(Published in The Homeopath, Autumn 2000)

Can I have it on the NHS? The human side of working in general practice

Francis Treuherz MA RSHom FSHom

Dear Friends
I am happy to be here amongst friends, and hope that I may speak frankly which means take some risks and say more than one might usually say in a formal lecture. When this contribution to the conference was first arranged I was in optimistic mode, but now a note of realism has arisen. I have been working in the NHS since 1990, but since April when fundholding ended I am working for less hours than I ever was before.

I want to share with you some of my experiences of what it feels like, some of the tales of what actually happens, some of the sorts of things we would not wish to see in the Guardian or Times tomorrow so not too many red herings from journalists present please.

I strongly believe that one way to be effective is not to make claims, not to make claims to cure. There are urges by allopaths to classify us by deciding to discover what conditions homeopathy is good for, what we could help them with. Can we cure flu or multiple sclerosis? I say we should avoid this. We know that we work at curing people. Instead I presented a protocol based on my work at Marylebone which avoid these ethical pitfalls and remains true to our spirit of working with people rather than disease names. To my mind the way to get it on the NHS is to appeal to their passion for management of patients so that we may cure them.

OHP or HANDOUT

Bounds Green Group Practice: Primary Heath Care Team
To: Dr **********
From: Francis Treuherz, Homeopath
Subject: Referrals for homeopathy, some suggestions

Here are some criteria for referral. They do overlap and are not in priority order. These may guide you with deciding who is suitable for referral. If you are unsure whether someone is suitable do discuss.

To raise the level of health of the patients.
To reduce costs through the provision of homeopathy.

- To reduce the need for long term palliative medication.
- To reduce the demands made by some patients on their medical practice.
- To prevent the need for non-urgent surgery.
- To assist patients where there is no known diagnosis, where tests disclose nothing abnormal, but the patient is suffering.
- To assist patients with chronic disease where there may be a poor prognosis without an alternative approach.
- To assist patients who have requested homeopathy, for themselves or their children.
- To assist in cases where drug treatments are contraindicated, for example in pregnancy.
- To prevent the need for referral to expensive specialists.
- To provide an environment where the relationship between a patient's physical and emotional or somatic problems may be discussed without any label of mental illness.
- To provide information and guidance on safe homeopathic self-care for minor ailments and so prevent the need for medical intervention.

For medico-legal reasons all referrals should be authorised by a doctor, even if this is just a line in the notes or the computer.

STARTING UP

When I began my practice full time in 1984 I had bad dreams about my abandoning a stressful career in public social services and University teaching, for private medicine. It was a part of my belief structure that all such health and social services should be freely available for all and provided by the state with some space for voluntarism also. But as I went through homeopathy college I realised that what the state provided was not adequate, it was a sickness service based on medical practices that seemed to break the Hippocratic oath of 'at least do no harm'. So on these grounds I adopted the Hahnemannian ethic of 'rapid gentle cure' as more positive and allowed this to also to become more important than my fears of the bogy of private medicine. I worked as a homeopath for 6 years (with an half year interval for a study trip to India and Greece.)

I have worked in a pre fundholding practice, and in a fundholding practice and in two non fundholding practices. I still work in one of the latter, but of course they are all now in Primary care Groups (PCGs). How I was recruited to each of these was different and even in the new PCG environment such methods still persist.

MARYLEBONE HEALTH CENTRE

In the summer of 1990 I was approached by the Marylebone Health Centre, would I like to be apply for a post of part time homeopath and be interviewed? Would I just. I called my friend Miranda Castro to talk it over and discovered that she too had been invited. The interview was curious in that I was asked in 3 different ways, what was my attitude towards conflict? How would I resolve conflicts? Would I create conflicts? I made suitably placatory, compromising and mild responses, while inwardly wondering what hotbed of controversy was I entering. I had also explained something of homeopathic principles and these were not up for bending.

