A project to examine and define the principles and philosophy of Complementary and Alternative medicine

An interim discussion document
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Objectives of the project

1. To stimulate and support a continuing debate amongst professionals and the public which explores the basic principles underlying those therapeutic practices that are generally included under the broad heading of complementary and alternative medicine (CAM).
2. To identify differences in principle that may exist between CAM and conventional medical practice and assess their significance for relationships between practitioners of both persuasions

Rationale

1. Although they are part of the indigenous health care system in certain parts of the world such as the Orient, systems of CAM have come to be defined predominantly by their political and social position outside the mainstream of conventional medical science on which healthcare worldwide is based. In practice they are identified by their techniques of treatment and are, therefore, perceived as isolated modalities with little in common. Underlying principles are rarely discussed and little understood outside the relevant CAM professions.
2. The social and political borderlines between CAM and orthodox medical practice are fuzzy, change over the years, and vary from country to country. In addition, there may be differing perspectives among social sciences, medical sciences, and even between the disciplines within the field of CAM itself. Many practitioners within CAM believe there are common precepts that distinguish them from the paradigms of mainstream medicine. If fundamental differences do exist, the exploration of these issues is of great importance in terms of research, compatibility between conventional and CAM practitioners, and for patient understanding of treatments offered.
3. This debate becomes increasingly significant as public usage of CAM grows throughout the western world, as the legal status of products and practice come under closer scrutiny by governmental organisations, and as CAM and conventional medical practice appear to draw together under the organisational umbrella of ‘integrated’ or ‘integrative’ medicine. A further need for clarification of their principles is critical if CAM disciplines are to retain their autonomy in the overall field of medical care.

1. Introduction
1.1 The wide range of medical systems and therapies which are not part of the practice of conventional medicine have come to be known as ‘complementary medicine’. In the UK the term is applied not only to what are known as the six main primary-care disciplines but also
to many derivative therapies, some of which were, in the past, regarded as part of one of the six principal disciplines. (In some cases these derivative therapies are now practised independently by people who may not have had training in basic medical sciences and therefore have limited primary-care capability.)

1.2 In the rest of Europe, under Napoleonic law, the professions have evolved somewhat differently and natural medicine systems are more widely used by conventional doctors with licensing requirements for non-medical practitioners. Australia and New Zealand have a similar situation to that of the UK, while in the USA and Canada autonomy of the natural medicine professions varies according to individual state law. In the orient and Far East some CAM treatments are part of the indigenous systems of medicine and are more widely available.

1.3 Through long historical precedent, with a well-established professional autonomy and educational infrastructure, and voluntary self-regulation in the UK, the following have come to be regarded as the six major systems of CAM (Newman Turner, 1998):

Acupuncture  
Chiropractic  
Homoeopathy  
Medical herbalism  
Naturopathy  
Osteopathy

In addition, traditional medical systems such as ayurveda, and unani, and anthroposophical medicine come within the orbit of CAM.

1.4 The following are examples of derivative therapies or diagnostic approaches:

Aromatherapy  
Massage  
Reflexology  
Meditation  
Kinesiology  
Iridology  
etc.

Many of these have gained in popularity in more recent years and some have become professionally autonomous.

1.5 The term ‘alternative medicine’ has given way to ‘complementary medicine’ as, in many cases, these systems can complement conventional medical care. Some do, however, provide an alternative way of treating disease, for example, herbalism or homoeopathy might be used instead of synthetic drugs. For this reason many people use the terms together, as in complementary and alternative medicine (CAM). ‘Complementary and alternative’ describes these systems by their political position outside orthodox medicine; the older terms ‘natural therapeutics’ or ‘natural medicine’, however, come closer to describing them by one of their major precepts (Pizzorno & Murray, 1985). While these terms may be questioned in relation to some CAM modalities (e.g. acupuncture) they are used on the basis that such approaches
are largely non-synthetic and compatible with body physiology.

1.6 Certain underlying principles are common to most of the CAMs and these are set out below. Whilst they may be regarded as a better way of defining CAM, as opposed to the political or social criteria referred to above, they are not unique to it, and are a feature of all good medical practice. Their validity may be open to question which is, of course, the object of this project.

2. Some fundamental principles of complementary medicine

Each of the major disciplines within CAM have evolved with a particular philosophy and guiding principles based on their specific approach to the patient. Often, these have much in common with other systems.

Such principles are widely accepted as the foundation of all major disciplines in CAM. Although not always clearly articulated in the terms described here, they are expressed in other ways peculiar to each system, some of which may be rooted in the philosophies of the societies in which they evolved (e.g. oriental medicine).

