Complementary and alternative medicine: What your patients may be using
Editorial board

A publication from the BMA Science and Education department and the Board of Science.

Chair, Board of Science               Professor Sir Charles George
Director of Professional Activities  Professor Vivienne Nathanson
Head of Science & Education / Editor  Nicky Jayesinghe
Research & writing                    Hilary Forrester

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Professor G Lewith, Complementary and Integrated Medicine Research Unit, School of Medicine, University of Southampton

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There were no competing interests with anyone involved in the research and writing of this report. For further information about the editorial secretariat or Board members please contact the Science and Education Department which holds a record of all declarations of interest: info.science@bma.org.uk
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SCOPE AND RATIONALE

The British Medical Association (BMA), through its Annual Representative Meeting (ARM) and Board of Science, has developed policy on complementary and alternative medicine. Please see Current BMA policy on Complementary and Alternative Medicine (CAM).

At the 2008 ARM a resolution on CAM (see current BMA policy on CAM [sub link]) was referred to the Board of Science for further consideration. The Board, in deciding how best to action the resolution agreed that while there is a lack of consensus among BMA members on the validity of CAM therapies, patients are increasingly asking their doctors about CAM, as such the best way forward was to produce an information resource to inform doctors about the various CAM therapies available and the changing face of CAM regulation.

Therefore, this resource provides:

- links to sources of information relating to the use of CAM within primary and secondary care
- background information on the different types of CAM therapies
- an outline of the progress that has been made towards regulation of CAM therapies.

The resource does not form BMA policy, nor does it endorse any of the therapies. It does not consider the clinical efficacy of individual CAM therapies but directs the reader to sources containing research data and information on safety, efficacy, effectiveness and cost-effectiveness. Each section of this resource includes a summary text outlining the main themes and developments, accompanied by links to further information. These links are not meant to be exhaustive. They are to sites unrelated to the BMA. They are provided for information purposes only. The BMA DOES NOT endorse or accept responsibility for their content.

The resource will be updated at regular intervals to maintain the latest information of interest to healthcare professionals. If you are aware of any further information which may enhance this resource, please email: info.science@bma.org.uk.
1. INTRODUCTION

In the 1970s and 1980s, Complementary and alternative medicine (CAM) therapies were viewed mostly as being alternative to conventional health care and were often described as “alternative medicine”. The term “complementary medicine” developed as CAM therapies began to be used more alongside and in conjunction with orthodox medical treatment, for example acupuncture, osteopathy and chiropractic.

By contrast, ‘alternative’ therapies could be seen as those given in place of conventional medical treatment, such as herbal medicine, which may be used as an alternative to conventional drugs. Most CAM appears to be supplementary or additional to conventional care, rather than an alternative. The distinction between complementary and alternative is, however, problematic. Most forms of CAM can, in some circumstances, be used as an alternative or a supplementary form of treatment.

There is much interest in the use of CAM. A survey in 2005 showed that 10 per cent of adults in Britain had consulted at least one therapist in the past 12 months. Acupuncture, homeopathy, chiropractic, osteopathy or herbal medicine, were the most popular, accounting for 6.4 per cent of the consultations. This interest has coincided with changes in healthcare provision which aim to facilitate greater patient choice.

At the present time, only two CAM therapies are subject to statutory regulation, namely osteopathy and chiropractic. The CAM therapies of acupuncture, herbal medicine and traditional medicine systems are working towards statutory regulation following the recommendations of the House of Lords Science and Technology Select Committee (2000) report. In 2008, a new regulatory body, the Complementary and Natural Healthcare Council (CNHC) was established to provide voluntary self-regulation of other CAM therapies. The emphasis of the CNHC is on patient safety rather than efficacy and it is hoped that many of the CAM therapies will seek voluntary self-regulation through this route. Critics of the CNHC are concerned that as registration is voluntary, the system would not prevent unregistered CAM therapists from practising, and that efficacy must be included if the regulatory system is to be effective.

Research into the efficacy of CAM therapies has been, and continues to be conducted. Randomised clinical trials (RCT) are increasingly being used and this has been followed by systematic reviews and meta-analyses of these trials and has raised questions about the use of NHS resources for CAM provision. A survey in 2001 estimated the annual NHS expenditure on the six main CAM therapies (acupuncture, chiropractic, homeopathy, hypnotherapy, herbal medicine, osteopathy) to be £52.8 million, and the total amount spent annually on CAM to be £1.6 billion.

NOTE: While much of the much of scientific medicine can be shown to be effective, this is not the case with all CAMs. As such, while individuals may choose to use CAM therapies, please do not understand from this resource that the BMA endorses its use.

* For further information, go to Sources of further information for specific CAM therapies.
† Also spelt ‘homoepathy’
2. **BMA POLICY ON CAM**

Over the last 20 years the Board of Science has worked extensively to develop BMA policy on CAM. The first report, *Alternative Therapy*, was published in 1986. It provided an overview of the five main therapies used in the United Kingdom (UK).[^1] Current BMA policy on CAM is contained in *Complementary medicine: new approaches to good practice*, and *Acupuncture: efficacy, safety and practice*.[^2] For more information see [Current BMA policy on CAM](#).

The BMA has focused its policy development on the discrete therapies which have established training programmes, criteria of competence, professional standards and the potential for use alongside orthodox medical care. These include acupuncture, osteopathy, chiropractic, herbalism and homeopathy. Doctors have a duty to safeguard public health and BMA policy has therefore focused on the principles of good practice in CAM which would safeguard the individual against possible harm to health and maximise the potential benefits of particular CAM methods.

The BMA has long been concerned about the difficulties that doctors and members of the public face in determining whether a CAM therapist is competent to practice. The Association first called for the regulation of CAM in 1993, noting that a situation in which anybody is free to practise, irrespective of their training or experience, is unacceptable. At that time, the BMA recommended that a single regulatory body should be established for each therapy, with responsibility for registration, professional standards, training and research. (see Box 1) The Association subsequently noted that operating a single body for all CAM therapies not currently subject to statutory regulation had cost savings, established a continuity of approach, and would be beneficial to practitioners who work across professional boundaries.[^3]

[^1]: BMA POLICY ON CAM: Over the last 20 years the Board of Science has worked extensively to develop BMA policy on CAM. The first report, *Alternative Therapy*, was published in 1986. It provided an overview of the five main therapies used in the United Kingdom (UK).

[^2]: Current BMA policy on CAM is contained in *Complementary medicine: new approaches to good practice*, and *Acupuncture: efficacy, safety and practice*. For more information see [Current BMA policy on CAM](#).

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Box 1: Recommended features for CAM regulatory bodies

Registration:
- A single register of members, open to public scrutiny, entry to which is limited to competent practitioners.