Marylebone at that time was a self conscious and deliberately conspicuous experiment designed to change the nature of primary health care and general practice set up by Dr Patrick Pietroni and friends. (Some of these people were heavily involved in the British Holistic Medical Association. While professing an interest in alternative ways of approaching healthcare this body would not admit non medical members.) The location was a special conversion of the crypt of St Marylebone Church into a subterranean clinic. This was before fundholding, but Dr Pietroni had procured funds from a Foundation to support his work, and managed to interest Prince Charles and the then Conservative government and its Ministers of Health. In addition to the GPs there were what he called complementary therapists, providing massage, traditional Chinese medicine, osteopathy, counselling, and homeopathy. Also there was a student health service for the nearby University of Westminster. The whole project included built in research, quantitative, and qualitative, the latter including much emphasis (perhaps it was stress!?) on the dynamics of the group of practitioners and the psychological processes involved in sharing patients and working as a team. The team met weekly and there were also regular days for reflective interdisciplinary discussions. We all had to fill out countless monitoring and referral and evaluation forms, which changed frequently. One day each week was never enough.

A regular program of publication was promoted, usually these were academic articles in medical journals signed by those with medical qualifications who were seeking academic advancement. The whole project was firmly in the hands of the medical profession. The team and the people were great and convivial colleagues. But we all knew who was boss, especially when the team attempted to turn itself into a collective in order to change a hierarchical or even despotic management structure. The doctors would not let go of the partnership model. They were the partners and the rest of us were sessional hired hands.

At an early team meeting I heard the term heartsink patient, and brought everyone to their knees with laughter by asking if this was a cardiac condition I had not met before; no, it was that one's heart sank when seeing the name of a certain patient in the diary … .

Another interesting term is cure. I had been used to hearing and using this word as we all are as students and practitioners. GPs use the terms 'management' and 'containment' instead. Doctors did not seem to like hearing the word 'Cure'. Their sights were lower. I avoided controversy by getting on with curing my patients but not being pretentious about it or making claims. Also gender roles were unreconstructed. The GP partners were male, the osteopath, the Chinese medicine practitioner the homeopath and the research boffin were male, a part time GP, the massage therapist and the counsellor and all the administrators and nurses were female.

It was often difficult for the doctors to decide to whom to send the patients, and it was clear that some referrals were to a person rather than just to the therapy he or she practised. This was a hint that the doctors did not all grasp what we were about.

Here, as in every place I have worked, I was given complete clinical freedom to work as I wished, as a homeopath, with any patient referred to me. Only at Marylebone I was discreetly given some signed blank NHS prescription forms each day and could write in the remedy names for myself. And I know in the way that we all know, that I saw some remarkable cures. I reported on two of them in the small remedies presentation I made at an SoH cases conference in 1992. For example one patient was referred for a cough but I cured him of chronic fulminating hepatitis with a prognosis of liver failure, as well. Another had hypo or hypercalacaemia, they could not diagnose which.

I cured another patient of TB after conventional drugs had failed.

I produced an outcome study of all my patients seen over 3 years from 1990 to 1993. The results were spectacular. No, not what you think, I produced the same sort of results that most of us do, many remarkable cures and improvements, many people who were much better, some who remained about the same, and some who were not helped and or never came back. No, what was spectacular was that I was not believed. This is where I helped create conflict. It was made clear to me that it must be because I was so nice, and because I spent so much time with them, that the patients had improved. It could not have been the medicines. Scepticism. I could not believe it. The word Holistic was interpreted by the GPs as meaning taking a view of the patient as a whole person, understanding somatic illness, being sympathetic, but not having really learned any more therapeutic responses than reaching for the prescription pad. I was not allowed to publish my audit and I was dismissed on the pretext of lack of funds. The team were shocked but powerless to do much, and fearful for their jobs. A subsequent book about the centre avoided all mention of the presence of a homeopath. (Patrick Pietroni & Christopher Pietroni, Christopher, *Innovation in Community Care & Primary Health, the Marylebone Experiment*, Edinburgh 1996.) It was some 5 years before another RSHom was appointed, and the same professional imbalance is still in evidence when it was a doctor who presented research results of homeopathy at the RLHH conference in April, instead of their new RSHom.

