1

Introduction to the complementary concept of healthcare

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Definitions

Trying to construct a definition that covers a large heterogeneous group of complementary and alternative therapies is difficult. Many therapies are well known whereas others may be exotic, mysterious or even dangerous. Some relaxation techniques, massage therapies, special diets and self-help groups could be considered to be lifestyle choices rather than true therapeutic interventions, although it could be argued that an enhanced feeling of well-being is sufficient to warrant the inclusion of a procedure in the latter.

Support for the complementary notion of healthcare is far from universal. Saks rejects the term complementary and alternative medicine (CAM) because, in his view, it 'excludes therapies such as homoeopathy which in their purest form are based on philosophies that fundamentally conflict with medical orthodoxy'.[1] He opts for the term 'alternative medicine' and defines it thus:

> Alternative Medicine can be taken to encompass all the health care practices that at any specific point in time generally do not receive support from the medical establishment in the British context, whether this be through such mechanisms as orthodox medical research funding, sympathetic coverage in the mainstream medical journals or routine inclusion in the mainstream medical curriculum. (page 4)

The term 'alternative' is used widely in the USA, the point being made that not all alternative therapies complement allopathic medicine.[2] The opposite approach has been expressed by a paper in which the authors' aim was to determine the association between the use of non-conventional and conventional therapies in a representative population survey.[3] A total of 16 068 people aged 18 years or older were involved in the study. Participants were asked about their visits to

non-conventional and conventional practitioners during the past year. From the resulting data it was estimated that:

- 6.5% of the US population had visited both types of practitioner during the year studied
- 1.8% visited only non-conventional practitioners
- 59.5% visited only conventional practitioners
- 32.2% visited neither type of practitioner.

It appeared, therefore, that unconventional therapies were being used to complement orthodox treatments rather than to replace them.

In fact, CAM is often used alongside orthodox medicine (OM) to treat different aspects of a disease. Rarely are the two therapies used to treat exactly the same symptoms. In fact evidence suggests that many Americans use CAM in addition, rather than as an alternative to, OM.[4]

The following definition has been suggested by colleagues working at Harvard Medical School:[5]

> Alternative medicine refers to those practices explicitly used for the purpose of medical intervention, health promotion or disease prevention which are not routinely taught at US Medical Schools nor routinely underwritten by third-party payers within the existing US health care system. (page 5)

Lannoye has suggested that it may be misleading to make a firm distinction between the terms 'complementary' and 'alternative', because it is the precise context within which a therapy is being used that will determine just how it should be defined at any one time.[6]

Not all proponents of complementary medicine agree with the terms 'complementary' and 'alternative'. They believe that the use of such terminology serves to emphasise the gap between the OM and CAM approaches. They would prefer to see the various CAM therapies referred to as *specialities* within an integrated medical system of practice (see Chapter 2) and not grouped together under a separate label.

Complementary and alternative medicine is frequently described by what it is *not*, rather than what it is. Thus, it may be described as being 'not taught formally to health professionals' or 'not having a robust evidence base'. Current definitions often obscure the debate about holism and integrative care and give therapies and therapists precedence over patients in the design of healthcare systems, for example:[7]

> CAM is a group of non-orthodox and traditional therapies that may be used alone, or to complement orthodox or other non orthodox therapies,

> in the treatment and prevention of disease in human and veterinary patients. (pages 413–16)

The term 'traditional therapy' is defined in Chapter 11. Ernst et al have proposed the following definition:[8]

> Complementary medicine is a diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy or by diversifying the conceptual framework of medicine.

This definition poses at least two questions:

1. What is meant by 'mainstream'?
2. Whom does complementary medicine seek to satisfy?

A rather more comprehensive definition by the Cochrane Collaboration was reported by Zollman and Vickers in 2000.[9] The Cochrane Collaboration is an international organisation that aims to help people make well informed decisions about healthcare by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions. The main output of the Collaboration is through the Cochrane Library an electronic database that is updated quarterly and distributed on CD-Rom and via the Internet.

The Cochrane definition is as follows:

> CAM is a broad domain of healing resources that encompasses all health systems, modalities and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health systems of a particular society or culture in a given historical period.
>
> CAM includes all such practices and ideas self-defined by their users as preventing or treating illnesses or promoting health and well-being. Boundaries within CAM and between the CAM domain and that of the dominant system are not always sharp or fixed.

