterns in life situations
- the language for communication with patients during therapy is derived from the use of colour and form and more subtle elements of light, dark, warmth, coolness, flow and movement; this often has direct parallels with elements of the illness itself

> *Certain things in the artistic processes are directly translatable into the health and illness picture ... you can talk in terms of a person's balance…whether they're feeling well centred in themselves or whether they're feeling scattered and fragmented. You can talk in art terms about composition and whether that composition is whole or whether it's fractured and fragmented. You can talk in terms of…whether it's a cold illness, a sclerosing sort of illness or whether it's an inflammatory kind of an illness. And you can talk in terms of warmth and coolness in art…you can use the same terms all the time so things that manifest and appear in illness conditions…have got a direct correspondence in the elements that are part of artistic processes….* (Art Therapist)

The patterns displayed in art therapy allow the therapist to gain an understanding of the patient's situation and to select exercises that relate to the development needed:

> *… it enables a person to work directly on those things. So whether a person is working with light and dark, black and white, warmth and coolness, flow and movement, stillness, fixity, form, rhythm, arhythmical, symmetry, asymmetry, all has a bearing on what may be taking place in the illness process….* (Art Therapist)

Common to all patients is the translation of these elements into an 'imaginatively based journey', facilitated by the therapist, which relates to the patient's development and growth needed for change:

> *… it relates to the imagination in both the person who's the patient and…my imagination. So part of my task is helping that person unfold a journey which will last over varying lengths of time…, which is imaginatively constructed [and] which allows them to translate things, aspects or components of their overall health and illness picture into something that they can work on, pictorially or form wise.* (Art Therapist)

The exercises are built up so as to guide patients through various phases of development and are paced quite specifically to the needs and abilities of the individual. In acknowledging that parts of the process may not be easy for the patient and that they are working in 'uncharted territory', therapists are keen to find a balance between activities that are enjoyable and 'nourishing' for the patient whilst providing appropriate challenges and opportunities for change.

As in all therapies, a key way of working is to balance the patient in respect of their natural tendencies, as illness tends to produce imbalance. For example, in artistic terms, a person with inflammatory conditions may paint hot colours as a direct expression of their illness and continuation in such a manner would reinforce the illness. Instead, attention and energy is redirected away from the self and into more positive elements through the colour or form or drawing. Change is achieved by redirecting attention and energy away from the direction of the presenting conditions.

Central to the patient's development is an understanding of, and engagement in, the process. By engaging in creative production patients may begin to learn a new 'language' which enables a different type of 'dialogue' with themselves. Bound up in this is the ability to reflect which is developed directly through the process of the exercises given:

> *… the process of doing and reflecting…can be quite a moving experience…some patients begin to feel that they are learning to talk to themselves again, not in words, in a different language which ultimately is a nourishing, life giving, confidence building, waking up process.* (Art Therapist)

7.1.4 Specific techniques employed

Two key types of exercises shared by sculpture and art therapy are formative (relating to elements of the forming process of the etheric body) and rhythmical (related to breathing and the three-fold system). This section briefly describes some of the techniques employed with reference to the type of effect sought and how this relates to patient and condition factors. Patients often move from one type of exercise to another as the therapeutic aims are adjusted according to the progression of the patient.

Watercolours (wet on wet)

Watercolours are broadly applied to wetted paper, which allows greater freedom of movement and gives the patient an immediate experience of the colours and how they may be blended and harmonised on paper. Colours are selected to suit each patient and the desired effect, for example yellows to stimulate and bring patients out of themselves or blues to calm and 'centre' patients. The results are quite effective and rewarding as images can be created quite quickly. Such exercises are helpful for patients in a weak or fragile state and were reported to have an enlivening effect on the emotions.

Veil painting

'Dry' or 'Veil' painting techniques involve the application of layers of paint to dry paper with pauses in between each layer to allow the paint to dry. The time in between these layers is intended as a quiet 'reflective space' where patients can stand back and absorb the work and focus in the present moment. These pauses are intended to develop patience and encourage those with an intensity of intellectual or emotional activity to slow down. This technique was reported as working more directly with the elements of form to bring clarity to patients' thoughts and to encourage more reflective behaviour.

Plant and mineral paints

Special paints prepared with plant and mineral extracts are used to produce more natural and subtle colours and scents which increase patients awareness. Exercises with this medium are more challenging for patients in that the work is more subtle, where layers of paint are used to build colours. It is used in situations where increased sensitivity and awareness form part of the therapeutic aims.

Clay work

Exercises with the use of clay are used in both art and sculpture therapy and relate specifically to the formative processes associated with the life forces. One type of exercises involves forming different geometric shapes in sequences that provide the patient with a sense of development and recognition of the ability to change.

Observational Exercises

Exercises outside of therapy sessions tend not to be widely encouraged, especially during the initial stages of therapy. Patients are more likely to be given observational exercises, where they are encouraged to observe aspects of nature regarding colour, shape, texture or form. The therapeutic aim is to increase awareness in the present moment and to produce a calming effect.

7.1.5 Conditions suited to treatment

Patients who are referred to art therapy span the whole spectrum of ages and conditions with a great deal of overlap with sculpture therapy (approximately 80% of patients could be treated in either therapy). Several conditions were reported as particularly appropriate to these therapies:

- compulsive/obsessional disorder
- anxiety
- depression
- psychotic disorders
- personality disorders
- panic attacks
- exhaustion
- sleep disorders
- anorexia
- chronic fatigue syndrome
- cancer
- multiple sclerosis
- drug rehabilitation
- asthma
- diabetes
- recovery from illness
- eczema

7.2 Music Therapy

Music therapy used in the centres relates closely to Creative Music Therapy and specifically to the work of Paul Nordoff and Clive Robbins who initially developed their work with children with physical and learning disabilities, and later extended it to other patient groups.

Patients are seen on either a one-to-one basis or as part of a group. The principal instruments used are: the hand lyre (a hand-held stringed instrument) and a range of percussion instruments and small flutes. The therapist normally accompanies patients, often by piano, and a key method used in individual sessions is improvisation. This allows the patient to build up the range of musical expression and provides an immediate musical experience. The main focus in therapy is on the 'flow and meaning' of the music rather than the accuracy of playing.

7.2.1 Therapeutic sessions

Initial session

Therapists and referring doctors are sensitive to the fact that patients can be intimidated and overly worried about not having any musical experience. They therefore approach sessions in ways suited to individual patients.

Often the first instrument introduced is the hand lyre as it is immediately accessible and requires no skill or musical ability to achieve a sense of creating music.

> Very quickly you get a sound that most people will deeply recognise as musical…. It's something in the quality of the tone. And if they're tuned to a major or minor chord, this is familiar ground. I didn't get any wrong notes. And it's terribly simple. (Music Therapist)

Other patients may be shown the range of instruments available and given the opportunity to play whichever appeals the most. The key aim of the initial session, as throughout therapy, is to engage the patient, which involves a flexible and imaginative approach on the part of the therapist.

Patient responses to initial sessions and the way that they approach exercises provide important information for therapists. Central is the degree of *'musical logic'* demonstrated by the patient, from which parallels can be drawn to aspects relating to the patients condition and personality (see therapeutic rationale). In brief this is the degree of sensitivity a person has to the rhythm, tones, tempo and feeling of the music:

> *… a feeling by conventional harmonic standards is something we all have in our ears, no names for it, we know when it feels like a piece has ended, whether it's pop music or jazz or and we know when the ending leaves us up in the air and we've reached one of those spots, virtually everyone does, that's nothing to do with musical training, if we have ears, if we have hearing, we're surrounded by it and those things register so lightly, hardly at all….* (Music Therapist)

Subsequent sessions

Patients are initially seen on a one-to-one basis but most move into group sessions as therapy progresses. Occasionally this occurs after just one or two sessions and is dependent on the patients' suitability to working in a group setting.

The instruments, exercises and style of play are tailored to the individual and, as with other therapies, are dependent on factors relating to the patients medical background, constitution and biographical factors. The principal aim of the therapeutic sessions is to engage patients in actively creating music themselves, though in some situations calming music may be played initially to relax them. On rare occasions the music therapist will play to the patient but most often the therapist accompanies the patient.

Sessions last approximately fifty minutes and are generally on a once-weekly basis. The average length of therapy is around twelve sessions over a period of a few months.

Group sessions

Music therapy lends itself well to group settings. The social contact provided for patients is particularly appropriate for patients isolated through their illness (a phenomena frequently observed in chronic conditions). As will be discussed, a key feature of music therapy is that it provides a form of communication between individuals and groups, which makes it particularly suited to patients for whom this is a problem.

7.2.2 Therapeutic rationale: aims and processes

There are three main principles that underpin the form music therapy might take: the relationship between music and emotion, achieving balance, and developing communication and personal/social contact.

Influence on emotions

The idea that music can strongly influence emotions and feelings is widely acknowledged. In music therapy, these effects could be described as being mapped out in a way that makes the impact on emotions accessible to both the therapist and the patient.

Achieving balance

Specific instruments and exercises are selected to address and produce a change within these elements and to address imbalances within the three-fold system of 'head pole', 'metabolic pole', and the 'rhythmic system'. An example of this is those patients with too much mental activity (e.g. schizophrenia) where the natural effects of music can be employed to draw attention away from the head and into the body. The nature of music was described as having this capacity in itself, which relates to what is referred to as 'musical logic'.

As described in art therapy, the principal methods used aim to balance the patient in respect of their natural tendencies, which in ill health were reported to be imbalanced. Similarly in music therapy exercises are focused in the opposite direction to the patient's natural tendencies. Instead, attention can be redirected from 'unhealthy' patterns into more positive elements through the creation of music. Through an awareness of feelings, patients are able to move 'beyond rationality' to 'deeper spiritual issues'. This was also an element which was particularly suited to terminal conditions, helping patients prepare on an emotional and spiritual level.

Developing communication

As with other artistic therapies, patients can develop another 'language' that provides a different form of 'dialogue' for the patient. In music, this language has the key components of rhythm, tone, tempo, and so on, which can directly affect elements relating to the three and four-fold system. This creates opportunities for patients to express themselves, develop skills in communication such as listening and responding appropriately and can provide a 'bridge to opening up communication' on a verbal level. In so doing, patients can develop the way that they relate to others.

Ultimately the key therapeutic goal, common to all patients is to bring them into what is termed 'musical creativity'.

> *… bringing the person into real music is the central thing. Actually getting a person actively responding musically out of themselves.* (Music Therapist)

7.2.3 Instruments and techniques employed

Instruments

The three main types of instruments used are hand lyres, small flutes and percussion instruments. The lyres are quite specific to anthroposophic music therapy. As a lyre is small, light and held in the hand, it allows for a freedom of movement, which can be used to change the tone of the music whilst played. The lyres are particularly easy for patients to be 'musical' with, and allow people to work in groups as it is relatively simple to create harmonies.

Although not specific to anthroposophic practice, small basic flutes, similar to recorders, are used. The flutes are responsive to breath and thus was described as being closer to singing than playing a musical instrument per se. A full range of percussion instruments is also used including, drums (African djembes) and cymbals. The drum and cymbal are capable of producing a wide range of sounds that contrast well.

The choice of instrument used partly relates to features of the instrument and their likely effects. For example, the flute is quite high pitched and 'felt' in the head when played and thus suitable for patients who have a propensity to overly think. At the opposite 'pole' of the anthroposophic three-fold framework, the drum may be selected as a means of working up to the 'musical' or 'rhythmic centre' for those patients relating too much to 'form'. Lyres were reported as being able to work across all levels, in part due to the wide spectrum of sound they are capable of producing.

Improvisation

One of the principal techniques employed in music therapy is improvisation. This allows 'dialogues' between the patient and therapist to be built gradually from single tone responses by adding tones to form more complex patterns. By imitating (a kind of musical mirroring), responses to the tone and quality of the music, communication is developed between patient and therapist. Improvisation requires a spontaneous and explorative approach that for many patients is beyond the scope of their everyday experience, habits and patterns of behaviour.

Prescriptive exercises and activities

When the therapist feels benefit would be gained from more input than once a week, patients are encouraged to practice routines based on the exercises from the therapeutic sessions. With percussion, instruments are not necessary as rhythms can be tapped out by hand.

7.2.4 Conditions suited to treatment

Music therapy principally relates to the development of the 'soul-life'. This makes it suitable to patients with chronic and terminal conditions, which can be of either a physical or psychological nature. Generally conditions where patients need to calm down the degree of mental activity and those with little direct access to their feelings are also ideally suited to this therapy. Similarly, it is well suited to people who have problems in communicating and relating to people on a personal level.

7.3 Occupational and social therapies

Each organisation is at a different phase in the development of what is termed 'social' therapies such as gardening, café's, and craft groups. The occupational project at the Blackthorn Trust has the most fully developed services, made possible through statutory funding, and has in turn enabled the development of greater opportunities for fundraising and development. The activities of the project are fundamentally based on anthroposophic principles and informed by research into similar projects already operating in England, Holland and Sweden. This section describes the work carried out at Blackthorn, as an example of how the more socially oriented therapies have been developed within a strongly anthroposophic framework.[16]

Approximately sixty patients (referred to as co-workers) were attending at the time of the research. Half are referred through local mental health services with which the trust has built strong relationships. Patients are assessed by one of two doctors at the trust who are then available to advise on medical aspects when needed throughout the patient's time at the project.

The remaining patients, who have a wide range of predominantly physical conditions, are referred to the services by GPs at the practice.
Patients are initially shown around the facilities and can, to a large extent, choose the activities on which they would like to work. These include:

- gardening, including work in the greenhouses
- café, including, preparation, baking, cooking and serving
- crafts and preparation of oils and other products sold in the café

Patients spend between a half to four days a week involved in activities at the project. Although patients are not formally assigned a key-worker, staff team-members and leaders have close contact with patients on a regular basis. For example, they may attend regular review sessions with the patients and other professionals involved in patient care at the trust and take responsibility for alerting the therapeutic team to any issues that arise regarding patient care. The project leader attends the regular therapeutic team meetings where any issues arising from particular patients can be discussed with doctors and therapists in the team.

7.3.1 The patients

A wide range of mental and physical problems are appropriate to garden and occupational therapies. At Blackthorn gardens, half of those who attend the project do so as part of a complex care programme involving multidisciplinary teams and are considered either 'at risk' or have regular relapses, such as psychotic episodes involving hospital stays.

These patients fall into two distinct groups of older patients who have had a history of long-term hospital care, some of whom need a considerable amount of individual attention. The second group is made up of younger patients from the practice who have conditions where there is a need to either stabilise or come to terms with an illness.

Among those from the practice population, approximately half have predominantly long-term physical problems, some with associated psychological and social difficulties. These include conditions such as; MS, chronic fatigue, cancer, Parkinson's disease and those with limited mobility due to accidents or severe back problems.

There are also a number of patients with non-specific illnesses, often with elements of anxiety, who frequently attend GP appointments and who find difficulty in coping with everyday life. Others are people with mental health problems such as long-term depression who have their illness treated and monitored within a primary care setting.

7.3.2 Therapeutic rationale: aims and processes

The therapeutic nature of the project is felt to derive from a number of key features:

- the inclusion of patients with long-term physical problems thus avoiding a 'mental health culture'
- the creation of a 'normalised' environment
- providing work experience with an emphasis on quality of work and produce
- team working
- involvement of the local community

The rationale behind such an approach was developed to relate strongly to anthroposophic principles. The initial starting point was how to address the isolation often encountered by patients with severe long-term physical and mental health problems:

> *They fall out of work, their involvement with life becomes very limited often, and the days are the same, seven days a week if they're not involved with other things… They are cut off from life, cut off from work, and cut off from the community and their friends reduce, their family has difficulty with it, many they can't find employment….* (Project Director)

A core principle of all the therapeutic work is to engage those aspects of the patient that are, despite illness, considered 'healthy'.

> *… our starting point should be that we engage that what's healthy…and to bring the illness and pathology more to the background…and challenge that through work.* (Project Director)

In so doing the aim is to avoid the disruptive patterns of behaviour that can occur with mental health problems, particularly in institutional settings.

The opportunity to be involved in work that make a contribution to the wider community helps towards building patients self-esteem and respect. There is also an emphasis on quality which enhances that engagement.

> *… the quality that it can be sold, not for charity, but that we are as good a restaurant in town, as good a nursery in town and…consistency in everything we produce. Because…if you put a qualitative output as your focus then the process of that will follow…and in quality outcomes people have to bring their attention to it and engagement. They can't just do it routinely. And we felt that that is the way to… call on their individuality…of that what is healthy in them to get more and more engaged.*
> (Project Director)

Each area of the project works as a small team, involving patients, staff and volunteers, and which provides a supportive social context. The fact that the gardens and café are open to the public offers opportunities for patients to socialise and gain further support through the local community thus addressing the problems of isolation and stigmatisation that can be encountered in long-term illness. The project thus offers wider opportunities for patients to engage in the usual activities and interactions of day-to-day living:

> *… their horizons of life again open up and they can be involved, they can hear about other things and have conversations and go to the pub and have birthdays and…festivals and start to look at nature and things, all aspects of ordinary life. And so to colour that up…where beauty plays an enormous role, but also reading, activity, having meals together and things like that.* (Project Director)

The decision to develop a garden project was in part related to land made available adjacent to the practice. However, the three elements of garden, bakery and café were selected quite specifically for their contribution to healing and individual development:

> *… the land offers all kinds of opportunities and so if we grow our vegetables then you can work with the concept from land to table. And so in the morning the kitchen will say, well we have this menu, once a week or once a fortnight the gardeners will tell which crops are there and need to be eaten. But on the day itself the cook will say well we need this, this and this…. And so someone goes out and picks it in the garden…in the kitchen it's prepared and two hours later, three hours later it's all served. So there is that whole connection.* (Project Director)

The therapeutic aims for those patients with long-term mental health problems, often institutionalised for many years of their lives, differs somewhat from the younger patients referred through mental health services. The former group was described as needing to be 'carried' much more in terms of ongoing support and a regular working environment. For younger patients, the issue is of coming to terms with the illness and thus the project tends to provide more of a wider network of support where they can gain confidence and trust in taking developmental steps.