Professional standards:
- A defined protocol for communicating with medical practitioners and other therapists both within and outwith their own discipline and a system for maintaining case records of patients/clients
- Clearly understood areas of competence, including limits of competence and contraindications to treatment
- Enforceable ethical code governing all aspects of professional conduct, linked to effective disciplinary mechanisms
- Well-publicised and accessible complaints procedures

Training:
- Training structure appropriate to the task and of a credible duration at accredited and externally monitored educational establishments
- All practices claiming to have a therapeutic influence should include in their training courses a foundation in the basic medical sciences
- Consideration should be given to a core curriculum for the training schedule of each therapy including appropriate clinical and medical input
- Limits of competence must be established for each therapy during the training process. Patients suffering from conditions not amenable to treatment must be identified and referred to the appropriate agency. This is particularly important in cases where medical attention is needed
- Provision should be made for continuing education for qualified members, and for refresher courses
- Training in clinical audit, so that practice and management of patients are evaluated rigorously at regular intervals

Research:
- Encouragement of professional development and research


Statutory regulation should be applied to those therapies in which the diagnostic process is integral to the application of the therapy, and whose practice involves invasive and potentially harmful techniques. The BMA, therefore, supports the action currently underway to introduce statutory regulation for acupuncture, herbal medicine and traditional medicine systems. It should be noted, however, that the proposed regulation
excludes consideration of the efficacy and effectiveness of these treatments. Current General Medical Council (GMC) guidance in *Good Medical Practice* states that a doctor must provide effective treatments based on the best available evidence.⁹

Since April 2008 other CAM therapies have had the opportunity to seek voluntary self-regulation through the CNHC. In 2008 the BMA confirmed that all complementary practitioners should be regulated to the same standards expected of the medical profession (which is statutorily regulated) and have an independent regulatory body. For some CAM therapies, regulation through the CNHC is a logical step towards statutory regulation.

**Informed consent**

Irrespective of the therapies used, whether orthodox, conventional, complementary or alternative, it is essential that patients give their fully informed consent to treatment. This requires that patients fully comprehend the professional status and qualifications of the practitioner and are not led to believe the practitioner is medically qualified when they are not.

To that end, no practitioner should use a style or title which might be confused with that regularly and traditionally used by registered medical practitioners. Though there is no direct legal protection for the use of certain titles by members of the medical profession, it should be noted that section 49(1) of the Medical Act 1983 provides liability for a fine for:

...any person who wilfully and falsely pretends to be or takes or uses the name or title of physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, surgeon, general practitioner or apothecary, or any name, title, addition or description implying that he is registered under any provision of this Act, or that he is recognised by law as a physician or surgeon or licentiate in medicine and surgery or a practitioner in medicine or an apothecary...

For further information about confidentiality and guidance on how this can be adhered to please refer to the BMA publication *Medical ethics today* (2004).¹⁰

3. **PROVISION AND USE OF CAM**

There is much interest among patients in the use of CAM, (whether by self-referral or GP referral), and among GPs and other healthcare professionals in offering such treatment. Estimates suggest that there could be more than 60,000 CAM therapists and 20,000 statutory health professionals regularly practising a variety of CAM therapies in the UK.
The popularity of CAM has led to greater demand for CAM on the NHS. This has coincided with changes in healthcare provision which aim to facilitate greater patient choice (read more Department of Health policy and guidance on improving patient choice).

In 2001, a survey of GPs found that 49 per cent of practices offered access to some form of CAM. In almost 30 per cent of practices this was provided by one or more members of the primary care team (GPs, nurses and others). Independent CAM therapists worked in 12 per cent of practices, and 27 per cent of practices made NHS referrals to external CAM providers. The proportion of practices with CAM provided by the primary health care team had increased 38 per cent since 1995. No change was found in the proportion of practices making NHS referrals for CAM.11

In 2008, researchers from the University of Southampton explored GP experiences of referring patients for CAM therapy under an NHS contract. They found that factors which increased the likelihood of referral were: the positive attitude of the individual GP to, and experience of, CAM; the patient’s attitudes, openness and request for CAM therapy and confidence in the CAM therapist. Referral to CAM therapists appears to differ from referrals to conventional medicine, for example:

a) In conventional referrals, there is usually an evidence-based clinical need. CAM referrals are not usually evidence-based.

b) In conventional medicine, the referral may be doctor-driven on the basis of clinical need, but can also be driven by the patient, based on their demands and expectations. CAM referral is often due to a consensual agreement between the doctor and the patient for a referral to occur.12

A survey in 2004 estimated that 10 per cent of the population had received treatment from a CAM therapist in the past year. More than half of those who had used CAM in the past year had not told their GP. The most popular therapies were acupuncture, homeopathy, chiropractic, osteopathy and herbal medicine. Estimates for CAM use were similar for England, Scotland and Wales. The main reason for receiving a therapy was to treat an illness for which conventional medical advice had been previously sought.

**Referral to CAM therapists**

In 1999 the BMA produced guidance for GPs on referrals to complementary therapists which was updated in 2008.13 The guidance aims to clarify the legal and ethical obligations of GPs in responding to requests for such treatment. It contains a section on delegation to other CAM practitioners, referrals to therapists in regulated disciplines and to registered professionals. The guidance notes that GPs may not wish, or feel able to delegate or refer a patient to a CAM therapist. They should however make it clear that they have no objection to the patient independently consulting whoever they wish. (read Referrals to complementary therapists here)

Communication is of central importance to good medical care and is always in the patient’s best interest. BMA guidance states that in delegating to CAM therapists, GPs must pass on enough information about the
patient and the treatment needed (as stated by the GMC). The GP will need to exercise a degree of professional judgement in identifying the information that the therapist needs, and must ensure that they have the patient’s clear consent to the disclosure of this information, particularly if it is likely to be of a sensitive nature. The BMA recommends that CAM therapists must not alter the instructions or prescriptions given by a patient’s medical practitioner without prior consultation and agreement with that doctor. It is essential that there is a proper process of mutually respectful exchange of information between both practitioners.

CAM provision on the NHS

Research into the efficacy of CAM has raised questions about the use of NHS resources for such provision. A survey found that 10.6 per cent of the adult population of England had visited at least one therapist providing any one of the six most established therapies in the preceding 12 months (acupuncture, chiropractic, homeopathy, hypnotherapy, herbal medicine, osteopathy). This amounted to some 22 million visits, of which the NHS provided an estimated 10 per cent. The annual NHS expenditure on these six CAM therapies was estimated as £52.8 million. It was concluded that more detailed quantitative information is required on the levels of CAM use in the United Kingdom and that the total amount spent annually on CAM is nearer £1.6 billion.

CAM provision is currently available in both primary and secondary care settings.

