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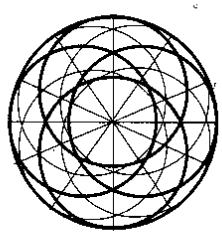

UK government funds CAM research

The 6th Report of the Select Committee on Science and Technology was published in November 2000 entitled 'Complementary and Alternative Medicine'.[1] It set into motion a chain of events that recently culminated in the UK Department of Health funding several CAM research projects. This article outlines the recommendations of the report on research,[1] together with the UK government response[2] and contrasts it with the research that has been recently funded.[3,4] It also contains invited commentaries.

The recommendation of the House of Lords

The following text is a direct quote of the recommendations, which are very clear and outspoken as to what the research priorities are:

'We recommend that three important questions should be addressed in the following order:

- To provide a starting point for possible improvements in CAM treatment, to show whether further inquiry would be useful, and to highlight any areas where its application could inform conventional medicine – does the treatment offer therapeutic benefits greater than placebo?
- To protect patients from hazardous practices – is the treatment safe?
- To help patients, doctors and healthcare administrators choose whether or not to adopt the treatment – how does it compare, in medical outcome and cost-effectiveness, with other forms of treatment?'

The UK government response

'The questions the report identifies are important questions to address when considering research on a particular CAM intervention. However, there is also a need to identify priorities across CAM interventions to ensure effort and resources are invested in the most productive areas.

Given the limited research capacity in this area and the barriers to developing a research culture in CAM, the feasibility of the research should be an important consideration, for example, where there are opportunities to develop high-quality research programmes which can act as "models" or "beacons" of research excellence in CAM. The identification of priorities for research should also take account of whether the nature of a treatment, the condition being treated, or the scale of use, creates an exceptional public health need to gain evidence of safety or efficacy.'

The research projects recently funded by the UK Department of Health

The Department of Health funded CAM research through two initiatives. The first was specifically dedicated to qualitative research into CAM for cancer. The successful projects were:[3]

- Complementary and alternative medicine (CAM) and the care of patients with cancer. (Dr Philip Tovey, University of Leeds.)
- A study of the use of complementary and alternative therapies among people undergoing cancer treatment. (Prof. Jessica Corner, University of Southampton.)
- Male cancer patients' views on and use of complementary and alternative medicine (CAM): a qualitative study. (Dr Alison Shaw, University of Bristol.)

The second initiative was aimed at research capacity building within CAM. The five successful projects were:[4]

- (1) Male cancer patients' view on and use of CAM: a qualitative study; (2) the use of CAM for asthma. (Dr Alison Shaw, Primary Care Research, University of Bristol.)
- (1) An ethnographic study of medical and lay homoeopathic training; (2) homoeopathic doctors' clinical decision making processes. (Dr Christine Barry, Brunel University.)
- Homoeopathic treatments as a whole-system intervention for chronic fatigue syndrome: design for a comparative study with cognitive behaviour therapy. (Dr Elaine Weatherley-Jones, University of Sheffield.)

- The process of acupuncture treatment: an RCT and qualitative study to evaluate the relative contributions of specific and non-specific effects. (Dr Peter White, University of Southampton.)
- Real-world evaluation of acupuncture: with a focus on depression. (Dr Hugh McPherson, University of York.)

Invited comments

The next section is devoted to invited comments by UK experts in various relevant fields. Particular focus of these comments should be the relevance of the funded projects to healthcare in the UK and the match between the priorities as defined in the Lords' report and the funded projects. Their aim should be to provide constructive criticism for similar activities in the future.

References

1 *House of Lords Select Committee on Science and Technology Complementary and Alternative Medicine. 6th Report, 1999–2000.* London: Stationery Office, 2000 (available on the Internet at http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm).

2 *Government Response to the House of Lords Select Committee on Science and Technology's Report on Complementary and Alternative Medicine, Command Paper 5124.* London: The Stationery Office, Crown Copyright 2001 (available on the Internet at http://www.official-documents.co.uk/document/cm51/5124/5124.htm).

3 http://www.doh.gov.uk/research/rd3/nhsrandd/cam/cam_index.htm

4 http://www.doh.gov.uk/research/rd1/campostdocawardholdersmay2003.htm

Invited comments

John Garrow

The House of Lords Select Committee (HLSC) took evidence from a very wide range of special interest groups, including 55 oral hearings. Their report, published in November 2000, ran to 141 pages, with nine chapters and nine appendices. Chapter 7 was concerned with research and development, and I can confirm that the quotation in the introduction above is an accurate transcript of section 7.7 on page 76. It was in bold type and was clearly intended to guide publicly funded research into CAM concerning the type of research that should be funded. Read in context, it says that research should address a sequence of questions. Do therapies in Group 1 (acupuncture, chiropractic, herbal medicine, homoeopathy and osteopathy) offer therapeutic benefits greater than placebo? If so, are they safe? If so, how does their cost-effectiveness compare with other forms of treatment?