Concerns were expressed at the time of the research that the time needed for planning, reviewing and developing therapeutic aspects of the project were being overtaken by the demands on the service that have grown through its success and popularity. The proposed resolution to this was to have a period of time to evaluate how staff increases, combined with a reduction in the quantity of work, could be achieved in the future.

8 THE PATIENTS

8.1 Profile of patients receiving anthroposophic treatments

The following table provides a summary of the data collected for the medical records analysis as detailed in chapter one (1.3.2). Data was collected on a total of 492 patients.

Table 8.1 Summary of data collection figures

Practice	Year period under analysis	Total number of patients *	Total Sample (50%)	Number of patient on which data was analysed (%)
Park Attwood	01/01/98 - 31/12/98	161	80	72 (89)
Blackthorn	01/09/97 - 31/08/98	412	206	178 (86)
Wallis Ave	01/01/98 - 31/12/98	46	23	23 (100)
Mytton Oak	01/01/98 - 31/12/98	116	58	47 (81)
Camphill	01/01/98 - 31/12/98	74	37	33 (92)
Helios	01/01/98 - 31/12/98	121	60	56 (92)
St. Luke's	01/01/98 - 31/12/98	192	96	83 (86)
Totals		**1122**	**560**	**492 (88)**

** The total number of patients included those patients receiving therapies or treatments as trust or foundation patients. In* unified *practices, only those patients who had received a therapy were included in the sample.*

Comparison with national general practice

We have combined data from the anthroposophic practices. Despite the differences in location and the variation in how anthroposophic treatments were combined with other care or services available within the practice, demography of patients getting treatments, the consultation rate and the range of patient conditions were similar across practices.

Here we report these patient characteristics and make some comparisons to national general practice data. This analysis is not extensive because denominator data from the practices is not available and comparisons between patients on special treatment programmes and total patient populations from national data are of limited value.

8.1.1 Gender, age and occupation

Gender

72% of patients receiving therapy within anthroposophic practices were women, compared to 51% of general practice consultations nationally.[17]

Age

The largest group of patients attending for therapy in 1998 was aged between thirty-five and fifty-four years (42%). 23% were aged between fifty-five and seventy-four, and 15% between twenty-five and thirty-four. 8% percent were aged seventy-five or over and 8% aged 18 or under.

Table 8.2 Age of patients

Age Group	Number	Percentage
1-10	21	4
11-17	20	4
18-24	17	4
25-34	71	15
35-44	102	21
45-54	105	21
55-64	63	13
65-74	49	10
75-84	33	7
85+	6	1
Total	**487**	**100**

Occupation

Data on occupation was recorded from medical records and was only available for approximately one third of all patients. For the purposes of classification, last or current occupation were grouped together as 'last recorded occupation' and coded using the Standard Occupational Class categories from the Office of Population, censuses and surveys, 1990.[18] If a patient' s occupation had been recorded as 'housewife' this was included in 'other occupations'. If a patient was unemployed, on sick benefit or a student this was also recorded. The category 'retired' has been excluded; if a patient's last recorded occupation was also available this was included. As many of the anthroposophic practices did not record patients' occupational status this data does not accurately reflect the occupational status of patients attending for therapies. However these figures give some indication of the socio-economic status of particular patients.

Table 8.3 Occupation of patients

Occupation	**Number**	**+Percentage**
Managers and administrators	5	4
Professional occupations e.g.health and teaching professional	36	28
Associate Professional and technical e.g. science and engineering, health associate	14	11
Clerical and secretarial occupations	14	11
Craft and related occupations e.g.skilled construction, engineering trades	10	8
Personal and protective service occupations	6	4
Sales e.g.buyers, brokers, sales reps.	4	3
Plant and machine operatives	3	2
Other occupations including housewife, other occupations in agriculture, forestry and fishing.	25	19
Unemployed or on sick benefit	9	7
Student	4	3
Missing	328	
Not included in analysis	34	
Total	**130**	**100**

The largest group (43%) recorded were professional: managers and administrators, teachers and associate professionals. 26% were in clerical positions and other skilled jobs. Only 2% were manual workers. 19% were recorded as having 'other occupations', which mostly included women who said that they were housewives. 7% were unemployed or on sickness benefit due to their illness and 4% were students.

Even in the absence of demographic data on the patient populations of the practices, we conclude that there are a disproportionate number of patients with professional and associated professional occupations. This suggests some form of clinician or patient self selection for the therapies associated with higher socio-economic status.

8.1.2 Length of time registered at the Practice

Data were available for approximately 80% of the patients at the anthroposophic centres. These figures exclude Park Attwood, as only the medical records held by the clinic were accessible due to the wide geographic spread of patients.

Thirty-one per cent of patients attending for therapy had been with their practice between one and three years, and 17% between three and six years. Over 50% of the patients had been with their Practice for seven years or more.

Table 8.4 Length of time registered at the Practice

Number of years at the Practice	Number of patients	Percentage of patients
1	46	14
2	39	12
3	16	5
4	35	10
5	15	4
6	10	3
7	173	52
Total	**334**	**100**

Without practice data on patient turnover, it is impossible to judge whether length of registration is associated with likelihood of being referred to therapies.

8.1.3 Number of consultations

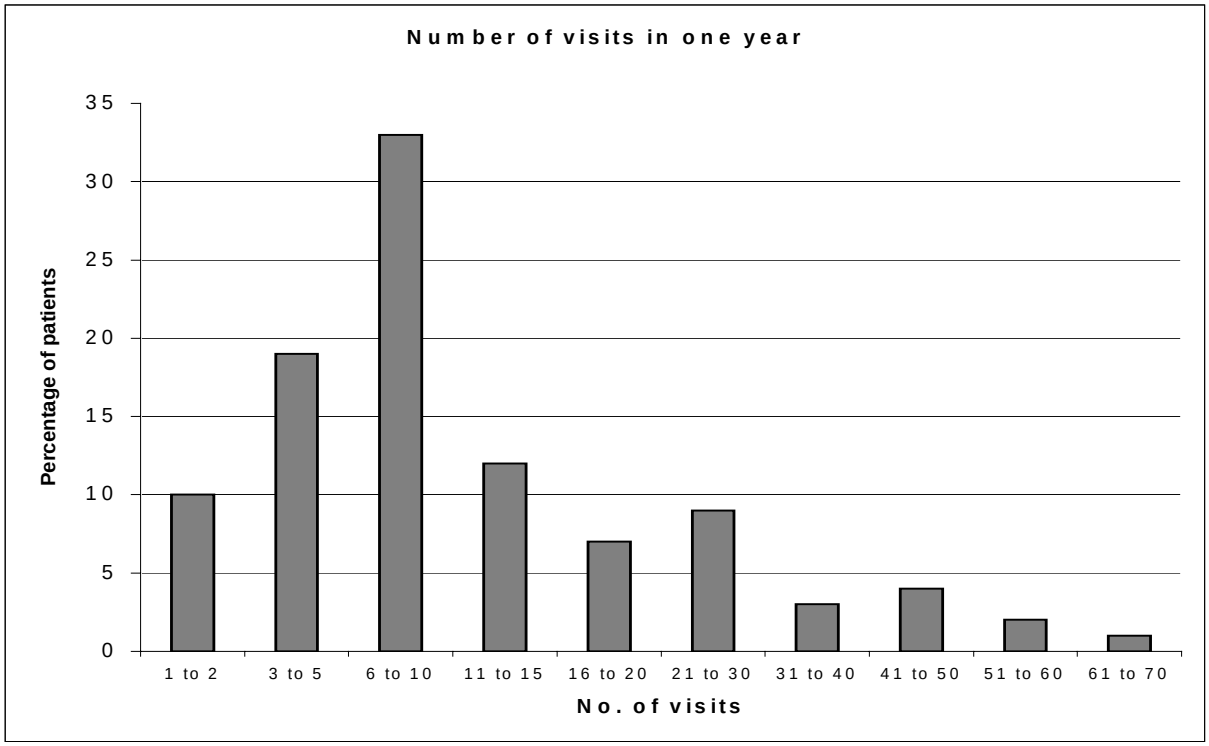
Data was collected on the total number of times, recorded in the notes, that a patient consulted a general practitioner or practice nurse at their practice for seven years previous to the date of commencement of therapy. The figures were then re-calculated to obtain a yearly average. These figures do not include Park Attwood attendance rates, as they are not comparable to the practices consultation rates.

60% of the patients using anthroposophic therapies consulted ten times or less. The general practice fourth national morbidity survey (1991-1992)[17] reported that those that consulted their general practitioner or practice nurse did so on average 3.8 times per year. As can be seen from table 8.5 only about 30% of the anthroposophic patients attended their practice this infrequently. This difference is not surprising: patients referred to anthroposophic therapies are more likely to have chronic conditions and are more likely to consult their general practitioner or practice nurse than other patients.

Table 8.5 Frequency of consultations of patients referred to anthroposophic therapies

Practices	Number of patients	% of practice data	Mean consulting rate/year	Minimum consulting rate/year	Maximum consulting rate/year
All practices	307	73	14.4	.71	143
Blackthorn	106	60	12.8	.71	63
Wallis Ave	21	91	13.4	1.00	34
Mytton Oak	39	83	11.5	1.43	69
Camphill	28	85	18.9	1.29	138
Helios	47	84	13.8	1.14	65
St. Luke's	66	80	17.5	1.57	143

Graph 8.6 Number of visits by patients in one year



8.1.4 Diagnoses

The types of diagnoses recorded were taken from the patients' medical records and thus do not reflect the condition for which the referral to the services or therapies was made.

Diagnoses were recorded using the same classification of conditions as used in the purposive sample or were recorded as 'unspecified' if there were no specific diagnoses given (for example, references to a breast lump but no record of fibrocystic breast disease or cancer). Most patients had one or two different health problems, but a few had a variety of medical conditions. 18% of those patients whose details had been recorded had five or more diagnoses.

The most frequently recorded diagnosis was connected with mental health (20% of all recorded diagnoses). 9% of recorded diagnoses were associated with musculoskeletal problems. A variety of other medical conditions were recorded in the practice notes (see Table 8.7).

These figures cannot be said to accurately reflect the patients' main diagnoses due to the anomalies of coding and recording of diagnoses but they do give some indication of the variety of medical conditions that patients suffered from. Referral to the therapies was not based on specific medical conditions.

Table 8.7 Recorded diagnoses

Diagnosis	No. of recorded diagnoses	% of total recorded diagnoses
Mental Health	272	20
Musculoskeletal	124	9
Gynaecological	94	7
Dermatological	90	7
Surgical	89	6
Neurological	71	5
Cardiovascular	67	5
Respiratory	65	5
Digestive	73	5
Cancer	53	4
Trauma	59	4
Unspecified	57	4
ENT	47	3
Urinary	34	2
Visual	31	2
Endocrine/hormonal	36	2
Infections/viruses etc. (Unspecified)	32	2
Social Problems	11	1
Blood diseases	13	1
Circulatory	15	1
Special needs	20	1
Paediatric	14	1
Idiopathic	7	<1
Auditory	2	<1
Congenital	7	<1
Genetic	1	<1

8.2 Awareness and understanding of anthroposophic practice and its origins

The patients interviewed as part of case study or in depth documentary interviews (see Chapter One) were asked about their awareness of anthroposophic medicine, prior to treatment, and how this had first arisen. Many of the patients were not familiar with the term 'anthroposophic' although some were aware that the approach at the centres was influenced by the work of Rudolf Steiner.

It is possible to identify five different groups of patients in terms of their previous knowledge and of initial receptivity to anthroposophic treatment.

- ***Anthroposophically orientated.*** A small but significant number of patients who belong to *unified* practices had many years of experience of anthroposophic medical care and some involvement with the broader principles of anthroposophy. Previous experiences of treatment meant that such patients were very positive about taking up their recent referral.

- ***Openness to complementary medicine.*** Patients who had some experience of other complementary medicines such as acupuncture, osteopathy or homeopathy were also receptive to the idea of anthroposophic medicine and similarly motivated to follow a programme of treatment.

- ***Orthodox and open.*** Some of the referred patients had a background of purely orthodox treatments but were open to other options. They included people who have explored a number of conventional treatments for their condition and those who have been dissatisfied with orthodox treatments they had received:

  > *Basically, I was sick and tired of the way that I had been messed around by conventional medicine and I thought there has to be something better than this which is not going to…make such demands on the system. I was looking for something a bit more user friendly, shall we say.* (Male, mid-fifties, mental and physical exhaustion)

- ***Orthodox and ajar.*** Some patients had a similar history of conventional treatment history but were more reserved about other approaches:

  > *I suppose its as much for me really to feel I'm doing something because…if you go to the doctors and they say "Oh yes, you've this, we'll give you these pills they'll make you better", you go away and you believe that's it don't you? But when you go and they say "Oh no, can't really do anything", and you think "well, I've got to do something myself" so that was why I wanted to do something…I know it's not going to cure me, but make me feel better or motivate me…give me some sense of purpose or direction or something like that, rather than just sitting there and accepting it year after year.* (Female, late fifties, stress, diagnosis of M.S.)

- ***Orthodox but closed.*** Among the patients referred for anthroposophic treatments were some who had both a history of and preference for an orthodox approach. These patients were often described with reference to the Wallis Avenue surgery where, in general, there had been much less exposure to other forms of treatments than at other practices.

In the main patients in the latter three groups knew little about the anthroposophic approach, although they were generally aware that the doctors and therapists worked 'in a similar way'.

The patients generally were more inclined to relate to the principles that were evident to them in practice rather than information given about the approach. They learned from how they or their family had been treated and the resulting outcomes. In hindsight, some patients had felt that it was appropriate that they knew nothing of the underlying philosophies as they thought this would have made them more sceptical about the approach.

Very few patients outside of the first two groups had been aware of a 'spiritual' aspect of the approach at the onset of treatment. This was especially so for patients who were externally referred to the services. But for some of those oriented to anthroposophic or complementary medicine, the more spiritual elements had been key in their initial attraction to anthroposophic medicine.

There were several sources of information from which patients had gained prior knowledge of the approach:

- relatives and friends
- through the practice they are registered with
- articles in health magazines, leaflets, books
- a previous anthroposophic doctor
- involved in anthroposophy through work or through Steiner schools

Some patients were concerned that the literature given by the practices did not fully reflect the services on offer. They were more impressed by the actual treatment or therapy they received than by reading about it in any leaflet or other literature. Several patients remarked that they felt greater promotion was needed so that more patients could benefit from the services. Patients who had been given leaflets on the structure and running of the practice with brief introductions to the therapy were satisfied with this type of information.

Among those who were from orthodox medical traditions, there was a degree of scepticism about the treatments prior to receiving them. In similar vein, there were also some misconceptions and apprehensions about what might be delivered:

> *I didn't think it would do anything and I hate to say it really because it just worked wonders but at the time I just thought it was a bit of…I don't know it was all a bit sort of New Age you know finding your inner spirit and feeling your energy flows around your body and stuff it was just like, "When are you going to get the crystals out?" Do you know I mean? It was like, I don't think this is going to work….* (Male, late twenties, depression and anxiety)

> *Just the word "therapy" in general scared me off a bit really.* (Male, mid-twenties, epilepsy and heart condition)

An interesting dichotomy was apparent as to whether prior information contributed to delaying or encouraging uptake, which was mirrored in the discussions with doctors and therapists. Similarly, there was divided opinion about the value of information given to patients about the therapeutic rationale.

There were differences between practitioners in the information given to patients about the rationale that lay behind the prescription of medicines. It was reported by some patients to have an element of 'mystique'. Patients familiar with anthroposophic practice were more likely to understand how the medicines worked with regards to both symptoms and potential effects. Patients with very little prior knowledge of the approach were at least aware of what medicines might do. Others commonly referred to anthroposophic remedies as homeopathic and thus had some understanding of constitutional remedies.

8.3 Aspects of patient care

8.3.1 Experience of practitioners and the therapeutic team

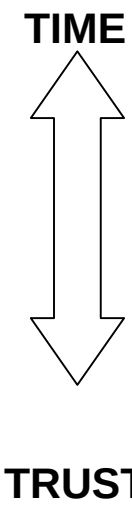
The Doctors

When describing the approach of anthroposophic practitioners, patients often made comparisons with the shortcomings of orthodox GPs. But in both relative and absolute terms, the patients were very positive in their appraisals of the doctors. A few criticisms were made regarding limited GP time, gender bias and abrupt manner in cases. These comments were comparable with comments of other patients on orthodox care.

In *unified* general practices where more than one doctor provided anthroposophic care, patients had tended to select doctors to whom they either personally related; or had chosen a particular person for a specific area of expertise, such as mental health. However these patients were still happy to see any of the doctors at the practice, especially for routine appointments or minor illnesses, although preferred their 'own' doctor for their chronic conditions and for overall responsibility of their care.

Patients new to the approach were often pleasantly surprised by the approach taken by anthroposophic doctors finding it different from previous experiences of orthodox care. Many patients reported a 'feel good factor' after appointments in that they felt more positive than when they went in.

The key aspects of care from the doctors that were favourably mentioned were largely reflective of the areas covered in the General Practice Assessment Survey [19]. The predominant themes were: time, technical care, communication and information, and personal care and support.



