NUFFIELD COUNCIL ON BIOETHICS

Forward Look 2014
13 May

Complementary medicine

Introduction

The forward look session on complementary medicine began with presentations from invited speakers and respondents, followed by discussion among guests, members of Council and the secretariat. This note summarises themes that emerged during the meeting, and possible questions for further exploration. Views expressed are those of individuals are not necessarily shared by others present, or the Council.

Emerging themes from presentations and discussions

Role of complementary treatments

- From the 1980s onwards, a gradual change in attitudes to these therapies can be observed, from seeing them as 'fringe' or 'alternative' to 'complementary', and with the potential to somehow augment the effectiveness of conventional medicine.
- Today we might be moving towards a degree of integration between the 'two schools' of medicine (though some perceive that there is currently a backlash against complementary therapies, driven in part by negative media coverage).
- Suggested factors driving this change included frustration among health professionals and patients at shortcomings in conventional treatments. For example, one small survey of GPs[1] identified 'effectiveness gaps': a range of common conditions that GPs did not feel well equipped to treat on the basis of their training or where the available treatment was not effective or unsatisfactory for other reasons.
- Doctors dissatisfied with the options available to them in conventional medicine may as a result seek contact with or training for themselves in alternative or complementary treatments for new ideas on how to respond to the needs of patients with complex conditions.

[1] Fischer P, van Haselen R, Hardy K and McCarney R (2004) Effectiveness gaps: a new concept for evaluating health service and research needs applied to complementary and alternative medicine, available at: http://www.researchgate.net/publication/8360922_Effectiveness_gaps_a_new_concept_for_evaluating_health_service_and_research_needs_applied_to_complementary_and_alternative_medicine

Regulation

- Regulation is currently inconsistent in the area of complementary medicine: some professions are regulated and some are not.
- It was argued that where there is statutory regulation, this has often come about because professional groups have campaigned to become regulated for the status they gain from it.
- Since 2012 The Accredited Voluntary Register[2] has been in run by the Professional Standards Agency – effectively a consumer protection scheme within which there are 11 voluntary registers covering 27 different occupations and 47000 registrants including practitioners of complementary medicine
- There were different opinions on whether there is a need for more regulation in this area:
    - Some highlighted examples of advice from unregulated practitioners leading to very serious health outcomes for patients (e.g. by not accepting potentially life-saving conventional treatments) as a possible reason to have more regulatory control over these professions
    - Others pointed to the relatively low risks associated with complementary treatments in general and argued that regulation is "unnecessary, inappropriate and disproportionate" for most of these occupations.
    - From the perspective of someone sceptical of complementary treatments on the basis of the lack of evidence about them, regulating alternative and complementary treatments could be seen as official endorsements, with the possible effects of undermining the integrity of conventional (i.e. evidence-based) medicine and misleading patients into thinking they are equally effective treatment options even where this has not been proven.

Questions about definition/classification

- How do we decide what a complementary therapy is? A GP may suggest a wide range of measures in the care of a patient which do not necessarily fall under the rubric of conventional medicine – it could be acupuncture or it could be going on holiday or taking up a hobby.
- Historically treatments and medicines have moved between being regarded as conventional and alternative (e.g. the use of leeches).
- Instead of thinking in terms of 'two schools' of medicine, could one imagine a continuum of medical practices from treatments for which we are fully confident about the evidence base on one hand to ones for which there is no evidence on the other? On such a continuum conventional and complementary treatments may overlap.

[2] http://www.professionalstandards.org.uk/voluntary-registers/about-accreditation

Evidence

- The evidence is currently inconclusive for many but not all complementary therapies, and there is considerable critique of both positive and negative results that are published.
- Several difficulties in evaluating research on complementary treatments were identified, including:

    - The lack of clarity around the definition of the concept 'complementary medicine' and sheer multiplicity of available therapies and uses.
    - The variety of perspectives among practitioners even within a type of therapy (e.g. multiple strands of practice within acupuncture including 'western', 'traditional' etc) and the possibility of very different interpretations of results
    - Complexities related to the patients' interpretations of results: how they will report on these may depend on who they speak to.

