Regulation of complementary and alternative medicine (cam)

Using Osteopathy as an example, describe and critically evaluate the ways in which the organisation and regulation of Complementary and Alternative Medicine (CAM) in the UK provides safeguards for users.

The provision of CAMs in the UK is historically both a component of healthcare services and viewed with suspicion by the dominant medical model of healthcare which has characterised the NHS since its inception in 1948. The kinds of CAMs which are included under the aegis of NHS provision have been restricted, to, for example, homeopathy and osteopathy (Nicholls, in Lee-Treweek et al,). Such provision is typically regulated and monitored in ways that a wide range of other therapies which come under the same umbrella are not. This essay explores the ways in which this organisation and regulation can provide service users with the same kinds of safeguards that other NHS services have always provided. This kind of regulation, such as that provided by the professional bodies of Nursing (the Nursing and Midwifery Council) and Medicine (The General Medical Council, is a valuable means of ensuring the highest quality of care provision by ensuring only properly trained practitioners are allowed to practice, whilst at the same time holding practitioners accountable for their practice.

Patient feedback and other studies has demonstrated that the provision of CAMs within NHS care provides valuable treatment and support for patients with complex medical conditions. This is a symptom what Heller et al (2005) describe as the ‘ late modernity’ of healthcare in the preesent context, characterised by increasing diversification (which is often not recognised by the dominant medical authority of the NHS). Rigorous randomised controlled trials, the gold standard for the provision of evidence for medical care, have

demonstrated that CAMs are effective, yet the Medical model of care still does not always allow for the value of such treatments, and they are treated as ‘ fringe’ medicine. Because of this, and because of the general standards of regulation and surveillance of medical care, very few complementary therapies are provided as a matter of course within the NHS, despite some therapies, such as Homeopathy, having a history of regulation and care provision going back to 1844 (Nicholls in in Lee-Treweek et al).

The training of CAM practitioners has also changed, with a more rigorous training process which reflects professional education processes and principles, and some standardisation (though not national standardisation) of education and standards. However, one therapy which is provided in this context is osteopathy.

The changing face of medicine has both served the inclusion of CAMs within the NHS and served to bring about regulation by aligning the training and provision of such therapies with the principles which have governed medicine and medical practice in the UK (Heller et al, 2005). The concept of health has also evolved (Cant, in in Lee-Treweek et al; Heller et al, 2005). This has led to the emergence of integrative medicine, in which CAM practitioners work in conjunction with multi-disciplinary healthcare teams which manage patient care in an holistic and comprehensive manner (Cant, in Lee-Treweek et al). Obviously, this is the ideal from the point of view of the service user, because the hitherto unchallenged medical model of health has been replaced by a growing understanding of the complex nature of health and illness and the similarly complex responses required from those charged with promoting health and treating illness, disease and injury (Cant,

in Lee-Treweek et al). However, this has had what some view as a negative effect on CAM provision. As Heller et al (2005) state, “ the growth of ‘ integrative medicine’ represents an undermining of counter-cultural values, as more holistic paradigms based on challenging orthodox biomedical or ‘ scientific’ theories may become displaced proximity to the dominant biomedical systems” (P xiii). Another issue is that as CAMs become more prevalent within ‘ normal’ medicine and health, medical and nursing staff who are asked to advise on these therapies may not have been able to maintain current knowledge of the evidence about these therapies (Heller et al, 2005).

One of the potential benefits of this influence, however, is that of ensuring patient safety. Heller et al (2005) state clearly that patients must make informed choices about such therapies, and should be able to have the information to evaluate the safety of the practitioner and the therapy. This is evident in the ways in which most people access CAMs, through private practice, through seeking out treatment and evaluating which practitioners of which therapies to access (Heller et al, 2005). However, there is such a diversity amongst many practitioners of sources of training and regulation that for many therapists, having a certificate of membership of a ‘ professional’ organisation is no guarantee of quality or of redress should the service user be dissatisfied with or harmed by the therapy provided. The author has anecdotal evidence of discussions with medical doctors who believe that CAMs practitioners are dangerous, poorly regulated, and represent a danger to the public by preventing sick people accessing or utilising medical healthcare services. This is a rather limited view, but one

which signifies certain areas of public opinion, which in turn reflects the ways in which many therapies have not been regulated, evaluated through rigorous testing, or been subject to the same kinds of quality control and surveillance as conventional medicine.

Osteopathy, however, is regulated by Acts of Parliament in a similar fashion to medicine, nursing and allied healthcare professionals, and is described as one of the ‘ big five’ of the CAMs, which have a better reputation and standing within conventional medicine (Heller et al, 2005). It is this regulation which is supposed to protect patient safety and safeguard the interests of service users, but it also serves other purposes. Stone (1996) argues that regulation is not merited by the majority of therapies and would be inappropriate for therapies which are too different from medicine. Regulation ensures that the profession itself has a better professional status, that all its practitioners are trained in a similar manner, and provides support, guidance and legal support to practitioners. This suggests an increased level of responsibility and accountability, because professional bodies maintain agreed and defined standards. Therefore, in terms of informed choice, any service user can be assured that any practicing osteopath is subject to the same standard of training and the same regulation, and so should be ‘ safe’ to access, much in the same way as medical care is accessed. Thus regulation may safeguard patient safety by being required to formally adhere to ethical principles. Heller et al (2005) describe the requirements of professional ethical practice as:

“ a duty to tell the truth; a duty to act honestly and fairly; a duty to respect people’s wishes, and not to treat people as a means to an end, but as

individuals with rights; a duty not to harm people;...[and the right] not to be harmed [and] not to be lied to.” (p 85).

While these may be considered general human rights they are augmented by principles which are generally agreed to underpin healthcare, including the principles of beneficence and non-maleficence (Heller et al, 2005). It could be argued that no therapy should be provided, therefore, which does not have proven benefits to the patient, and is proven to do no harm to the patient. Professional regulation may serve this purpose, because it professionalises the therapy and demands acceptable standards of evidence to demonstrate these features. But only therapies which can provide this standard of evidence would be regulated (Stone, 1996) which could have detrimental effects on the status and reputation of more esoteric therapies which cannot be subject to the kinds of evidence that underpins medicine. Voluntary regulation may be the answer:

“ Consumers will best be protected by a dynamic, ethics-led approach to voluntary self-regulation in which high standards of practice together with visible and effective disciplinary procedures are given higher prominence than the pursuit of professional status (Stone, 1996 p 1493).

In conclusion, this author believes that regulation, either statutory or voluntary, holds practitioners accountable and serves the interest of consumers by demonstrating that those providing CAMs are at the least educated to some kind of agreed standard, and by offering consumers a means of redress should they be dissatisfied with their treatment. However, only statutory regulation would give proper redress, but in the current legal

context, there is so much legislation protecting the interests and rights of consumers of goods and services that there is plenty of room for redress through other means. Only statutory regulation could offer assurances of safety, but this is not suitable for all therapies (Stone, 1996).

References

Heller, T., Lee-Treweek, G., Katz, J. et al (2005) (eds). *Perspectives on complementary and alternative medicine.* Milton Keynes: Open University Press/Routledge.

Stone, J. (1996) Regulating complementary medicine: standards, not status. *BMJ* 312 1492-1493.