The definition of CAM differs slightly from country to country. For example, in Japan, Japanese herbal medicine (part of Kampo medicine) and acupuncture are covered by public health insurance, so Japanese practitioners of Kampo and acupuncture would object to their inclusion in CAM and would rather regard themselves as belonging to the authentic traditional medicine. However, these treatments are categorised as CAM in Europe and the USA.

The following definition is preferred by the author because it implies a greater degree of flexibility:

> CAM is a group of non-orthodox and traditional therapies that may be used alone, or to complement orthodox or other non-orthodox therapies,

in the treatment and prevention of disease in human and veterinary patients.

It would be appropriate to offer two further definitions at this stage.

Patients: by convention anyone who is unwell is usually called a patient derived from the Latin *patior* – 'to suffer'. Throughout this book this generic term will be used to identify people who are unwell, whether they are to be treated by orthodox or complementary medicine. This is not meant to imply that other words such as 'client' or 'customer' are inappropriate in certain circumstances, merely that one word is being used to prevent confusion.

Disease is used in its orthodox sense to mean the following related items, collectively recognised as having a separate coexistence and origin:

- A group of subjective problems reported by the patient (symptoms)
- Objective alterations in body functions, usually identified by a trained observer (signs)
- The results of various investigations or procedures (investigations).

It has been pointed out that disease and health are commonly thought of as distinct opposites.[10] In fact, both may be considered to be facets of healthy functioning, each necessary for the other and each giving rise to the other. Thus, disease may be thought of as a manifestation of health – it is the healthy response of an individual striving to maintain equilibrium within his or her body. Disease can be viewed as a meaningful state that can inform health professionals how to help patients heal themselves. People's problems then become 'diseases of meaning'.

The art and science of medicine

Throughout history there have been two separate traditions in the practice of medicine. One is the so-called 'art of healing' and usually involves its own specialised brand of training and relies mainly on a prescriber's intuition and patient perceptions of successful outcomes. The tradition should not be confused with the art of healing programme, an initiative that aims to use the arts as a form of therapy to soothe patients' minds and bodies and help them on their path to recovery[11] (see Chapter 18). The second tradition, the 'science of healing', is based on technological and scientific ideas and leaves much less opportunity for practitioners to express an innovative and intuitive approach to medicine.

In the past, the phrase 'art of medicine' was often applied to the practice of CAM. Practitioners have used the phrase to cover up a good deal of muddled thinking and uncritically accepted prejudices. The term is perhaps most misleading when applied to aspects of medical practice that are amenable to empirical study but about which sufficient data have not been accumulated. Practitioners commonly used the word 'philosophy' in a similar context, e.g. 'My philosophy for using antihistamines to treat allergies is . . .'. Implicit in such usage is the erroneous assumption that what has been labelled a matter of philosophy or personal opinion is thereby exempt from rigorous evaluation. This view has hampered the progress of CAM. However, the situation is being forced to change with the growing importance of evidence-based medicine to purchasers, providers and patients alike.

There has not always been a clear and strict division between art and science.[12] The purpose of anatomical images from the Renaissance until the nineteenth century had as much to do with aesthetics and disclosing the 'divine architecture' as with the intention of medical illustration. Medical science was more closely linked with a 'naturalistic observation' than with 'intervention', and this was the dominant view until well into the nineteenth century. Since then scientific medicine and non-scientific medicine have interacted. In some cases this interaction has had positive results, with one supplying features that the other has lacked, e.g. homeopathic remedies may be used alongside orthodox medicines to treat different aspects of the same disease. Complementary therapies usually stress the idea of restoring a patient's overall wellness rather than merely seeking a reduction in any particular clinical symptom.

Unfortunately, there has been considerable suspicion, and scepticism, voiced by members of the scientific and medical community when referring to CAM. Orthodox medicine insists that the evidence supporting CAM is flimsy or absent.[13,14] Some treatments are not supported by any randomised clinical trials at all. In other cases there are trials that are methodologically flawed with inappropriate conclusions. Sceptics go on to claim that the inability to explain mechanisms of action of most complementary disciplines equates to a simple placebo response at best, and quackery at worst. CAM proponents point out that many orthodox interventions are not proven to be effective beyond reasonable doubt nor can their mechanisms be adequately explained, yet they still remain in routine use. Further a placebo effect is evident in orthodox medicine. A study testing pain relief from analgesics showed that merely telling people that a novel form of codeine that they were taking (actually a placebo) was worth $US2.50 (£1.25 or €1.58) rather than

10 cents increased the proportion of people who reported pain relief from 61% to 85.4%.[15] When the 'price' of the placebo was reduced, so was the pain relief.