Technical care
- Thoroughness
- Knowledgeable
- Increased options and flexibility

Communication and information
- Effective communication
- Information giving
- Information sharing

Personal care and support
- Interest and enthusiasm
- Empowerment and involvement
- Knowledge and understanding

Time

The amount of time spent in consultation was the factor most often compared with experiences of orthodox practice. Patients externally referred or new to the practice were often surprised by the amount of time spent by the doctor at their initial appointment and subsequent sessions. 'Time' related to the patients feeling they were given enough time to discuss their concerns as well as the 'calm' and 'unrushed' nature of the practitioner:

> *I have no hesitation in going to the doctor, he never makes you feel as though you are wasting their time, he's always happy to sit and chat.* (Female, late twenties, bereavement)

> *He's not got the pen there ready (for a prescription) when you walk through the door, he's got time.* (Female, late thirties, gynaecological problems)

> *There's nothing brusque or hurried about him.* (Female, late sixties, myelodysplasia, stress, physical depletion, eczema)

In particular, patients belonging to *unified* practices, whilst being aware of the time constraints of modern general practice, were appreciative that their doctors were prepared to spend time when needed. This was particularly noted in relation to waiting times, which could be long.

Technical care

The most striking feature of technical care mentioned by patients was the thoroughness with which medical and biographical histories were explored:

> *… we talked about all sorts of things because we went right the way through sort of history and sort of both in health and personal, all that sort of thing, because as I said there were some, shall we say, emotional issues which were involved as well, which came to a head later on but nevertheless were sort of not making the situation any easier at that particular point.* (Male, mid-fifties, mental and physical exhaustion)

> *I think I was in there for about 40 minutes you know, they're not like a normal practice, you don't go in and they see you for 10 minutes, give you some tablets and push you out the door, they want to know everything about you, your past history, everything, so they start from scratch so that they get it right the first time rather than making any mistakes…. I felt good about that because I felt like somebody was actually interested and they wanted to get to the bottom of all the problems rather than just giving me a prescription and pushing me out the door, you know, I'm not saying that all doctors are like that but there are one or two that are may be rather over-worked and the hours and you know the stress gets to them as well so they have a tendency to not have the time to spend with their patients….* (Male, early forties, depression accompanied by agoraphobia, stress and hypertension)

A key element in appraising this thoroughness was the connections that could be made between physiological problems and their underlying causes:

> *I think conventional medicine to me is, this is what my wife likes about it, they deal with the symptoms straight away and, well blood pressure, it's Warfarin or some harder drug to control blood pressure. Here they talk about why you've got blood pressure, not just treat it, they try and find out…why is it fluctuating…and the doctor spends time talking to you.* (Male, late fifties, high blood pressure, anxiety and depression)

In the main, practitioners were seen as knowledgeable and flexible in their approach to diagnosis and treatment. Patients generally felt well informed and had been given realistic information about there not being any 'guarantees of cure'. Patients with chronic conditions were especially appreciative of the positive approach taken by the doctors and a sense of hope they gave that not all possibilities of improving their condition had been exhausted:

> *… he gave the appearance of being more positive than my own doctor, I mean Dr (own GPs name) is very good, don't misunderstand me I can't fault the man, but Dr X was far more positive, it was a kind of "Yeah, we can do this" kind of attitude and that's what I need.* (Male, early fifties, fractured vertebrae, osteoporosis, strokes and depression)

> *… just because he seemed to understand and he seemed to have practical solutions and if one didn't work he was quite happy to try another one whereas everyone else just seemed "If that doesn't work I'll pass you on to someone else.".* (Male, late twenties, depression and anxiety)

Value was consistently placed on having both an orthodox and anthroposophic approach combined:

I have to say that was part of the attraction that anthropop doctors are all medically qualified first and then they do the Steiner training so you get the best of both worlds really. (Female, early sixties, sciatica and neck pain)

I think it's a very good balance and (Dr Y) is not set in his ways, he's not anti drugs you know, but he likes to keep things in moderation which I think is very sensible. (Male, late seventies, multiple physical symptoms referred for anxiety and stress)

Communication and information

Patients consistently described communication with their doctor as more of a 'dialogue' or 'two way process'. The approachable and friendly manner of the doctors was frequently noted and often patients were on first name terms. Key factors that patients felt made their doctor a 'good communicator' were the ability to listen, the amount of attention given to what the patient had to say without interruption and perhaps most importantly that there was an obvious element of understanding. Some connected the ability to pitch information at the right level to a sense that there was a thorough knowledge of the patient:

He was very patient because when I talk I tend to waffle. He listened and understood that and that impressed me because very few people can be that patient…I'm never afraid to say to him what I'm thinking. You know if I think, if he says to me "Well, you need magnesium", I'm not afraid to say "Why?" Under ordinary circumstances you wouldn't do that with a GP because you know the answer would probably be "Well, because I said so"… I knew exactly what I was doing taking it on because like I said, that's part of the whole approach, that's what I found very refreshing, talk about it first and then you know "Would you be happy with taking this?"… "Yeah fine, if you think it's going to help." (Male, early fifties, fractured vertebrae, osteoporosis, strokes and depression)

The ability to communicate with and confide in their doctors meant that some patients felt able to discuss things they would previously have found difficult, like drug taking, feelings of depression or anxiety or more philosophical aspects of their ill-health.

Personal care and support

Patients emphasised the level of care and concern that the doctors showed in their consultations and the degree of personal encouragement they gave:

… without his sort of reassurance and his instillation of confidence…just that phone call, you know, I remember that phone call, not…exactly what was said or anything but just the thought of it…in the middle of the afternoon he phoned me up, just because he'd heard I was going through a bit of a rough patch, he wanted to check I was alright and make an appointment to see me and that was just immense. (Male, late twenties, depression and anxiety)

I'm of the belief that people can help themselves and I am at the stage where I've had to depend on somebody to help me and Dr X is providing that. (Female, late sixties, myelodysplasia, stress, physical depletion, eczema)

Patients generally felt that doctors took a genuine interest in their problems. They were also often aware of the tailored nature of their treatment and were struck with the personalised and holistic approach taken:

… you're treated differently even if it's the same symptoms. (Female, early fifties rheumatoid arthritis and stress)

> *… to actually have somebody who was prepared and interested in the whole person rather than just the symptoms and somebody who was actually honest and said you know "It's no cure but you may find it helpful", and to allow you the time and the space to actually experience it is a plus….* (Female, early fifties, Multiple Sclerosis)

> *… he's interested in other aspects of life not just your complaint.* (Female, early thirties, leukaemia)

> *… she remembers everything, she doesn't forget anything, you go back and she's remembered everything she asked you last time….* (Male, early forties, depression, agoraphobia, stress and hypertension)

Patients externally referred to services were particularly impressed with the depth of information covered in consultations. Although this may be experienced by some patients as uncomfortable, because issues not addressed for some time were explored, being listened to and understood often gave rise to a sense of relief. The patients also valued what they saw as the doctors' honesty, straightforwardness and incisiveness:

> *[DoctorX] seems to understand completely, as if he'd read the book about it almost…a lot made sense.* (Male, late twenties, depression and anxiety)

> *He sits and looks at you and listens and he immediately puts his finger on the spot, he's an amazing man.* (Female, late sixties, myelodysplasia, stress, physical depletion, eczema)

Trust

Many of the comments on the doctors were underpinned by a sense of trust in them as professionals. This in turn made patients more likely to accept the suggestions made by the GPs and to increase their involvement in the therapeutic process:

> *I'm definitely going to…go along with exactly what they say because I feel that they've been pretty open with me and haven't forced me into it…or anything.* (Male, late twenties, stress, paranoia and anxiety 'nervous breakdown')

A few patients with quite negative prior experiences of the medical profession reported that their faith had been restored since encountering the anthroposophic doctor. Other resulting factors were feelings of empowerment and involvement in their own health care which was seen as a real benefit by those who wanted to take some control of their illness:

> *… to come to decision together and…to share responsibility for co-ordinating treatment.* (Female, early sixties, MS and seeking H.R.T replacement)

Therapists and nurses

Patients were overwhelmingly positive in their views of therapists and nurses involved in their care. There were noticeable similarities with views about the care they received from doctors, specifically; good communication, knowledge and competence, understanding and especially providing support and encouragement in the patients' progress.

Several patients referred to the ease with which they built rapport and felt able to talk freely to therapists, in some cases, this was felt as very much a part of the treatment itself:

… we have a lot of chats like that so you know half of the art session was really just for you know talking yourself into it, sort of winding down, talking yourself into what you were going to do in the way of water colour painting and…it was almost sort of counselling, a counselling session in itself. But having to quiet yourself down and, you know, get into a better sort of frame of mind….
(Male, early forties, chronic fatigue)

… it wasn't just the massage I found I enjoyed talking to her and I was quite happy talking to her and she talked back, …so it was pleasant, it was enjoyable, it wasn't a chore to go, I enjoyed going and looked forward to going…. (Male, late twenties, depression and anxiety)

The extent of discussion inevitably varied considerably between therapies although there were many patients who had discussed aspects of their care and life in general in the less verbal therapies:

… it wasn't sort of medical chat it was just chatting about my general well being and she [masseuse] was very encouraging…. (Male, late twenties, depression and anxiety)

Very few patients mentioned elements of the therapist's approach that did not sit comfortably with them:

… whenever she felt that I was sort of a bit tied down by traditional values that I was quite happy with…I rather felt with her it was her own hobbyhorse that I didn't like and wasn't really interested in.
(Male, early fifties, cancer)

For a few patients such feelings were more related to initial impressions which were very quickly dissipated through getting to know the therapist:

At first I thought she (the counsellor) was a bit of a tree type…at one with everything and very deep, and I'm not really that kind of person but she came across a bit like that to start with, but no, she was just very understanding…she seemed to know exactly everything that I was trying to say she knew what I meant…. (Female, late twenties, bereavement)

The key elements of effective communication mentioned were giving patients the *space to express themselves* and the ability to *listen* and *understand* what issues were of importance to them:

… they (Eurythmy therapist) listened like my other therapist that I was going to see, that was the treatment, they listened and when somebody actually listens to me I know that's the right thing to do because that's one of my frustrations, I find that I can be saying something and they're not hearing, there's a difference between sitting and listening and actually hearing what people are saying. (Female, early thirties, Musculoskeletal problems, depression and bouts of agoraphobia)

… if you feel that your therapist is understanding you then you feel well there is hope that she will be able to help me and I suppose that's how I've looked at it. (Female, early fifties rheumatoid arthritis and stress)

There was an overall sense that therapists provided information that was pitched at an accessible level, although some patients required greater depth. Patients were generally interested in understanding the connection between the treatment and it's impact on their condition:

I was very impressed with how she talks to you with what you're doing and the movements and thinking about things…and how she taught it, it really makes you think about life differently. (Female, late forties, chronic fatigue)

… probably after one or two (sessions) I began to make some query…it seemed to me that she might be trying to make a little bit of mystique about it and I may be totally wrong…. Just that I felt she didn't really want to actually discuss it in a lot of detail. On the other hand, it may well be she thought I wouldn't have understood it because I think I was sort of asking why did she pay more attention to one bit of me one week than the other and I think it depended on what…she picked up from my feelings. (Female, late sixties, allergies)

Patients developed trust and confidence in practitioners quite often over short periods of treatment, some of the key reasons given were:

- a thoroughness in examining factors contributing to the condition;
- obviously giving time over to thinking through patients problems;
- picking up on symptoms not discussed with doctors, e.g. menstrual problems, arthritis;
- a sensitivity to patients' needs;
- the professionalism and skill involved in their approach;
- offering useful and effective advice.

[The massage therapist] is excellent and he really knows his stuff, not only from the massage point of view but we talked about things like ginger is very good for you and not just for your digestive system. (Male, early fifties, fractured vertebrae, osteoporosis, strokes and depression)

I felt the (Art) therapist…was a serious practitioner of the therapy and I began to develop confidence in her that she knew what she was doing. (Male, mid-fifties, 'breakdown' and back injuries)

Particular reference was made to the degree of interest in, and care shown to, patients, which contributed to patients feeling valued and supported in their progress:

… it's very genuine that…she [Art therapist] does…care how you're feeling. But also, I mean, it's her job to know how you're feeling because it's part of, of why you're there and what you're doing, so it's, you know, she needs to know. But, she is very genuine and very caring…very warm and…she just makes each of us I think feel very, you know, very important and valued and that's important and it's, as I've gradually started doing more in other areas of my life. (Female, late thirties, chronic fatigue)

Unconditional support, absolute unconditional…they could see that I was holding back and they were just, "Come on it's okay, you're safe". (Female, early thirties, musculoskeletal problems, depression and bouts of agoraphobia)

Team experiences

Most patients were aware of the team meeting where their case would be discussed. Those patients with some knowledge of the anthroposophic approach were generally more aware of the content and purpose of the sessions. Doctors had varied in the degree to which they had discussed the meetings and the consensus from patients was that this information had been pitched at an appropriate level. Very few patients expressed a wish for feedback from the meetings, though this was combined with a feeling that the information itself would 'get in the way.'

The only thing that I do find a bit strange but I think it's all probably tied up in the way of working …is that you never get any feedback. I know that they do sit around and discuss us as a team but we never get any feedback from that…. From the team discussions and part of me says "yes I'd like to" and the other part of me says "No" because that will probably actually get in the way. (Female, early fifties, MS)

What was key to patient satisfaction was the fact that the therapeutic team were meeting together to work at their problems collectively. This was felt to be very much in the patient's interests and to provide consistency in information and treatment:

> *… the therapies are so geared to each individual patient…it isn't just a case of everybody being given the same thing to do, there's so much careful looking at what each person is needing and what would be best for that person at that time and…they used to have their…medical meetings where everybody was talked about and although I didn't know what went on behind closed doors one was very aware that one was being given what they felt was right for you…. I don't think personally I felt that was too much of a problem because…the fact that one knew that they were communicating meant that one was aware that it was a whole, it was a sort of embracing of each person in themselves.* (Female, mid-fifties, chronic depression)

> *I think it was, I don't know how to describe it really, it was partly I no longer felt as if I was being pushed from pillar to post, it was all at the surgery and Dr X was there and [the masseuse] was there and they talked to each other about me and they spoke to me about what they were talking about….* (Male late twenties, anxiety and depression)

Only one person had attended a full case review and, although they had felt daunted by the prospect, had been pleasantly surprised by the experience. They felt able to talk honestly and without fear of judgement:

> *… you felt they weren't judging you, they were listening, and there were occasionally a few words thrown in and there was…quite a bit of banter as well, quite a few little jokes and things like that.* (Male, early thirties, back problems)

Some comment was made about the need for increased external supervision of therapeutic work:

> *I think there's a sort of lack of supervision, it's one of the words that's used in counselling and psychiatric, psychological medicines, people from outside looking to see what's going on. So I just think that needs to, to be developed and then very good…there's quite a lot of insularity, they're like little islands, you know, in their little world, which I don't think is very healthy and, you know, there needs to be networks opening up.* (Female, early thirties, chronic anxiety)

8.4 Responses to anthroposophic medicine and treatments

Chapter Nine examines the outcomes that patients reported as a consequence of receiving anthroposophic medicines and treatments. This section considers the responses to the anthroposophic approach and to receiving anthroposophic medicines.

8.4.1 Appraisals of an anthroposophic approach

Some of the key aspects of an anthroposophic approach that patients viewed favourable were:

- holistic and person centred
- treats the person and not the symptoms
- individually tailored
- learning about themselves
- deals with different levels, not just the body
- not just addressing symptoms
- bringing out symptoms so that the body fights the disease
- looks at the underlying causes
- involving patients in the management of their illness
- looks at patients feelings about their illness
- giving patients a chance to think about the way they approach life
- patient has to put effort in to increase efficacy
- unconditional respect
- treats illness in as natural way as possible
- increasing options for treatment
- accepts the effects of events in life
- being given a different outlook on life
- not mechanistic
- helps the *'healing process.*

For some patients there had been an element of discomfort regarding spiritual aspects, which they knew underpinned the approach:

> *I am happy to accept anthroposophic treatment, although I'm not an anthroposophist…there's a cut off point as far as I'm concerned.* (Male, late sixties, 'nervous breakdown', diabetes and high blood pressure)

For a minority of patients, with no apparent religious or spiritual beliefs, an underlying basis of Christian principles had the potential to alienate them. Particular reference was made to the religious festival activities, for example at Christmas and Easter. Feelings of 'not fitting in' stemmed primarily from an inability to relate to the 'calmness' of staff members. Other patients related more to the underlying philosophies mentioned in 8.4.1. Some patients were very much drawn to an approach which had a 'spiritual' element, in the sense of concepts relating to the soul:

> *… although there was certainly a Christian input although it was in a very open way…because in a way it was totally multi-faith as well but there was this incredibly strong sense of belonging. I was hearing people saying things that I knew to be true in a sort of inner way and that was just incredibly important for me…and felt that I was out on a lone path for many years and I was hearing things being said that I just knew were true.* (Female, mid-fifties, chronic depression)

Other patients with quite defined spiritual beliefs such as Hindu, Jehovah's Witness or Quaker felt more at ease. A few patients commented that they felt an anthroposophic approach enabled a multi-faith environment that was accepting of quite diverse belief systems, whereas another felt this contributed to the erosion of more traditional values:

> *I don't like the modern world…. Multi-faithism and liberalism…and the general slackening of values all round…I don't like that sort of thing but…I thought that the actual working with colour…I was enjoying…was itself quite a good thing.* (Male, early fifties, cancer)

8.4.2 Anthroposophic medication

The patients who knew something about anthroposophy tended to know in more detail how the medicines prescribed worked with regards to both symptoms and therapeutic aims. Some patients had a concept of remedies relating to their constitution or to the underlying approach of treating like with like. Others simply knew the medicines aimed to encourage the body's own natural healing responses.