Primary care services providing CAM

The decision to provide CAM on the NHS is still a matter of clinical judgement by the GP, but not all Primary Care Trusts (PCTs) have funding provisions dedicated to CAM. In some cases, this is due to lack of resources and, in other cases a decision may have been made not to fund CAM. A survey by Pulse Magazine in 2008 found that 37 per cent of 132 PCTs had contracts for homeopathic services. More than a quarter had either stopped or reduced funding for the therapy over the past two years. Some of this reduction may have been the result of PCTs targeting complementary therapies in budget cuts to reduce the NHS deficit.14

CAM may be provided by a CAM therapist attached to the health centre or surgery, or by GP referral to a private therapist or to an NHS provider. CAM may also be provided by the doctor, or another member of the healthcare team. In 2000, 58 per cent of PCTs provided some access to CAM via primary care.15 The Department of Health (DH) has produced guidance on establishing a policy for the provision of CAM in primary care. Some examples of such provision include:

Glastonbury Health Centre Complementary Medicine Service is a three-partner GP practice, of approx 5,000 patients. The project is supported by Somerset Trust for Integrated Health Care. The aims of the Trust are to support the integration of effective CAM in primary care by:

- subsidising access to CAM,
- researching the impact of integrated CAM,
- establishing links and disseminating information to other providers
- lobbying the NHS to support integrated CAM.
The therapies provided are acupuncture, herbal medicine, homeopathy, massage and osteopathy.

Marylebone Health Centre offers a counselling and complementary therapy service for patients.

Plymouth Teaching PCT provides CAM as part of the palliative care service for patients and their main carer. It includes a choice of CAM to support their well-being, assist in symptom control and aid relaxation.

Dorset PCT has a contract with the Centre for Complementary and Integrated Medicine for Dorset or Bournemouth and Poole residents to provide CAM for the following conditions: irritable bowel syndrome; migraine; eczema; chronic fatigue syndrome (ME); childhood behavioural disorders.

Secondary care services providing CAM
CAM provision is mainly located in primary care, but there are examples of secondary care services which use CAM. These include:

- acupuncture provided by physiotherapists. More information is available from the Acupuncture Association of Chartered Physiotherapists
- acupuncture and other therapies such as the Alexander Technique and massage have been integrated into pain clinics
- acupuncture and occasionally aromatherapy have been integrated into some obstetric and cancer services and into palliative care, rehabilitation and care of the elderly. The DH Research and Development Programme has commissioned research into the role of CAM in the care of patients with cancer.
- The National Cancer Research Institute has a CAM clinical studies group which specifically promotes CAM research contact Julie Flynn Julie.Flynn@cancer.org.uk
- The Arthritis Research Campaign (ARC) has a particular interest in investigating CAM and published a report on Complementary and Alternative Medicine for Arthritis in 2008. The ARC is also planning a further report on physically based interventions (eg acupuncture, healing). For further information contact Professor Alan Silman a.silman@arc.org.uk
- homeopathy is provided within secondary care through the five NHS homeopathic centres:
  - Bristol Homeopathic Hospital
  - Glasgow Homeopathic Hospital
  - Royal London Homeopathic Hospital
  - Tunbridge Wells Homeopathic Hospital
    Church Road, Tunbridge Wells, Kent TN1 1JU
    Tel: 01892 632801
  - Department of Homeopathic Medicine
    The Old Swan Health Centre, St Oswald’s Street, Old Swan
    Liverpool L13 2BY Tel: 0151 285 3707
4. DIFFERENT TYPES OF CAM THERAPIES

In 2000 the House of Lords Science and Technology Select Committee reported on the range of CAM provision in the UK. It considered questions relating to use, regulation, training, research and NHS provision. The committee classified the therapies broadly into three groups according to the level of statutory or voluntary professional regulation, and the availability of studies of effectiveness in an emerging evidence base. (see Box 2)

Box 2: CAM hierarchy

Group 1: Professionally organised alternative therapies
Contains therapies that may be called the principal disciplines, two of which, osteopathy and chiropractic, are already regulated in their professional activity and education by Acts of Parliament. The others are acupuncture, herbal medicine and homeopathy. These therapies claim to have an individual diagnostic approach and are considered to be the ‘Big 5’ by most of the CAM world.

Group 2: Complementary therapies
Contains therapies which are most often used to complement conventional medicine and do not purport to embrace diagnostic skills. It includes aromatherapy; the Alexander Technique; body work therapies, including massage; counselling; stress therapy; hypnotherapy; reflexology and probably shiatsu; meditation and healing.

Group 3: Alternative disciplines
Embraces those other disciplines which purport to offer diagnostic information as well as treatment and which, in general, favour a philosophical approach and are indifferent to the scientific principles of conventional medicine, and through which various and disparate frameworks of disease causation and its management are proposed. These therapies can be split into two sub-groups. Group 3a includes long-established and traditional systems of healthcare such as Ayurvedic medicine and traditional Chinese medicine. Group 3b covers other alternative disciplines which lack any credible evidence base such as crystal therapy, iridology, radionics, dowsing and kinesiology.


The five therapies classified as belonging to “Group 1” were considered by the Select Committee to be most appropriate for NHS funding, namely acupuncture, homeopathy, chiropractic, osteopathy and herbal medicine. The committee recommended that the interests of the public in their use of CAM would be best served by improved regulatory structures. For acupuncture and herbal medicine, statutory regulation was
preferred on the basis of possible risk to the public from poor practice; a pre-existing robust voluntary regulatory system; and the presence of a credible evidence base.

For information about different types of CAM therapies go to Sources of further information on CAM therapies.

Further information about the most commonly used therapies is provided in A guide to the most commonly used complementary therapies, published by The Prince’s Foundation for Integrated Health. The guide includes information about the different treatment approaches and common uses, links to professional associations and organisations representing each therapy, and information on finding CAM therapists.

5. TRAINING FOR DOCTORS IN CAM

It is difficult to ascertain the number of medically qualified individuals practising some form of non-conventional therapy. The category of medically qualified practitioner may embrace a broad range of activities, from a doctor employing homeopathic skills on a fairly full-time basis to the doctor practising hypnotherapy on patients very occasionally. Fulder estimates that there are around 2,000 doctors practising non-conventional therapies. Other estimates suggest that CAM is practised by 20,000 statutory health professionals, although this figure also includes nurses, physiotherapists and dentists.

The GMC gives advice regarding the responsibility of doctors in relation to standards of medical care. While medical practitioners are free to practise whatever form of medicine is appropriate for the patient, there are stringent requirements to achieve the basic qualifying standards of medical competency and knowledge in the application of whatever branch of medicine or technique they practise. A medically qualified practitioner remains accountable to the GMC whatever treatment he or she is undertaking. The GMC specifies that a doctor must recognise and work within the limits of their competence. Where there are clear and recognised standards of practitioner competence laid down for a CAM therapy, the therapist, whether medically qualified or not, should satisfy those criteria. This will apply to CNHC standards as these are developed, although there is no provision for verifying the effectiveness of the therapy.