Modern scientific thinking believes that knowledge should be pursued by the following criteria:[16]

- *Objectivism*: the observer is separate from the observed
- *Reductionism*: complex phenomena are explainable in terms of simpler component phenomena
- *Positivism*: all information can be derived from physically measurable data
- *Determinism*: phenomena can be predicted from scientific laws and environmental conditions.

Complementary medicine just does not fit into this mould. Most complementary disciplines have developed from patient-oriented studies – observational and anecdotal information assembled over hundreds and, in some cases, even thousands of years. This does not answer the very real criticisms about lack of detailed evidence of effectiveness or concerns over possible dangers.

Complementary and alternative approaches to healthcare

Complementary and alternative medicine is a term applied to over 700 different treatments and some diagnostic methods. A distinction is sometimes made between CAM (involving the use of medicines or other products) and complementary and alternative therapies (including interventions that rely on procedures alone). In this book the term 'complementary and alternative medicine' (CAM) is used to describe all types of non-orthodox medicine.

The words *complementary* and *alternative* are often used interchangeably. In the UK, health professionals prefer to use the former because it implies an ability to complement or complete other treatments. There is evidence to show that this is what happens in practice. Users of CAM are not so much seeking alternatives as a result of direct dissatisfaction, but are more probably using complementary therapies in parallel,[17] except in the case of purchasing homeopathic medicines over the counter in a pharmacy.[18] Alternative, on the other hand, implies 'instead of' or a choice between two courses of action, e.g. whether to treat a patient with orthodox (or 'allopathic') medicine or with homeopathy. In fact there are many instances where patients can benefit from using the best of both worlds. It is not unusual for homeo-

pathic doctors in the UK to prescribe an antibiotic and a homeopathic medicine (e.g. Belladonna) on the same prescription form. In some cases CAM practitioners may use more than one complementary discipline concurrently. Asthma, for example, may be treated by a whole range of therapies, including relaxation, breathing exercises, yoga, as well as neutraceuticals, homeopathy and acupuncture.[19]

It is significant that the 1986 BMA report was entitled 'Alternative medicine',[20] whereas 6 years later in its next report it was using the title 'Complementary medicine'. A similar trend in the literature can be observed over the same period of time. In the early 1990s a British pharmacy launched an involvement in what it initially called alternative medicine, quickly changing its promotional material to use the term 'complementary medicine' within some months (see also Chapter 2).

Perceptions of the OM and CAM approaches to healing

The following terms have been applied to describe the OM and CAM approaches to healing:[21]

OM	CAM
Orthodox	Unorthodox, unconventional
Conventional	Alternative
Established	Fringe
Scientific	Natural
Proven	Unproven

All of these words communicate a particular viewpoint, some betraying the preconceptions of people who apply them to the practice of medicine.

The words 'orthodox' and 'conventional' clearly imply a certain correctness in the approach to healing. 'Established' similarly suggests that a degree of authority has been applied, perhaps by learned bodies or even society as a whole. 'Scientific' and 'proven' imply an expected, almost guaranteed, successful outcome.

By contrast, in the other column we find 'unorthodox' defined as *being irregular*, *unwanted* or *unusual*. From a sociological viewpoint unconventional therapy refers to medical practices that are not in conformity with the accepted standards of the medical community and therefore not taught at medical schools. 'Alternative' is a neutral word meaning *presenting a choice*. 'Fringe' and 'unproven' are words associated with a wish to marginalise the subject. Used in this context 'natural' could mean unstandardised.

Over recent years OM has become better at curing and helping with diseases but worse at relieving illness and sickness, and providing comfort. One of the key roles of CAM is in the management of illness and sickness and the provision of human comfort.[22]

The healing response

What does *healing* mean? In the minds of many CAM practitioners healing means restoring an unwell patient to his or her own particular state of wellness – not simply seeking to treat a condition in isolation. Does the term mean *actively treating*, i.e. a meaningful intervention provided by a practitioner during a consultation? Reilly[23] has suggested that the healing response begins long before the consultation and ends long after it finishes. A potential for change is inherent – and a creative 'meeting' may be the potent agent of its release – with or without prescriptions.