The total experience was a great one, the total impact of that centre has been enormous, in opening the way for imitators, and improved imitators at that. But working there was to work for a less than benevolent dictatorship. I fear that the ideology prevalent at this centre will provide the basis for the Integrated Medicine approach in which Stephen Gordon is involved and I look forward to his comments.

FITZROVIA MEDICAL CENTRE

I wrote many letters, rather anxiously but I soon found another GP in the same neighbourhood who wanted a part time homeopath. We already knew each other from a different context. The Fitzrovia Medical Centre had just lost a part time GP who was a medical homeopath (MFHom). I was welcomed warmly. It was agreed that as a smaller practice I would be employed for one half day each fortnight, for a low fee, and would be able to see my own patients privately for a low service charge one day each week, and so it has remained from 1993 to now, even in the new PCG system.

The practice is very relaxed and laid back. I have many medical students placed with me for half days. ‘Go upstairs and spend the morning with Francis and do not believe a word he tells you!’ was the refrain which has mellowed over the years. I have never attended a team meeting and am not even sure when they take place.

What has changed is the whole climate externally, and the attitude of the full and part time GPs internally. Dr John Cohen, the senior GP partner, at least in years, has recently left University College Medical School where he was a GP trainer to become a Professor and head of the department at the University of Westminster which now validates the LCCH course. (The Department of Primary Care and Community Health). This came into being directly through the work of Marylebone. His inaugural lecture emphasised Integrated Medicine. He is not sure what happens when someone is prescribed a homeopathic remedy but acknowledges that something does happen and that he should like to enable it to happen by integrating the homeopathy into his practice. He is considering Chinese medicine but has not yet considered how he would distinguish which patient would be sent for which alternative.

I have not done an audit here, but I know I am kept busy within the limits of the size of the practice, some doctors refer more than others, but there is no argument or stress. I am accepted as a normal part of the small team. Any consultations about patient progress is done informally.

I was paid by the health authority for a while, and now I am paid out of the practice budget, and whether the PCG have any policy I am not clear. I expect I shall be the last to know.

BOUNDS GREEN GROUP PRACTICE

That same summer of 1993 I also found myself on a network of events which led me to the fundholding practice. I taught on the Oxford course for medical homeopaths and one of the students was a partner at Bounds Green. I had seen some patients from Bounds Green at my private practice, then a member of staff, then the child of a GP, then a GP came as patients. I met one of the GPs at a medical ethics study day. I was invited in on the basis of a fortnightly half day which immediately became one day weekly. I was there each week on the day that the Primary Care team met, so I could attend the regular meeting and become a part of this team. I

started for myself keeping records, which 5 years later resulted in the report which is being launched today. I was fortunate to be given a grant by the Homeopathic Trust to complete this work.

It was daunting at first to find myself in a large team. Some were supportive, some were frankly sceptical. There were many doctors, GP trainees, nurses, health visitors, psychiatric nurse, midwife, dietician, physiotherapist, podiatrist, visiting specialists like a surgeon, psychiatrist, and a neurologist, as well as a yoga teacher, shiatsu practitioner, acupuncturist, osteopath, a stream of students came and went, administrators, and me. There was nothing self consciously experimental about this practice. It was simply doing its job to a very high standard, and doing it well. The staff worked as a team with little stress. I was often asked for my opinion when cases were discussed, and taken very seriously. I was given opportunities to present my work to discuss my own cases, and on one occasion to present Hering's law applied to asthma and eczema as a sequel to a specialist nurse discussing her asthma clinic. This was to me a very moving occasion, presenting Hering's law to a multi disciplinary mainly allopathic team. Some of the group were very interested, borrowed books, and continued the discussions over some weeks.