Evidently the government felt free to ignore this advice. Having acknowledged that the HLSC report identifies 'important questions', it then chooses to fund projects that (in their view) 'ensure that effort and resources are invested in the most productive areas'.

This implies that establishing if Group 1 CAM therapies are effective, safe and cost-effective is not a 'most productive area'. The logic of this view escapes me. If CAM treatments for cancer are not effective/safe/good value, how can any of the three projects in the first initiative be 'most productive'? It is difficult to assess the content of a research project solely from the title, but it seems that the issues of efficacy/safety/value are not central to any of the five projects in the second group. Also, unless there has been a typographic error, it seems that Dr Alison Shaw at Bristol is being supported twice for a project on 'Male cancer patients' view on and use of CAM'.

I have no conflict of interest in this matter. I gave evidence to the HLSC, but had no part in any of the applications for support or selection of the projects now to be funded by public money. I was very pleased that the government had allocated a substantial sum of money for CAM research, but I am concerned that it now seems that this money will not be used to answer the questions so clearly given priority by the HLSC.

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Sheila Glenn

Other than information provided by the titles, it is not clear what the funded projects actually entail or the methods employed; therefore, it is difficult to comment on their excellence relative to other projects submitted. The feedback that our candidate received was detailed and helpful, and we have no complaints in that respect. What was of concern was the composition of the panel making the decisions. This was first brought to our attention prior to the final interviews and remains a concern given the close relationship between panel members and applications that were successful. It may indeed be the case that these were the best projects. However, we would be more confident in the result had independent panel members been appointed.

What is apparent is that specific institutions appear to have been funded, most notably the two universities

that were each funded twice. While the credibility and expertise of these projects are not in question, it does appear that a *modus operandi* of funding preferred providers exists. Specific projects that had already been funded formed the basis of a successful bid and, in the case of at least one, the same project appeared to be funded twice. This is particularly surprising given that the successful projects did not all appear to address the brief for CAM research laid out by the House of Lords report on CAM, viz., 'Is the treatment safe? Does it offer therapeutic benefits greater than placebo? How does it compare, in medical outcome and cost-effectiveness, with other forms of treatment?'

There is surely a case for pump priming in terms of allocation of funds to get research started in places where potential is identified? The current situation implies that most universities will be excluded from the research agenda and that only designated centres will be funded. There is not a large evidence-base for CAM, therefore, there is considerable scope for research on a number of different therapies. It is early days in CAM research to identify particular centres as being centres of excellence, yet this is what this current round of funding suggests. If this is a policy, then a clear and unambiguous statement would be welcomed in order to ensure that departments do not waste their time applying for funding. In the present climate of accountability in decision-making such transparency would be welcome.

Finally we recommend that proposals be reviewed 'blind' in future, and also that care is taken in the composition of panels. Future panels could include some CAM therapists and lay members as well as independent methodologists and others involved in researching the specific health conditions and therapies. This should reassure the research community.

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Paul Wilson and Jos Kleijnen

Increasing numbers of patients are seeking information on, and making use of, CATs as part of their own health care. While the majority of CM is provided outside the NHS, it is also available within the NHS.

However, healthcare resources are finite. In the *NHS Plan*, the current UK government made a commitment to ensure that expenditure on health services would be used in the most efficient way possible.[1] This commitment was highly dependent upon making the right judgements about which types of health care were effective, offered value for money and thus could justifiably be funded.

Two recent issues of the *Effective Health Care Bulletins* focused on the effectiveness of two of the most established complementary disciplines, acupuncture and homeopathy.[2,3] In both bulletins, we commented that there was insufficient evidence of the effectiveness of these therapies for the conditions of most interest to patients, clinicians and, importantly, in the context of the NHS, purchasers. For example, the bulletin on acupuncture highlighted that while there are a large of number of acupuncture studies on nausea and postoperative pain, the more chronic and intransigent problems that are poorly responsive to conventional treatment have had little investigation. It can be argued that this situation has arisen in part because of the lack of a formalised research infrastructure.

Insufficient evidence of effectiveness is a scenario that benefits no one. Practitioners, purchasers and the public all need access to high-quality information if they are to make informed and appropriate judgements about the treatments they use or provide.

It is therefore pleasing to see that the Department of Health's research capacity building initiative has attempted to redress some of the shortcomings of the existing evidence base. There is a focus not only on building research capacity and methodology, but also on 'real world' evaluations and on research involving priority areas such as cancer and depression. However, based on titles, only one of the studies funded seems to directly address any of the questions recommended by the House of Lords. In addition to the projects funded, emphasis is needed on studies comparing CAM with placebo, studies about the safety of CAM and studies assessing the cost-effectiveness relative to other forms of treatment.

Building a research infrastructure and enhancing the existing evidence base can only help to determine where complementary and alternative approaches may be used to their best advantage, and whether or not current NHS provision should be maintained, increased or reduced.