Self-healing

One aspect of healing that is common to all the therapies that collectively make up CAM is the belief that they work by stimulating the body to heal itself.

This response can be initiated by administering carefully chosen interventions – medicines or a physical procedure by the practitioner alone during a well-structured consultation. The quality of the consultation can be an important element in initiating a positive response in human patients[24] and perhaps in animals too. It is an interesting argument that, if this is indeed the case, i.e. if the interaction is so important, then self-treating with CAM including the purchase of over-the-counter (OTC) medicines without advice, might exclude a major source of the healing process. Not being able to see the wood for the trees might be the appropriate expression!

One could consider whether a definition of healing should include a reference to a person's intrinsic genetic or acquired ability to withstand disease itself, without external intervention. There are many examples of the body's ability to heal itself if given the chance.

Hippocrates was born on the Greek island of Kos, now a popular holiday destination. During his lifetime it is said that people came to him in their thousands to seek his advice for their ills. They found a Temple of Healing dedicated to the god Asclepius. Inside the stone walls of the Temple and beside bubbling mineral springs, the medical pilgrims experienced a ritual relaxation programme called incubation or temple

sleep. Hippocrates made little use of drugs, relying on fomentations, bathing and diet. The last was very simple and included vinegar and honey. Above all he did not attempt to interfere with nature; he made no attempts to modify or block biochemical pathways. He knew that many diseases were self-limiting. He is said to have believed that:

> Our natures are physicians of our diseases.

Further examples come from modern times. Proportionally more soldiers died of their wounds in Vietnam than in the Falkland Islands conflict between the UK and Argentina. In Vietnam helicopter evacuation was quick, and casualties were given blood transfusions and kept warm. In the Falklands, evacuation was often impossible because of the appalling weather. Doctors could not reach soldiers on exposed moorland to administer transfusions. Many casualties survived despite injuries that could have been expected to kill them. Without transfusion natural clotting mechanisms were not disturbed and haemorrhage was less severe. The cold weather complemented the normal effects of shock, slowing the body mechanisms.

A second example comes from an African sex worker. Despite the fact that over the past 20 years 1 or 2 of the 8 men she serviced each day at a cost of less than 50p ($US1) had HIV, the girl has never become infected. While many people are dead and dying of AIDS in Africa, there are about 200 sex workers, all of whom appear to be disease free. Are these girls genetically protected? When these girls give up their repeated exposure to the deadly virus they seem to lose their immunity. The spiritually minded might say that divine providence is at work offering protection during the working life of these girls.

A final example of what might be called intrinsic self-treatment is provided by the treatment of asthma. The UK has one of the highest prevalence rates for asthma in the world, along with New Zealand, Australia and Ireland. The 2001 Asthma Audit by the National Asthma Campaign provided a higher estimate of the number of people suffering with asthma in the UK than ever before. The audit estimated that 5.1 million people – 1 in 13 adults and 1 in 8 children – were being treated for asthma.[25] By contrast, it is almost unheard of in parts of Africa where there is more exposure to germs in childhood, and families are bigger. Research has found that young children in a family are less likely to develop asthma in later childhood than their older siblings.[26] Fewer babies would develop asthma, hayfever and other allergic diseases in the first place if they were exposed to dirt. Parents who are over-concerned with hygiene may be weakening their

children's resistance. This comes as good news to grubby little boys and girls everywhere!

The foregoing is by way of providing evidence that there does seem to be an intrinsic ability – genetic or acquired – to self-heal one's body. Stimulating or encouraging this ability in some way might therefore be a reasonable approach to healing. This is the aim for most CAM disciplines.

The holistic approach to healing

The term 'holistic' has traditionally been understood to refer to CAM. In fact the concept is being increasingly adopted by OM.[27,28]

Definition

The origin of the word 'holism' is attributed to Jan Christian Smuts (1870–1950), a South African botanist and philosopher with the distinction of having the international airport at Johannesburg named in his memory. Smuts, who was Prime Minister of his country after World War I, wrote a book entitled *Holism and Evolution*[29] in which he described holism as:

> . . . the principle which makes for the origin and progress of wholes in the universe.

He further explained his idea thus:

- Holistic tendency is fundamental in nature.
- It has a well-marked ascertainable character.
- Evolution is nothing but the gradual development and stratification of progressive series of wholes, stretching from the inorganic beginnings to the highest levels of spiritual creation.