I recall one doctor who was a sceptic initially, sending back a patient for a second referral a year after some treatment, he was a middle aged man with an enlarged heart, and was also a smoker, very obese, unemployed and very depressed; a walking health risk. The referral simply read 'Francis, please do another of your miracles on this man.' I mean it when I say I felt integrated into this team.

Some of the staff at all levels became patients and here confidentiality is essential and tricky as they did not all know about each other. This happens to me wherever I work, with no conscious recruiting. Can you help someone with 'x' and I know they mean themselves. Bounds Green was no exception. Be prepared for this.

One of the partners was by now a Faculty member and this was important. At Marylebone there was no supervision for my role as a homeopath, only as a team member. Here we sat down regularly for peer supervision about our cases on paper, and if we were really stuck we also saw each other's live patients together. Imagine that. We are taught as homeopaths to learn to practice alone, but perhaps reluctantly, with some supervision. Here I was a full member of a multidisciplinary and multi-level medical team where we even admitting that sometimes we were stuck, and in peer supervision with an MFHom.

The practice was also a teaching practice with GP students on longer placements, so I became accustomed to open minded advanced medical students and even GP trainees (people who were already doctors doing advanced professional training) spending a day with me.

I also enjoyed having some homeopathy students. I must say that this was very demanding but rewarding. I would never have someone whom I had not met first, to ascertain that I thought that we could work together harmoniously. They had to understand the nature of this kind of work for which there is rarely preparation in college, and that they were willing to attend the team meeting as part of the experience. I felt they were my ambassadors for the future.

DR RAJ SINGH IN N15

One of the associate GPs who referred many patients was an allopath from New Delhi who knew the value of homeopathy from India. He left to start up on his own as a single handed GP, and invited me to join him for a fortnightly session. He paid me from his own pocket until he persuaded the health authority to fund me. This was in a very deprived part of north London, with many ethnic minority groups, and consequent communication difficulties. Here I saw patients with advanced pathology, I could almost have been back in Calcutta. I am sure I have seen many more cases of more severe pathology than in private practice, and many more patients who are old, and or from ethnic minorities other than my own. Without my experience in India I could not have managed. I would recommend anyone thinking of joining Peter Chappell in the Balkans to work in an NHS practice like this one for the experience.

I recently saw a Bengali family. The father had a withered arm from an industrial accident and was not working, the toddler was headbanging and not speaking, and neither parent had much English. I arrived at my prescription from observing the child's behaviour with little linguistic explanation. Soon the child became still, and started speaking. We had no way to express our feelings to each other, later when my contract was terminated, the parents and myself, than to cry, all of us.

Evaluation at this practice was difficult as patients tended not to return even if this was

suggested. One found out later, perhaps from reception staff that all was now well. Or not!

In all these places I saw many many people who would never have come near private medicine for reasons of income. It was just a spending decision they were not free to make. Many of these people would never have chosen alternative medicine. While there were always some who chose homeopathy, there were more who had never heard of it. I saw many people who lived on benefit, who were refugees, or settled immigrants. I also saw just a few who had been to an RSHom and now preferred to get it on the NHS.

I saw patients who were referred rather than chose to come to see a homeopath and have absolutely no interest in who we are and what we do, nor any insight into how to talk about themselves. We know that the right remedy will change that but we have to get through to them what we wish to know.

I was always given enough time, one hour for new patients and a half hour for follow up patients has always been enough. Occasionally I have asked someone to return for a further half hour. When I have run on, there was always a consultation that took less time and I caught up again, much the same as in private practice. And also like in private practice mothers will turn up with 2 or 3 children when an appointment was made for just one. It is important not to prescribe for any child who was not referred, and one learns to judge what can be fitted in, and what can be signed for after the event.

