Funding for CAM

George T Lewith (15 October 2007)

David Colquhoun presents an interesting point of view. In the UK 0.0085% of our medical research budget is spent on complementary and alternative medicine (CAM). CAM is widely available throughout the NHS via physiotherapy departments and pain clinics (acupuncture and mind body therapies) as well as forming an essential and effective element of palliative care within our hospices (mind body therapies, reflexology, massage and aromatherapy). Much of our current conventional pharmacopeia is derived from herbals.

Furthermore, 15-20% of the public in the UK access CAM each year in spite of the fact that they are told not to; as taxpayers surely they have a right to understand if what they are being offered is safe and effective. Can he be seriously suggesting that there should be no funding for this mixture of therapies that we collectively define as complementary or integrative medicine? The history of the enlightenment would suggest this exclusive attitude may not be a sensible approach to the acquisition of knowledge.

Reference List


Competing interests: None declared
Scientific heavyweights deplore the NHS money wasted on unproved and disproved treatments used by CAM practitioners 1,2, but a CAM proponent responds that “The BMJ reckons that 50% of the treatments we use in general practice aren’t proven, and 5% are pretty harmful but we are still using them.”3 Dr Lewith’s data were taken from the BMJ Clinical Evidence website 4. A pie chart indicates that, of about 2500 treatments supported by good evidence, only 15% of treatments were rated as beneficial, 22% as likely to be beneficial, 7% part-beneficial and part harmful, 5% unlikely to be beneficial, 4% likely to be ineffective or harmful, and in the remaining 47% the effect of the treatment was “unknown”. The text says, “The figures suggest that the research community has a large task ahead and that most decisions about treatments still rest on the individual judgements of clinicians and patients.” I have visited the site again to see if the situation had changed. It has, but not for the better. On 09/10/07 treatments rated “beneficial” had decreased from 15% to 13%. The associated text is unchanged.

I studied in detail the management of acute low back pain, which is an extremely common and well-investigated condition. BMJ Best Treatments reports that back pain affects 70-85% of all adults, and each year almost half of us get back pain that lasts at least a day. There are 18 treatments for acute low back pain which have been tested by RCT, of which two (11%) were graded “beneficial”, and 13 (72%) are labelled “unknown”. The attached Table taken from BMJ Best Treatments shows all of the 18 treatments for acute low back pain and their rated effect. Here is a curious situation. A condition that is extremely common, and for which many treatments have been intensively researched, has an even higher-than-average proportion of treatments that are labelled “unknown” efficacy, or in other places “need further study”. There must be some mistake.

The solution to the mystery is that the label “unknown” does not mean, “We have no knowledge of the effect of this treatment because it has not been tested in an RCT”. Astonishingly, it means, “We have tested this treatment in several RCTs, but on balance there is currently no convincing evidence that it is effective for this condition.” So really the efficacy of these 13 treatments for acute back pain is not “unknown” but “not demonstrated”.

I conclude that Dr Lewith’s interpretation of the pie chart is highly misleading. The research community has been commendably diligent, but of course RCTs often fail to find that certain treatments are effective. Euphemisms such as “unknown” or “needs more study” for the inefficacy of such treatments may soothe the feelings of proponents of those treatments that have so far failed to show efficacy, but it does an injustice to the researchers who obtained these data, and misleads both practitioners and patients about the extent to which orthodox medicine is evidence-based. It is particularly ironic that CAM therapies are over-represented in the not-shown-to-be-effective category, so if anyone should be concerned about lack of evidence it should be CAM practitioners rather than conventional medics.

Grading of the efficacy of treatments for acute low back pain
Treatments that work n=2 (11%)

Non-steroidal anti-inflammatory drugs (NSAID)

Keeping active

...that are likely to work n=2 (11%)

Multi-disciplinary treatment programmes (Drs, psychologists, physiotherapy)

Spinal manipulation ... that work, but harm may outweigh benefit n=1 (6%)

Muscle relaxants ... that “need further study” (aka “unknown”) n=13 (72%)

Acupuncture Massage

Back schools Painkillers

Behaviour therapy Temperature treatments

Biofeedback Traction

Epidural steroid injections Transcutaneous electrical nerve stimulation (TENS)

Back supports ... that are unlikely to work n=1 (6%)

Exercise, including back exercises. ... that are likely to be ineffective or harmful n=1 (6%)

Bed rest

References

1. Kamerow D. Wham, bang, thank you CAM. BMJ 2007;335:647 (29 September)

2. Calquhoun D. What to do about CAM. BMJ 2007; 335:736 (13 October)


Competing interests: None declared

Food is live medicine. Medicine is dead food. 16 October 2007

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In recent years, health-care has become so complex, that it is almost incomprehensible. Many physicians have a hard time keeping up with their own specialty, let alone other specialties. There are 24 medical
specialties and 88 sub-specialties. How can the average person choose or afford so much health-care?

If you surf the internet, you will find many websites that relate to health-care. These websites can be divided into three categories: traditional medicine, alternative medicine, and complementary medicine. Complementary medicine (also called integrative medicine) combines traditional medicine with alternative medicine.