Doctors increasingly require more information on CAM. They need to know more about different therapies in order to delegate care appropriately, and to advise patients about the likely benefits and hazards of treatment. Some doctors may wish to undertake more detailed training in order to practise as a CAM therapist. In 1993 the BMA recommended that:

- Accredited postgraduate sessions should be set up to inform clinicians on the techniques used by different therapists and the possible benefits for patients
- Consideration should be given to the inclusion of a familiarization course on CAM within the medical undergraduate curriculum.
The BMA called for CAM courses such as acupuncture, to have a core curriculum, with components including research methodology, information technology, statistics, fundamentals of orthodox medical diagnosis, ethics, and human anatomy and physiology. Such courses should be subject to rigorous validation, with an examination board and external examiners.

CAM familiarisation courses are available in some medical schools, e.g., Peninsula Medical School and the University of Southampton, but coverage is patchy. A recent survey of medical schools in Wales found that the majority of medical students would like to receive CAM teaching, and significant numbers support a role for CAM in the NHS. In spite of this, little formal teaching is currently provided.21

“We awarded the Dawkins prize to Southampton University to develop CAM familiarisation courses for medical school students.”22
Professor G Lewith Complementary and Integrated Medicine Research Unit, School of Medicine, University of Southampton

6. CAM RESEARCH

Research is important in any field of medicine as it creates better healthcare for the future. CAM therapists should conduct or arrange for research into their methods and practice because the true value of any treatment depends not only on its benefits but also its hazards. For example, when considering possible adverse effects of herbal and other medicines, an important area for further research is a consideration of the consequences of combining different therapeutic treatments on a patient. Results from trials may confound expectations and assumptions previously held by experienced practitioners2.

The advantages of randomised clinical trials, in which subjects are allocated at random to the experimental treatment, such as a particular drug therapy or a control regimen, are well documented. The benefits of both the subject and the researcher being unaware of which regimen is being followed (a ‘double-blind’ trial) has also been demonstrated. CAM therapies could benefit from the appropriate use of this method, alongside other established methods of scientific research. Research on CAM therapies has been, and continues to be conducted, including surveys and outcome studies. Randomised clinical trials (RCTs) are increasingly being used and this has been followed by systematic reviews and meta-analyses of these trials.23 There is considerable debate as to whether trials should be RCT, pragmatic and/or involve some health economic evaluation. RCTs are widely accepted as the most reliable method of determining effectiveness, but most trials have evaluated the effects of a single intervention such as a drug. In recognition that other, non-pharmacological interventions should also be rigorously evaluated; the MRC has produced a framework for developing and evaluating complex interventions such as those involving CAM. (read the MRC framework here)

An overview of research into CAM is available from the National Library of Health and from a range of books24,25 and review journals.26 Research advice and support is available for CAM therapists, for example
through the Research Council for Complementary Medicine, Complementary Medicine at the Peninsula Medical School, or the Complementary and Integrated Medicine Research Unit (University of Southampton).

7. EFFICACY, EFFECTIVENESS, COST-EFFECTIVENESS AND RISK OF CAM

In 2005, a report entitled The role of complementary and alternative medicine in the NHS, was commissioned by The Prince of Wales, and produced by Christopher Smallwood. It examined evidence relating to the effectiveness of the five main CAM therapies (acupuncture, homeopathy, chiropractic, osteopathy and herbal medicine) and considered their cost-effectiveness for use in the NHS. The report found that the most useful CAM therapies correspond to recognised ‘effectiveness gaps’ (conditions which are poorly addressed by conventional medicine). In these areas, they may have the potential to make an important contribution to the delivery of healthcare, eg in managing chronic pain, certain mental disorders, and in palliative care. The report concluded that insufficient evidence exists to suggest that some CAM therapies may be more effective than conventional approaches in treating certain chronic and psychosocial conditions. It was also not possible to say whether specific treatments offer possible cost savings, particularly where they are provided in place of, rather than in addition to, orthodox treatment. The report has attracted serious criticism for being biased, unreliable and misleading.

As noted above, homeopathy is provided on the NHS, particularly by the five NHS homeopathic centres. In 2002, a study by the NHS Centre for Review and Dissemination, based at York University, concluded that there was insufficient evidence of effectiveness either to recommend homeopathy as a treatment for any specific condition, or to warrant significant changes in the current provision of homeopathy within the NHS. The report did not go so far as to recommend that homeopathy should not be provided on the NHS.

A 1997 review in the Lancet found that the clinical effects reported in randomised clinical trials of homeopathic remedies are not only a placebo effect. They concluded, however, that there was insufficient evidence to show that homeopathy is clearly efficacious for any single clinical condition. The same authors (Linde et al) then re-analysed the same data set and concluded that “there was clear evidence that studies with better methodological quality tended to yield less positive results” Ernst summarised no less than 11 systematic reviews published after Linde’s Lancet paper and found that “the best clinical evidence for homeopathy available to date does not warrant positive recommendations for its use in clinical practice”. This conclusion was also confirmed by two further systematic reviews.

“Many experts believe that the most serious risk of CAM is its use as an alternative to effective intervention. For instance, some homeopaths, chiropractors or naturopaths advise against immunisation and for alternative methods such as ‘homeopathic’ vaccination.”

Professor E Ernst, Complementary Medicine, Peninsula Medical School
In 2000, the BMA report on *Acupuncture: efficacy, safety and practice* considered the evidence base and reported that acupuncture appeared to be more effective than sham acupuncture or other control interventions for nausea and vomiting (most convincing for post-operative nausea in adults), and for back pain, dental pain and migraine. The evidence relating to osteoarthritis and neck pain to acupuncture was unclear. Acupuncture’s role in recovery from stroke, and the treatment of tension headache, fibromyalgia and temporomandibular joint dysfunction was also uncertain. The report also commented that acupuncture appeared not to be superior to sham acupuncture for smoking cessation or weight loss.