References

1 Secretary of State for Health. *The NHS Plan: A plan for investment. A plan for reform*. London: Stationery Office, 2000.
2 NHS Centre for Reviews and Dissemination. Acupuncture. *Effective Health Care* 2001; **7**(2).
3 NHS Centre for Reviews and Dissemination. Homeopathy. *Effective Health Care* 2001; **7**(3).

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John Walton

I was privileged to chair Subcommittee 1, which conducted the Enquiry into Complementary and Alternative Medicine, on behalf of the House of Lords Select Committee on Science and Technology; as the accompanying introduction above points out, our report was accepted by the parent Select Committee, and was published in November 2000. I, and my colleagues, were glad to learn that the Department of Health had decided to set aside dedicated funds to support research in this field, in order to underline the objectives set out in our recommendations, and I have noted the details given above of the projects which have been supported with that funding.

It seems to me that a useful start has been made, though I confess that I would have preferred to see included in the projects receiving support a number setting out to confirm in a quantitative manner the efficacy of various complementary or alternative interventions when compared with standard Western medical practice. In the evidence we received from those working in CAM, much was made of the difficulty encountered in planning and conducting double-blind controlled trials and comparing various healthcare interventions, including those in the complementary and/or alternative field. Nevertheless, as our report made clear we did not think that the difficulties referred to were insurmountable, and it was our view that every effort should be made to carry out such trials in order to confirm the efficacy, or otherwise, of a wide range of interventions. I hope very much that subsequent financial support from the Department of Health will be devoted to such studies. I also hope that Government funds will be made available for training in research and statistical techniques, perhaps under scholarships or fellowships for complementary practitioners who wish to undertake such research. As our report made clear, it was our hope that a limited number of such research appointments involving training in methodology as well as research projects themselves, might be established in centres where there are existing good relationships between those practising conventional medicine on the one hand, and those working in the complementary and alternative disciplines on the other. While those projects already supported are likely to generate results of considerable interest and of relevance to health care in the UK, they constitute, in my view, no more than preliminary and explorative projects that need to be followed by others, with well-defined concrete objects and firmly established endpoints.

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Both the House of Lords report and the Government response to it, state clearly '... we recommend that three important questions should be addressed in the following order: ...' (1) does the treatment offer therapeutic benefits greater than placebo? (2) is the treatment safe? (3) how does it compare, in medical outcome and cost-effectiveness, with other forms of treatment? These aims seem admirable, but to what extent do the projects that have been funded match these recommendations?

The answer, sad to say, is that they do not seem to follow the recommended order of priorities at all. None of the studies in the first initiative (Tovey, Corner and Shaw) appears to address the question that the recommendations specify should be done first. With the possible exception of White, none of those in the second phase (Shaw, Barry, Weatherley-Jones, White and MacPherson) do. (Dr White, like most other recipients, has declined to provide any information about his project so it is impossible to be sure.) None really addresses the second priority directly. The third recommendation is worded much more vaguely than the first two, but it is only this third aim, the one that was meant to be done last, that might be furthered by most of these studies.

The rationalisation given by some of the applicants for uncontrolled, or 'pragmatic' trials is that they are conducted under real clinical conditions and tell you what the patient actually thinks. It is quite true that, from the point of view of the patient, it does not matter in the least whether they feel better because of a placebo effect or because of a specific effect of the treatment. That is an important consideration but it is not the only one. If the first priority had been addressed first (which it has not) it is quite possible that the outcome could be that the entire effect could be a placebo effect. Such a possibility has been envisaged by no less a luminary of the CAM world than Peter Fisher.' If that were to turn out to be the case it might matter little to the patient but it would matter a great deal to universities, which are under continual pressure from CAM people to run degree courses (though only a few have acquiesced). If the whole effect were placebo, it follows that the 'principles' of homoeopathy, reflexology, etc., are mere mumbo jumbo and so not appropriate for teaching in universities (or, indeed, anywhere else). The question of courses and 'training' cannot be considered until the first question is answered because, until then, we do not know if there is anything real to train people about. That is why it is the first priority. There would,

however, be a dilemma for clinical practice. The placebo effect does appear to be useful, so the question would then become how best to produce a good placebo effect without too much intellectual dishonesty. Perhaps that is a question that deserves more research.

The fact of the matter is that the Department of Health has ended up spending £1.3 million of public money in a way that directly contravenes the recommendations of the House of Lords and of the government (with one possible exception). They claim that this happened because very few applications were received that addressed the government's first priority. That alone says something about the extent to which the CAM world is interested in tests against placebo – hardly surprising since a negative result would destroy their livelihood. But, arguably, if few applications were received that addressed the first priority, then the funding should have been postponed until appropriate applications were forthcoming. The reason that this did not happen is, I fear, only too obvious. The judging panel was dominated by CAM people who clearly share the lack of interest shown by the rest of the CAM community in answering the most important question first. If such research must be done, because of public demand for it, it should have been organised by the Medical Research Council using the same criteria they would use for any other treatment.

References

1 Fisher P, Scott DL. A randomized controlled trial of homeopathy in rheumatoid arthritis. *Rheumatology (Oxford)* 2001; **40**: 1052–55.

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