Traditional medicine relies on prescription pharmaceuticals, such as antibiotics, tranquilizers, vaccines, and chemotherapy. Alternative medicine relies on over-the-counter pharmaceuticals, such as vitamins, minerals, herbs, and enzymes. Complementary medicine relies on both prescription and over-the-counter pharmaceuticals.

Since all three categories rely on pharmaceuticals, society is led to believe that health depends on pharmaceuticals. This is fortunate for the pharmaceutical companies, but is this fortunate for the patient?

Pharmaceuticals are a mixed blessing. They can prolong life, but they can also shorten it. Pharmaceuticals are semi-poisons that interfere with the body's normal functioning. This is why most pharmaceuticals have a long list of side effects. In contrast, food is nutrition that enhances the body's normal functioning. This is why food is live medicine, but medicine is dead food.

Competing interests: None declared

Using CAM services with Medicine 18 October 2007

Ikhlaq H. Din, Independent Health Consultant BD7 3DN

Dear Sir/Madam,

We are in the process of conducting research into the use of Alternative Medicine among older Pakistanis in two study locations (Karachi, Pakistan and Bradford, UK). The chief investigator in Karachi is Dr Atif Zafar. Preliminary pilot research data shows that a high number of older Pakistanis use hakims (alternative therapists) in both study locations. Briefly, the data reveals the following: respondents in Pakistan use CAM services frequently instead of their GP for all types of conditions including minor ailments such as colds, often they have family history of using CAM services, payment to hakims can sometimes be considerable depending on the condition and its importance. Traditionally, Bradford is a popular place for hakims and this trend is continuing in fact we find that more and more younger people are using hakims where once they may have been used by their parents. Most of those sampled would like the treatment to be made available on the NHS this may be typical of the White majority populations.

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Reference: Health of the Pakistanis: The Role of Alternative Medicine among Older Pakistanis in the United Kingdom and in Pakistan

Competing interests: None declared

A misunderstanding? 24 October 2007

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Send response to journal: Re: A misunderstanding?

What to do about CAM? Let’s keep it. 24 October 2007

Jennifer A Boyle, Associate Specialist Royal London Homeopathic Hospital WC1N 3HR

Send response to journal: Re: What to do about CAM? Let’s keep it.

Do doctors really want to lose their freedom to refer patients for CAM within the NHS? David Colquhoun, a professor of Pharmacology, thinks we should (1). He believes it is right that some primary care trusts are reducing funding to our NHS Homeopathic hospitals. But Medicine is not a pure science like pharmacology. Medical doctors often have to think outside the prescription pad. Having access to high quality CAM practised by qualified doctors within the NHS can only be good for patients can’t it?

As I did my outpatient clinics this week at the NHS Royal London Homeopathic Hospital, I wondered how Professor Colquhoun would treat the patients with “pure science”. The vast majority have chronic and complex conditions. They have usually seen numerous consultants in numerous different hospitals, had extensive investigations, and taken a variety of conventional drugs. Their GPs and their consultants have referred them to us for a different approach.

CAM treatments don’t usually lend themselves to standard research techniques like placebo controlled trials (2), but observational studies, such as the one from our sister hospital in Bristol, have produced encouraging results (3).

Professor Colquhoun is well known as a vociferous advocate for the closure of our hospital. Yet I have not seen him sit with us at clinics to observe exactly what we do. He would find a team of 26 medical doctors with expertise to prescribe appropriate CAM treatments alongside conventional medical care. We have 28,000 consultations with patients every year and very high levels of patient satisfaction. Our hospital is recognised world wide as a centre of excellence in the provision of Integrated Medicine.

Would patients, doctors and the NHS be better of without us? I think not.

to be structured around a quote attributed to me in the Guild of Health Writers’ Newsletter; one would not usually consider this to be a reliable source of academic information. Among the newer professions allied to medicine are osteopaths and chiropractors. John Garrow’s argument is interesting when related to them, might he be suggesting that the recent legislation pertaining to their registration should be overturned? Dentists gained statutory regulation sometime after the medical profession, furthermore I understand that evidence-based dentistry is a slim volume (1,2). Is he also suggesting that we abandon NHS dentistry?

1. Coulter ID. Evidence-based dentistry and health services research: is one possible without the other? Journal of Dental Education. 2001; 65 (8): 714-724.


Competing interests: None declared
Evidence is important but should not be the only consideration

31 October 2007

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Send response to journal: Re: Evidence is important but should not be the only consideration

Health systems need to use resources to their maximum effect. This naturally leads them towards evidence based medicine, since those interventions that have been shown in well conducted (randomised) studies to be most effective should usually be prioritised over those where high quality evidence is lacking.

Problems arise where systems have to juggle alternative choices where the evidence is lacking or weak, or the benefits/harms trade off is marginal. The figures quoted by Garrow from BMJ Clinical Evidence are correct, but they provide an over pessimistic picture of the state of evidence for orthodox medicine, since CAM interventions and other non orthodox treatments are included, and indeed are over-represented in the “unknown” category. Nonetheless, the general point is correct that many orthodox and complementary interventions are in common use despite uncertainty about their effectiveness.