A *review of the effectiveness of acupuncture* as a health service intervention36 (2001) noted that the majority of randomised clinical trials evaluating the effectiveness of acupuncture are of poor quality, or provide conflicting evidence. Acupuncture does appear to be effective for postoperative nausea and vomiting in adults, chemotherapy-related nausea and vomiting and for post-operative dental pain. The review noted that in the light of current evidence “acupuncture is unlikely to be of benefit for obesity, smoking cessation and tinnitus. For most other conditions, the available evidence is insufficient to guide clinical decisions.” A more recent analysis came to similar conclusions.37

A *review of the cost effectiveness of complementary treatments in the United Kingdom* conducted in 2005, found that CAM treatments such as acupuncture and manipulative therapies represent an additional healthcare cost in four out of the five rigorous cost-effectiveness studies. Acupuncture was an effective addition to usual care for chronic headache. Estimates of cost per quality adjusted life year compare favourably with other treatments approved for use in the NHS. For spinal manipulation in the treatment of back pain, however, the health benefits were small to moderate and were of questionable clinical significance.38

**Natural = safe?**

Contrary to a commonly held belief and perception that CAMs are natural so they are safe, none of the CAM treatments are free of risk. For instance, acupuncture needles have caused death through puncturing vital organs and spinal manipulation is associated with several hundred cases of vertebral arterial dissection.39 Some herbal medicines may pose a risk to human health since they, like any other medicine, have the potential to cause adverse effects.24,25 Many herbal medicines have not been established as being safe for use by pregnant women, breastfeeding mothers, children, and older people. St John’s Wort (*Hypericum perforatum*) is an unlicensed herbal remedy widely used in the UK and available from pharmacies, health food shops and herbal practitioners. It has been found to interact with other medicines, reducing their effectiveness or increasing their toxicity.4 Unlicensed Ayurvedic or traditional Chinese medicines have been found to contain heavy metals such as mercury, lead and arsenic. This is a significant international problem which poses a serious risk to public health.

4 In transplant patients, self-medication with St John’s wort (*Hypericum perforatum*) has led to a drop in plasma levels of the immunosuppressant drug Ciclosporin, causing tissue rejection. *Xenobiotica* 2002 -- Jun;32(6):451-78 -- Pharmacokinetic interactions between herbal remedies and medicinal drugs. -- Ioannides C.
The Medicines and Healthcare products Regulatory Agency (MHRA) provides herbal safety advice, including information and safety warnings for health professionals about side-effects and interactions with other medicines.

**CAM evaluation by the National Institute for Health and Clinical Excellence (NICE)**

In 2000, the BMA recommended that the DH should select acupuncture for appraisal by NICE. It was noted that NICE had been established to consider the value of particular treatments in clinical practice, and should therefore be well placed to consider CAM therapies and produce guidance for the NHS. This recommendation was extended in 2008 when the BMA called upon NICE to review and report on the cost effectiveness of homeopathic remedies and to recommend whether they should continue to be funded by the NHS. (see Current BMA policy on CAM)

The BMA recommendations were echoed in the report on *The role of complementary and alternative medicine in the NHS*, (commissioned by The Prince of Wales) which stated that Health Ministers should invite NICE to carry out a full assessment of the cost-effectiveness of the five main CAM therapies and their potential role within the NHS. In commenting on this recommendation, however, Thompson and Feder argue that a more efficient approach would be for NICE to pay greater attention to reviewing CAM when developing the scope of new guidelines on chronic conditions. They suggest that CAM therapists with particular expertise for each specific condition should be invited to join guideline development groups. Where evidence of effectiveness is uncertain, recommendations relating to the CAM therapy could still be included, with modelling of cost effectiveness as part of the guideline development.

In 2007, the British Medical Journal (BMJ) rehearsed the advantages and disadvantages of CAM evaluation by NICE. Franck, Chantler and Dixon argued for such evaluation, concluding that NICE has an effective systematic review process that takes into account all available evidence, including observational studies. It would therefore be appropriate for NICE to consider whether CAM therapies are safe and effective in relieving symptoms (compared with no treatment), and whether the treatment is cost-effective. As a counterpoint, Colquhoun expressed concern that CAM research has already been extensively reviewed and found to contain little convincing evidence. NICE cannot afford to re-examine evidence that has shown little benefit.

In 2008, the need for proper evaluation of the effectiveness of CAM therapies was emphasised by the Steering group on the statutory regulation of practitioners of acupuncture, herbal medicine, traditional Chinese medicine and other traditional medicine systems practised in the UK. This steering group’s Report to Ministers concluded that “public funding from the NHS should only be used to fund CAM therapies where there is evidence of efficacy, safety and quality assurance.”
8. **CAM REGULATION**

Regulation involves establishing a system governing how a professional works. It aims to protect the public by setting agreed standards of practice and competence such as completing a recognised course, participating in continuing professional development (CPD), having current professional indemnity insurance and signing up to a code of conduct, ethics and disciplinary procedures. Those who are competent to practice become registered and are then entitled to use a specific title. The registering body can apply sanctions such as removing from the register any therapist whose fitness to practice is impaired.

There are a great many bodies representing different CAM therapies. Some therapies have more than one representative body (see [Sources of further information for specific CAM therapies](#)). Representative bodies such as the [British Acupuncture Council](#) and others, may include voluntary regulation schemes, but, there is no single regulatory system for all CAM professions in the UK. This can be very confusing and offers little protection to the public. The main purpose of such representative bodies is to support their profession. Under the present heterogeneous arrangements, if a CAM therapist is removed from the register of one representative body, there is little to stop them from joining another. Regulatory bodies, on the other hand, function to protect the interests of patients and deal with complaints. The Foundation for Integrated Health has compared the characteristics of regulatory and representative bodies. [Read more here](#).

There are two different types of regulation – statutory and voluntary. In statutory regulation, therapists have to join the register of the regulatory body otherwise it would be unlawful for them to practise. The title of the therapist is protected so that it can only be used by registered individuals, eg osteopath. In voluntary regulation, the regulatory body does not have statutory status. The voluntary regulatory body keeps a register, but therapists do not have to join the register in order to practise. The title of the therapist is not protected (eg homeopath), but therapists are able to indicate that they are registered with the voluntary regulator as a mark of quality for their profession (eg registered with the CNHC). Statutory regulation is a stronger form of regulation than the voluntary system and is therefore potentially a better means of protecting the public.

Orthodox medicine is statutorily regulated. The GMC is the statutory regulator which registers doctors to practice medicine in the UK ([read more about registration here](#)). Many other healthcare professionals are statutorily registered including nurses (see [Nursing and Midwifery Council](#)) and physiotherapists (see [Health Professions Council](#)).

Osteopathy and chiropractic are currently the only CAM therapies to be statutorily regulated (see [General Osteopathic Council](#) and [General Chiropractic Council](#)). Box 3 provides a summary of current CAM regulation in the UK.
Statutory regulation of acupuncture, herbal medicine and traditional Chinese medicine

In 2000 House of Lords Science and Technology Select Committee Report on Complementary and Alternative Medicine concluded that

- the CAM regulatory framework should be stronger to ensure that practitioners are properly trained and supervised;
- the evidence base for many therapies is weak and robust research into their efficacy is needed;
- only well regulated therapies should be provided by the NHS.

The Committee also urged that legislative avenues be explored to better control the unregulated herbal sector.