The patients consistently made reference to the benefits they perceived from taking anthroposophic medicines. There was much comparison with orthodox medication and it was clear that many patients wanted an alternative to, or a reduction in, allopathic treatment in order to take 'something more natural.' In particular there was a wish to avoid the harmful side effects of certain medications or avoid potential addiction. Many chronically ill patients had been on courses of medication they believed to be harmful, such as steroids, painkillers and antidepressants.

> *I'm fed up of taking bloody chemicals.* (Male, mid-fifties, mental and physical exhaustion)

> *I was fed up with being shoved full of pills.* (Female, late sixties, myelodysplasia, stress, physical depletion, eczema)

In comparison, anthroposophic remedies were experienced as having few side effects and generally ones that were not harmful. Only one patient reported mild side effects, which dissipated soon after ceasing to take the remedy.

Anthroposophic medicines were viewed primarily as having a 'build up effect' over a period of time, as opposed to a 'quick fix' temporary solution that was associated with orthodox medicines.

There was some scepticism about the efficacy of the remedies and certainly more doubt about their value than about the benefit of specific therapies. Patients were more likely to stop taking their remedies than to stop attending therapy sessions. However, other patients said they had built up faith in the remedies through having felt or seen their effect over the longer term.

A number of patients felt that taking more natural remedies contributed towards an 'old-fashioned' approach to patient self-care. Indeed, patients belonging to *unified* practices were likely to have a host of natural remedies, ointments and lotions in their bathroom cabinets that they had either been prescribed or bought over the counter.

Echoing the doctors we interviewed, patients emphasised the benefits of having the option of being prescribed both orthodox medicines, where necessary, as well as anthroposophic remedies. There was a consensus amongst patients that orthodox medicines were too frequently prescribed in conventional general practice and were continued for too long:

So, it really just reinforces what I've…thought for several years, I suppose, is that conventional medicine and, and complementary medicine, and I always call it complementary and not alternative, you know, that it is complimentary to, to main stream medicine and…the two approaches both have their place, and they work alongside, and there are times when an emphasis on one is more important than the other, and, times when the balance swings the other way. (Female, late thirties, chronic fatigue)

8.4.3 Experience of the service in general

Many general features of the anthroposophic service were discussed in case and documentary interviews. Some patients described themselves as 'fortunate' in having access to these services and underlying such comments was a sense of gratitude towards all the staff involved in service provision and development.

… it is the whole approach of the surgery that's good. (Male, late twenties, depression and anxiety)

They have designed this place to make people feel better about themselves and show them they're worthwhile. (Male, early fifties, fractured vertebrae, osteoporosis, strokes and depression)

Some patients of well-developed anthroposophic services remarked that their practice had a very good reputation in their local area:

I know various other people that go to the practice and they talk very highly of it and I just thought it sounded right for me, the whole approach, the whole philosophy is different from your average GP. (Female, early thirties, chronic anxiety)

… it has got a very good name, but definitely among my friends I always recommend [the practice]. (Female, late forties, migraines)

Access and availability

Therapists were reported as being punctual and few problems were experience by externally referred patients in seeing the doctors. No discernible patterns were evident other than in *unified* practices, where long periods spent in the waiting room were generally balanced with an understanding of other patient's needs and an appreciation of time being made available to the patients themselves when necessary.

Therapists saw the majority of patients within two weeks of being referred. Waiting times varied from a matter of days up to a maximum of four months, which were seen to compare favourably with referrals to orthodox health services within the NHS. There were no complaints regarding the length of time patients had waited for referrals, although one patient expressed frustration at being unable to contact the therapist over a period of weeks, which was perceived as a failure in the system of leaving messages at the practice to arrange appointments with the therapist. Another patient felt that the telephone service in their practice was no longer adequate to deal with the increased demand in services, making contact with the surgery difficult.

Some male patients commented on a noticeable lack of male patients at the clinic and one felt there was a certain element of gender bias in their practice, with a preference for referring female patients to therapies and less GP time given in consultation with male patients. One explained this was related to the patient literature given out at the time, which he felt was aimed more towards female patients.

Payment for therapies and funding issues

Payment for therapies

A third of all patients interviewed had paid in full for their treatments, including two patients who had taken up regular payment schemes in *dedicated* practices. Approximately 20% of patients made contributions that was more often near to the full cost of treatment and just under 50% of patients were non fee-paying. Non fee payers consisted predominantly of patients receiving treatment from *synchronised* practices.[vii]

There were no evident differences between fee or non-fee paying patients with respect to the reported degree of engagement in their treatment. The cost of therapies to patients was, however, a significant factor in barriers to uptake of therapies for those with limited finances. A number of patients reported that they would have been unable to receive treatments without financial assistance. Payment plans made it easier for some patients with limited financial resources.

For those patients who were able to pay for their treatments in full, there was a general sense of 'value for money', especially in comparison with other forms of complementary therapies. A few patients felt that charges were not set high enough for those patients who were able to pay.

A number of patients were quite concerned when financial details were not made explicit, despite reassurances from practices that there was no immediate pressure to pay. Some of these patients felt that greater clarity was needed about the exact amount they were likely to pay, or that guidelines for contributions should be made available. This would avoid embarrassment and concern, especially for patients who found it difficult to discuss their finances.

Funding issues and views

Patients varied in the degree to which they were aware of funding arrangements, although generally they knew about fundraising activities and the help that they could get in paying for treatments when contributions were required. Those who said that they had little knowledge of the funding assistance belonged to one of the *synchronised* practices. In general patients had gained an awareness of the funding constraints and activities over the course of their treatment. Those who had contributed in some way reported that it had enabled them to 'give something back'

Some of the patients with limited finances felt uncomfortable in taking up resources made available through charitable means and would have preferred an NHS funded service. Some of these patients highlighted the fact that they had already paid towards NHS services through national insurance and income tax contributions, whereas patients who could comfortably afford therapies were more likely to refer to such services as 'free' treatment. These patients were more inclined to be of the opinion that patients should meet the cost of therapies where possible, which some felt would be most suitably assessed though a sliding scale.

There was a general consensus of opinion that the approach may be cheaper, in the long run, than orthodox options due to the preventative nature of the approach as well as treatment of the underlying causes, than suppression, of symptoms. A few patients pointed out the further ramifications of what they felt were the wider social and financial costs:

[vii] The purposive selection of the sample precludes quantitative conclusions (see chapter eight)

I know a lot of people are funded by (their local health authority) but not all health authorities are supportive…for me being able to go…I'm sure it has kept me more normal for longer, it's definitely kept me at work which is what I wanted to do because my work was and is still very important. (Female early thirties, depression)

Aspects of service provision

Frequent comparisons were made with experiences of orthodox service provision, emphasising that visits to the centres were more enjoyable and less stressful.

… it's a lovely building, it's a nice atmosphere, I think it's…a good place, you go in and you feel good when you go in, you don't feel agitated or anything, you feel it's a good place and the doctors all seem very calm, not like my GP you know harassed and a nervous wreck, they seem very laid back and calm…. (Female, late fifties, stress, diagnosis of MS)

Three key aspects of service provision were seen, at the majority of sites, as contributing towards a particularly pleasant and welcoming atmosphere: the approach of staff, the design of the premises, and social and fundraising activities.

Staff members approach

Non-medical staff members, such as receptionists, practice managers, project managers, fundraisers and so on were consistently described as 'very nice', 'friendly' and 'helpful' in their approach. Often, patients commented on the fact that the staff in general seemed happy in their work. Other aspects of competency, trust, support and understanding were valued by patients:

The attitudes at [the centre] are totally different to people at the renal unit who talk to you like a child. Some of nurses really talk down to you, think you're stupid as well as ill. At [the centre] they treat you with more dignity. (Male, early thirties, chronic renal failure, anxiety and stress related symptoms)

They're always really helpful, they're never intrusive or if you phone up and say you want to talk to [the doctor] it's not "What do you want to do that for?", it's like, "Well, I'm afraid he's not here at the moment" or, "He's in surgery, he'll have to phone you back", so yeah, the people in the…office and stuff, and they walk about and they've got people coming in, and there's always something being organised and it's a nice place to go. (Male, late twenties, anxiety and depression)

Patients very much appreciated the development of quality services and recognised the hard work and dedication of staff members:

I think it's a lot of credit to the team. I think their heart is in it and it's the right atmosphere. (Male, late seventies, multiple physical symptoms referred for anxiety and stress)

Building design premises

Almost all patients who attended centres with purpose built premises commented enthusiastically on the positive aspects of the design of the buildings, which is specific to anthroposophic architecture. These were characterised by good design, a 'light', 'airy' and 'spacious' feel and the use of calming colours:

… they haven't got stairs which to me is quite good because I can't manage them very well…and the rooms are quite nice the colours, very peaceful. It will be nice when the garden has been done…. It's nice open and…it's not sombre. (Female, early fifties, rheumatoid arthritis and stress)

Patients also remarked on the benefits to staff in having moved to larger purpose built or adapted premises. One patient commented on noticeable improvements to staff morale and perceived professionalism.

Social, community and fundraising activities

The majority of those interviewed had not engaged in social or fundraising activities. None the less, patients still felt the impact of a strong community element built up in some practices:

> *…it's just sort of a community…spirit almost and knowing that there's lots of people that gets lots out of it and … do lots of different things…like people who work in the garden or work in the café or do painting or do music or whatever it is.*

Patients who were more isolated, such as people new to the area, accounted for those who had been encouraged to take part in social and fundraising activities at the centres. Other patients quite clearly felt no desire to add to their social life.

One aspect that was criticised was the apparent exclusivity of an established group, making contact difficult, though the group had been recommended by members of the therapeutic team specifically to increase the level of patients' social contact. Another criticism related to one patient's opinions regarding strong boundaries between therapeutic and social activities and maintenance of professional distance.

Continuation and expansion of services

Few comments were made about the changes patients would like to see at the centres, although patients were aware of future developments through the regular newsletters produced by the centres.

Most prominent was the perceived need for improved and increased levels of publicity to access a wider patient group:

> *I think they could make themselves more widely known. Not many people know about them…they are recognised by the NHS and as such I think that they…should have some kind of access there…GPs probably wouldn't think to refer people there. And I would like it to be a situation where GPs would think of, as a viable alternative rather than a last ditch,…shot in the dark. Because I…don't see it as being alternative. I see it very much as being…something which is sympathetic to normal treatment. And, in many ways I think it could make normal treatment more effective.*

Many patients felt that many others could benefit from such an approach. Some felt that these services could be easily transferred to other general practice settings:

> *I think it's something that will be copied by other organisations, well other surgeries possibly.*

> *I think it's very much got a place in this modern age yes absolutely.*

One patient suggested routine dissemination of dietary information to patients and exercise classes for general keep fit purposes.

PART III

CLINICAL OUTCOMES AND THEIR MEASUREMENT

9 THE OUTCOMES OF COMPLEX INTERVENTIONS

This chapter considers a number of issues surrounding the measurement of outcomes that result from complex medical and therapeutic interventions. We begin by describing the sources of information that were used to identify outcomes in this study and then examine the nature of the outcomes derived. We then move on to discuss some of the issues that these analyses raise for the measurement of outcomes. Although the discussion focuses on anthroposophic medicine, this can be seen as representative of other multi-dimensional or complex interventions in primary care. Indeed the evaluation of primary care, particularly the central role of the clinician-patient relationship in general practice,[20] faces similar methodological challenges to the evaluation of anthroposophic medicine in a primary care context.

The complexity of interventions within anthroposophic treatment programmes is matched by the clinical and psycho-social complexity of patients referred to the programme. Chart 9.1 summarises the conditions of just two of the patients who took part in the research and the treatments and medication they were receiving. Each of them was suffering from four or five major conditions with a number of symptoms they considered serious; and each of them received a number of medications and treatments for their various complaints. Anthroposophic treatments were then given as shown at the base of the chart.

Chart 9.1 Two patients

Condition(s) and symptoms	
Arthur B has Arthritis Shortened leg ligaments Restricted mobility and paresis following strokes Osteoporosis Depression Hypertension From which he has multiple **symptoms** including Neck pains, stiffness in the neck and back Headaches Weak muscles Anxiety Problems with sleep	Audrey C has Multiple sclerosis History of deep vein thrombosis Anxiety Constipation Bladder infection From which she has multiple **symptoms** including Restricted mobility (wheelchair) Panic attacks Incontinence Frequent drowsiness Muscle pain in her legs
AND existing treatments/medication	
Seven types of medication Counselling from clinical psychologist Pain clinic Relaxation classes Meditation	five types of medication Art therapy TENS Physiotherapy Catheter Reflexology
Anthroposophic Treatment	
Massage	Counselling

9.1 Sources of information

Health care research has moved from total reliance on mortality and clinical events (e.g. myocardial infarction) to the use of patient centred measures to judge the effect of treatments or programmes. The measures, based on questionnaires or interview schedules, attempt to assess health, illness and benefits of health care interventions from the patient's perspective. In a systematic review of these measures, Fitzpatrick and colleagues identified seven types: [21]

- disease specific
- site or region specific
- dimension specific
- generic
- summary items
- utility
- individualised

To complement the qualitative interviews that were our main source of data for the investigation of outcomes, we chose to use two 'individualised' measures: measure your own medical outcome profile (MYMOP) and the patient generated index of quality of life (PGI). Individualised measures were chosen because they most closely represent patient priorities for their lives and health care, addressing their concerns rather than imposing standard questions that may not be relevant to them. Disease or site specific measures were inappropriate for the heterogeneous group of patients choosing anthroposophic treatment programmes in the practices. Dimension specific (e.g. depression or pain measures) suffered from the same limitation. We chose not to use generic instruments (e.g. SF36), because in general they are less sensitive to change from interventions. Summary items, where patients are asked for global judgements of health or well-being are too crude for detecting subtle changes in a patient's experience, and tend to miss conflicting changes in health and psychological status. Finally, utility measures that underpin economic analyses of health care were not used, as these analyses were not in the remit of this study.

The data on outcomes were collected primarily through a series of case studies carried out with patients that were currently undergoing anthroposophic treatments. Patients were interviewed on two occasions - the first just as they began treatment and the second usually after it was complete.[viii] The patients were also asked to complete MYMOP and PGI questionnaires on both occasions. There were also interviews with the therapists that carried out the treatments and with the referring GP.

A total of 20 case studies were carried out in three study centres. The conditions for which patients were being treated were various and often multiple. However, they mainly fell into three broad categories of chronic illness – mental illness, musculoskeletal complaints and neurological conditions - although other conditions (e.g. cancer) were represented.

9.1.1 Qualitative assessment of outcomes

The qualitative assessment of outcome was based on a series of questions to patients about the effects that had been felt, or observed, from taking part in the study treatment. The patients were asked to describe changes that occurred in their symptoms or conditions, the effects of participation in the programme of treatment as a whole and about any fluctuations that occurred during or after treatment.

[viii] In some cases where extended treatment was intended the second interview occurred at what was considered a staging point.

They were also asked about other factors that were operative at the time that might have had an effect on their conditions. The referring GPs and therapists were asked similar questions to identify any changes that they had noted during, or following, the programme of treatments. To illustrate the type of evidence derived, three sets of accounts are summarised below:

Margaret is in her late forties and suffers from migraines. These had increased in frequency until she was having them once every week or two. She received a course of seven **massages** and was also prescribed anthroposophic medicines.

Patient (second interview)

I've not had a migraine for ten weeks…[the] last migraine [was] not as bad, only lasted a day. When I first had [the massages] I really felt tired…as if I had been out working all day, my legs would ache…but that gradually was alleviated…they're very relaxing…. I feel less panicky inside when I wake up…it used to happen every morning…I've got a slight circulation problem… when I first went there they started shifting everything around…getting everything moving to the right places…and I can sleep anytime, anyway, so it just encourages that…they definitely do help you to relax…it's like time out, it's like ..pampering yourself, a nice hot perfumed bath…the same sort of thing…it's a hands on thing and I think that's quite therapeutic…it's like attention…somebody doing something for me…. When I first went there was a lot of tension in my shoulders and upper neck…so maybe the feeling of well being, maybe I am physically more relaxed so everything is flowing better I am physically more relaxed.

Massage therapist

After three sessions she didn't have a migraine every week but then she had one…. In the seven sessions I think she had two migraines…warmth to her metabolic system which was very cold…a little bit more movement…. Her metabolic system was much stronger that was the biggest change,…that the liver was warmer, the abdomen was warmer,…the feet were still cold but not nearly as cold as they were before…you felt she was more integrated…she was less cut in half as she was when she first came…there was more flow in the lower body as well.

GP

Blood vessels, which are the cause of migraine, the contraction and dilation, they are not meant to be behaving in that way…so there is an indication, this is in very a, b, c terms, that an activity in the head is happening which is foreign, in the gut it's not foreign…and you need to get that activity away from the head and bring it down to the gut and [the therapist] would have played a major part in doing that…. When I saw [the patient] in _____ she said she'd been very well for four months and she had had a bad migraine last weekend…but you see already there we've got an indication that we haven't effected a cure…but it does seem that the migraine was helped.

