Notes from the Editor-in-Chief

In their invited essay, Kelner and Wellman approach complementary and alternative medicine (CAM) from a sociological perspective. They begin by addressing the various definitions and scope of CAM and the complexities of decision-making being faced by individual consumers, providers, suppliers and governments alike. The authors chart the growth of popular interest in CAM and clearly outline the apparent mushrooming consumption of CAM by the general public.

The idea of CAM is viewed as a social movement that is taking on a significant role in the day-to-day provision of health services in Canada as elsewhere. It is clear that the term CAM is used to embrace a wide variety of products and services. Typically, such products and services are identified and recognized by the fact that they are not routinely reimbursed by insurance systems. In addition, they are distinct in that they do not fall under the regulation of the Canada Health Act as necessary medical services and historically their use has not been taught as part of the curricula in medical schools. Kelner and Wellman choose to define CAM as a broad domain of healing resources that includes practices and beliefs outside the dominant health system of the country or society. In their definition, CAM emphasizes the natural ability of the body to heal itself and integration of the body, mind and spirit.

In addressing CAM in the Canadian context, Kelner and Wellman indicate that typical Canadian CAM users are most likely to be female and younger (about 44 years of age), to have higher household incomes and education levels and to consider spirituality as an important aspect of their lives. CAM is used for a variety of health issues, including treatment of chronic illnesses, preventing illnesses, improving the quality of life and sometimes for dealing with the side effects of traditional medicine.

The federal government has regulated CAM products since 1999. Regulation of CAM practitioners falls under the jurisdiction of the provinces. However, most practitioners are not regulated at all. Chiropractors are the only occupation to have achieved self- regulation in all provinces. There are now five provinces that partially include CAM practitioners for payment in their health insurance schemes.

Kelner and Wellman provide us with an outstanding review of the main issues around CAM in a fair and objective way. These authors are both knowledgeable and experienced in the controversial issues about CAM, as demonstrated by their previous excellent publications in this area. In their essay, Kelner and Wellman succinctly outline four complex, interrelated issues. First, what is CAM and what constitutes evidence of its effectiveness to safeguard the public's interests? Second, should the products and services of CAM be subject to the same kinds of effectiveness research as traditional medicine, and what methodologies are most appropriate for understanding CAM? Third, what is the extent of professionalization of the occupations that practise CAM? And fourth, what should happen in the future in terms of the extent of integration of CAM with traditional medicine?

We are fortunate to have a group of highly qualified experts responding to the Kelner and Wellman paper from a variety of perspectives. Each respondent has provided a thoughtful commentary on the lead paper and contributed greatly to the discussion and debate. Richardson, Research Director, School of Integrated Health at the University of Westminster, begins her response with a discussion of the social construction of medicine and places CAM in a historical context. She describes how in ancient times medicine itself was linked to mysticism. For example, in various cultures, mankind was linked directly to nature and to be in harmony with it. In a later period, medicine was often linked to "humours." In the Middle Ages, those who seemed most knowledgeable about medicine were the witches who used herbal remedies, but this ended with the advent of Christianity. Richardson describes how the Church threw out the herbal and surgical remedies and replaced them with more brutal practices of medicine such as mortification of the flesh.

On the question of evidence, Richardson describes how the establishment of the U.K. Cochrane Centre in 1992 had the potential to draw distinct lines between evidence-based traditional medicine and the more complex, subtle and difficult-to-measure healing approaches inherent in CAM. She notes that in 1994 the first complementary therapy outpatient department was opened in a general National Health Services hospital, accompanied by a plan to examine the effects of treatments on patient health. A report and government response in 2000 suggested that regulation, training and research should receive attention.

Willis from the Faculty of Humanities and Social Sciences, La Trobe University, addresses directly the issue of nomenclature. Willis comments that there are problems with all the current terms – for example, "complementary" or "alternative" to what? Does the domain include all health practices except the one currently sanctioned by society? The use of the term "integrative" may also perhaps imply a "whale and guppy" takeover, as has happened in previous history. On the question of evidence, Willis's view is that CAM cannot afford not to climb aboard the evidence train given the societal and professional expectations of traditional scientific evidence. Willis, along with other commentators, indicates that CAM may always be disadvantaged in the arena of science because the nature of the healing processes is not easily amenable to traditional scientific method. But if part of the goal is for CAM to gain legitimacy, some steps may be achieved through national funding for scientific work.