Following this report, two working groups were established to make recommendations for statutory regulation of acupuncture, and herbal medicine. In 2004, the DH consulted on proposals for a regulatory framework involving a single Council to regulate acupuncturists and herbal medicine therapists (read more here). A Joint Working Group (JWG) was then set up to deliver a proposal for the regulation. No further action was undertaken pending the outcome of the Shipman Inquiry and the publication of two reviews of professional regulation by the Chief Medical Officer for England and the DH.

For further information see:

- Good doctors, safer patients: proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients and the BMA summary of The Donaldson Report - Good doctors, safer patients
- The regulation of the non-medical healthcare professions.

In response to the increasing public interest in the use of herbal products and parallel concerns regarding the safety of such medicines for patients, the Traditional herbal medicinal products directive was agreed in 2004. The regulations implementing this Directive in the UK gave new impetus to the regulation of herbal medicine. After 2011, the manufacture of herbal medicines by a third party for the use of individual patients would no longer be permitted unless the therapist was statutorily regulated and therefore able to have such products made up under Article 5 of Directive 2001/83/EC. (The community code relating to medicinal products for human use). More information is available from the European Medicines Agency website.

The JWG (subsequently called the Steering group on the statutory regulation of practitioners of acupuncture, herbal medicine, traditional Chinese medicine and other traditional medicine systems practised in the UK) began work in late 2006. In February 2007, the White Paper, Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century was published. This concluded that there should be no new statutory councils to regulate professions aspiring to statutory regulation. Instead, statutory regulation of emerging professions should take place through existing regulatory bodies such as the HPC. The steering group
submitted their Report to Ministers in 2008 recommending that effective, safe and cost-effective statutory regulation, as demonstrated by the multi-professional HPC, could be extended to cover acupuncture, herbal medicine, traditional Chinese medicine and other traditional-medicine systems practise within the UK. It was noted that complementary therapies did not meet all the criteria currently required for entry into the HPC (read the full HPC registration criteria here). The Group considered that in the interest of public safety, statutory regulation should proceed quickly. They encouraged the various disciplines to establish a robust evidence base, in order to demonstrate benefit and gain credibility with other health professionals.

In July 2008, the BMA called for all complementary therapies to be regulated to the same standards expected of the medical profession and to have an independent regulatory body. (see Current BMA policy on CAM)

In response to the Steering Group’s report, the Minister requested a further public consultation on the report’s recommendations which took place in late summer 2008. The DH will, together with the devolved administrations, consider the consultation findings and respond in 2009.

Voluntary self-regulation of other CAM professions

Since 2005, with support and facilitation from The Prince’s Foundation for Integrated Health, a number of other CAM professions have been working towards voluntary self-regulation. These include the Alexander technique, aromatherapy, Bowen technique, cranial therapy, massage, naturopathy, nutritional therapy, yoga therapy, reflexology, reiki and shiatsu.

A new regulatory body, the CNHC, was established in April 2008. The CNHC aims to protect the public by providing a robust process for handling complaints, a code of conduct and ethics, and a registration system for qualified professionals. Therapists will be able to register with the CNHC from mid January 2009 onwards. They will need to prove that they meet the standards of the CNHC, and will then be entitled to use the mark ‘Registered with the CNHC’. The public will be able to check whether a therapist is registered. The relevant CAM professional associations will continue to provide support for the therapists registered with the CNHC by setting standards for education, providing training courses, CPD and other professional support. The emphasis of the CNHC is on patient safety rather than efficacy. It is hoped that many of the CAM professions which have participated in developing the CHNC will seek voluntary self-regulation through this route.

Critics of the CNHC are concerned that as registration is voluntary, the system does not prevent unregistered CAM therapists from practising. If a registered CNHC member is removed from the register for misconduct, for example, there is nothing to prevent them from continuing to practise without registration. It should also be noted that not all CAM therapies are likely to seek voluntary self-regulation through CNHC. This will mean that therapists from those professions will not be regulated in accordance with CNHC standards. Another

5 ‘Report to ministers from the Department of Health steering group on the statutory regulation of practitioners of acupuncture, herbal medicine, traditional Chinese medicine and other traditional medicine systems practised in the UK’, May 2008. http://hdl.handle.net/10059/176
criticism is that the CNHC will not be considering the efficacy of CAM therapies. Ernst points out that “the regulation of nonsense will result in nonsense”.

In 2008, the BMA called for an outright ban on the use of NHS resources to fund unregulated CAM therapies including those which do not have voluntary self-regulation through the CNHC. This would mean that only osteopathy and chiropractic could receive NHS funding at present, with therapists from other CAM professions becoming eligible from 2009 once they have gained registration with the CNHC. Acupuncture, herbal medicine and traditional medicine systems would be eligible for NHS funding following confirmation of their statutory regulatory status.
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<tr>
<th>CAM profession</th>
<th>Regulatory status</th>
<th>Regulatory body</th>
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<td>Osteopathy</td>
<td>Statutory regulation</td>
<td>General Osteopathic Council (since 1993)</td>
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<tr>
<td>Chiropractic</td>
<td>Statutory regulation</td>
<td>General Chiropractic Council (since 1994)</td>
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<td>Acupuncture</td>
<td>Working towards statutory regulation</td>
<td>Health Professions Council</td>
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<td>Herbal medicine</td>
<td>Working towards statutory regulation</td>
<td>Health Professions Council (by 2011)</td>
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<tr>
<td>Traditional Chinese medicine and other traditional medicine systems practised in the UK</td>
<td>Working towards statutory regulation</td>
<td>Health Professions Council</td>
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<td>Alexander technique</td>
<td>Most are likely to seek voluntary self-regulation</td>
<td>Complementary and Natural Healthcare Council (established 2008)</td>
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<td>Aromatherapy</td>
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<td>Bowen technique</td>
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<td>Other CAM therapies</td>
<td>Unregulated</td>
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9. CURRENT BMA POLICY ON CAM

**Annual representative meeting (ARM) and conference policy**

That this Meeting with regard to CAM:

(i) calls for the BMA to compile and produce guidance for clinicians on all currently available complementary and alternative therapies, with graded evidence for specific clinical areas or problems;

(ii) calls for the Board of Science to work with organisations and charities to encourage and produce validated research into complementary and alternative therapies that have little evidence available, particularly with regards to efficacy and safety;

(iii) believes that all complementary therapies should be regulated to the same standards expected of the medical profession and have an independent regulatory body;

(iv) calls for an outright ban on the use of NHS resources to fund unregulated therapies, whose associations choose not to join the Complementary and Natural Healthcare Council;

(v) calls upon the National Institute for Health and Clinical Excellence (NICE) to review and report on the cost effectiveness of homeopathic remedies and to recommend whether they should continue to be funded by the NHS.

**ARM 2008**

That this Meeting believes that complementary therapy should be regulated by statutory authority.