John is in his early fifties and has had chronic pain and severely reduced mobility due to damaged vertebrae and osteoporosis for over ten years. This is further complicated by a series of small strokes, and feelings of depression and frustration connected to his illness. His initial treatment consisted of anthroposophic remedies, **massage** and a few sessions of **art therapy.**

Patient (second interview)

… massage didn't just alleviate the spinal problem [but also] muscle…and shoulder problems, headaches and that in turn makes you feel better about yourself…life is infinitely better…leads to you feeling a little more positive,…things used to worry me very easily…not so much now…less pain…only after treatment, it's…localised in one spot as opposed to spreading across your shoulders and down the backs of your arms and into your elbows and your wrists…. More mobility…. I…find doing stuff around the

house is a little easier…it's a general all round improvement…in some ways I'm a lot more aware…because I recognise the symptoms early on like a headache…I stopped …medication before I went…to find out how much pain relief I got…. Absolutely spectacular I thought…I'll cut these down with a view to knocking them on the head…I don't suppose I'll ever be able to do that because of the nature of the problem but that's why I can't wait to get back there… [In art therapy] I found sitting down and bending the neck forward gave me a headache…I didn't really see a lot of point in it but you never know…in order to treat you they have to communicate with you first…the whole approach…to the whole person…I find…very refreshing.

Massage Therapist

… a treatment sequence that I felt would avoid stirring up any pain problems but…address his whole muscular skeletal situation…we had a number of different problems, relating to the two 'poles'…expressed itself in massive amounts of tension in the neck and shoulder region and that was also where the majority of his pain was…. But then there was the stroke situation to address…In the course of the treatment he did begin to come out more,…about what he felt about himself and his feelings…and trying to enable more freedom and space to develop in his life…that he has insight enough into himself to understand how to work with his problems and…his soul dynamic a bit more, began to understand his fear, the symptoms did begin to disentangle a bit and….to realise that a certain quality of life may be possible…little things worry him [greatly], and things are likely to collapse in again. … The need to accompany someone long term is very important because…they go through these crises,…you've got to…find some way of picking them up until…they really are through and on some firm ground…. I did feel and he felt…'improvements all round'…not just on physical level, [he] is much softer and warmer, less hard on himself…the amount of pain is less, less headaches, his mood is more balanced and…his tension…his positive attitude towards treatment and the fact that he'd already taken himself on in terms of his digestion and diet…was a good start.

GP

[The masseuse] felt that he had…a strong muscular element to his disability, to his pain sensation and magnesium has a strong relationship to muscle both orthodox and homoeopathically and … relates to the metabolism and so there was, the Hepar magnesium…a liver remedy…whereas the Magnesium Phosphate is more directly aimed at…the muscular system…. It's trying…to link his constitution to the way he perceives pain…as well as his symptom…. There's a limit to my expectation …first of all he has got chronic, impossible to cure joint problems…. More importantly the stroke that…may have woken him up but it's led to a certain…rigidity in his thinking life…caused a bit of turbulence by the look of it and so it was perfectly okay to back off…his response to art tells me that he was probably developing coping strategies…not necessarily a failure and helps define likely outcome which is that he's been helped a bit…in a moderate way…mobility, some pain reduction and…already a bit calmer…some unanswered questions,…about his…relationship with his thinking to his feeling if you like…they're all life questions and he's doing okay.

Paul is in his early forties and has depression accompanied by agoraphobia, stress and hypertension. He has along history of both physical and mental health problems following an accident at work. He was receiving **art therapy** although this was one in a series of anthroposophic treatments.

Patient (second interview)

I feel more confident, I can go to places where there's people, even though I was going shopping, going places, I was still very edgy and very nervous…..[art therapy] was something I was doing completely on my own, with strangers….it's changed the way I go about my life, it's put it back to like it should be, normal…. I look upon things differently now…I don't take things for granted now….it's a bit like what you do with yourself through life so it makes you understand what life is about…. I have a tendency to not be satisfied with what I do, anything I do, ever, I'm never happy with it, it can always be better than

that so I spent two weeks on one sphere till I got it perfectly round…. [I've realised] I've got to the shape I'm supposed to be…that final sort of shape, so I'm there now, I'm satisfied, I'm happy…that's how it explains it to me…. I come out feeling relaxed, like I've achieved something, you know confidence, I go home feeling chilled out…every time I go…. I sometimes get such terrible pain in my back…you know I can live with that…I can get so much more from the art therapy that a bit of pain is neither here nor there.

Art therapist

What was difficult for him was to do something free…he just couldn't be creative, I had to tell him exactly what to do…we have in the mean time now moved to something freer…. I was very pleased with that because it was no longer so perfect…with compulsive obsessive [behaviour]…it's not only in the emotional mind, its much deeper than that…it is really something in the habit life and that takes a long time to shift…. So far, because of the way he has been responding, I feel very hopeful…. At first he could only cope with very prescribed forms….it's clearly a step into something freer and more creative…I would say that…true creativity would be the antidote to compulsive behaviour…by working creatively, his obsessive behaviour diminished…less compulsive behaviour at home.

GP

I don't think he has had that much (benefit) yet. I have only talked with him about it once…and then he said he enjoyed it and that he enjoyed something was for me the first good sign…. He's not going to be better in a few week's time, not even a few month's time. It's a year's process. … I think there's possibly more positivity. I think it's a good sign and I'm not saying this is due to art therapy …before that he wanted not to depend on drugs any more…he is definitely on much less anti depressants which he'd been on in the past…. So I would think the decision to actually come to this practice…to have a different attitude to his illness and how he could get better is for me the first step.

It is evident from the above descriptions that patients, GPs and therapists describe the outcomes in different terms although it is clear that they are referring to the same events, signs or signals. For the main part of this chapter, the patients' evidence will be used to describe the outcomes achieved since this provides the most appropriate base for comparison with the other patient centred measures. However, the practitioners' views have been reviewed to support or qualify patients' perspectives.

A number of other features of the outcomes identified are also evident from the descriptions given above. Perhaps most notably, it is clear that the effects of treatments may be multi-featured, interrelated, time related, cumulative and open to change or influence from other interventions. These are all features that will be discussed in the final section of this chapter.

9.1.2 The patient centred outcome measures

We chose to use the PGI because some of the problems of comparability that individualised measures present have been addressed in its design.[22] The labour intensive requirement for face-to-face interviews in other patient-centred measures has also been diminished by the possibility of postal or telephone follow-up. The PGI was designed to measure quality of life, based on Calman's definition: 'the extent to which our hopes and ambitions are matched by experience.'[23] Patients are asked to list the five most important areas of life that are affected by their condition, to rate how badly they are affected and to weight the relative importance of potential improvements in these areas. This tool has been validated in different clinical settings, largely in secondary care. The MYMOP[9] is a simpler tool, adapted from the PGI, for use in general practice consultations. It has two symptom scales and two relating to activities of daily living and general feeling of well-being. It does not take into account the relative importance that a patient ascribes to these domains nor has it been adequately validated.[10]

As an example of the kinds of responses elicited, we list those from the three patients whose symptoms we presented at the start of this section.

Margaret	**MYMOP**	**PGI**
Symptoms	Migraine Apprehension	
Activity/area of life	Voluntary work	Family responsibilities Self confidence Actively support friends Work Social life
John	**MYMOP**	**PGI**
Symptoms	Headaches Neck/shoulder pain	Headaches Tiredness
Activity/area of life	Thinking	Social life Sex life Sleep
Paul	**MYMOP**	**PGI**
Symptoms	Stress Back pain (upper)	Tiredness
Activity/area of life	Shopping	Inability to work Hobbies Enjoyment of food Sleep

In addition to complementing interview data, a secondary aim of using quality of life-based outcome measures in this study was to test their feasibility with the patient population entering anthroposophic treatment programmes. Further evaluation of the programmes in the context of controlled studies or trials will need robust, acceptable measures.

9.2 The classes and categories of outcomes

9.2.1 Qualitative data

The outcomes resulting from anthroposophic treatments that patients identified were briefly illustrated above. This gave some sense of their diversity and of the differing levels to which the effects of anthroposophic medicine could be ascribed. There are various ways in which the outcomes can be classified but, at the simplest level, they fall into four main categories:

- physiological
- psychological
- spiritual
- behavioural

Chart 9.2 lists the main positive outcomes described within each of these main classes. Although this list is not fully comprehensive, it contains all the effects most frequently mentioned, both generally and for specific conditions.

There was a sequence to the way in which outcomes were described with a general pattern of movement from the physical to the psychological, the psychological to the behavioural and the behavioural to the spiritual. Because of this sequential pattern, the longer-term effects are open to the influence of other factors and interventions. Nevertheless these deeper level outcomes were still attributed, at least in part, to the anthroposophic treatments received.

Chart 9.2 lists only positive outcomes because the majority of the outcomes noted are positive, rather than negative, in their orientation. This is how the patients that were interviewed spoke of their response to anthroposophic medicine, both in the case studies and in the documentary interviews. But other factors also operate to weight responses in the positive direction.

First, there is the absence of any really significant impact, which left patients saying that a treatment did not really have any effect on them:

> *I would say that I looked forward to [art therapy] and generally enjoyed it...all I can say is it's extremely difficult to say,…I was in a very much unknown phase medically,…and so who's to say what caused it, whether the art therapy helped or not is what I feel about it…. I think I benefited from it but I can't say that it's sort of…how it, how many points it moved me, whether it moved me anything on the scale of feeling better or worse in terms of health…. I enjoyed it, I feel that...I can't physically say that it was doing something, I found the rhythm things difficult…I think that …my situation...you've got to keep trying things, and miraculous results don't necessarily happen it just…very difficult to measure results and it maybe that it's a sort of what if situation, what if I hadn't done this would I still be alive at all? For instance, I mean you can't answer that,…I feel it's worth investing,…two or three hours…I'm prepared to do that as a sort of act of faith that there's something in it. I mean if I didn't enjoy it at all, if the experience was totally negative, then I wouldn't bother.* (Male, early fifties, cancer)

Second, some people felt an immediate benefit but then noted that its presence was temporary:

> *I felt OK for a few days [after each massage] then felt myself going stiff, I just started going back slowly to the way I was* (Male, early thirties, leg injury and lower back pain)

Third, and most crucially, it is evident that the anthroposophic practitioners, whether they be therapists or GPs, are supportive in their relationships with patients and place considerable priority on patient centred medicine. This relationship alone would almost certainly receive positive appraisal, almost irrespective of the treatment being given. This observation should not be seen to diminish these aspects of the practitioners' approach. There is growing evidence that good quality relationships between clinicians and patients improve clinical outcomes.[24] It is methodologically difficult, however, to disentangle this effect from other influential factors in the anthroposophic treatment programmes.

There are a number of other features of the outcomes described that have particular relevance for outcome measurement. These are discussed in Section 9.3. Before considering these features it is important to compare the outcomes derived from the two more structured measurements of outcomes.

Chart 9.2 Outcomes from anthroposophic treatments

PHYSICAL, somatic physiological

Less pain
Less headache/migraine
Strong walking
Increased mobility
Can walk further
More confidence walking
Better balance
Better posture
More comfortable sitting
Breathing more regular
Better circulation
Make regular bowel movements
Better digestion
Feels lighter
Less nausea
Less cramps/less severe cramps
Gently stretched muscles
Relieved muscle tension/pain spasms Reduced soreness
Lowered blood pressure
Less cold/feel warmer
Less tiredness/fatigue
Quality of energy different
More energy
Energy more centred
Less fits
Sleep better
Reduced toxins
Improved co-ordination
Lost weight

PSYCHOLOGICAL, emotional, mood

Less sad
Less depressed
Raised self-esteem/more self value
More pride
More confidence
Less tearful
Believe in myself
More patient
Less anxiety/ calmer
Still mind
More at peace
More relaxed
Less panicky
Less stressed/uptight
Greater enthusiasm
Feel sense of achievement
More optimistic
Feel happier
Feel stronger in myself
Feel less vulnerable/more secure
Helped grief to come out
Learned to appreciate other people
More focussed
More grounded
Better concentration
More realistic
Listen to my own body
Emotionally stronger
Less emotional savings
Confidence to explore
Learned to pace myself
Have 'feel good' factor about life

SPIRITUAL, purpose meaning

Stopped taking things for granted
Changed way I think about life
Reorganised way see myself
Discovered new things about myself
Greater life force
More creative expression
Questioned meaning of life
Felt a complete human being
Priorities changed
Feel like there is a future
More accepting of illness
Stirred 'some kind of faith'
Helped to make sense of what was happening
More understanding of unresolved issues
Felt nourished in an inner way

BEHAVIOURAL, personal, social occupational

Changed diet
Cut down smoking
Take less medication
Less rushing about
More self care
Take less drugs
Less self harm
Feel more purposeful
Make time for myself
Able to nurture self
Learned to say no
Learning to read
Gone back to work
Got new job
Applying for jobs
Improved school attendance
Do more around the house
Do more ordinary things/more shopping/gardening
Stimulated new rhythm in weekly routines
Play music
Go swimming regularly
Started painting
Been on holiday
Speaks to people in the street
Re-established relationship with partner
See friends more often
Greater interest in other people
Go out more
Goes to parties again
See more of the family

9.2.2 PGI and MYMOP

Administration of both tools proved feasible with the purposive sample of patients chosen for case studies. Generally, participating patients found the MYMOP easier to complete and found symptoms easier to articulate than the broader areas of life targeted by the PGI, although several patients also appreciated the question about general well being, which is not present in the PGI. On the other hand, many appreciated the broader and deeper coverage of the PGI and several spontaneously noted that it reflected how they really felt or that it was 'more personal'. A few patients reported that neither tool adequately captured their experiences of illnesses or treatment. Administration of the PGI over the telephone was also feasible. Most patients stressed that without an initial face-to-face interview, this would have been more difficult.

Chart 9.3 lists the symptoms and areas of life identified in the PGI and MYMOP, broadly classified into the four main groups reported above, derived from the interviews. Both measures are effective in identifying physical symptoms and in similar terms. Although both identify a range of psychological factors, those characterised in the PGI are more specific than in MYMOP. The PGI identifies more behavioural features (consequences of illness) than MYMOP and, again, these are more specific to individual patients. Neither tool captured the spiritual elements that emerged from our interviews.

Chart 9.3 Symptoms activities (MYMOP) and areas of life (PGI) identified by patients

	M.Y.M.O.P.		P.G.I.
	SYMPTOMS	**ACTIVITIES**	**AREAS OF LIFE**
PHYSICAL	Pain++		Pain + (2)
	Head pain+		Pain and lack of ability+ (1)
	Headaches+		Headaches + (1)
	Migraine++		Related ailments eg tregemial neuralgia+ (2)
	Neck pain+		Moving around+ (1)
	Neck/shoulder pain+		Mobility+ (2)
	Upper back pain+		Balance + (2)
	Back pain+		Bladder and bowel control +(1)
	Lower back pain+		Physical health + (2)
	Abdominal pain+		Blood Pressure + (2)
	Pain in legs+		Sight + (2)
	Sciatica+		Energy runs out too quick+ (1)
	Trigeminal Neuralgia+		Tiredness+ +(1) + (2)
	Multiple Sclerosis+		Tired +(1)
	Tiredness ++++		Feeling tired++ (1)+++ (2)
	Extreme exhaustion brought-		oomph' energy, motivation, enthusiasm+ (1)
	On by low blood count+		Stamina+ (2)
	Lack of energy++		Coordination + (2)
	Spasms+		
	Stiffness+		
	Physical moving +		
	Physically poorly+		
	Skin Problem+		

Number of + signs indicates frequency. Regarding PGI areas of life, BLUE indicates first PGI completed and RED the second. MYMOP symptoms and activities remained consistent.

	M.Y.M.O.P.		P.G.I.	
	SYMPTOMS	**ACTIVITIES**	**AREAS OF LIFE**	
PSYCHOLOGICAL	Stress++ Anxiety ++ Apprehension+ Anger+ Depression+ Being dysfunctional+ Not coping+ Concentration + Low self esteem++ Unknowing-ness ie not knowing How symptoms/illness will progress+	Thinking+	Anxiety + (2) Stress + (2) Feeling apathetic Frustration due to accident complications - not able to function properly + (1) Ability to cope with day to day problems + (1) Very sensitive easily upset + Being oversensitive and easily upset+ (2) Feeling vulnerable + (2) Tolerance + (2) Confidence +++ (2) Lack of confidence+(1)+ (2) Varying self esteem + (2) Self confidence + (1) Ability to make decisions + (2) Motivation + (2) Having enough energy/motivation+ (2)	Wellbeing + (1)+ (2) Memory loss (short-term)+ (1) Concentration + (1) Communication + (1) Lack of interest+ (1) Worry about the future ++ (1)+ (2) Fear of future strength +(1) + (2) The future + (1) Fear for future + (2) Worry about future prospects+(1) Relationship with husband+ (1) Break up of relationship+ (1) Relationships ++ (1) ++++(2)
SPIRITUAL			Expectations of life +(1)	

	M.Y.M.O.P.		P.G.I.	
	SYMPTOMS	**ACTIVITIES**	**AREAS OF LIFE**	
BEHAVIOURAL/	Bad sleep +	Sleep ++++	Sleeping + (1)+ (2)	Sex life + (1) + +(2)
SOCIAL/		Going to work+	Sleep+++(1)+++++ (2)	Housework - slow + dragged out+ (1)
PRACTICAL		Office work+	Sleep loss+ (1)	Only being able to do main day to day needs+ (1)
		Working+	I don't sleep+ (2)	Day to day living+ (1)
		Voluntary work+	Work situation + (1)	General day to day living+ (2)
		Socialising+	Work ++++ (1) ++++++++(2)	Functioning from day to day + (2)
		Social Relationships+	Ability to work + (2)	Housework + (1) + (2)
		Housework+	Career + (1) + (2)	Being restricted in what I do+ (1)
		Shopping+	Working effectively + (1)	Physical activity (limits) + (2)
		Physical activity+	Inability to work+(1)	Driving + (1)
		Walking (country etc)+	Not being able to work+ +(1)+ (2)	Hobbies + (1)++ (2)
		Walking on windy days+	Voluntary commitments + (2)	Hobbies, badminton, dancing & gardening+ (1)
		Walking +	Having no money+ (1) + (2)	Gardening + (2)
		Driving++	Home situation + (1)	Walking + (2)
		Swimming+	Household problems+ (1)	Going for long walks +(1)
			Family responsibilities++ (1)+ (2)	Dancing++ (2)
			Not allowing me to see more of my kids+ (1)	Enjoying sports such as sailing & skiing + (1)
			Social life ++++++ (1)+++++ (2)	Eating + (1)
			Socialising ++ (2)	Enjoyment of food+ (1)
			Actively supporting friends + (1)	Drug use (illicit) + (2)
			Helping friends+ (2)	Too many drugs(orthodox pain killers) + (2)
			Loss of the little social life I had + (1)	Ability to plan ahead + (2)
			Entertaining (dinner parties) + (2)	Being able to plan ahead +(1)
			Isolation + (1)	

The scores on both instruments were clustered in the middle of the range with notable outliers. The aggregated scores for the instruments were sensitive to change, both showing changes in the same direction between baseline and follow up (Chart 9.4) The sample was not intended for statistical comparison.