Particular questions related to Randomised Control Trials (RCTs) and quantitative evidence

- The Randomised Control Trial (RCT) has become a 'gold standard' for testing the efficacy and effectiveness of medical interventions, but there are questions about how well this model - and quantitative research more widely – applies in the context of complementary medicine.
- For some, this indicates problems specifically with the RCT as a model for testing complementary medicine. Many such treatments are highly individualised, e.g. focussing on 'treating the person, not the disease'. This may not be compatible with the degree of standardisation required in RCTs. However, it was suggested that this problem may also come up in the context of new and more 'personalised' or targeted approaches in conventional healthcare such as in stratified medicine, so complementary treatments may not be unique in this regard.
- For others, any difficulties in applying RCTs and otherwise in gathering and evaluating quantitative evidence on the efficacy of complementary therapies can be seen as a reason in itself to regard these therapies with scepticism – if they cannot be tested, they should not be considered to be 'medicine'.
- It was argued that continuous, systematic and rigorous testing is how modern medicine has progressed to its current level and that evidence-based medicine should be the guiding principle for healthcare professionals and policy makers. If complementary treatments cannot be subjected to the same rigorous testing as is conventional medicine, this means that the uses of complementary treatments will not develop in the way conventional medicine is continually progressing.
- Meanwhile, it was felt to be important not to be naive about the evidence base in conventional medicine, where many treatments currently in use are not fully tested or understood.
- Moreover, participants were told that in current primary care practice, GPs will encounter a range of cases on a daily basis where "patients don't conform to the evidence", or where quantitative evidence is not entirely relevant or

helpful, e.g. ‘revolving door’ patients with complex issues, chronic illnesses, or physical symptoms with no obvious physiological explanation.

- It was argued that patients’ experience should be at the centre of health care - but is not always adequately taken into account in research. For example, it was pointed out that in evaluating (evidence about) treatments, doctors often discount side effects, although they can have a significant impact on patients daily lives (for example if incontinence is a side effect of an efficacious treatment).
- It was suggested that RCTs and quantitative research represented a reductionist view on medicine and that qualitative research may better capture patients’ experience of their own health and responses to treatment.

Choices and decision making

- Those who have to make decisions with regard to complementary treatments include
    - Patients and the public, who are often self-selecting and self-treating in complementary medicine
    - Practitioners and health professionals, both in conventional and complementary medicine
    - Policy makers, for example in terms of in terms of resource allocation in the NHS
    - Regulators
    - Funders of research

Private or public?

- Some suggest that people should be free to choose complementary treatments as they would any other private ‘ritual’ (e.g. prayer, exercise).
- Some, however, thought this was an unhelpful approach for different reasons:
    - Because all use of medicine can be described as being surrounded by ritual
    - Because ‘private’ choices made about complementary therapies can have a public impact (e.g. in creating a market, or because patients use such treatments while also being in publicly funded care)
    - In so far as they are used in publicly funded care or regulated by public bodies, they cannot be considered to be private.

Patient autonomy versus patient protection

- It was suggested that patients are not given enough information about their (complementary) treatment options or are being ‘scaremongered’ into thinking they don’t have a choice.

- Questions were raised about whose role it should be to provide information about complementary treatments and the available evidence about them:
    - What is the most ethical way to interpret the evidence for the purposes of informing patients?
    - How can or should we support patients to make choices about complementary medicine?

Suggestions for Council work topics

- An exploration of the current narrative of a dichotomy between ‘reductionist’ versus ‘holistic’ approaches to medicine
- A deliberation on the ethics of using placebo in treatment
- An objective assessment of the different types (e.g. qualitative and quantitative) evidence in medicine or in the wider policy context, considering questions such as:
    - Do current arguments about qualitative and quantitative evidence “stack up”?
    - What is *enough* evidence?
    - How should the evidence be interpreted, and by whom?