

ORIGINAL PAPER

A patient reported outcome measure in homeopathic clinical practice for long term conditions

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Background: This study was initiated as part of a quality improvement audit process to create standards around goal setting with our patients to understand and improve outcomes of homeopathic treatment.

Method: We used the Measure Yourself Medical Outcome Profile (MYMOP2) as a tool to assist clinicians in setting the treatment goals across a wide range of diagnoses and other complaints in routine clinical practice at the Bristol Homeopathic Hospital. The data collected from the MYMOP2 is of significance in its own right and the results are now reported in this paper.

Results: A total of 198 patients with a wide range of complaints attended one to five consultations with 20 homeopathic doctors. Diagnostic categories were most commonly neoplasms (16.7%), psychological (13.9%) and genitourinary complaints (12.3%), with 66.7% suffering from these problems for at least one year. The three symptoms that bothered patients the most were pain, mental symptoms and tiredness/fatigue. A paired-samples t-test using an intention-to-treat analysis showed that the MYMOP2 profile score improved from 4.25 (IQR 3.50–5.00), with a mean change of 1.24 (95% CI 1.04, 1.44) from the first to the last consultation ($p < 0.001$). Results were statistically significant both for completers ($n = 91$) ($p < 0.001$) and non-completers ($n = 107$) ($p < 0.001$) using last-observation-carried-forward, although completers did better than non-completers ($p < 0.001$). The overall clinical significance of improvements was at least moderate. A repeated measures ANOVA test also showed statistically significant improvements ($p < 0.001$).

Conclusion: The MYMOP2 results add to a growing body of observational data which demonstrates that when patients with long term conditions come under homeopathic care their presenting symptoms and wellbeing often improve. Offering a low cost high impact intervention to extend the range of choice to patients and to support self-care could be an important part of the NHS. *Homeopathy* (2016) ■, 1–9.

Keywords: Homeopathy; MYMOP; Long term conditions; Self-care

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Introduction/Background

The Bristol Homeopathic Hospital (BHH), at the time of this study was part of a large NHS foundation trust working on creating standards around goal setting with our patients to understand and improve outcomes of homeopathic treatment. The aim has also been to communicate goals and outcomes more effectively to referring colleagues and

commissioners of the service. A standard setting initiative carried out within the unit and linking to other UK homeopathic hospitals used a patient reported outcome measure, the Outcome in Relation to Impact on Daily Living (ORIDL) and it was found to be useful for assessing outcomes in a large population of patients.²⁶ In this paper we present the outcomes of the Measure Yourself Medical Outcome Profile (MYMOP2)¹⁶ data collected as part of a quality improvement audit submitted to the clinical audit department at University Hospitals Bristol NHS Foundation Trust.

Choice of outcome measure

ORIDL used in the standard setting initiative is an exit score where patients, with the help of their doctor, rate any improvement or deterioration of the presenting complaint over a package of care using a seven point numerical rating scale. The number of visits in a package of care vary from unit to unit. The BHH service introduced a package of care of one new patient consultation of one hour, plus four 20 min follow-up consultations spaced every 6 weeks to 6 months depending on clinical need. One limitation of ORIDL is that it does not have a baseline, so comparison of symptoms from before to after an intervention relies on recall. We therefore used the Measure Yourself Medical Outcome Profile (MYMOP2). As well as introducing a baseline score which helps to improve the credibility of changes in patients' symptoms, MYMOP2 encourages doctors to identify what patients experience as their most problematic symptoms, and records changes in those symptoms over time. This has the potential for doctors to use this information to set goals and report outcomes as a measurable response.

MYMOP2 supports an approach that values both conventional and complementary treatments which has been termed Integrative Medicine (IM) and is championed by the UK homeopathic hospitals. It has been extensively used in the integrative care setting,²⁰ in conventional care¹⁷ and complementary and alternative medicine (CAM) settings.⁴ It has been used to assess patients' experiences after treatment with acupuncture (e.g. Ref. 4), massage (e.g. Ref. 18), homeopathy (e.g. Refs. 2,11), and conventional medical treatment (e.g. Ref. 17).

MYMOP2 is a patient generated measure that has been validated against other quality of life measures such as EQ-5D, MOS-6A and SF-36.^{10,16,19,20} Patients are asked to volunteer the two most troublesome symptoms associated with their condition, plus an activity score and overall wellbeing score, all measured on a seven point numerical rating scale. A complaint may be a diagnosed disease, such as asthma or chronic fatigue syndrome, or an undiagnosed healthcare problem such as difficulties in breathing or lack of energy. Diagnoses and complaints often consist of several symptoms. The outcomes for these symptoms are tracked over time. This encourages and facilitates a more realistic setting of goals that relate to symptoms considered important by the patient, rather than the complaint or diagnosis itself. This makes the

goals of care patient-centred and it acknowledges the complementary nature of treatment modalities such as homeopathy and may be used to assess symptoms across a wide variety of complaints.

Aims

Aims of this audit were to use MYMOP2 to encourage medical staff to identify and record patients' most problematic symptoms, to facilitate goal setting, to assess outcome over time, to track utilisation of the package of care, and to test the internal consistency of the MYMOP2 profile score.

Methods

Recruitment ran from November 2005 to April 2006. Twenty patients for each of 10 doctors (i.e. 200 patients in total) in the BHH team were given a laminated letter inviting them to take part in the audit. All consecutive patients were included with the exception of two who refused to participate. As we merely observed routine practice no written consent was necessary. The doctor asked each patient to list her or his two most bothersome symptoms (sub-score 1 and 2) rated on a seven point numerical rating scale (0 = as good as it could be, 6 = as bad as it could be) as part of MYMOP2. If the patient was uncertain as to which symptom(s) to list, the doctor could help the patient by referring to what the patient had said during the consultation. MYMOP2 also identifies the patient's experience of the effect of her or his problem on a chosen (physical, social or mental) activity (sub-score 3) and general feeling of wellbeing (sub-score 4), both rated on a seven point numerical rating scale. The first consultation MYMOP2 form also asks patients to state how long they have had their most bothersome symptom. Patients are asked to rate the same symptoms at each consultation over the five visit package of care. MYMOP2 follow up form was completed at every subsequent visit attended. The main outcome measure was the MYMOP2 profile score comparing changes from the first to the last consultation for each individual patient. The profile score was the arithmetic mean of the reported sub-scores.

Assessing outcomes

The main analysis was an intention-to-treat analysis including both completers and non-completers and involved a paired-samples t-tests with a before to after treatment comparison as the difference in means for the main outcome measure (profile score) was found to be normally distributed (intra-individual differences were assessed using histograms and Fisher–Pearson standardized third moment coefficient = 0.060, normal range -0.281 to 0.281 for samples of 200). The median and interquartile range is presented for the MYMOP2 profile score and for all sub-scores as it is an ordinal rating scale and data therefore will be skewed. However, for the change in scores, the mean and standard deviation is presented if changes in scores are normally distributed, in

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