Chart 9.4 Aggregated scores for MYMOP and PGI

MYMOP 1	**MYMOP 2**		**PGI 1 (%)**	**PGI 2 (%)**
5.25	5		18	10
5	*4.25*		20	28
4.75	4		28	31
4.75	3.75		28	36
4.5	3.25		29	36
4.25	3.25		31	39
4.25	3.25		31	41
4	3.2		*31*	41
3.75	3.2		34	47
3.5	**2.75**		**38**	**50**
3.25	**2.5**		39	*52*
3.25	2.5		43	58
3.25	2.25		45	59
3	2.25		49	60
2.75	2.25		51	63
2.75	2.25		52	63
2	2		53	85
1.75	1.25		63	87
0.25	0		*63*	99
0	0			
3.375	**2.625**	**MEDIAN**	**38**	**50**

The figures in *italics* are scores that are calculated for 'intention to treatment' where the baseline data are scored identically for before and after measurements, due to an absence of information.

MYMOP 1 median **3.375** 6 = As bad as it could be
MYMOP 2 median **2.625** 0 = As good as it could be

QoL improvement across all patients **12.5%**

PGI 1 median **38%** quality of life
PGI 2 median **50%** quality of life

QoL improvement across all patients **12%**

9.3 Problems of outcome measures

It is evident from the discussion above that the measurement of outcomes for patients with chronic conditions participating in complex treatment programmes poses significant methodological difficulties. Although these are by no means unique to anthroposophic medicine, they are certainly raised by key features of an anthroposophic approach. Methodological developments in the evaluation of complex interventions[25] have tackled some of the challenges in identifying the effects of different components of an intervention. But the combination of complex interventions and a heterogeneous group of patients with chronic conditions makes quantitative evaluation problematic. Here we articulate some of the problems in capturing relevant outcomes in the context of anthroposophic treatment programmes.

The nature of outcomes identified

Not unexpectedly, there are differences in the nature of the outcomes that patients will choose to describe depending on the instrument used for data collection. The most extensive list of items is generated through in depth qualitative methods, the least extensive by measures that are symptom related (e.g. MYMOP). Despite this diversity there is a remarkable degree of consistency in our study across the three types of assessment in terms of physical, and to a lesser degree, psychological outcomes. This poses two questions:

- Is this where outcome measures should stop?
- Is there scope for integrating different measures depending on the type of intervention being appraised?

Limiting outcome measures to physical and a few psychological measures is an unsatisfactory solution, as this would miss many of the subtle and specific changes that were detected by the depth interviews and the PGI. The extensive validation of the PGI in research contexts, albeit in secondary care, and the feasibility of its use in our study makes it a strong candidate for a quantitative study. A limitation of the quantitative measures we tested in the context of anthroposophic practice are their theoretical underpinnings, more apparent in MYMOP then PGI, that – as far as *content* is concerned – is atheoretical. Yet the premise that a numeric value can be meaningfully applied to life areas affected by illness or priorities may be difficult for some anthroposophic practitioners (and, as emerged in a few interviews, patients).

Combination of different measures is one option and there were 'clinician-defined' aspects of MYMOP (e.g. patient views about medication) that are absent in a purely patient defined tool. Both tools showed sensitivity to change even in a population of patients with chronic conditions.

Finally, when choosing outcome measures that might be affected by treatments, we need to remember the relatively small impact of health status on quality of life and its 'existential and variable nature.'[26] It is necessary to evaluate the claim that treatment programmes directly address quality of life, rather than just manage specific symptoms. The evidence from the depth interviews, complemented by the pilot results of quality of life measures for patients in these programmes, encourages further evaluation.

Time frame for measurement

At what point is it appropriate to take a reading on outcomes when 'early' will give the immediate effects of a treatment (felt relaxed, forgot all about my problems) and 'late' will give a collection of changes (go out more, feel better about myself) for which the causes cannot be clearly identified?

Linked to this, there is a problem over the repeated use of the PGI or MYMOP that do not deal with patients changing their priorities in the course of treatment. This may well be an important outcome of anthroposophic therapies (or any 'deep' approach to the human condition).

There is also an issue surrounding the cumulative nature of treatments, certainly within the field of anthroposophic medicine but also more generally.

The measurement of single treatments or clinical packages

A related point concerns the nature of the intervention that should be measured to determine outcomes. Should it be a single form of treatment or is it more meaningful to investigate the 'package' of treatment that is being provided for a particular condition? Although, in this study, we have tried to isolate the effects of a particular treatment, it is doubtful that this has been achieved, particularly with the more deep-rooted outcomes. Indeed, it could be argued that it is inappropriate in anthroposophic medicine to attempt such isolation since compound treatments (e.g. anthroposophic medicines plus a therapy plus GP consultations) are often what is deliberately prescribed. On the other hand the interpretation of any evaluation of treatments is more problematic if participants in a study can receive a range of treatments (see Chapter 10).

The influence of other factors

In the qualitative discussions about outcomes from treatments, patients and practitioners were asked whether other factors might also have had an influence on the effects they were attributing to the anthroposophic treatments. The answer was usually positive yes and often more than one source was cited – dietary changes, changes in relationships, circumstantial change, altered activities. In some cases anthroposophic treatments had themselves been a spur to the use of other methods, in others they were coincidental. Although the existence of these other variables complicates measurement, they have to be recognised rather than ignored or in some way controlled. They represent the complexities of measurement in the midst of 'real life' rather than in controlled conditions.

Conclusions

The overlap between the outcomes articulated in the interviews with patients and the validated patient centred outcome instruments means that the latter are legitimate measures in the context of anthroposophic practices. Our study did not attempt to disentangle the individual impact of treatments nor to separate treatment effects from other factors impacting on patients. Methodologically this would be misleading in a non-comparative study, but would also not be feasible with the complexity of conditions under study and the complexity of the outcomes themselves. Some outcomes are more open to measurement than others, particularly tangible physical and psychological states, either through validated instruments or through reported accounts.

The possible combination of qualitative and quantitative data may be particularly useful in the study of anthroposophic practices which aim to address a broad range of human needs from the physical to the spiritual.

10 EVALUATION OF ANTHROPOSOPHIC TREATMENT PROGRAMMES IN THE UNITED KINGDOM

10.1 The need for research on effectiveness of anthroposophic medicine and complementary therapies

As chronic conditions are increasingly cared for in primary care, both practitioners and patients have turned to alternative therapies. Recently the *British Medical Journal* commissioned a series of papers, in the form of clinical reviews, to inform conventional practitioners of the range and use of such therapies. [27] Anthroposophic medicine is cited in a table of 'common complementary therapies'. Our interest here is not in definitions of complementary therapies – except insofar as anthroposophic medicine clearly falls outside the realm of conventional medicine – but in their evaluation. An holistic approach is described as characteristic of, but not exclusive to complementary practitioners. This entails a multifactorial and multilevel view of human illness, with disease thought to result from disturbances at a combination of physical, psychological, social, and spiritual levels. Anthroposophy is cited as an example of a holistic approach.

Example of a holistic approach-Rudolph Steiner's central tenets of anthroposophy:

- each individual is unique
- scientific, artistic, and spiritual insights may need to be applied together to restore health
- life has meaning and purpose – the loss of this sense may lead to a deterioration in health
- illness may provide opportunities for positive change and a new balance in our lives

The review identifies and challenges, a range of 'unhelpful assumptions' about complementary medicine, for instance that they are not provided by the NHS, that they are unregulated, unconventional, that they are natural, intrinsically holistic, alternative, unproved, irrational, and harmless. It points out, for instance, that complementary medicine is increasingly available on the NHS, and that 39% of general practices provide access to complementary medicine for NHS patients. At the same time, there is a growing body of evidence that certain complementary therapies are effective in certain clinical conditions, and that the effect of some complementary therapies can be understood within conventional scientific frameworks.

The review identifies a range of factors limiting research in complementary medicine, including lack of funding, research skills and academic infrastructure, as well as insufficient patient numbers, difficulty in undertaking and interpreting systematic reviews, as well as specific methodological issues. In preparing their review the authors drew on the work of the Cochrane collaboration, which defines complementary medicine as including:

> *All such practices and ideas which are outside the domain of conventional medicine in several countries and defined by its users as preventing or treating illness, or promoting health and well being. These practices complement mainstream medicine by (1) contributing to a common whole, (2) satisfying a demand not met by conventional practices, and (3) diversifying the conceptual framework of medicine.*

Anthroposophic medicine is included in their diverse list of therapies, but is not addressed within their glossary of commonly used complementary therapies.

The Cochrane Collaboration has established a complementary medicine field in order to meet a growing need for evidence-based research in complementary and alternative medical practices. They argue that, while complementary therapies are widely used by patients and frequently recommended by doctors, there is a dearth of published evidence on effectiveness. The establishment of a cross-cutting 'field'- in addition to disease-specific groups - has three

advantages: many randomised controlled trials of complementary medicine interventions have not been published in standard medical journals, and therefore require specialised searches; the evaluation of complementary interventions presents unique methodological challenges that are not common issues in conventional interventions; the common conditions for which people seek complementary treatments are diverse.

10.2 Research on complementary medicine in primary care

As care for chronic conditions has become an increasingly large part of the role of general practitioners, so too has a need for the evaluation of complementary therapies in a primary care context. In 1998 the Royal College of General Practitioners considered a report from the Foundation for Integrated Medicine,[28] recognising the strong public demand for complementary practitioners. They emphasised that general practitioners and complementary and alternative practitioners shared one important philosophy, that of whole person care. The College identified two research questions as being of particular importance:

- What is the evidence of effectiveness and efficacy?
- What are the adverse effects? How often do they occur?

They found a summary table of research methods particularly helpful, and agreed with the authors of the report that randomised trials were of particular importance, but that other research methods, including qualitative research, could be appropriate to the research questions. The College also expressed their particular interest in research studies which separated out the provision of time from the therapy itself, anticipating that the amount of time provided by practitioners both in orthodox and alternative medicine is likely to be important and is in itself a key research question.

The table is reproduced opposite to provide context for the discussion on the choice of research methods:

Examples of research questions	**Some appropriate methods/designs**
PROVING (controlled trials)	
Is there a specific beneficial effect (efficacy)?	Explanatory RCT
How well does it work in practice (effectiveness)?	Pragmatic RCT Outcome studies
Is it safe, do benefits outweigh risks (safety)?	Pragmatic RCT Outcome studies Epidemiological studies
Is it value for money (cost effectiveness)?	Pragmatic RCT Cohort studies (prospective and retrospective) Case control studies
IMPROVING (developmental studies)	
Can I improve my results by changing the treatment (treatment variation and clinical outcomes)?	Clinical case studies Audit Reflective practice
Is this a useful diagnostic test (diagnostic accuracy)?	Comparative studies
How can we improve the organisation of our CAM service (organisational effectiveness)?	Quasi-experimental designs Multi-factorial studies Action research Audit
How can we make the referral system between GPs and CAM more effective (service delivery models)?	Organisational case studies, eg co-operative inquiry
How can I better understand and develop the relationship with the patient and facilitate their motivation and commitment to change (personal and inter-personal effects)?	Qualitative case studies Focus groups and interviews Audit
PICTURING (snapshots)	
Who uses which therapies and why (attitudes/current use/provision/consumer demand/purchaser demand)?	Population surveys Purchaser and provider surveys Focus groups and interviews
UNDERSTANDING (basic clinical research)	
How does the therapy work (underlying processes and mechanisms of action)?	Laboratory research Explanatory RCT Case studies
Can different 'systems of medicine' be understood within a common framework (relationships between theory and practice)?	Transcultural research Discourse analysis
DEVELOPING research tools	
How do we assess the full consequences of processes activated as a result of a therapeutic intervention (outcome measures instrumentation)?	Development and validation of measures and instruments Cohort studies

10.3 The need for primary health care service research and development

The research agenda arising from the 1997 White Paper *The New NHS: Modern Dependable*[2] focuses particularly on quality, equity and partnership. To better understand quality in primary care, questions concern the way in which services should be organised, and how health professionals consult with patients, in order to improve clinical outcomes and patients' experience of care. Research is also needed to define a broad range of valid indicators in primary care.

Referrals for anthroposophic treatments, both within and between practices, is an important topic for research because the transfer of patients within a PCG/T is likely to have cost saving consequences and patient outcomes may differ in different settings. Research areas include evaluations of different models of care and service innovations, investigation of patients' experience of care and identification of cost-effective methods for improving care within a PCG/T.

There are also questions that concern partnership: between practices; with other agencies; and with patients and carers. There is a need for a clear development agenda with research that defines the theoretical and conceptual frameworks and describes the partnership processes, identifies the outcomes of partnership working, and leads to questions about how to best measure 'success'.

10.4 Understanding, assessing and improving quality in primary care

There is a risk that the performance indicators used to monitor quality in primary health care will be concerned only with the biomedical aspects of care, because research into other aspects of care is relatively poorly developed. Research is required in order to redress the balance and ensure a more complete understanding of quality:

- What are the features of primary care that influence the users' assessment of quality and how can primary care groups and trusts (PCG/Ts) encourage and ensure that appropriate modes and standards of care are provided?
- How should the traditional model of primary care be developed to meet the changing needs and preferences of patients?
- What are the consequences of different forms of PCG/Ts for patients' perceptions of care (expectations, trust, satisfaction, enablement) and clinical outcomes?
- What is the relationship between patients' perceptions of, or reactions to, care and clinical outcomes and which consultation competencies particularly influence the outcome of care?
- Which are the most effective methods of overcoming consultation weaknesses and enhancing strengths? The development of an operational measure of patient-centredness and methods to implement it, such as incentives and investigation of the relationship between patient-centredness and measures of biomedical performance.

Research is required to define a broad range of indicators of quality in primary care:

- the use and implementation of national service frameworks in primary care and the need of PCG/Ts for practical methods for identifying the needs of their local populations, monitoring the performance of primary health care teams, identifying and applying research evidence, and involving the community in planning and evaluating care;
- effective methods of clinical governance including the validity, reliability and impact of revalidation; and the particular organisational features of PCG/Ts that support quality.

Several research questions relate to improving quality in PCG/Ts:

- Does clinical governance result in improvements to quality of care? If so, how?
- What incentives are used, and which are most effective in influencing patterns of professional behaviour?
- What aspects of care do PCG/Ts focus on? Are these the most appropriate? Do they include the more difficult aspects such as communication with patients? How can all practices be involved?
- Does clinical governance lead to multidisciplinary quality assessment; does quality improvement cross inter-sectoral boundaries (e.g. with complementary therapists)?

10.5 Addressing co-morbidity and professional Issues

Co-morbidity may be defined as the extent to which health and social problems are concentrated within families. Its impact may be considered not only in terms of the effectiveness of primary care consultations, but also the consequences for delivering high quality care to such families when they are concentrated within some practice populations and such practices are concentrated within some local areas. Relevant research issues include:

- the prevalence and nature of co-morbidity and the effect of co-morbidity on help seeking behaviour and concordance with professional advice;
- the effect of co-morbidity on consultations in primary care and the implications for chronic disease management.

Primary care is particularly demanding in many respects, not only in terms of the effects of co-morbidity on consultations and the organisation of care, but also the life circumstances of the population served and their effects on help-seeking behaviour and concordance with professional advice:

- How do health professionals cope with high levels of need and demand and do they recognise and address the wider health agenda?
- What are the motivations and professional satisfactions of professionals who work in anthroposophic Medicine and what do they consider that they can realistically achieve?

10.6 Methodological and capacity developments

The amount of research undertaken in primary care has increased in recent years as a result of increased investment through the NHS R&D programme. The low level of funding for R&D in primary care is beginning to be addressed, but an inevitable consequence of past limitations in funding is restrictions on the amount of research relevant to primary care, and research capacity in primary care is still restricted. The funding of studies in this field is heavily dependent on NHS sources, with a relatively smaller contribution of research councils, charities and commercial funders. There is a particular need for coherent programme funding for the evaluation of complex interventions. There is a consensus that the capacity of many or most primary care organisations to deliver key aspects of current policy is limited and there is the need for a clear development agenda. For research findings to make a difference in practice, there is a need to involve potential users of research findings at an early stage of the research process.

