SOCIETY OF HOMEOPATH'S RESPONSE TO THE CHARITY COMMISSION CONSULTATION ON ITS APPROACH TO ORGANISATIONS PROMOTING COMPLEMENTARY AND ALTERNATIVE MEDICINES

Question 1: What level and nature of evidence should the Commission require to establish the beneficial impact of CAM therapies?

We consider that evidence concerning the beneficial impact of complementary and alternative medicines (CAM) therapies is wide ranging, and that no one modality should be singled out as the sole indicator of 'evidence.' Some CAM therapies such as homeopathy have been the subject of many randomised control trials, published in a variety of peer-reviewed journals, including the Lancet and the British Medical Journal, and these would be considered 'scientific' evidence. There have been 6 systematic reviews and meta-analyses of homeopathy, 5 of them demonstrating some beneficial effects (1-5). There has been much controversy regarding the methods used in the one meta-analysis which did not demonstrate beneficial effects (6).

In considering the level and nature of evidence, it is important to be aware that CAM therapies rarely treat single symptoms, which can make their various effects, (in particular psychosocial effects), difficult to accurately assess using quantitative methods alone. Also, CAM practitioners usually tailor their treatments to the needs of each individual, adjusting the treatment at subsequent appointments, in the light of patient feedback. This individualisation of treatment does not fit so readily into the standard model of placebo-controlled clinical trials, which are more suited to the testing of pharmaceutical products, where a single drug is being developed for use by a large group of the population. It is therefore necessary to consider other forms of research, which are likely to be more relevant yet equally rigorous. Observational studies provide information on the real world use and practice of CAM – for example, a considerable body of evidence exists from such studies that homeopathic treatment provides "real world benefits." Comparative trials are also a way of evaluating the effectiveness of homeopathic treatment (7). Systematic evaluation of patient reported outcome measures, such as Measure Yourself Medical Outcome Profile (MYMOPs), should also be considered (8). Patient and public survey data is an accepted method for gathering a target population's experience of benefit.

It is appropriate that the Commission considers whether there is potential for harm when assessing whether an organisation's purposes are beneficial. Potential for harm could either result from the treatment itself or if people using CAM treatments may not seek conventional treatment. While there may be inherent risks associated with a few CAM treatments, studies have indicated only minimal risks in relation to homeopathy (19). Where practitioners are members of a register with requirements

to demonstrate appropriate levels of education and CPD, the potential for harm from the actual treatment should be minimal. A number of CAM practitioners are statutorily regulated or are on registers accredited by the Professional Standards Authority, which sets standards in relation to education, professional conduct etc. The risk that people might not seek or delay seeking conventional treatment can be mitigated when practitioners are members of a professional organisation with a Code of Ethics containing relevant guidelines, a robust complaints system and comprehensive insurance cover.

Question 2: Can the benefit of the use or promotion of CAM therapies be established by general acceptance or recognition, without the need for further evidence of beneficial impact? If so, what level of recognition, and by whom, should the Commission consider as evidence?

General acceptance of any CAM therapy does not necessarily equate to public benefit. Nevertheless, on the important basis of patient choice it is worth noting that CAM remains popular with patients and consumers in the UK. Across surveys on CAM in general, the average one-year prevalence of use of CAM was 41.1% and the average lifetime prevalence was 51.8% (9). Studies in European Union (EU) countries including the UK, Germany, Norway, Switzerland and Italy confirm that homeopathy remains a popular choice of complementary medicine for children (10-13). Across eleven countries, the estimated use of homeopathy (over the counter and by homeopaths), over 12 months by adults ranged from 0.7% to 9.8% with a median of 3.9% (7).

Official recognition of a therapy is significant and should, we believe, be taken into consideration. For example, homeopathy is an officially recognised medical system in a number of countries including the United Kingdom, Brazil, India, Mexico, Pakistan and Switzerland. India has an estimated 300,000 homeopathy practitioners, while in France 43.5% of the overall population of healthcare providers prescribe homeopathic medicines, (mostly co-prescribed with allopathic medicines) (14). It should also be noted that the World Health Organisation (WHO) has deemed France to have the best health care in the world.

Other evidence of recognition which should be considered by the Commission as evidence includes statutory or voluntary regulation, or recognition from respected organisations such as the UK Professional Standards Authority for Health and Social Care (PSA). Qualified homoeopaths registered with the Society of Homeopaths are on a PSA-accredited register.

Question 3: How should the Commission consider conflicting or inconsistent evidence of beneficial impact regarding CAM therapies?