In spite of the diversity of their approach and the specificity of many of their therapeutic interventions all CAM systems start from the common assumptions that:

- the body has inherent self-regulatory mechanisms
- treatment will facilitate their operation and will often support other levels of body function through the interactive processes of the metabolism
- the intervention will be free of any side-effects
- the treatment is determined by the assessment of the patient’s individual need for support and potential for health, rather than by a definable disease entity

2.1 Vitalism – the recognition of the ‘innate intelligence of the cell’ (Lindlahr, 1913, 1975) and the organism as a whole. The term ‘vitalism’, favoured in empirical schools of thought, is considered by rationalists to be rather old-fashioned. In the sense that it first surfaced in the 17th and 18th century debates against mechanism and was promulgated by Smuts and others in the 19th century, it is, but no less relevant for that. It relates to the concept of a ‘life force’ that imbues all living things, the self-regulatory or adaptive processes. (See 2.6)

As applied to CAM it embraces the various concepts of ‘energy’. It is often applied to phenomena for which no tangible explanation is available, although it is increasingly likely that neuro-humoral or electromagnetic factors may account for them (Oschman, 2000). Described in various traditions as ‘vital force’, ‘energy’, ‘chi’, ‘prana,’ its exact nature may never be fully understood, but it may eventually be explained in molecular terms. (This would still leave the question of the spirit open to debate)

Some CAMs are more immersed in vitalistic principles than others, with oriental systems, such as acupuncture, and ayurveda, subscribing to them more than physical therapies, such as chiropractic and osteopathy (Fulder, 1995).

Being a rather nebulous concept, it is likely to confound certain issues of research, particularly into the mechanisms of some modalities.

2.2 Health is seen as a positive attribute and not simply the absence of disease.
‘If there is to be a true science of medicine, it must be before all else a science of health and it must recognise that health and disease, like everything else, are subject to laws and are not matters of chance and beyond our control as is now so very generally believed. A beginning must be made to discover at least some of the basic laws and principles which govern health and the violation of which lead to disease.’ Jocelyn Proby, DO, in Editor’s introduction to Philosophy of Natural Therapeutics by Henry Lindlahr, ND, (1913) republished by Maidstone Osteopathic Clinic, Maidstone, 1975.

Perceptions of health vary considerably according to ethnic and social perspectives. The emphasis of most CAM treatment is upon the restoration and maintenance of health at an optimal level for each individual within his or her circumstances. Treatment may, for example, be applied to give palliative care with non-invasive or non-toxic agents rather than with the object of curing a disorder.

There have been many attempts to define health but that of the WHO is probably the most satisfactory: ‘complete physical and mental well being, with or without infirmity, (and not merely the absence of disease)’ (Alma Ata Declaration, 1977).

Even this does not take account of the belief that health is not a fixed state but, rather, a continuum. For example, many practitioners of CAM regard the ability to mount and resolve an acute illness as a healthy phenomenon (see Law of Cure below), the symptoms being the expression of a vital healing response.

2.3 The ‘triad of health’ – the recognition of the web-like interdependence of the body on all levels, emotional/spiritual, biochemical, and structural. Therapeutic endeavours within CAM target different aspects of the triad according to their emphasis (e.g. osteopathy and chiropractic to the structural, naturopathy, medical herbalism to the biochemical) while still taking account of the vital interactions that make up the whole person. This is the basis of the patient-centred health care that is the main thrust of the functional medicine movement in the USA. Functional Medicine is the use of ‘assessment and early intervention to improve physiological, physical, and cognitive/emotional function.’ (Institute for Functional Medicine, 1999)

2.4 Unitary theory
When investigating the ‘nature of disease’ J.E.R. McDonagh placed emphasis on the underlying disturbance rather than its various manifestations within the body (McDonagh, 1948).

Closely allied to this are the ‘toxaemia theories’ that emphasise the importance of adequate balance between assimilation and elimination. The inadequate neutralisation and elimination of endogenous and exogenous toxins (now recognised as free radical compounds) is considered to be a significant factor in the causation of many illnesses (Newman Turner, 1996).

The toxaemia theories proposed that the accumulation of the waste products of metabolism and xenobiotic compounds obstruct cellular function and the body’s ability to maintain homoeostasis. This shifts the target of therapy from the pathogen or antigen to the state of the internal milieu, (Dubos, 1965), hence McDonagh’s contention that ‘there is only one disease……..which has many manifestations’ (the Unitary Theory of Disease). The disease, he maintained, was due to a disturbance in the proteins of the blood.
Although considered to be of particular relevance to the practice of naturopathy and medical herbalism, the rationale for different CAM systems in managing free-radical biochemistry varies and might be indicated by the following examples:

- Osteopathy, chiropractic - restoration of circulation, innervation, and lymphatic function
- Acupuncture - restoration of energetic harmony to facilitate adaptive mechanisms
- Homoeopathy- functional support through subtle modification of responses.
- Naturopathy - reduction of exposure to free radical sources; promotion of eliminative functions and immune response; antioxidant nutritional support.
- Medical herbalism - promotion of eliminative functions and immune responses; support of organs and tissues, e.g. liver, intestinal membranes

2.5 The stability of the internal milieu, or terrain, is considered more important than the specific pathology or pathogen, which may happen to be active. Dubos, reflecting McDonagh’s thesis, has suggested that this, rather than microbes, should be the principle target of therapy (Dubos, 1965). This concept has been discussed under 2.4 Unitary theory.