The concept of holism is much, much older, dating back to Cicero (106–43 BC), to whom the following has been attributed:

> . . . a careful prescriber before he attempts to administer a remedy or treatment to a patient must investigate not only the malady of the person he wishes to cure, but also his habits when in health, and his physical condition.

The precise definition of what is now understood by a 'holistic approach' seems to vary between practitioners according to Rosalind Coward.[30] She found that some practitioners consider holism as the

ability to integrate different treatments for different needs, such as using herbal medicine for a specific ailment, acupuncture for chronic pain or hypnosis to stop smoking. A small minority stressed that holism implied links between individual and environment, and suggested treatments that would balance not only the internal parts of an individual but also the relationship between the individual and the environment. More generally, however, practitioners and patients define holism as the treatment of the whole person, an approach that considers body, mind and spirit as a single unit.

Pietroni has described holistic medicine in the following terms:[31]

- Responding to the person as a whole entity (body, mind and spirit) within that person's own environment (family, culture and ecological status)
- Willingness to use a wide continuum of treatments ranging from surgery and drugs to nutrition and meditation
- An emphasis on a participatory relationship between practitioner and patient
- An awareness of the impact of the health of the practitioner on the patient.

The World Health Organization defines health as follows: 'Health is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity.' (Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.)

The WHO Commission on Social Determinants of Health has called for a new global agenda for health equity. In a report entitled 'Closing the health gap in a generation' the Commission points out that our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in several African countries, fewer than 50 years. And within countries, the differences in life chances are dramatic and are seen worldwide. the poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socio-economic position, the worse the health. The report cites the example of the Carlton area of Glasgow, Scotland, where a boy growing up can expect to live 28 years less than if he was born around eight miles away

in the more privileged area of Lenzie. The report published in 2008 may be viewed online at http://tinyurl.com/5qnyu9.

It is difficult to see how this could possibly be achieved without a holistic approach to health delivery as detailed above.

CAM and the holistic approach

Virtually all CAM practices claim to be holistic, i.e. treating the whole person rather than a condition in isolation. This in turn leads to a highly individual approach, which means that patients with apparently similar symptoms may be treated in a very different manner. Conversely it also means that particular treatments may be used to treat widely different conditions.

When a patient visits a complementary practitioner for the first time, the consultation may well extend to over an hour, although about 40 minutes is more usual. During this time a complete picture of the patient will be built up. The aim is to obtain the best therapeutic outcomes for patients, by integrating clinical expertise and knowledge with patients' needs and preferences, using the most current information available in a systematic and timely way.

The CAM community has tended historically to understand something important about the experience of illness and the ritual of practitioner–patient interactions. It has been suggested that the rest of medicine might do well to acknowledge the benefits of this approach.[32] Many people may be drawn to CAM practitioners because of the holistic concern for their wellbeing that they are likely to experience, and many may also experience appreciable placebo responses. Why should OM not try to understand what alternative practitioners know and do, because this may help explain why so many patients are prepared to pay to be treated by them, even when many of the treatments are unproven?

Gathering information from the patient In providing holistic care the CAM practitioner needs to obtain information on how the patient functions in a normal state of wellbeing, in addition to hearing about symptoms that prompted the visit so that they may be returned to their own state of good health. Environmental and social factors also have to be considered. To obtain this information patients are often asked a list of seemingly unrelated questions on their first visit including the following:

- What type of food do you like – sweet, salty, spicy or bland?
- What type of weather conditions do you prefer – hot, cold, wet, dry, etc.?

- Do you like to be with other people or do you like to be alone?
- Are you a gregarious extravert type of person or are you quiet and introverted?
- Do you dream and if so can you remember the main subjects involved?

Patients' style of handwriting and colour preferences could be useful in establishing various personality traits, and therefore in choosing an appropriate therapy.[33] Personality and demeanour are important because they can determine how a patient is treated. This procedure is known in OM, but is usually practised covertly. For example, in an American study, medical staff were found to have given placebos to unpopular patients who were suspected of exaggerating their pain or had failed to respond to traditional medication.[34] The holistic practitioner acknowledges that people have different personalities and treats them, taking this fact into consideration overtly.

Practitioners may be interested in any modalities – what makes the condition feel better or worse, or whether the condition is better or worse at certain times of the day. The exact site of the problem will be identified. In response to the patient's statement 'I have a sore throat' the practitioner may ask 'Is it worse on the right or left side?' Individualised treatment appropriate to the patient can then be chosen, the aim being to return him or her to his or her own particular state of good health.