Saunders from the Dundas Naturopathic Centre and the Canadian College of Naturopathic Medicine points out that not only is CAM gaining in popularity with consumers, but it is also increasingly seen in medical school curricula. He indicates that by the end of the last century there were over 120 courses offered in medical schools in North America. Saunders points out that the National Health Products Directorate of Health Canada has recently presented for discussion a grid for evaluating the evidence for diverse natural health products such as vitamins, herbs, nutritional oils and homeopathic medicines. The grid, which could also be used to evaluate CAM practices, outlines five levels or types of evidence. For example, Level I is defined as including randomized controlled trials, Level III (in the middle) descriptive and observational studies and Level V evidence through traditional publications.

Ruedy, Vice-President, Academic Affairs at Nova Scotia's Capital District Health Authority, suggests there can be no justification for different standards of validation of health products from alternative sources that are used by the public in the same way as prescription or over-the-counter drugs. He makes a distinction between interventions based on health beliefs and those of the biomedical model. Health belief models have existed for centuries in the Western world, but those outside the traditional biomedical model are more difficult to prove. A common factor underlying the alternative health belief models is that there exists a source of healing energy – cosmic, divine or internal – that influences health or healing. It is noteworthy that these practices promote healing rather than curing. Consumers often accept their validity on the basis of testimony by expert practitioners or by the test of experience. In Ruedy's view, a scientific foundation for complementary and alternative therapies may be inappropriate. The most important priority for him is patient safety.

Verhoef of the University of Calgary and Findlay of the Tzu Chi Institute of Complementary and Alternative Medicine, Vancouver, make the point that the most appropriate term for CAM is "healthcare" because the range of practices is much broader than just medicine. They suggest that research investigating CAM must look at whole systems. They make a plea for the research methods to be expanded beyond traditional quantitative methods to include a full range of qualitative methods. In a similar vein, Richardson indicates that CAM research provides a positive opportunity for creativity in developing methods and for a wide range of disciplines to come together and collaborate.

While all the writers indicate that research on the effectiveness of CAM processes could be augmented with a larger influx of dollars, Verhoef and Findlay suggest that one of the greatest advances in research into CAM has been the funding provided by the Canadian Institutes of Health Research (CIHR). Rieder and Matsui from the Division of Clinical Pharmacology at the Children's Hospital of Western Ontario, University of Western Ontario, suggest that all therapies need to be evaluated and recommend that CIHR create a Canadian Institute of Therapeutics. Investments such as these, along with the further development of research networks in Canada, can pave the way for a strong research initiative in this area.

There is much discussion in the commentaries around the idea of CAM practitioners as professionals and the need to be licensed to practise. Richardson sets the stage historically by reminding us that in the age of quackery – the 17th century – astrology and herb lore were fundamental to the practice of medicine. At that time, practitioners could claim the title "doctor" and obtain a licence to practise even without training. Only a minority of the public actually consulted licensed practitioners. The poor went to semi-professional healers such as midwives, wise women and bone-setters. Saunders points out the five concerns that are foremost on legislators' minds: Does the profession pose harm to the public? Can the profession self-regulate? Is the profession stable? Is the profession cohesive? And will the treatments be prescribed and dispensed without conflict of interest? Because traditional Chinese medicine is used so extensively in the Australian state of Victoria, Willis notes that a registration process has been established for practitioners.

In terms of integration, there is much debate. For some, integration means taking components of CAM and integrating them into traditional medicine. There is some concern that this will lead to cherry-picking. There is also concern that integration might mean eventual control by the pharmaceutical industry. However, Kalaria at Pharmacy.ca sees a number of positive reasons to integrate CAM at the local community level with pharmacies. He points out that locally the pharmacist is often the patient's adviser about different products and their suitability for different conditions. Also, pharmacists are now able to track drug utilization and could also track the use of CAM. Verhoef and Findlay stress the need to think about integrative healthcare (not just medicine) because the processes of care are so important in areas such as palliative care and chronic pain control.

Finally, Kelner and Wellman provide an excellent response to the commentators, suggesting, as I have tried to synthesize above, that there is agreement on what issues have to be addressed in the future. I have learned a great deal about CAM in preparing this issue of Healthcare*Papers*. What is very clear is that consumers buy with their feet. The rapid increase in the use of CAM is evidence that the products and methods are perceived to be useful. Look in your medicine cabinet. Do you have anything there that might be classified as a CAM product? I know I do.

Peggy Leatt
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