2.6 Homoeodynamics - the understanding of the adaptive mechanisms of the body and the recognition of the purposive nature of some acute illnesses. The now widely accepted concept of complex adaptive systems was first suggested by Selye’s Adaptation Syndrome which emphasises, among other things, the positive role of inflammation in striving for homoeostasis (Selye, 1976).

This is observed in the self-limiting illnesses and many febrile conditions, where CAM treatment may be supportive, or enabling the self-healing process, as long as the effort is within the vital capabilities of the patient. Selye also coined the term heterostasis to describe the potentiation of healing, such as the inducement of a febrile response by Echinacin in herbal medicine, or constitutional hydrotherapy in naturopathy.

Because the body physiology is never static, even in health, Bland has suggested that a more appropriate term for homoeostasis is homoeodynamic (Bland, 1995). Likewise, Fulder suggests that there are no firm boundaries between health and disease (Fulder, 1998).

2.7 The Law of Cure
This refers to the understanding of the stages of disease and the reverse order of cure. ‘Cure takes place from within out, from above down and in the reverse order as the symptoms have occurred in the body’ a principle first expounded by Constanzz Hering, the homoeopath) Lindlahr expanded this concept with his description of the ‘healing crisis’ (Lindlahr, 1975).

Selye described inflammation as an indication of body defence at work –the ‘alarm stage’ of his Adaptation Syndrome. In the short term – where the vitality (Selye called it ‘adaptation energy’) of the patient is adequate- this will lead to resolution. A similar phenomenon is observed in self-limiting febrile diseases.

In the management of some chronic disorders treatment may be aimed at raising the level of ‘combustion’ within the body in an attempt to improve elimination or enhance immune response. This is known as ‘fever therapy’. These procedures must be carried out under close supervision by practitioners adequately trained to guide patients through such treatments. (It
is now recognised that prolonged low grade inflammatory processes may lead to degenerative changes in, for example, the cardiovascular system.

Whether it occurs spontaneously or through induction, such a healing crisis (‘aggravation’ in homoeopathic parlance) is an expression of the Law of Cure. This has important implications for our understanding of the supposed ‘side-effects’ of CAM treatments and particularly for the management of acute symptoms in ‘integrated practice’ (where misunderstanding could lead to suppression of a ‘healing crisis’ by analgesics or antibiotics). A distinction may need to be made between natural responses of the body to treatment and genuine adverse reactions (Newman Turner, 2000). Practitioners should, therefore, have adequate training in the assessment of patients’ ability or otherwise to undergo a healing crisis.

2.8 Individuality
The concept of genetic polymorphism (Williams, 1956) explains the anatomical and physiological variations of patients and the need for treatment to be tailored accordingly. Professor Roger Williams’ concept of variability is borne out by the latest discoveries about the human genome. These have shown that a deterministic view of disease is limited and inappropriate in many cases. While genetic susceptibilities to certain diseases may occur, their expression is influenced much more by environment and lifestyle.

Genetic variability may have an important bearing on the suitability of certain treatments for individual patients and the safety of public health measures such as vaccination and fluoridation. (This is the basis of the concerns about these measures held by many CAM practitioners.)

The concept of individuality is used in various ways to select appropriate treatment protocols ranging from the use of metabolic typing and serotypology in naturopathy to the constitutional patterns of acupuncture and the tridoshas of ayurvedic medicine.

2.9 Non-toxic and non-invasive
The Hippocratic dictum ‘first do no harm’ is particularly important in CAM. A guiding principle is that its modalities are non-toxic and safe. Treatments are also predominantly non-invasive, exceptions being injections and enemas in some naturopathic practices and the needling of acupuncture. Venepuncture is also required for diagnostic purposes.

In practice, a potential for harm lies in many treatments within CAM if inappropriately or incorrectly applied. Unlike a number of synthetic drugs, however, they are not, by and large, inherently harmful.

2.10 Participative.
A fundamental aspect of many CAM systems is that patients play an active role in their healing process. In most cases, patients are encouraged to take responsibility for their own health rather than abrogating it to the physician.

References
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(Based on evidence presented as an independent witness to the House of Lords Select Committee on Complementary and Alternative Medicine, at their request, in February 2000)

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Page last updated: 14th April 2004