HOW TO GET IN

I have no easy answer about how to get in except that I am sure from my experience that cold calling does not work. My own networks of friendships and of patients is what got me in apart from the first invitation which was some sort of spontaneous combustion. Find out which GP looks after many of your patients, and with their permission offer to go to see that GP and take a dossier with you, your boasting book. My first ever GP referral was in Manchester when I went to see my GP for my own needs, for an insurance interview. He thought I had come to see him about his patients, and had some files out to suggest that they see me and could I look at them and could I help?

RECORDS

In most practices now computer records are standard, they often use the EMIS system, (I do not know what these initials denote). When I began some places still used the small paper so called Lloyd George notes. In addition to our own notes we must conform to the NHS system. It is a good idea to become familiar with it, and learn to do a two line summary of a consultation and a detailed prescription so that it is exactly known what you have given and the dosage. This is essential even if the medics do not know what our remedy name means, but if it says 3 doses ONLY and the patient takes 3 daily every day they will know that she did not do what you asked, which they call non-compliance. These are the main means of communication about a patient, the open record. Then you will need to keep your own records and they will need to be kept in the practice.

A patient of mine died last week, a middle aged anorexic woman, cause of death as yet unknown, and having written her prescription into the record precisely, has turned out to be very useful. I was the last to prescribe for her. Luckily it has already been acknowledged that the remedy was not toxic.

No one has ever made a complaint or a claim in such a way that it became a problem but I have often wondered which takes precedence in a negligence case, the Practice and NHS procedures, or the Society's procedures. Or what if it was a medical doctor who makes the complaint? I hope we never need to answer this one. As I remarked the only complaint I had was being too successful. (I needed *Staphysagria* after my departure.)

HISTORY

Case taking is both the same as everywhere yet different. We are presented with a complete record of the patient, from birth and can see the names and ages of everyone who lives in the same dwelling. Often these records are not legible and have no relevance to finding the remedy. But equally often there is a letter from a specialist or psychiatrist or counsellor which summarises the whole case very well. We may learn about a termination or a depression or some other confidential item, and so this will colour our perspective. Or the patient will be new in the practice and have no records just like in private practice. Sometimes we will learn about some aspect of the patient's health that they have suppressed in their memory and this has its uses, but all of this changes our perceptions.

Sometimes we will learn of events that should not be recorded. One GP even told me that he is reluctant to put 'counselling' down in the records as insurance companies will put two and two together and totally misinterpret the reason and

this can affect the policy for no good reason. So this is something else to avoid.

You must have some reference books and well written introductory texts available, in addition to your software, for doctors to see, they sometimes become curious and ask to read about a remedy or our ideas. Useful books for patients or other staff like the midwife are a help for them in understanding our work. I would give medical students a small book to read overnight, or when a patient did not want a student present. Having my own examination instruments is useful. A small first aid kit including *Arnica* is essential. People expect me to have *Arnica* with me always.

PRESCRIPTIONS

It is in the NHS context that I use more disguises for remedies, although little placebo. *Nosode C* and *Lueticum* are recognised by my regular pharmacist. So is *Papaverum somniferum!*

Prescriptions must be written twice, once on an FP10 form for the pharmacy and once again for the patient in a way that they understand. I often suggest that conventionally 'the doctor says "you must finish the pills", this is the opposite.' If the patient is NOT on benefit then a private prescription may be cheaper depending on what is available locally. Ainsworths do a replenishing kit but it depends on how the rules are interpreted locally about dispensing inside the clinic. GPs are usually forbidden to compete with pharmacists except in rural areas.

I was dismayed in Bounds Green to discover a patient taking *Sepia* 10m 3 times a day although she came to no harm. I had prescribed just 3 in one day, period. The local pharmacy had obtained the remedy from Nelsons who sent a plastic tub with 125 pills, which had been given out minus my precise instruction.