The consultation It is probably not possible to define a typical consultation even within one discipline, let alone generalise across all CAM consultations. Essentially the difference lies in the focus of the approach to healthcare. CAM seeks to focus on overall health, whereas the focus of OM is essentially disease oriented (see Chapter 3).

Consultations are so varied that any differences are only stereotypical, misleading or meaningless. Table 1.1 speculates as to how a consultation with a CAM practitioner might differ from one with a conventional healthcare provider.

The time taken for an initial consultation in which the practitioner seeks to establish a picture of the patient's whole health status with detailed questioning, as outlined above, and a sympathetic unhurried manner establishes a beneficial rapport. Kaptchuk and colleagues[35] undertook a dismantling approach to the examination of placebo effects. In 262 adults with irritable bowel syndrome, they examined the effects of placebo acupuncture in circumstances that involved observation only,

Table 1.1 Speculative differences between complementary and alternative medicine (CAM) and orthodox medicine (OM) consultations

Component	*CAM*	*OM*
Time	More	Less
Touch	More	Less
History-taking	Holistic, expansive	Specific, behavioural
Patient's role	Conscious, participatory	Passive
Decision-making	Shared with patient	Practitioner tends to make decisions (paternalistic)
Bedside manner	Empathic, warm	'Professional', cool
Language used	Subjective, simple words	Objective, uses jargon

sham acupuncture alone and sham procedure together with a 45-minute consultation with the treating doctor. The consultation involved questions about the patient's symptoms and beliefs about them, and was conducted in a 'warm, friendly manner', with empathy and communication of confidence and positive expectations. The second group improved significantly more than the first group but significantly less than the third, who improved by 37%. As the authors of a linked editorial conclude, the work shows that a constructive doctor–patient relationship can tangibly improve patients' responsiveness to treatment, be it placebo or otherwise.

Social considerations In the early days of the current wave of interest in CAM, some researchers were of the opinion that the holistic approach was inappropriate, because it provided an individualistic solution to problems of health, rather than seeking to alter the social structure that promoted an unhealthy environment.[36] The sociological literature often highlights the fact that, in concentrating on an individual, the needs of the wider community may be overlooked.[37] When responsibility is shifted to a single person, the social structures that constrain individual behaviour and lifestyle choices may be obscured. It has been suggested that this emphasis on such weaknesses in the holistic view may be one reason for its lack of acceptance by orthodox practitioners in the past.

Notwithstanding this opinion, the idea of individualising treatments is gaining acceptance and it is likely that modern biotechnology will provide the opportunity for future orthodox medicines to be tailored to patients' specific requirements.[38]

Change of emphasis Many practitioners are becoming concerned that the special holistic nature of CAM is becoming eroded by the modern trend towards a more disease-centred approach. The increasing appearance of over the counter (OTC) products that contain multiple ingredients and make the limited claims of efficacy (allowed under newly enacted legislation) promotes self-treatment without consultation. This is in contrast to orthodox medicine which, in many therapeutic areas, is moving to a more focused approach made possible by the advent of gene therapy noted above.

Classification of CAM

The British Medical Association report in 1986 identified 116 complementary medical treatments that were used 'reasonably often' in the UK;[20] this number has increased considerably by now. It also includes an uncertain number of traditional ethnic therapies. Many are well known, others are exotic or mysterious, and some may even be dangerous.

Pietroni presented an early classification of the different approaches in CAM:[39]

- Complete systems of healing including acupuncture, chiropractic, herbalism, homeopathy, naturopathy and osteopathy
- Specific therapeutic methods including aromatherapy, massage and reflexology
- Psychological approaches and self-help exercises including relaxation, meditation and exercise
- Diagnostic methods including hair analysis, iridology and kinesiology.

In their report published in 2000[40] the House of Lords Select Committee on Science and Technology divided CAM therapies into three groups (Table 1.2):

1. Group 1 embraces disciplines that have an individual diagnostic approach and well-developed self-regulation of practitioners. Research into their effectiveness has been established, and they are increasingly being provided on the NHS. The report says that statutory regulation of practitioners of acupuncture and herbal medicine should be introduced quickly and that such regulation may soon become appropriate for homeopathy. Some progress has been made in establishing statutory control over the practice of certain CAM disciplines.

