

From the editor

Complementary and alternative therapies: can we know what risks they present?

This issue carries the first of a series of articles in *Clinical Medicine* by Professor Ernst and colleagues from the Peninsula Medical School on the state of complementary medicine in the United Kingdom. The articles will predominantly comprise systematic reviews of surveys, and in this edition Ernst and Posadzki assess the potential for adverse effects of alternative approaches to the treatment of asthma.¹ The extensively referenced and tabulated nature of the data presented in some of these articles is such that the journal has decided to present much of those as an online supplement: if readers find that off-putting, we can only apologise for a compromise that ensures that these admirably collated and up-to-date data are available for reference.

Predictably these articles confirm substantial current usage of alternative therapies by patients/consumers in the UK (at least 25%), but will also present the strikingly high proportion of UK doctors who recommend alternative and complementary approaches and the extent to which they have been trained in these approaches. Other articles, both in the series and to be published elsewhere by the same authors, present the evidence for harm by alternative approaches.

One striking observation from Ernst's surveys is how poor the quality of evidence is in respect of both efficacy and the potential for adverse events. Rawlins in his Harveian Oration in 2008 described (before demolishing) the conventional hierarchy of evidence quality, which places high quality systematic reviews in the top rank and non-analytic studies, such as case reports, nearly at the lowest level (only just above expert opinion!)² The analyses of efficacy and side effects in the forthcoming series are hampered by the necessity to analyse only reviews of adequate quality; the proportion of published work in this field with major flaws is depressing. Much of the evidence for dangerous side effects comes not from systematic reviews, and even less so from controlled trials, but from individual case reports. Note, therefore, a marked difference in risk reporting from that governing conventional drug therapy. With conventional medications, post-marketing pharmaco-vigilance, such as 'yellow card' notifications, allows such data to accumulate, both on direct

adverse effects and on interactions. With conventional and alternative therapies, the systems for reporting are far less well-developed – and not only in terms of the prescriber's obligations to report them. A significant side effect or drug interaction may bring the patient to a conventional doctor, but then the patient's unwillingness to admit to the use of alternative therapies, and the conventional doctor's lack of curiosity in enquiring about them, easily combine to conceal any connection.

It would seem uncontentious to believe that the UK population should be protected against adverse effects of any medication – conventional or alternative. The eventual decision of the government, in February last year,³ to ask the Health Professions Council to establish a statutory register for practitioners of herbal medicine and traditional Chinese medicines must deliver this.

The decision to ask the Health Professions Council (HPC) (from August this year renamed the Health and Care Professions Council) reversed the decision of the Secretary of State in the previous government,⁴ who had advocated voluntary regulation by the Complementary and Natural Healthcare Council (which covers alternative therapies including hypnotherapy, aromatherapy, Alexander technique teaching and yoga therapy).⁵ The Health and Care Professions Council seems an unusual home for herbal practitioners: its current remit covers regulation of 15 health professions such as biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, art therapists, hearing aid dispensers, occupational therapists, operating department practitioners and radiographers, each with well delineated professional qualifications. Indeed in all of the professions that it regulates, at least one professional title is protected by law.⁶ It is one of the nine regulatory bodies (others include the GMC and the Nursing and Midwifery Council) scrutinised and overseen by the regulated Council for Healthcare Regulatory Excellence. It seems likely that the HPC will need to provide a different form of regulatory oversight for its newly acquired members, whose training, qualifications and title are – at the least – diverse in nature and quality. There has been substantial discussion of the fact that, for these practitioners, statutory regulation confers the very substantial advantage under European regulations of being able to continue to prescribe unlicensed herbal medicine products. It is to be hoped that, when the details of the regulations are finalised, part of the bargain with these practitioners is an obligation to report systematically on the adverse effects of the preparations they use.

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- 2 Rawlins M. De Testimonio: on the evidence for decisions about the use of therapeutic interventions. *Clin Med* 2008;8:579–88.
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Humphrey Hodgson

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