hijacking these effects for alternative medicine, certain aspects of conventional medicine should be reconsidered and these elements should be reintegrated into routine healthcare, wherever they are missing.[9]

In conclusion, if alternative treatments are found to be ineffective in rigorous clinical trials, it might be possible to make them appear effective in less rigorous, pragmatic, studies.[8] This approach of creating an 'alternative science' for alternative medicine is, however, profoundly misguided. It threatens medical progress and lowers the quality of healthcare.

References

1 Ernst E. Acupuncture: what does the most reliable evidence tell us? *J Pain Symptom Manage* 2009;37:709–14.
2 Zhao ZQ. Neural mechanism underlying acupuncture analgesia. *Prog Neurobiol* 2008;84:355–75.
3 Ernst E, Pittler MH, Wider B, Boddy K. *Oxford handbook on complementary medicine.* Oxford: Oxford University Press, 2008.
4 O'Connor BB. *Healing traditions. Alternative medicine and the health professions.* Philadelphia: University of Pennsylvania Press, 1995.
5 Hyman M. Paradigm shift: the end of 'normal science' in medicine understanding function in nutrition, health, and disease. *Alt Ther* 2004;10:10–5.
6 Black C. *Assessing complementary practice: building consensus on appropriate research methods.* London: King's Fund, 2009. www.kingsfund.org.uk/research/publications/complementary_meds.html
7 MacPherson H, Peters D, Zollman C. Closing the evidence gap in integrative medicine. *BMJ* 2009;339:b3335.
8 Ernst E, Lee MS. A trial design that generates only 'positive' results. *J Postgrad Med* 2008;54:214–6.
9 Ernst E. Disentangling integrative medicine. *Mayo Clin Proceed* 2004;79:565–6.

Address for correspondence: Professor E Ernst, Complementary Medicine, Peninsula Medical School, University of Exeter, 25 Victoria Park Road, Exeter EX2 4NT. Email: Edzard.Ernst@pms.ac.uk

EDITORIALS

Clinical Medicine 2010, Vol 10, No 5: 429–30

Community respiratory services

Roger J Wolstenholme

Community respiratory services are not new. They have played an important role in the management of tuberculosis, 'the white plague', from the Victorian era to the present. The British Thoracic Society guidelines on the management of asthma, published in 1993, promoted the development of the 'specialist' asthma nurse whose role often crosses primary and secondary care boundaries.[1] The pioneering work of the acute chronic obstructive pulmonary disease (COPD) service in Glasgow showed that many acute exacerbations could be managed safely in the community.[2] However, government aspirations to move care closer to the individual combined with the key drivers of patients' expectations and demographics have accelerated the desire for better and more consistent quality and safety in the community.[3] Prioritising the care of people with long-term conditions aided by care plans, self-management and personalised support requires increased flexibility and mobility of staff.[4]

COPD has an increasing prevalence and mortality. In the UK around 900,000 people have been diagnosed with the disease but the majority remain undiagnosed. Wigan, an archetypal post-industrial northern town with a male smoking rate of 31.7%, has a COPD prevalence of 1.86%, similar to that of Birmingham but, in both places, and indeed nationwide, the true prevalence is of the order of 5%.[5] The average age at which COPD is diagnosed is 67, usually after many years of increasing disability and debilitating symptoms. Confirmation of the diagnosis should be byspirometry. However this relatively simple test remains a source of mystery to many.

Accurate spirometry supported by correct interpretation and quality control provides the foundation for planned care. The spread of competencies by a 'ripple effect' from 'hubs' of excellence in the community will lead to an increase in diagnosis. The diagnosis, once established, can open the door to pulmonary rehabilitation (PR), surely one of the most cost-effective interventions of the 1990s. Lack of access to PR due to funding and logistical problems, notably transport, needs to be addressed by well-costed business plans and a decentralisation of staff and resources. Multidisciplinary teams of doctors, nurses, physiotherapists, occupational therapists and, where available, psychologists can lead to the development of personal action plans. 'Packages' of therapy, including, when indicated, simple antibiotics and oral corticosteroids, aid

Roger J Wolstenholme, consultant in integrated respiratory care, Ashton, Leigh and Wigan Community Healthcare

self-treatment to either abort or limit the severity of an exacerbation.[6] Prompt therapy leads to prolongation of time between exacerbations and has the potential to reduce short- and long-term morbidity.