Research and evaluation around innovative training and development programmes to respond to the challenge of partnership working is also necessary. There is therefore an urgent need for capacity building in primary care which should take place along with those who are to be partners (universities as well as service) with a need to involve potential users of research findings at an early stage of the research process. There is a particular need for investment in research infrastructure in new and established research general practices and in establishing a research ethos and capacity in the newly emerging PCTs.

10.7 Future research on anthroposophic medicine in the United Kingdom

Following the exploratory study we report here, what other research needs doing on anthroposophic treatment in the United Kingdom? The largely positive experience of patients in the treatment programmes we have studied and the articulation of the levels at which treatment outcomes are apparent are striking. In itself our study does not directly address the effectiveness of these programmes, but questions about effectiveness arise directly from it. There is little conventional research on the effect of anthroposophic therapies on patients, so that one further step would be to evaluate outcomes for individual or programmes of therapies in some or all of the centres we have studied. This evaluation could be in comparison to 'normal' primary care or to other complementary therapies or to other innovations in general practice.

Other questions that emerge include the acceptability of anthroposophic therapies to a broader group of patients than interviewed in our study and the potential transferability of integrated therapeutic programmes to non-anthroposophic care settings. The relationship between the anthroposophic medical paradigm that we glimpsed in interviews with doctors and therapists and mainstream general practice could also be a focus of research. Finally the challenges in integrating anthroposophic general practices into referral and commissioning pathways within the new primary care structures could be explored in policy research.

The choice of clinical and health service research questions – traditionally the prerogative of researchers – is now debated more widely by clinicians and patients. Our research project arose from a strong perception among practitioners in the anthroposophic practices that their work needed external evaluation to complement the internal development of the practices and Park Atwood. The context of growing scrutiny of clinical and therapeutic activity within the United Kingdom and internationally contributed to this impulse. Decisions about future research will depend on choices by the practices, but also on the wishes of funders or commissioners of research.

10.8 Evaluation of effectiveness

The effectiveness of clinical interventions is difficult to assess. Even the evaluation of simple clinical interventions – single drugs or therapies – needs to guard against biases that threaten the internal or external validity of the evaluation. This is particularly the case when the effects of treatment on morbidity and mortality are not dramatic or when the outcomes of interest are heterogeneous and subjective (see previous chapter). Randomised controlled trials have evolved as a method of maximising the internal validity of evaluation of clinical and other interventions.[29] Internal validity is undermined by changes in the health status of patient group that are independent of the intervention (spontaneous improvement of back pain for instance) and by selection bias, which means that patients likely to improve are selected for the intervention and compared to patients less likely to improve in a comparable group. Other methods of comparison, such as case control studies are useful for some questions (e.g. adverse effects of drugs or environmental/occupational hazards) but are prone to strong selection bias if used to evaluate treatments.

Randomised controlled trials are essentially quantitative comparative *experiments* in which participants have an equal chance of getting or not getting the intervention. By balancing the characteristics of participants at baseline, it is easier to estimate the effect of the intervention. Controlled trials are not the only method of reducing biases in the comparison of treatment methods. Parallel group designs that try to match the characteristics of participants in the groups can produce comparable results to trials in some settings, but 'hidden' confounding of the analysis is more likely if the participants are not randomised.[30] Other contributors of bias include the knowledge of participants which treatment they are getting and awareness of treatment groups by

investigators collecting data. 'Blinding' of participants and 'masking' of groups in data collection are methods of countering these potential biases.

The methodology of clinical trials for simple interventions has extended to the study of complex interventions both at the level of patient treatment and the health care organisation. The patient may be exposed to various treatments over a period of time (for example, in a chronic pain management programme) or the intervention may be targeted at patients and clinicians (secondary prevention programme after a heart attack). Complexity may also be introduced if different organisations are targeted or the intervention is modified and tailored over time. Randomised controlled trials are possible for complex interventions, but interpretation of these trials and an understanding of which components of an intervention are particularly effective requires qualitative methods as well as quantitative modelling.[25]

10.9 Is a randomised controlled trial feasible in anthroposophic practices?

We have shown in Chapter Nine that the use of validated patient centred outcome measures are acceptable to patients participating in anthroposophic treatment programmes and overlap with the outcomes that they report in depth interviews. These measures could be used in systematic audits of anthroposophic treatments to assess changes in the quality of life of patients. But before-and-after audits cannot evaluate the effect of the treatments compared to alternatives nor the effectiveness of the programmes. The patients entering these programmes will be self-selected; the emphasis in anthroposophic medicine on activating the will of the patient and their engagement in therapies means that they will not be comparable to patients choosing not to enter the programmes.

Randomisation of patients wanting to participate in the programmes into two groups, one participating and the other acting as a control group would allow evaluation of the effect of the programme itself. This creates an ethical dilemma for practitioners and therapists in the practices. Many patients registered with them have made a conscious choice to pursue anthroposophic treatments and randomisation to a control group (even if it is a 'waiting list' control group that eventually gets the treatments) would be seen as denying them treatment they have actively chosen. A solution to this dilemma comes from the status of some of the anthroposophic practices and Mytton Oak and Park Atwood Clinic as referral centres for local practices. It might be ethically more acceptable to the practices for patients referred from outside to be randomised into treatment and control groups. Recruitment of patients on this basis would be a challenge.

If one accepts that a randomised controlled trial of this kind was ethical, the issue of what aspect of treatment programmes to evaluate needs to be addressed. There are four possibilities:

- evaluate a whole treatment programme or package for the whole range of patients that we described in our exploratory study
- evaluate one treatment for a range of patients
- evaluate a whole treatment programme for a homogenous group of patients
- evaluate one treatment for a homogenous group of patients

The first option is closest to the real activity of the practices and would be a pragmatic trial. The problem with this choice would be interpretation of the results. Since none of the individual treatments have been conventionally evaluated, (in explanatory trials or other evaluations) it would be difficult to determine which aspects are more or less effective. It would also be more difficult to transfer the treatments into other contexts with any confidence.

The second (e.g. eurythmy for all patients referred) and third (e.g. range of treatments for patients with breast cancer) options fall half way between a pragmatic and explanatory trial and would be easier to interpret than the first option; although the evaluation of single therapy might be considered unacceptable by the therapists if the synergy between different therapies and treatments is considered essential for a full effect.

The third option would more capture more completely the effect of a programme and also would allow the use of disease-specific outcome measures in combination with patient centred measures. But recruitment of sufficient patients to fulfil sample size requirements might be difficult. The fourth option would be a 'pure' explanatory trial and logically would be the one to try first, except that it combines the weaknesses of the second and third options.

In this study we have explored the feasibility of using validated outcome measures. Before a full trial is implemented, it would be necessary to also pilot particular aspects: patient recruitment, adherence, standardisation (if multi-centred study) of interventions and follow up.

10.10 Beyond trials

We have made a case for a randomised controlled trial as an option for further research on anthroposophic treatment programmes in the United Kingdom. A trial will only answer relatively narrow questions about effectiveness, even if it uses the patient centred outcome measures that proved feasible in our study. Within conventional general practice, there is a well-articulated recognition that clinical trials are limited in their application to the complex needs of patients with multiple chronic conditions.[31] The focus on the individual patient in general practice[13] is amplified in anthroposophic practices in their view of the uniqueness of individuals and the aim of configuring unique treatment programmes to suit individual needs. Controlled trials are crude instruments for evaluating treatment effects in these contexts, but provide an objective measure that cannot be matched by other methods. Our study already provides a deeper understanding of what happens within anthroposophic practices and further qualitative exploration could address the relationship between these practices and mainstream general practice and assess how generalisable or transferable aspects of these practices are to the wider general practice community.

The argument in favour of more research on complementary medicine has received a boost from the recent report on complementary therapies by the House of Lords select committee on science and technology.[32] This committee emphatically recommended more funding for this research and endorsed a combination of qualitative and quantitative methods. The report mentioned anthroposophic medicine in passing, classifying it as a system "indifferent to the scientific principles of conventional medicine." This comment conflicts with our findings from interviews with anthroposophic doctors, all of whom prescribed conventional as well as anthroposophic treatment and welcomed further research. The select committee's judgement that there is "no convincing evidence of efficacy for any of the remedies" is also misinformed. For example, there is trial evidence for the benefit of mistletoe in the treatment of cancer, even though this evidence is not conclusive.[33]

Future research addressing the work of anthroposophic practices will be informed by the views of patients and clinicians, as well as by the concerns of conventional researchers and funders. The study that we have reported here was underpinned by a continual dialogue between researchers and practitioners, which we believe is essential for relevant health services research of mainstream or complementary health care.

APPENDICES

I DESIGN AND CONDUCT OF THE STUDY

A qualitative approach was adopted in this preliminary research to provide a systematic investigation of anthroposophic medicine in general practice. There was a need to 'understand and document'[33] the range of anthroposophic practice, particularly in the treatment of chronic illness.

The choice of in depth investigative interviews was made in order to develop the fullest possible information on anthroposophic practice. Due to the exploratory and responsive from, qualitative methods permit in-depth investigation into treatment 'effectiveness' in terms which are both relevant to and prescribed by those involved in it's delivery. Whilst emphasis must be given to the inability of qualitative methods to measure the extent to which outcomes are achieved, it is able, however, to provide clear insights into relevant outcomes, which allow wider inferences to be drawn about their nature and methods of achievement.

The three main components of this part of the research are:

- medical record analysis
- interviews with patients and various professional groups involved in the delivery of anthroposophic medicine to provide documentary evidence of the approach
- case studies of patients currently undergoing treatment

Medical record analysis

The chief aim of the medical record analysis was to characterise the patient population involved in anthroposophic treatment programmes. The participating centres provided records of patients during the full audit year of 1998 so as to incorporate any seasonal fluctuations (such as increased referrals for rheumatoid arthritis during the winter months). Basic details on demographic, medical, referral and treatment histories were provided. Fifty per cent of the total number of patients referred to anthroposophic services and therapies were randomly selected for analysis (SPSS).

Data was recorded from the NHS medical records of all those sampled, other than at Park Attwood, where only the use of clinic records was feasible due to the diverse geographical spread of patients. In the remaining six centres, medical records were accessed from the practice at which patients were registered. For externally referred patients, permission was sought to access the notes from the patients own GP. Among these, a small number were excluded for practical reasons because the general practice was more than twenty miles from the study practice.

The data extraction sheet shown in Appendix II was used to record information. The specific details sought are clarified in the 'Case Note Extraction – Variable Details sheet', also in Appendix II. Two researchers experienced in handling confidential medical records worked together to access and record details from patients' notes.

Several inconsistencies were noted from the data collection phase which were related to:

- legibility of notes: computerised records held by some of the practices of externally referred patients were the most comprehensive and less time consuming
- recording of socio-demographic information was variable between practices

- up-to-date summary sheets were only held by some practices, thus requiring additional time spent searching the main body of notes
- referral letters to secondary care services often provided clearer and more detailed information regarding socio-demographics, diagnoses and treatment histories than the main medical notes
- recorded dates of diagnoses were not clear in many cases
- diagnoses appropriated by anthroposophic doctors may in some cases differ from orthodox colleagues, thus diagnostic categories could be further expanded in future research to accommodate anthroposophic diagnostic concepts. Anthroposophic notes were often enriched with the inclusion of brief biographical data.
- detailed information on medication was particularly problematic due to the lack of clarity of recorded information. Some practices held computerised health authority records of prescribed medication, though this information was limited to the number of years the database had been in operation. Summary sheets of medication were particularly helpful in this respect. Accurate records of type, strength and frequency of medication prior, during and after anthroposophic treatment programmes may provide one valuable means for the assessment of outcomes.

After preliminary work at two centres, it was evident that a considerable amount of time was needed for data extraction. For this reason information gathering was limited to the key data in a random sample of 50% of the total number of cases that were initially sampled for analysis. In such cases data was not recorded on marital status, ethnicity, length of diagnosis and details of secondary care referrals and medication, (highlighted in bold on the case notes extraction sheet, Appendix II).

The data was analysed using SPSS and the results are presented in Chapter Eight.

Documentation of the approach

The principal researcher and one lead qualitative researcher carried out interviews with patients and professionals involved in the documentation and case study aspects of the research. The interviews were exploratory and interactive in nature and were conducted to obtain data on the following:

- aims and principles of the approach and the goals to which the practices aspire;
- how the approach is being implemented;
- how the approach is viewed by those involved in its development and delivery;
- the practice and its community setting.

The topic guides used for the documentation of the approach were structured similarly but with differing emphasis for service providers and patients. They are shown in Appendix II. Interviews lasted on average seventy-five minutes, with a longer time afforded to patients with complex conditions and treatment programmes. Interviews were recorded and transcribed verbatim.

Patients, therapists and other employees were purposively selected (see sampling and recruitment) to provide as maximum diversity in the circumstances and characteristics of the sample. The lead doctors were interviewed on more than one occasion to document their work, the overall organisational and funding aspects as well as case study follow-ups.

Case studies

The format of the interviews varied in the case studies, with different emphasis in interviews before and after treatment. The topic guides for practitioners and patients were designed to

extend the understanding of the treatment programmes and produce more specific evidence on treatment delivery and outcomes related to particular conditions. (Appendix II) For the purpose of continuity, the researcher involved in initial interviews conducted case study follow-up interviews. Patients were purposively selected to be part of the case study series (see sampling and recruitment).

Interviews with patients were approximately seventy-five minutes in length, again with complex conditions and treatment programmes requiring a greater amount of time. The doctors and therapists involved for each patient were interviewed for approximately forty-five minutes per patient. This was in some cases spread over a few interview 'sessions' as many practitioners were responsible for several of the case study patients.

Measures of patient-centred outcomes

As discussed in Chapter Nine, individualised measures were chosen because they most closely represent patient priorities for their lives and health care and provided a means for assessing the feasibility of patient centred outcomes for future studies. The questions have value in allowing patients to define and generate which symptoms and effects of their illness they see as most important for assessment. Both measures are currently being used in primary care research in the UK. The results of using these measures are discussed in detail in chapter nine (9.1.2).

The questionnaires were administered to 20 of the patients selected to take part in the study during the first interview, (in the case of the MYMOP, the majority was filled in by the patients facilitated by the researcher by telephone). Two participants did not complete the second part of the questionnaire, post-treatment, as one had not started the treatment programme due to hospitalisation and another had did not complete their treatment or take part in the follow up interview. Patient comments on the ease and relevance of the questionnaires can be found at 9.2.2.

Sampling and recruitment

All patients were purposively selected from the initial data supplied for the medical records analysis to achieve optimum diversity in clinical histories, referral patterns and socio-demographic characteristics (Tables I.1 and I.2). Professionals were also purposively selected to ensure maximum diversity of roles in the provision of anthroposophic treatment across all seven practices involved in this evaluation. Purposive sampling has similar qualities to 'maximum variation sampling' described by Patton.[35]

Documentation of the approach

Patients were selected from the initial data set provided by the centres for the 'medical records analysis' section of the research based on the following criteria; gender, age, source of referral, presenting condition(s), and anthroposophic treatment programme (see Table I.1). The target number of patients was four per practice and a minimum of four times that number was selected to allow for further refinement of the sampling criteria and some non-response. The doctor responsible for the patients' anthroposophic care assessed the list of patients to be contacted to ensure suitability, though doctors were not informed of which patients were interviewed. None of the selected patients were regarded as unsuitable.

Patients were sent initial packs with an introductory letter inviting them to take part in the research, from the centre from which they were receiving anthroposophic care, as well as an information sheet introducing the evaluation and explaining what their involvement would entail. Consent forms and Freepost (opt-out) cards were also enclosed for those not wishing to be contacted by the researcher.

A total of 114 patients were contacted across the seven centres from which fourteen opt-out cards were returned. Five patients declined participation upon contact and a further five were unavailable at the time data collection was being carried out. The opt-out system thus provided a rich selection of patients for the purposive sampling procedure.

Therapists, nurse, administration, managerial and fundraising staff were also purposively selected to ensure a balance between types of therapy and role in the organisational aspects of each centre.

Case studies

A similar method of recruitment was used for patients awaiting the start of the anthroposophic treatment programme. Doctors responsible for the patient's anthroposophic treatment programme eventually knew which patients were taking part in the research as they were also interviewed. Practitioners were not intentionally informed during the treatment programme so they were unaware of which patients were taking part in the research although some patients mentioned their participation to the practitioner.

Three centres were involved in the case study element of the research; Blackthorn Trust, St. Luke's Medical Practice, and Mytton Oak Foundation. Each represents respectively a *synchronised*, *unified* and *dedicated* practice (see Chapter two).

A total of fifty-one patients were selected, eight of which returned opt-out cards and seven refused on contact. The purposive sample was selected within diagnostic groups (see Table I.2) although some difficulties were experienced in finding sufficient numbers of patients commencing therapies during the recruitment phase of the research. For this reason, the recruitment period was extended and some patients who were some weeks into their treatment were selected.