I soon learned that in order to obtain the correct dose in a glass container with a typed label, to write 'ex Ainsworths' on the prescription and to add NP, *nomen proprium*, so that they would name the remedy. At that time Helios did not do NHS work, and Nelsons simply would not comply. Pharmacists in both retail community pharmacies, and large chains may be unfamiliar with the requirements of a standard homeopathic prescription as distinct from an over the counter bottle.

There will always be patients who will resort to their GP for antibiotics if they get a sore throat (even if it is viral) or earache or whatever. This was never a source of conflict as it is just the same in private practice. One has to realise that not all patients share our zeal and our ideals, and insist on using both schools of medicine simultaneously.

VACCINATIONS

Here is a potentially controversial subject which has never bothered me. I often see patients who wish to avoid vaccination, or who come to ask for help in making up their minds. I give them books to read, I tell them my own views if I am asked. I tell them that my children were not vaccinated if I am asked. I give them advice on how to cope with measles or whatever, and suggest to them a first aid book. I was often referred those patients who refuse vaccinations for their children. Of course the doctors perform vaccinations, and some of them do so despite their realisation that this is not a straightforward issue. But again this is not unlike private practice, when our values may clash, so all I can say is that we learn to love the contradictions we live with. I view my role as supporting the patients in whatever decision they take, and helping them take it if necessary.

EVALUATION

This is a vexed question as I am sure that I am really an amateur at this, despite all the training in qualitative and quantitative techniques I had at university. Some sort of audit or evaluation is essential to justify our work. And we need an economist, as costs was the weakest area of my report. How do we assess our value? Do our medicines cost less? Do our patients make less use of the medical practice? How can we put a value on enhanced quality of life?

Do we evaluate each prescription, or the changes from the start to the finish of each referral. Since it is our role to evaluate as a homeopath, between each prescription, I see that we should build our research onto this. What is different is how we record this verdict as evidence for research or audit rather than as evidence for our next prescription. How I have tackled this is to be seen in my full report. I want to mention here, with gratitude, that I was given the gift of time to do this by a generous grant from the Homeopathic Trust, that is the Trust which supports the Faculty of Homeopathy. Thank you.

Some would suggest that cure, the idea with which I began, was a weak area of my report as I aspired to rapid gently cure and my patients have few aggravations. A purist would say that aggravations are essential. My patients can do without them as in this context they would rush back to their GP and help create the conflicts which I think we can avoid.

THE END OR A NEW START?

I left Bounds Green with a heavy heart although I am still there. I see some patients privately, referred by the team members although now no referral is needed. The reason for my departure from NHS work, from Bounds Green and Dr Singh's practice in the same health authority, was prejudice of one powerful man, the Director of Public Health. He decreed that the new PCG may not be permitted to select homeopathy. He insisted that the PCG was a subcommittee of the Health Authority and as such could not make its own decisions in this matter. I can only display his letters so you can see what hit us. (After this departure I needed *China*.)

I attended a team meeting last week at Bounds Green. There were new nursing and health visiting staff. There was a new counsellor, osteopath, chiropodist, and great efforts were being made with private referrals as the practice has lost almost all its complementary services, and even some basic ones which it cannot purchase. The result is low morale, less feeling of teamwork, and the development of a private complementary health service within the premises of the NHS practice.

The new key words are equity and equality of access, which now seems to mean the lowest common denominator. Perhaps when the PCG itself becomes a Trust it can make its own decisions. To find work in a PCG is therefore likely to be much more bureaucratic, we will need to present a CV of our achievements, and a plan and a budget about how we would tackle homeopathy as a provider for a large group of GPs. Perhaps we can only do that if we are a team or a partnership, a PCG should have more homeopathic work than any one of us can carry out alone.

So, I have said very little about what is in the report on Bounds Green,[1] now published by the Society, which is more formal with statistical data as well as more stories. This talk was intended to be more personal. Do buy it and read it and I hope it will help us all find more work in the new NHS.

---

[1] Treuherz, Francis, *Homœopathy in General Practice*, Northampton 1999.