Oxygen, and its supply, remains a thorny issue. Several areas, including East Lancashire and Hull have shown that an oxygen service can be safely and efficiently run in the community. Firm guidelines and leadership enable assessment and follow-up to take place. The technology, in the form of portable capillary gas analysers, exists to allow the long-term management of the hypoxic COPD patient as well as allowing readily titratable oxygen for patients with interstitial lung disease. Support of patients with bronchiectasis is ideally suited to community services. Specialist nurse and physiotherapy input with the use of nebulised and intravenous antibiotics is cost-effective and also ensures basic servicing and maintenance of nebulisers. Although not glamorous, such action and planning is vital to maintain standards.

It has been recognised for many years that palliative care should be provided to patients dying from all progressive illnesses, not just those with cancer. Collaborative working with palliative care and primary and secondary teams can aid choice in addressing end-of-life issues for patients, families and carers.

Consultant-led specialist COPD clinics have been introduced in Salford and parts of London.[7] Although they provide easy access to specialist advice, one in five patients may require further secondary care-based visits. In Wigan there is a preference for 'virtual clinics'. In these the consultant and/or specialist nurse visits practices and discusses 10–14 case notes in a session. This reinforces the vital educational component which is appreciated, cost-effective and aids integration between services.

Liverpool has used the average 'total bed days per patient' as an indicator of combined hospital and community care.[8] Community care alone, although popular with patients and carers is not enough.[9] Secondary care costs may increase as they become 'hyper-acute' and concentrate resources on the complex patient with multiple severe pathologies. Therefore potential problems remain with community care. Clinical governance, leadership and lines of responsibility are of paramount importance. A safe, cost-effective service must be the prime aim. Robust and reliable chains of communication for advice and support must be established. User-friendly and compatible information technology systems are vital to prevent duplication of care and waste.

'Attitude' may also be a problem. Socio-cultural aspirations and preconceived ideas of primary and secondary care physicians can limit progress. Lack of flexibility and an inability to either delegate, or give way gracefully to other professionals, where appropriate, can prevent or inhibit integration. Integration of community, primary and secondary care teams should not just be vertical but also horizontal. Specialist nursing teams for cardiac failure, diabetes, care of the elderly and timely support from social services can deliver equitable care where it is most needed, and wanted, close to home.

However, the future is uncertain. The recent White Paper[10] devolves increased power to general practice consortia. This may encourage developments in community respiratory care but there is a danger of fragmentation of services. A particular concern is training and education. Opportunism by private health companies and the pharmaceutical industry may lead to loss of transparency, inequality and doubts regarding accountability and clinical governance.

Getting the basics right in the community can provide consistently high quality care which in local parlance gives more 'pies to the pound'.

References

1 British Thoracic Society. Guidelines on the management of asthma. *Thorax* 1993;48:S1–24.
2 Gravil JH, AL Rawas OA, Cotton MM *et al.* Home treatment of exacerbations of COPD by an acute respiratory assessment service. *Lancet* 1998;351:1853–5.
3 Department of Health. *Our health, our care, our say.* London: DH, 2006.
4 Department of Health. *High quality care for all.* London: DH, 2008.
5 Eastern Region Public Health Observatory, www.erpho.org.uk
6 Effing T, Kertjensh H, van de Valk P, Zielhuis G, Van de Palen J. (Cost)-effectiveness of self-treatment of exacerbations or the severity of exacerbations in patients with COPD: the COPD ll study. *Thorax* 2009;64:956–62.
7 Diar Bakerly N, Roberts JA. Consultant–led specialist community COPD clinics: does it work? *Thorax* 2009;64(Suppl lV):A164.
8 Tack G, Walker P, Thompson E *et al.* Could the average 'total bed days per patient' be an indicator of combined hospital and community care. *Thorax* 2009;64(Suppl lV):A66–7.
9 Ojoo JC, Noon T, McGlone S *et al.* Patients and carers preferences in two models of care for acute exacerbation of COPD: prospective randomised controlled trial. *Thorax* 2002;57:167–9.
10 Department of Health. *Equity and excellence: liberating the NHS.* London: DH, 2010.

Address for correspondence: Dr RJ Wolstenholme, Ashton Leigh and Wigan Community Healthcare, LTC Suite, Boston House, Frog Lane, Wigen WN6 7LB. Email: Rogwolstenholme@aol.com