**ARM 2004**

That this Conference believes that, in the interest of practising holistic medicine, there should be no restrictions on sharing worldviews with patients provided it does not compromise their care.

**Medical Students Conference 2002**

That this Representative Body asks the Board of Science to investigate the scientific basis and efficacy of acupuncture and the quality of training and standards of competence in its practitioners.

**ARM 1998**

**BMA CAM publications**


10. ADDITIONAL SOURCES OF INFORMATION

The following websites contain further information on CAM. Please note however, that these links are to sites unrelated to the BMA. They are provided for information purposes only and the BMA DOES NOT endorse or accept responsibility for their content.

This caution will appear each time a user clicks on one of the links as below together with a note that they are being directed away from the BMA website.

**General CAM guidance**

**Alternative Health UK Directory**
The site provides information on CAM therapies and includes a search facility for CAM therapists in the UK. It includes links to further CAM resources, books and UK CAM news items.

**ABC of Complementary Medicine**
This British Medical Journal publication containing definitions of CAM and examples of different therapies. Information is provided relating to CAM organisational structure, approaches to treatment, training and regulations. There are links to other sources of information.

**The British Complementary Medicine Association**
This website provides information about CAM for the public and CAM practitioners. It includes information about CAM schools and colleges, together with details of individual therapies, how to find CAM therapists.

**Institute of complementary and natural medicine**
UK registered charity, formed in 1982 to provide the public with information on all aspects relating to the safe and best practice of CAM. The site includes information on CAM education, together with a useful glossary and list of websites for specific CAM therapies.

**National Center for Complementary and Alternative Medicine (NCCAM)**
The NCCAM is the Federal Government’s lead agency for scientific research on CAM. The NCCAM aims to:

- Explore complementary and alternative healing practices in the context of rigorous science.
- Train complementary and alternative medicine researchers.
- Disseminate authoritative information to the public and professionals.
The Prince’s Foundation for Integrated Health
The website describes a holistic approach to healthcare and explores how CAM can be used in conjunction with mainstream medicines. There is a downloadable guide detailing 23 different complementary therapies.

Complementary Medicine, Peninsula Medical School
The website provides details of the research activity of this unit and gives references of over a thousand articles published by the Exeter team.

Sources of published research into CAM
The following resources provide graded research information into the use of CAM:

Allied and Complementary Medicine Database (AMED)
AMED is produced by the Health Care Information Service of the British Library. It covers a selection of journals in complementary or alternative medicine as well as palliative care, rehabilitation, physiotherapy and occupational therapy.

Bandolier
This independent journal about evidence-based healthcare includes a knowledge library containing the best evidence available about CAM for patients and professionals. (read more here)

British Library: Allied and Complementary Medicine Database
Alphabetic list of journal titles relevant to complementary medicine, palliative care, or selected professions allied to medicine.

Centre for Reviews and Dissemination (CRD)
CRD undertakes high quality systematic reviews that evaluate the effects of health and social care interventions and the delivery and organisation of health care. This includes reviews into the effectiveness of acupuncture (2001) and homeopathy (2002). Individual databases can also be searched for more information on these and other CAM therapies. These databases include:

- Database of Abstracts of Reviews of Effects (DARE) which contains structured abstracts of quality-assessed reviews
- NHS Economic Evaluation Database (NHS EED) which contains abstracts of quality assessed economic evaluations.
- Health Technology Assessment (HTA) Database which brings together details of completed and ongoing health technology assessments from around the world.
**Cochrane Collaboration**

This database provides access to Cochrane reviews on the use of CAM therapies in the treatment of a particular condition. Cochrane reviews explore the evidence for and against the effectiveness and appropriateness of treatments (medications, surgery, education, etc.) in specific circumstances. The reviews database can be searched by condition, eg ‘back pain’, and by CAM therapy, eg ‘acupuncture’. The CAM field is run by Professor Brian Berman, Maryland bberman@compmed.umm.edu

**Consortium of Academic Health Centers for Integrative Medicine (CAHCIM)**

The CAHCIM aims to help transform medicine and healthcare through rigorous scientific studies, new models of clinical care, and innovative educational programs that integrate biomedicine and the rich diversity of therapeutic systems. The website includes a health conditions A-Z resource which lists selected websites representing an integrative medical approach to each health condition.

**Focus on Alternative and Complementary Therapies (FACT)**

This is a journal and electronic database of published CAM articles complete with structured abstracts, comments from a reviewer and response from original authors.

**International Society for Complementary Medicine Research (ISCMR)**

The ISCMR is an international scientific organisation of researchers, practitioners and policy makers which fosters CAM research. This site includes links to CAM journals and research publications.

**MD Anderson Cancer Center**

This website provides access to complementary and integrative medicine education resources to help patients and physicians decide how best to integrate such therapies into their care. It includes a Reviews of Therapies containing evidence-based reviews of published research studies on a variety of CAM cancer therapies.

**Memorial Sloan-Kettering Cancer Center**

The Integrative Medicine Service at Memorial Sloan-Kettering Cancer Center provides inpatient and outpatient clinical care, research, education and training. In addition, the About Herbs, botanicals and other products database provides access to information about over-the-counter products and unproven cancer treatments and their impact in the context of cancer care via our.

**National Cancer Institute (NCI): complementary and alternative medicine summaries**

The NCI is a component of the National Institutes of Health (NIH) in the US. The NCI is the Federal Government's principal agency for cancer research and training. This includes a role to assess the incorporation of cancer treatments into clinical practice. The NCI ranks human cancer treatment studies according to statistical strength of the study design and scientific strength of the treatment outcomes.
measured. This classification system has been adapted to allow the ranking of human studies of complementary and alternative medicine treatments for cancer.

**National Library for Health: Complementary and Alternative Medicine Specialist Library (NLH)**
The UK NLH CAM Specialist Library aims to provide access to good quality, up-to-date, relevant information on CAM. The content of the library is intended primarily for health professionals, CAM therapists and researchers. Information is graded according to status, eg national guidelines, research evidence/reviews, educational material and patient information.

**Natural Standard: The Authority on Integrative Medicine**
Natural Standard is an international research collaboration that aggregates and synthesizes data on complementary and alternative therapies. Using a comprehensive methodology and reproducible grading scales, information is created that is evidence-based, consensus-based, and peer-reviewed.

**Office of Cancer Complementary and Alternative Medicine (OCCAM)**
The OCCAM contributes to the advancement of evidence-based CAM practice and the sciences that support it as well as providing the availability of high-quality information for the health care community, researchers, and the general public.

**PubMed**
PubMed provides access to citations from biomedical literature including MEDLINE as well as access to full-text articles at journal web sites and other related web resources.