We suggest that, while evidence of beneficial impact should be credible, conflicting evidence is a feature of most clinical research, including in orthodox medicine. According to a 2007 analysis of 3000 RCTs in the BMJ Clinical Evidence, only 11% of mainstream medical treatments had proven beneficial effects, while 50% had unknown effectiveness (15). However, while bearing this in mind, we would agree

that further evidence of the effectiveness of CAM therapies is required, indeed we consider that the amount of funding allocated to CAM research is wholly inadequate. This has led to some studies being too small or too brief for authors to reach conclusions concerning beneficial impact based on effectiveness.

Question 4: How, if at all, should the Commission's approach be different in respect of CAM organisations which only use or promote therapies which are complementary, rather than alternative, to conventional treatments?

The term 'alternative' is misleading here, as the vast majority of CAM is used in ways which are complementary to, or integrated with, mainstream medical and social care. The therapy itself might be based on an 'alternative' philosophical approach while its practitioners offer a service which is complementary to conventional healthcare.

Homeopaths registered with the Society of Homeopaths are expected to abide by a Code of Ethics, which includes clearly worded rubrics concerning communicating with a patient's GP or other agencies if required (16). Whether or not a CAM organisation uses or promotes complementary therapies alongside conventional treatments, the same requirement to demonstrate patient benefit should be expected.

The Commission's approach should be to adapt accordingly because, ultimately, it is for public protection and patient benefit to refer to the therapies as 'complementary' rather than 'alternative'. We do not want to give the impression that the public should not be seeking conventional treatment alongside other healthcare. The ideal is, as it suggests, that they should complement each other and work together for the benefit of the patient in order to reach the best possible outcome.

Question 5. Is it appropriate to require a lesser degree of evidence of beneficial impact for CAM therapies, which are claimed to relieve symptoms rather than to cure or diagnose conditions?

This may well be a false or at least an over-simplified distinction. It is at least possible that the same CAM therapy might have the potential for cure in relation to one specific condition and/or context while, in another, it might only be able to offer some limited relief of symptoms. One setting where CAM is often used is in hospices: here, where patients have generally been diagnosed with a terminal illness, one or more complementary therapies might be offered with a view to relieving symptoms associated with their disease, but there might also be occasions, even in this setting, when an unrelated problem has arisen which could actually be resolved by an appropriate CAM treatment.

CAM practitioners do not usually 'diagnose conditions'. It is common for patients to seek treatment from a CAM practitioner once they already have a diagnosis from their GP or consultant. If the patient has not recently seen a medical practitioner and the CAM therapist thinks they might be suffering from a particular condition, they would generally recommend that the patient seek a diagnosis from their GP.

We are recommending that a wider range of evidence should be considered when evaluating the possible benefits of CAM. However, it is not correct to assume that accepting a wider ranging view of evidence for CAM therapies necessarily equates with a lesser degree of evidence. If the research and evidence provided is of more relevance to what is studied, and therefore more accurately reflects 'real world' experiences, then it should be considered highly appropriate.

Question 6: Do you have any other comments about the Commission's approach to registering CAM organisations as charities?

We perceive that the purpose of the Charity Commission is not to establish the medical efficacy of CAM therapies, or even to judge whether or not there is evidence to support them, but to establish their public benefit. The most important purpose for most charities engaged with CAM is likely be the 'advancement of health or related purposes.' In the case of CAM, with its multi-modality approach, benefit must be construed in the widest and most holistic sense, in ways that are relevant to the target population of the organisation's work. It is also important that any evidence of benefit should simply need to be plausible rather than conclusive, as the latter would suggest that scientific validity is a prerequisite of a charity, which it is not.

We are concerned that a small but vocal group of individuals, who have been targeting CAM for over a decade, deliberately misrepresent these therapies, as there are many well designed studies indicating their benefits to patients. In a UK study of 5331 NHS GP patients receiving homeopathy over a 12- month period, 78% of patients had a positive clinical response, 19% no response and 3% a negative response (17). In a 6-year UK study involving 6.544 hospital outpatients with chronic conditions, 70.7% reported positive health changes after homeopathic treatment. (18) CAM therapies overall have an excellent track record in safety, with homeopathy being particularly benign (19), and suitable for infants, children, pregnant women and the elderly.

We support the Commission's use of the House of Lords Select Committee's review of 2000 as part of its framework for assessing applications. This was a thorough and wide-ranging review, with many of its conclusions and recommendations still relevant today.

We trust that any draft guidance notes produced following this consultation will be circulated to those who responded for additional consultation before they are finalised.

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