Table 1.2 House of Lords' classification of complementary and alternative medicine (CAM) disciplines[7]

Group 1	**Group 3A**
Acupuncture	Anthroposophical medicine
Chiropractic	Ayurvedic medicine
Herbal medicine	Chinese herbal medicine
Homeopathy	Eastern medicine
Osteopathy	Naturopathy
	Traditional Chinese medicine
Group 2	**Group 3B**
Alexander technique	Crystal therapy
Aromatherapy	Dowsing
Flower remedies	Iridology
Hypnotherapy	Kinesiology
Massage	Radionics
Meditation	
Nutritional medicine	
Reflexology	
Shiatsu	
Spiritual healing	
Yoga	

2. Group 2 covers therapies that do not purport to embrace diagnostic skills and are not well regulated.
3. Group 3 covers other disciplines that either are long established but indifferent to conventional scientific principles (3A) or lack any credible evidence base (3B).

There were criticisms of the Lords' classification, in particular the lowly status given to Chinese herbal medicine (CHM) by placing it in category 3A. Lambert complained in a letter to the *Lancet*[41] that the classification ignored the existence of research that has shown the usefulness of CHM in many disorders. Evidence supports its provision in state hospitals throughout China, alongside conventional medicine.[42] It is suggested that, although the research is of variable quality, it should still not be ignored. Furthermore, promising trials have been carried out in the west, including two successful, double-blind, placebo-controlled trials of a Chinese formula for atopic eczema which concluded that 'there is substantial clinical benefit to patients who had been unresponsive to conventional treatment'.[43,44]

The US National Center for Complementary and Alternative Medicine (NCCAM) classifies CAM in five domains:[45]

1. Alternative medical systems
2. Mind–body interventions
3. Biologically based therapies
4. Manipulative and body-based methods
5. Energy therapies.

In this book the therapies are divided into the following categories:

- Therapies principally involving the use of remedies (e.g. homeopathy)
- Therapies based on traditional use (e.g. traditional Chinese medicine)
- Complete complementary systems (e.g. naturopathy)
- Diagnostic procedures (e.g. iridology and jinesiology)
- Manual therapies (e.g. massage and reflexology)
- Mind body therapies (e.g. meditation and reiki).

References

1. Saks M, ed. *Alternative Medicine in Britain*. Oxford: Clarendon Press, 1992: 4.
2. Lin JH. Evaluating the alternatives. *JAMA* 1998;**279:**706.
3. Druss BG, Rosenbeck RA. Association between use of unconventional therapies and conventional medical services. *JAMA* 1999;**282**:651–6.
4. Eisenberg DM, Kessler RC, Foster C et al. Unconventional medicine in the United States. *N Engl J Med* 1993;**328**:246–52.
5. Micozzi M. *Fundamentals of Complementary & Alternative Medicine*. New York: Churchill Livingstone, 1996: 5.
6. Lannoye MP. Amendments to the Explanatory Statement (Part B-A3-0291/94-26.4.94) for the Report on the status of complementary medical disciplines to the European Parliament's Committee on the Environment, Public Health and Consumer Protection. In: Richardson J. *Complementary Therapy in the NHS: A service evaluation of the first year of an outpatient service in a local district general hospital*. London: Health Services Research and Evaluation Unit, Lewisham Hospital NHS Trust. 1994.
7. Leckridge B. The Future of complementary and alternative medicine – models of integration. *J Alt Comp Med* 2004;**10**:413–16.
8. Ernst E, Resch KL, Miller S et al. Complementary medicine – a definition. *Br J Gen Pract* 1985;**35**: 506.
9. Zollman C, Vickers A. ABC of complementary medicine. What is complementary medicine? *BMJ* 2000;**319**:693–6.
10. Jobst KA, Shostak D, Whitehouse PJ. Diseases of meaning: manifestations of health and metaphor (Editorial). *J Alt Comp Med* 2000;**5**:495–502.
11. Friedrich MJ. The arts of healing. *JAMA 1999*;**281**:1779–81.
12. Van Haselen R. Reuniting art with science: impossibility or necessity? *Proceedings of the Third International Conference*. London: RLHH & Parkside Health, 22–23 February 2001: 7.