TABLE I.1 SAMPLE STRUCTURE - QUOTA MATRIX
Documentation of the approach

Age	**Female**	**Male**
21-34	4	4
35-49	3	4
50-59	5	4
60+	3 (15)	3 (15)
Condition		
Muscular-skeletal	1	3
Mental Health	2	5
Neurological	2	2
Cancer	3	2
Multiple/idiopathic	6	3
Gynaecological?	1 (15)	(15)
Therapy		
GP only	1	
Massage	5- (2)	
Eurythmy	3 (2)	
Art	5- (5)	
Counselling	1 (2)	
Music	(1)	
Garden	(1)	
Combination:	**15**	
Music & gardening	1	
Counselling & Eurythmy	2	
Massage & Eurythmy	1	
Massage & Art	3 (1 rhythmical massage – PN)	
Counselling & Art	2	
Counselling group & Art	1	
Speech & Art	1	
Eurythmy, Art & Massage	2	
Combination @ Park Attwood	3	
Referral		
Anthroposophic GP	15	
Other anthrop GP @ practice	3	
Other GP @ practice–non AM	1	
GP outside practice	6 (3 Anthroposophic GP)	
Self	5	
Total	**15**	**15**

TABLE I.2 SAMPLE STRUCTURE – QUOTA MATRIX
Case Studies

Age	**Female**	**Male**
21-34	2	4
35-49	5- (1 DS)	2 (1 DO)
50-59	1	3
60+	3	
Condition		
Muscular-skeletal	2 (1 DS)	2 (1 DO)
Mental Health	3	3
Neurological	3	
Multiple	3	4
Therapy		
Massage	5	
Eurythmy	3	
Art	4	
Music	1	
Counselling	1	
Combination:	**6**	
Eurythmy & Art	1	
Counselling & Art	1	
Massage & Counselling	2 (1 DS)	
Massage & Art	1	
Massage & Eurythmy	1 (1 DO)	
Referral		
Anthroposophic GP	5- (1 DO)	
Other anthrop GP @ practice	3	
Other GP @ practice – non AM	2 (1 DS)	
GP outside practice	3	
Self	3	
Total	**11** (1 DS)	**9 (**1 DO**)**

D.S.: Did not start treatment programme
D.O.: Dropped out of treatment

Analysis

A systematic content analysis of transcripts of interviews from the documentation of the approach and the case studies was carried out with the use of 'Framework', a manual qualitative analytic method. The method has five key steps: familiarisation, identifying a thematic framework, indexing, charting and mapping and interpretation. Four researchers carried out the initial three stages, overseen by the two lead qualitative researchers. Consistency of meaning was checked through a small number of transcripts, which were analysed by more than one researcher. Five separate charts were drawn up for patients and professionals involved in the documentation of the approach and case studies. Doctor and therapist responses from case study follow-up interviews were added to the case study patient's data set to facilitate context and comparisons between responses. Information regarding the structure and organisation of the centres gained from doctors and administrative, managerial and fundraising staff were separately charted.

The final stages of analysis were carried out and reviewed by the principal researcher and the lead qualitative researchers. This form of analysis provides an explicit framework for both thematic analysis and interpretation. The charts permit both comparisons between respondents and the search for associations between responses. This method also ensures that the data from which the analysis has been developed is clearly accessible, and visible to those directly involved in the analysis and to external reviewers.

Preliminary presentation of findings

A conference was held in November 1999 funded by NHSE Research and Development West Midlands Region, to present the initial findings of the qualitative research and to discuss methodological issues associated with the evaluation. Contributions to this conference were made by members of the Anthroposophical Medical Trust, Queen Mary and Westfield College, the National Centre for Social Research and key figures in the field of qualitative and primary health care research and provision.

A further event was held in January 2000 among the research team and a representative group of therapeutic and administrative team members from each of the participating centres. Feedback from the above conference, preliminary findings in two key areas of the research, (referral criteria and outcomes), and the context of an anthroposophic approach within primary care provision were presented and discussed in small working groups. This event was specifically designed to help validate the findings and further triangulate the data gathered from the qualitative interviews.

II STUDY DOCUMENTS

DATA COLLECTION SHEET

Q. N°.	Variable ID	Variable Label	Value Names	Values
1	timea	Time started extraction		
2	pid	Practice identification number		
3	refpid	Referring practice ID number		
4	orefpid	Outside referring practice ID number		1-22
5	resid	Researcher ID number	J F JD JW	1 2 3
6	date	Date of extraction		
7	patid	Patient ID number		
8	gpid	General practitioner ID number		
9	post	Post code		
10	dob	Patients date of birth		
11	age	Patients age		
12	gender	Patients gender	Female male	1 2
13	status	Marital status	Married/co-habiting Divorced/separated Single	1 2 3
14	ethnic	Ethnicity	Ethnicity coding (see separate sheet)	1-20 99
15	ptime	Length of time registered @ practice	< 1 year 1-2 years 2-3 years 3-4 years 4-5 years 5-10 years 11+ years outside referral	1 2 3 4 5 6 7 9
16	curocc	Current occupation		
17	lastocc	Last recorded occupation		
18	strtprog	Date referred to AM program		
19	tncons	Total number of consultations 1^{c} team 7 years prior to AMP		
20	Sumdiag	Description of major diagnoses in summary 14 years prior to programme		

Q. N°.	Variable ID	Variable Label	Value Names	Values
21	notdiag	Description of major diagnoses in notes (referral letters) 14 years prior to programme		
22	catdiag	Category of diagnosis: Mental health, Neurological, Musculoskeletal etc		
23	diagat	Length of time had diagnosis *code these or put length of time on it*	1-5 years 5-10 years 10+ years	
24	diagbt	Length of time had diagnosis b		
25	diagct	Length of time had diagnosis c		
26	diagdt	Length of time had diagnosis d		
27	diaget	Length of time had diagnosis e		
28	diagft	Length of time had diagnosis f		
29	refspeca	Type of first specialist referral (7 years prior to programme)		
30	specawhy	Reason for referral a		
31	rspdata	Date referred to specialist a		
32	nuvisa	Total number of visits to specialist care a		
33	refspecb	Referral to 2nd specialist care (7 years prior to programme)	SOME LETTERS INDICATE WHEN CONSULTANT REPLIES BUT NOT CLEAR ON FIRST APPOINTMENT	
34	specbwhy	Reason for referral b		
35	rspdatb	Date referred to specialist b		
36	disspb	Date of discharge b		
37	nuvisb	Total number of visits to specialist care b		
38	refspecc	Referral to 3rd specialist care (7 years prior to programme)		
39	rpeccwhy	Reason for referral c		
40	rspdatc	Date referred to specialist c		
41	nuvisc	Total number of visits to specialist care c		
42	totref	Total referrals (7 years prior to programme)		
43	med	Medication @ time of referral to programme		

CASE NOTES EXTRACTION - DATA COLLECTION SHEET VARIABLE DETAILS

1 Date/time started extraction

2 Practice identification number

Identification number for the practice that the case notes are being extracted from (i.e. 01 - 07).

3 Referring practice ID number

Identification number for the practice that referred the patient (this should only be completed if it is one of the participating practices).

4 Outside referring practice ID number

Identification number for the practice that referred the patient (this should only be completed if it is **not** one of the participating practices). Hand-write the practice name before coding at input stage.

5 Researcher ID number

Identification number of the researcher who is filling in the sheet.

6 Date of extraction

Date the information is been gathered.

7 Patient ID number

Number allocated to patient from random sampling procedure.

8 General practitioner ID number

Identification number of the general practitioner of the patient.

9 Post code

The patient's post code.

11 Patient's age

Patient's age at time of treatment (calculated for 1998). To be completed prior to input.

14 Ethnicity

Ethnic group coded according to additional sheet.

15 Length of time registered at practice

Length of time the patient has been registered at that practice. Should be contained on cover of notes, sometimes written in the section marked CIPHER & DATE.

16 Current occupation

Current occupation of patient.

17 Last recorded occupation

Last occupation of the patient that was recorded prior to their current occupation.

18 Date referred to AM programme

The date when the patient was referred for treatment (i.e. either to the Trust, Foundation, or any of the therapies.). Where this is not possible the date treatments started should be used. If neither of these dates is available then the beginning of 1998 should be taken as the referral date.

19 Total number of consultations 1^{c} team 7 years prior to AMP

The total number of visits recorded in the notes to a member of the primary care team including, any general practitioner, practice nurse, etc.

20 Description of major diagnoses in summary 14 years prior to programme

Main diagnoses written on the summary card contained in the patient's notes. Diagnoses should be taken from the date indicated in Q18.

21 Description of major diagnoses in notes (referral letters) 14 years prior to programme

When no indication is given in the summary sheet then diagnoses should be taken from the notes and where possible referral letters to and from consultants. Main diagnoses only should be indicated here (exclude all minor illnesses e.g. cold, flu).

22 Category of diagnosis

Diagnoses will be categorised prior to input according to categories used in the documentation of the approach.

29 Type of first specialist referral (7 years prior to programme)

Type of consultant that the patient has been referred to in the seven years prior to the date indicated in Q18.

42 Total referrals (7 years prior to programme)

Total number of referrals to the different types of specialists in the seven years prior to the date indicated in Q18.

43 Medication @ time of referral to programme

Types of medication that the patient was taking at the time indicated in Q18.

NEW OPTIONS IN PRIMARY CARE

TOPIC GUIDE: INTERVIEW WITH PATIENTS

CASE STUDIES AND DOCUMENTATION OF THE APPROACH

BACKGROUND INFORMATION
Demographic information (age, occupation, educational background)
Present health problems
Length of time conditions existed
Any other long-standing health problems
Health problems prior to receiving treatments at the practice/clinic
Treatments for major health conditions prior to this referral (consultants/therapies etc)

REFERRAL
How were they referred to the service (self referral, non/conventional GP)?
Reasons for this referral (from self and referring GP)
Patient's understanding of why therapy(ies) may be beneficial for them
Length of wait to be referred for treatments – was there a gap, what happened?

TREATMENTS
Type of current/recent treatment
Expectations of treatment
Experience of treatment

HEALTH
What kind of changes in health do they expect/*have they had* as a result of the treatment programme?
To what do they attribute those changes?
Any other factors that are changing/*have changed* that may influence their health

MEDICATIONS
Changes made to the medication during treatment program (incl. new/anthrop/homeopathic)
Patients understand of why changes were made
Information given to them as to why changed
Changes in health that the patient thinks may be attributed to changes in medication

GENERAL PRACTICE & PROFESSIONALS INVOLVED IN AMA
Which professionals have been involved with the treatment(s)?
What form did that involvement take?
How do the 'anthroposophic' GPs compare to previous GPs?

EXPERIENCE OF SERVICE
Description of Patients experiences of treatment
Comparisons of the treatment with previous experiences
Changes in patient's involvement with their own healthcare
Changes in attitude towards patient's own illness

SOCIAL ELEMENTS
Description of experiences of social activities organised by the practice involved

FUNDING
Financial contributions made by patients
Patient's knowledge of how treatments are funded
Patient views on how these services should be funded

FUTURE
Future treatment planned/anticipated and patients views on this

OTHER ISSUES
Relevant issues raised by patients

NEW OPTIONS IN PRIMARY CARE

TOPIC GUIDE: FIRST INTERVIEW WITH LEAD GP

BACKGROUND INFORMATION
Type of practice/number of GPs
Number of patients in the practice
Characteristics of practice catchment area
When did the practice first open?
Major changes/developments
How is the practice structured?
What facilities/services offered?
Description of linked community /trust activities

LEAD GP
Number of years as GP
Number of years in present practice
Outline of medical career

DEVELOPMENTS OF AMA
When did the practice first start introducing anthroposophic approach?
How did it come about (in detail)/why was it introduced?
How was it first introduced?
How has the use of AMA developed over the years?
What were the major landmarks?

PROFESSIONALS INVOLVED IN AMA
Who is (and who is not) involved in the delivery of AM?
What form does their involvement take?

IMPACT ON REST OF PRACTICE
How does AMA impact on the rest of the practice (positive & negative)?
Are there any resistances? Details?
Has there been any significant organisational change as a result of implementation?
Any other changes as a result? Details?

TREATMENTS*
What treatments are on offer?
FOR EACH *Full explanation of what they involve?*
For what kinds of conditions/symptoms might they be recommended?
How long has this been available?

PATIENTS*
Numbers of patients treated (approx)
Over what period?
At present time
Are there any specific types of patients that are referred (subjective)?
Any specific illness that are referred more frequently than others?
Types of illnesses that respond better to treatment than others; which treatments

REFERRAL*
What is the referral process?
--From within the practice
--From outside of the practice
--Self-referral
How long do patients normally wait to be referred for treatments – is there a gap, what happens?
What treatments are on offer?
How are referral decisions made; what are key criteria – what makes one patient suitable, another not?

CRITERIA FOR JUDGING OUTCOMES*
What constitutes a positive outcome; what criteria are used?
How does this differ for different conditions/treatments?
What constitutes a negative outcome?
How does this differ for different conditions/treatments?

SUPPORT/LINKS
How do they connect with other practices?
- within AMA partners group
- in the UK
- abroad
- joint activities

Importance of linkage/support
Community activities and their impact

TRAINING & SUPERVISION
What are the training requirements to becoming an AM GP?
Who moderates/supervises?
Ongoing support & supervision
Who checks on standards/prescribing AM medicines?

FUNDING
How are the practice/anthroposophic elements funded?
Funding constraints difficulties?
Cost to patients – donations – Views about
How do they think they should be funded?

FUTURE DEVELOPMENTS
Developments planned
Developments they would like to see

OTHER ISSUES
Anything else they want to add/ that needs to be considered in the research
Anything specific to the treatment of chronic illnesses

* ***indicates items that will be revisited in*** subsequent ***interviews- overview only at this stage***

NEW OPTIONS IN PRIMARY CARE

TOPIC GUIDE: FIRST INTERVIEW WITH THERAPIST

PROFESSION RELATED INFORMATION
What kind of therapy do they practice?
Training background
How is their type of therapy related to AM (i.e. is the training specific to AM?; Are they aligned to the theoretical/spiritual notions of Steiner or is it that they specialise in one particular field)?
When did they fist get involved with AM & how?

INFORMATION SPECIFIC TO PRACTICES
How long have they been working at that particular practice?
On what basis are they employed (self-employed, hours, other involvements)?
How do they feel about working in a primary care setting?
Are they involved in any organisational aspects of the work?

TREATMENTS*
What treatments are on offer?
Do they know much about the other treatment programmes on offer?
FOR EACH *Full explanation of what they involve*
For what kinds of conditions/symptoms might they be recommended?
How long has this been available?
How does a usual treatment plan go – can they describe a 'typical' treatment plan?

PATIENTS*
Numbers of patients treated (approx. possibly just to their type of therapy)?
Over what period
At present time
Are there any specific types of patients that are referred (subjective)?
Any specific illness that are referred more frequently than others?
Types of illnesses that respond better to treatment than others; which treatments?

REFERRAL*
What is the referral process?
--From within the practice
--From outside of the practice
--Self-referral
How long do patients normally wait to be referred for treatments – is there a gap, what happens?
What treatments are on offer?
Are they involved in referral decisions?
How are referral decisions made; what are key criteria – what makes one patient suitable, another not?

CRITERIA FOR JUDGING OUTCOMES*
What constitutes a positive outcome; what criteria are used?
How does this differ for different conditions/treatments?
What constitutes a negative outcome?
How does this differ for different conditions/treatments?

SUPPORT/LINKS
Do they work in any with other GPs/ other 1^{c} centres / other places of work?
How do they connect with other practices in the UK and abroad?
Importance of linkage/support?
Community activities and their impact?

TRAINING & SUPERVISION
What are the training requirements to becoming an AM Therapist – has it changed?
Who moderates/supervises?
Ongoing support & supervision
Who checks on standards/prescribing AM medicines?
In what way do they think benefits of AM could be measured?

FUNDING
How are the practice/anthroposophic elements funded?
Do they get involved with funding aspects?
How do they think they should be funded?

FUTURE DEVELOPMENTS
Developments planned
Developments they would like to see

OTHER ISSUES
Anything else they want to add/ that needs to be considered in the research
Anything specific to the treatment of chronic illnesses

* ***indicates items that will be revisited in*** subsequent ***interviews- overview only at this stage***

NEW OPTIONS IN PRIMARY CARE

TOPIC GUIDE: FIRST INTERVIEW WITH PRACTICE/PROJECT MANAGER

PRACTICE/PROJECT MANAGER ROLE AND INVOLVEMENT
What is their role in the practice?
How long have they been working at that practice?

BACKGROUND INFORMATION
How is the anthroposophic work administrated – separate/integrated?
What aspects of anthroposophic work to they get involved in?
Was the practice already taking an anthroposophic approach when they joined?
Did that have any bearing on whether they applied for the job?
Or:
Has the introduction of AM changed the nature of their job?
How different from other PC settings?
How are records held – any indicators of how can access & organise?

DEVELOPMENTS OF AMA
When did the practice first start introducing anthroposophic approach?
Do they know anything about how did it come about (in detail)/Why was it introduced?
How has the use of AMA developed the practice over the years?
What were the major landmarks?

IMPACT ON REST OF PRACTICE
How does AMA impact on the rest of the practice (positive & negative)?
Are there any resistances? Details?
Has there been any significant organisational change as a result of implementation
Any other changes as a result? Details?

TREATMENTS*
Do they know anything about the treatments that are on offer?
FOR EACH *What they involve*
For what kinds of conditions/symptoms might they be recommended?
How long has this been available?

PATIENTS*
Numbers of patients treated (approx)
Over what period
At present time
Are there any specific types of patients that are referred (subjective)?
Any specific illness that are referred more frequently than others?

REFERRAL*
Do they get involved in the referral process?
What is the referral process?
--From within the practice
--From outside of the practice
--Self-referral
How long do patients normally wait to be referred for treatments – is there a gap, what happens?
What treatments are on offer?

SUPPORT/LINKS
How do they connect with other practices?
Joint activities
Importance of linkage/support
Community activities and their impact?

FUNDING
How are the practice/anthroposophic elements funded?
Funding constraints difficulties
Cost to patients – donations – Views about
How do they think they should be funded?

FUTURE DEVELOPMENTS
Developments planned
Developments they would like to see

OTHER ISSUES
Anything else they want to add/ that needs to be considered in the research
Are they the best person to get in contact with for case notes extraction

- ***indicates items that will be revisited in*** subsequent ***interviews- overview only at this stage***

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