**Research Council for Complementary Medicine (RCCM)**
RCCM was developed to extend the evidence base for CAM in order to provide practitioners and their patients with information about the effectiveness of individual therapies and the treatment of specific conditions. This site includes links to the CAMEOL database which contains reviews of the published research in specific complementary therapies, focussing on key areas of NHS priority. Much of the work carried out as part of the CAMEOL project has been used in the development of the National Library for Health Complementary and Alternative Specialist Library.

**Society for Integrative Oncology**
The Society for Integrative Oncology (SIO) provides a forum for presentation, discussion and peer review of evidence-based research and treatment modalities in the discipline known as integrative medicine. It makes a clear distinction between ‘alternative’ or unproven and ‘complementary’ or tested useful therapies in cancer care. SIO promotes scientific evaluation of these modalities, shares results, and encourages symptom control with therapies found to be beneficial, focussing on the oncology practice of massage and other touch therapies, acupuncture, music therapy, botanicals, meditation and other mind-body approaches, nutrition, and fitness therapies.
**World Health Organization (WHO): traditional medicine**

This website includes general information about traditional medicines and CAM, including a fact sheet, Q&A about the safety of traditional medicine, definitions, and links to WHO publications on traditional medicines and CAM.

**Sources of further information for specific CAM therapies**

Given below are brief working definitions of the principal therapies and CAM terms referred to within this resource (this is not intended to be an exhaustive list). A list of CAM organisations and bodies for the main CAM therapies is also available from the NLH, Complementary and Alternative Medicine Specialist Library (read more here).

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**Acupuncture**

Traditionally a branch of Chinese medicine, in which needles are inserted into the patient’s body as therapy for various disorders or to induce anaesthesia.

- [British Academy of Western Medical Acupuncture](#) (BAWMA)
- [British Acupuncture Council](#) (BAcC)
- [British Medical Acupuncture Society](#)

**Alexander technique**

Postural re-education by teaching people to stand and move more efficiently.

- [The Society of Teachers of the Alexander Technique](#)
- [Professional Association of Alexander Teachers](#)
- [Alexander Technique Voluntary Self-Regulation Group](#) (ATVSRG)

**Aromatherapy**

Massage with external use of plant essential oils diluted in a base oil of vegetable origin. For more information, [click here](#) to go to the Aromatherapy Council.

**Bowen Technique**
Promotes self-healing through a series of gentle moves on skin (or through light clothing). The therapist detects stress build up in muscle groups and then uses Bowen moves to release that stress. For more information, click here to go to the European College of Bowen Studies.

**Chiropractic**
Uses joint-adjusting procedures, manipulation, massage, and other techniques to treat musculo-skeletal complaints. Much emphasis is placed on use of spinal X-rays for the diagnosis of mechanical problems.
- British Chiropractic Association
- General Chiropractic Council

**Cranial/craniosacral therapy**
A system promoting self-healing involving very light touch to the body and particularly the head. For more information, click here to go to the Craniosacral Therapy Association of the UK.

**Crystal therapy**
Healing by use of crystals, gems, and elixirs. For more information, click here to go to the Crystal and Healing Federation.

**Healing**
A system to restore to health which uses psychic healing, often involving the ‘laying on of hands’. For more information, click here to go to National Federation of Spiritual Healers.

**Herbalism/herbal medicine**
Systems of treatment in which various parts of different plants are used in order to restore function and to treat symptoms.
- British Herbal Medicine Association
- Register of Chinese Herbal Medicine (RCHM)
- National Institute of Medical Herbalists (NIMH)

**Homeopathy**
Treatment of patients by administering highly diluted forms of natural substances that in a healthy person would bring on symptoms similar to those which the medicine is prescribed to treat.
- Alliance of Registered Homeopaths
- British Homeopathic Association and Faculty of Homeopathy
- Homeopathic Medical Association
- Society of Homeopaths

**Hypnotherapy**
Inducing a state of hypnosis as a relaxation technique, to reduce pain and to bring about changes in mental state.

- British Society of Clinical and Academic Hypnosis
- General Hypnotherapy Register
- General Hypnotherapy Standards Council
- Hypnotherapy Association UK
- National Council for Hypnotherapy
- Register for evidence-based hypnotherapy and psychotherapy
- UK Confederation of Hypnotherapy Organisations

Iridology
Method of diagnosis based on studying the markings on the irises of the eyes and observing changes in them. For more information, click here to go to Guild of Naturopathic Iridologists.

Kinesiology
Testing muscles to access information about the body. Using light touch or firm pressure on the reflex points of the body, together with diet, to restore health. For more information, click here to go to The Association of Systematic Kinesiology.

Massage therapy
Rubbing and kneading of areas of the body, normally using the hands. For more information, click here to go to Massage Therapy UK.

Naturopathy
Uses naturopathic modalities such as dietetics, detoxification techniques, hydrotherapy, physical therapy, electrotherapy and psychotherapeutic techniques to promote self-healing.

- Association of Naturopathic Practitioners
- College of Naturopathic Medicine
- General Council and Register of Naturopaths

Nutritional therapy
The application of nutritional advice to enable individuals to maximise their body’s own healing ability to maintain good health and to prevent or alleviate illness.

- British Association for Applied Nutrition and Nutritional Therapy
- Nutritional Therapy Council

Osteopathy
System of diagnosis and treatment whose main emphasis is on conditions affecting the musculo-skeletal system. Uses predominantly gentle manual and manipulative methods of treatment to restore and maintain proper biomechanical functions.

- British Osteopathic Association
- General Osteopathic Council (GOsC)

**Radionics**
Method of healing, using instrumentation to provide specific corrective energies to the patient through contact, medication, or broadcasting at a distance. Note: includes the practice of biomagnetics and signalysis therapy. For more information, [click here](#) to go to The Radionics Association.

**Reflexology**
Compression and massage techniques using reflex points in hands and feet. For more information, [click here](#) to go to the British Reflexology Association

**Reiki**
Reiki is a system promoting self-healing in which the therapist places their hands non-intrusively in a sequence of positions which cover the whole body, and each position is held for several minutes.

- The Reiki Association
- The UK Reiki Federation

**Sham acupuncture**
Sham acupuncture is used in research, and uses techniques that are not intended to stimulate known acupuncture points. There is controversy over the use of sham acupuncture in control groups. For example, in studies on pain, sham acupuncture may have either an intermediate effects between the placebo and ‘real’ acupuncture or effects similar to those of the ‘real’ acupuncture. There is disagreement on correct needle placement as any needle position elicits a biological response that complicates the interpretation of studies involving sham acupuncture.

**Shiatsu**
Japanese form of massage, literally meaning ‘finger pressure’. Uses pressure on hundreds of surface points of the body. For more information, [click here](#) to go to The Shiatsu Society.

**Yoga therapy**
Involves the use of yoga techniques of physical and mental exercise to manage health problems. For more information, [click here](#) to go to The British Council for Yoga Therapy.
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