Perhaps surprisingly, I cannot completely agree with Colquhoun in his denunciation of homeopathy. A principle of evidence based practice is that the evidence should be only one influence on clinical decision making, alongside the expertise and perspectives of both patients and clinicians. However uncomfortable for health system planners, an evidence based service should reflect expressed patient preference.

One solution would be for CAM practitioners to involve the “stuck” patients Dr Boyle describes in N of 1 trials. As the highest level of evidence this might be a desirable, appropriate and ultimately informative approach in selected situations.

References:

Colquhoun D, What to do about CAM? BMJ 2007; 335: 736-a

Garrow JS, How much of orthodox medicine is EBM? http://www.bmj.com/cgi/eletters/335/7623/736-a#178646

Boyle JA, What to do about CAM? Lets keep it. http://www.bmj.com/cgi/eletters/335/7623/736-a#178646

Competing interests: I am Editorial Director for the BMJ Knowledge department, which produces evidence based products for clinicians and the public
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Send response to
journal:
Re: What to do
about CAM?
Increase research
funding by several
factors!

We live in an age of exploding health care costs. We also live in the
information age which made evidence based medicine feasible.
However, acquiring sufficient evidence base requires a lot of money
nowadays. It is impossible to get exact estimates of individual drug
development costs. In 2003 in the DiMasi simulation, for example, 95%
of cost estimates that included cost of capital fell between $684
million and $936 million per compound. 1

Is it as bad as a recent report by respected New York Investment firm
Sanford Bernstein which states that in 1998 the FDA approved 24 new
drugs developed out of an R&D budget of $27 Billion? Last year only
13 new drugs were approved after R&D costs of $64 Billion. 2
Between 1990 and 2002 the pharmaceutical R&D expenditure in
Europe, USA and Japan went from 19.9 Billion to 55.5 Billion national
currency units while the number of new molecular entities launched
worldwide fell from 35 to 26. 3 It is certainly undisputed that drug
development costs are exploding.

What is happening? It is probably a combination of inherent drug
safety issues, rising evidence standards, competition against proven
therapies and fear of litigation. More drugs is probably not the answer
to all our health problems; there is a limit to what can be achieved with
drugs. Additionally Marcia Angell’s critique on the all too cosy
relationship between drug industry and the FDA seems to start bearing
fruit. 4 As the former editor of the NEJM she is an influential voice of
wisdom. Such R&D development costs can only be sustainable with
patent protection!

But what about the many therapies without patent protection like most
CAM therapies, life style management, diets and psychotherapies.
They have often been around for much longer than conventional
therapies and are inherently much saver and potentially cheaper.
Additionally, they seem to be increasingly popular with and suitable for
an ecologically conscious public. However, they are unable to attract
even the smallest fraction of these R&D costs due to the usual lack of
patentability.

Profs David Colquhoun and Wallace Sampson seem to think that $1
Billion worth of research funding spread over a decade over hundreds
of different CAM therapies by NCCAM without proving anyone to
“industry standard” proves their ineffectiveness; any further research
funding is a waste of money. 5,6

In Europe CAM research funding has only been a fraction of US
funding. Given the exploding costs of conventional drug development
this can only be seen as a rather cynical attempt to steer towards a
therapeutic drug monopoly in medicine which is clearly counter
intuitive and not financially sustainable. If they succeed in their
campaign against CAM, it will lead to an acceleration of an inherent
economic systemic trend towards synthetic and patentable therapies
due to the enormous research funding inequalities.

The budding science of CAM therapies might hold the key to a better
understanding of the non linear ways of healing; it will transform this
art into more of a science. We need several factors more research
funding to realize the vast potential of these therapies. We need to address the systemic funding bias against non patentable therapies. The support of institutions like the RLHH and Westminster University’s CAM courses is crucial to maintain clinical excellence and research capacity while improving integration into conventional medicine. This will lead to a more cost effective and ecological health system.

Competing interests: None declared

2. The economist; Oct 27 –Nov 2 2007
4. Marcia Angell: The truth about the drug industry
6. Sampson WI. Why the National Center for Complementary and Alternative Medicine (NCCAM) should be defunded. www.quackwatch.org/01QuackeryRelatedTopics/nccam.html

Dilemmas of CAM

I'm not at all surprised that Boyle and Roniger should disagree with me, because they are both employed by the Royal London Homeopathic Hospital, from which many PCTs have, very sensibly, withdrawn funding.

I was, though, very surprised to find the Editorial Director of BMJ Knowledge, David Tovey, apparently defending homeopathy. A quick check of BMJ Knowledge shows that, as expected, it does not recommend homeopathy for any condition whatsoever. I'd be very interested to hear Dr Tovey's response to my dilemmas of alternative medicine. I have the impression that he has not thought through clearly the consequences of believing things that are not true.

Competing interests: None declared