Letters

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CAM — trick or treatment?

We write in response to Professor Edzard Ernst's critique of complementary and alternative medicine (CAM) in the April issue of the *BJGP*.¹ The article is typically well written and persuasive; however, we take issue with a number of the author's opinions.

Professor Ernst takes a very reductionist view of CAM, that is clear from his other work;² indeed, we note that 25% of the references were of his own work.¹ However, female genital mutilation and infanticide surely have about as much relevance to CAM, whether in the Western or any other setting, as the use of leeches has to modern medical practice.

Furthermore, the article is unbalanced, making no concession to the fact that many alternative remedies have useful therapeutic benefit. Just one example is that St John's Wort has very respectable efficacy in mild to moderate depression,³ and may empower people with milder illness to manage their condition without formal medicalisation.⁴

A potent argument against trying to make CAM an exact science is that mainstream medicine is hardly that. There are numerous testimonies to this in education and clinical practice. Balint's seminal analysis of the consultation⁵ was a process-based exercise dependent on experience and intuition, yet is rightly highly regarded and cannot possibly be derided as being anti-scientific or regressive. In mainstream therapeutics, biomedical factors are attenuated by psychosocial ones, the classic example being the partial placebo response to many drugs; indeed Thomas showed that a positive manner from the prescriber can

enhance placebo and, therefore, total therapeutic efficacy, without breaching the ethical framework.⁶

Indeed, one of the most interesting aspects of health care is the inherent variability of the human response, and some mystique will always surround this. No less a figure than Albert Einstein stated that: 'The most beautiful thing we can experience is the mysterious. It is source of all the art and all the science'.⁷ A true paradigm shift requires challenging the established orthodoxy. Of course CAM must be critically assessed, but a blanket condemnation risks throwing out the baby with the bath water. Rather than be taken as gospel, we hope that Professor Ernst's article stimulates further debate and research in this emerging field.

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Author's response

Lakasing and Grover state that, in my article,¹ I take a 'very reductionist view of CAM' citing my book *Trick or Treatment? Alternative Medicine on Trial* as evidence. This book is one of the few of my publications aimed not at healthcare professionals but at lay people. I have published well over 1000 articles in the peer reviewed medical literature (<http://www.pms.ac.uk/compmed/>), and that body of work would perhaps be a better measure of my research.

Lakasing and Grover also state that I make 'no concession to the fact that many alternative remedies have useful therapeutic benefit' citing St John's Wort as a case in point. Ironically, it was I who published the first systematic review of St John's Wort that showed its effectiveness.² The article Lakasing and Grover criticise¹ includes the following statement 'My team have shown repeatedly that some forms of CAM have considerable potential; in order to apply it to the benefit of patients, the best way forward is that of evidence-based medicine'. Only a few months ago, I detailed in the *BJGP* which types of CAM, according to our own analyses, are sufficiently well evidence-based to be considered for routine practice within the NHS.³

Lakasing and Grover then put up a strawman by claiming that I want CAM to become 'an exact science'. This is not true. What I was saying in my article¹ is that double standards are detrimental and

CAM should abide by the rules of evidence-based medicine. My article' is by no means not a 'blanket condemnation' of CAM, it is a critique of the muddled thinking that unfortunately is prevalent in CAM. I am nevertheless thankful to Lakasing and Grover for stimulating further debate that can only, I am sure, be a good thing.

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Waste in the NHS

In January I had the misfortune to sustain a supra-condylar fracture of my femur. Initial pain and subsequent immobility have given me rather too much time to reflect! This reflection was even more poignant as the accident coincided with the escalation of 'co-lateral' casualties in Gaza.

I had almost instant relief from pain by the expert administration of nitrous oxide by efficient paramedics. X-rays were prompt and access to theatre, though a little delayed, was managed without causing any distress on my part.

So what has this to do with waste? My splint was redundant after no more than 5 weeks. It was a splendid affair, not too heavy but reinforced with steel rods and padded with foam, held in place with yards of very wide high quality Velcro® and buckles. Using what I considered to be common sense I took it back to the

fracture clinic only to be told that it was unwanted; I could bin it or they would! Home it came, daily glaring dolefully at me from a corner of the hallway.

As a result of this and with the help of Médecins Sans Frontières I tracked down a charity that collects unwanted, but not always unused, medical equipment of any kind; old journals and textbooks but not pharmaceuticals. This is sorted and dispatched mainly to sub-Saharan Africa, but wherever the need is identified, at no cost to the donors or recipients. (The legal requirement is for the charity to provide donors with a transfer of ownership certificate).

In the first 18 months of the establishment of this resource between £70 000 and £100 000 worth of equipment has been distributed, and none of it salvageable by the NHS according to its current guidelines.

If you can encourage local colleagues to join you in this 'recycling' project please contact Human Resource International on 0161 225 0225.

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Depression in younger people

Surely the headline of your editorial in March presents a false dichotomy.¹ It led me to reflect on the patients between 16 and 20 years of age who, as a psychiatrist working in a rural area of Scotland, I have seen over the past year. The vast majority of these patients were neither 'clinically depressed' or 'moody'. They did have major emotional problems but these problems were completely understandable in the light of horrendous circumstances that they have been brought up in. One could say that if they didn't feel unhappy there would have been something wrong with them. It is

just not true to pretend that there is evidence that medical intervention, whether psychotropic medication or psychological therapy, has been shown to be of major benefit to such folk.

I am proud of what psychiatry can achieve in relieving the chaos of psychosis or the despair of clinical depression, but I think that psychiatry and general practice should reject all efforts made to pretend that they can deal with the understandable sadness of the victims of our horrendous society.

After 30 years as a doctor — in psychiatry and general practice — it is a terrible sadness to see the decline in the quality of life experiences that young people have. I think it is our duty as doctors to point out the facts about the experiences of young people and to endeavour to get society to change its values so that it sees the upbringing of young people as the core function of society. We must not pretend any longer that we can cure the victims of society's failings.

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