Guest editorial

The ethics of complementary medicine

Edzard Ernst *University of Exeter, Exeter*

Complementary or alternative medicine (CM) is an area of intensive growth. At present about a third of the general population of the US use at least one form of complementary treatment.¹ In Europe its prevalence ranges from 49% in France to 24% in Denmark.² In some countries (for instance Austria) CM can only be practised by physicians; in most countries, however, its practice is dominated by non-medically qualified practitioners. This popularity of CM raises issues relating to its efficacy, safety and cost. It also raises ethical concerns which are often neglected.

The following will address some important ethical issues relating to CM. The framework adopted here is the one by R Gillon.³ It is based on the four principles – respect for autonomy, beneficence, non-maleficence and justice – which can be readily applied to CM.

Autonomy

Autonomy entails respecting decisions of all parties involved in the therapeutic process. Complementary medicine comprises many treatments that are of unproven effectiveness.⁴ Therefore many doctors may be against their application even if the patient wants to give them a try. Autonomy, however, requires doctors to respect patients' decisions. Therefore an ethical conflict may arise between the three parties involved: the patient, the physician and the practitioner.⁵ If a given treatment is against the best interests of the patient (for example, associated with a risk that clearly outweighs the predicted benefit), then the doctor is obliged to refuse cooperation.⁶ As the risks of most complementary therapies are not fully understood,⁷ this conflict is often uncomfortably real. The problem may become more complex, for instance when parents demand an unproven treatment for their child.⁶ If the remedy in question is not known to be hazardous, the best solution for a doctor may be to oblige. If, however, there is evidence that the treatment in question is detrimental, its application would clearly be unethical.⁶

Autonomy also requires consulting and seeking the agreement of patients before therapeutic interventions. Informed consent obviously demands that

the doctor/therapist outlines to the patient the chances of benefit from, and potential risks of, the treatment in question. In the area of CM this is a difficult, in certain cases even an impossible, task simply because our knowledge is too incomplete.^{4,7} In this particular situation the best approach may be to be truthful to the patient, communicate the known facts and point out where our present knowledge is incomplete.

It has been said that it is unethical to use an unproven therapy and merely wait and see what happens⁸; ethical standards require that proof (or disproof) be established if essential aspects (for example the effectiveness and safety of the treatment in question) have not yet been documented. It would seem to follow that any professional community applying unproven remedies has the ethical obligation to conduct (clinical) research in those areas where our knowledge is unacceptably incomplete.

Autonomy also means not deceiving patients and communicating adequately with them. Therefore doctors must not promote unproven treatments with the aim of financially benefiting from the desperation of patients. This notion seems too obvious to state, yet in CM, where therapists may be untrained and unregulated, this is an issue in need of more detailed attention.⁹

Beneficence and maleficence

The "*nihil nocere*" principle requires us to base therapeutic decisions on a (tentative) risk/benefit analysis.¹⁰ Since there is no effective therapy without potential harm (complementary therapies are often promoted as natural and wrongly equated with harmless), this issue relates to the net benefit that a remedy will predictably bring to a given patient. In CM such a risk/benefit analysis is rarely possible, because neither the potential benefits nor the risks have been investigated to the full.^{4,7} In medicine we often have to rely on educated guesses and we may become so confident in our guesswork that we confuse opinion with evidence¹¹; in CM, where evidence is more scarce than in mainstream medicine, therapeutic decisions are more likely to be based on opinion rather than evidence.

To avoid ethical problems arising from this fact, one must be quite clear and outspoken about beneficence and maleficence towards the patient. With sad regularity, fatalities following the use of CM are reported in the medical literature, for example¹³ which should remind us that the issue is not theoretical or academic, but real and burning. To avoid future ethical dilemmas in this situation, the need for rigorous research to fill the present gaps in our knowledge cannot be stressed often enough.⁴

In addition to these direct risks of CM, there is the possibility of harm through malpractice and incompetence (much as with any other type of medicine). As formal training and regulation of complementary practitioners are often insufficient or non-existent, this problem seems to be more prevalent than in other areas of medicine.⁹ From the point of view of medical ethics it therefore seems essential that professional standards be adopted by non-medically qualified practitioners.¹³ Providing medical treatment, including alternative medical treatment, presupposes that the physician in question possesses diagnostic competence.⁵ Professional competence, it seems is a "*sine qua non*" also for non-medically qualified practitioners.

Justice

In relation to CM, the fair distribution of the (usually finite) resources for complementary therapies may represent a problem. In a simplified model of a health care system, spending money on anything that is in addition to usual care (the data available clearly indicate that CM is used mostly as an adjunct, rather than an alternative to mainstream medicine) may mean that these resources will subsequently not be available elsewhere. Therefore the subject of rationing has become topical in health care,¹⁴ and its ethical implications are receiving more attention. Negligence of the cost issue can deprive patients of care from which they would benefit more; this is both inefficient and unethical.¹⁵ At present there is no compelling evidence to support the notion that the integration of CM into a health care system would save money.¹⁶ Increasing the funds available would be the optimal way to cope with additional costs, but this is rarely possible. Therefore therapies (and diagnostic procedures) have to be judged by their relative merit, which creates a host of potential dilemmas. How, for instance, would one weigh the merit of an orthodox treatment (say to alleviate pain in arthritis) against a complementary option that increases well-being? To do this, one would require sound data on prevalence, effectiveness, safety, costs, cost-effectiveness and cost-utility. However, such data are at present not available. Therefore an ethical problem arises when considering integrating complementary health care options into (national) health care systems. Policy makers may be badly advised to

decide purely on the basis of patient demand. Yet patient demand is the only aspect related to CM where our knowledge is sound.¹²

Conclusion

The ethical issues relating to CM are multifold and complex; in many ways they are similar to (yet possibly more acute than) those encountered in mainstream medicine. They have, so far, received little attention. Considering the increasing popularity of CM these issues would seem to be worthy of more detailed research.

Edzard Ernst, MD, PhD, is Professor of Complementary Medicine, Department of Complementary Medicine, Postgraduate Medical School, University of Exeter, Exeter.

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