13. Ernst E. Quadruple standards? (Editorial). *Focus Alt Comp Ther* 2000;**5**:1–2.
14. Colquhoun D. Head to head. Should NICE evaluate complementary and alternative medicines? *BMJ* 2007;**334**:507.
15. Waber RL, Shiv B, Carmon Z, Ariely D. Commercial features of placebo and therapeutic efficacy. *JAMA* 2008;**299**:1016–17.
16. Micozzi M. *Fundamentals of Complementary & Alternative Medicine*. New York: Churchill Livingstone, 1996: 3.
17. Sharma U. *Complementary Medicine Today: Practitioners and patients*. London: Routledge, 1992
18. Kayne SB, Beattie N, Reeves A. Buyer characteristics in the homoeopathic OTC market. *Pharm J* 1999;**263**:210–12.
19. Huntley A, White A, Ernst E. Complementary medicine for asthma. *Focus Alt Comp Ther* 2000;**5**:111–16.
20. British Medical Association. *Alternative Therapy: Report of the Board of Science and Education*. London: BMA, 1986.
21. Buckman R, Sabbagh K. *Magic or Medicine?* London: Macmillan, 1993.
22. Dieppe P. The role of complementary medicine in our society and the implications that this has in research. (Editorial) *Focus Alt Comp Ther* 2000;**5**:109–10.
23. Reilly D. The therapeutic encounter. In: Kayne SB (ed.), *Homeopathic Practice*. London: Pharmaceutical Press, 2008: 98.
24. Howie JGR, Heaney DJ, Maxwell M, Walker JJ, Freeman GK, Rai H. Quality at general practice consultations: cross sectional survey. *BMJ* 1999;**319**: 738–43.
25. National Asthma Campaign (Asthma UK). Survey. London: Asthma UK, 2001.
26. Ball TM, Castro-Rodriguez JA, Griffith KA, Holberg CJ, Martinez FD, Wright AL. Siblings, day-care attendance, and the risk of asthma and wheezing during childhood. *N Engl J Med* 2000;**343**:538–43.
27. Mitchell CA, Adebajo A. Managing osteoarthritis of the knee: Holistic approach is important. (Letter) *BMJ* 2005;**330**:673.
28. Ventegodt S, Kandel I, Merrick J. A short history of clinical holistic medicine. *Sci World J* 2007;**7**:1622–30.
29. Smuts JC. *Holism and Evolution*. New York: Macmillan, 1926: 84–117.
30. Coward R. *The Whole Truth. The myth of alternative health*. London: Faber & Faber, 1989.
31. Pietroni PC. Holistic medicine: new lessons to be learned. *Practitioner* 1987;**231**:1386–90.
32. Spiegal D. What is the placebo worth? (Editorial) *BMJ* 2008;**336**:967–8.
33. Mueller J. Handwriting as a symptom. *Allgemeine Homoöpathische Zeitung* 1993;**238**:60–3.
34. Goodwin JS, Goodwin JM, Vogel AV. Knowledge and use of placebos by house officers and nurses. *Ann Intern Med* 1979;**91:**112–18.
35. Kaptchuk TJ, Kelley JM, Conboy LA et al. Components of placebo effect: randomised controlled trial in patients with irritable bowel syndrome. *BMJ* 2008;**336**: 999–1003.
36. McKee J. Holistic health and the critique of Western medicine. *Soc Sci Med* 1988;**26**:775–84.

37. Labonte R, Penfold PS. *Health Promotion Philosophy. From victim blaming to social responsibility*. Vancouver: Western RO Health & Welfare, 1997: 7.
38. Davies M. From genomics to the clinic: the challenge for molecular science. *Pharm J* 2000;**265**:411–15
39. Pietroni PC. Alternative medicine. *Practitioner* 1986;**230**:1053–4.
40. House of Lords Select Committee on Science and Technology. Complementary and alternative medicine, 6th report 1999–2000 [HL123]. London: The Stationery Office, 2000.
41. Lampert N, Ernst E, Moss RW. Complementary and alternative medicine. (Letter) *Lancet* 2001;**357**:802.
42. Dharmananda S. *Controlled Clinical Trials of Chinese Herbal Medicine: A review*. Oregon: Institute for Traditional Medicine, 1997.
43. Sheehan MP, Rustin MHA, Atherton DJ et al. Efficacy of traditional Chinese herbal therapy in adult atopic dermatitis. *Lancet* 1992;**340**:13–17.
44. Bensoussan A, Menzies R. Treatment of irritable bowel syndrome with Chinese herbal medicine. *JAMA* 1998;**280**:1585–9.
45. National Center for Complementary and Alternative Medicine. *CAM Basics*. Available at: http://tinyurl.com/2jhwml (accessed 14 October 2007).