COMMENTARY

This paper presents legitimate criticism of the nebulous field described as CAM. It has relevance to primary care whose practitioners may encounter the muddled thinking it describes. But it does not tell the whole story. As it stands, its pejorative tone and tendentious quality, even its element of sophistry, undermine its argument. There are CAM researchers and practitioners who bring a proper spirit of scientific enquiry to its exploration; who do not succumb to, indeed deprecate the vagaries described here. Nor are GPs so susceptible to them.

GPs’ approach to decision making is eclectic, involving collective experience, tacit knowledge and professional networking, succinctly expressed as ‘informed empiricism’, (RPinsent, personal communication, 1980) rather than an exclusively linear-rational model of enquiry to its exploration; who do not succumb to, indeed deprecate the vagaries described here. Nor are GPs so susceptible to them. A combination of knowledge, clinical experience and sound judgement ensures they usually get it right.2 GPs have expressed as ‘informed empiricism’, (RPinsent, personal communication, 1980) rather than an exclusively linear-rational model of evidence-based care.7,4 They are aware of the shaky evidence base for much conventional practice and its element of sophistry, undermine its argument. There are CAM researchers and practitioners who bring a proper spirit of scientific enquiry to its exploration; who do not succumb to, indeed deprecate the vagaries described here. Nor are GPs so susceptible to them. A combination of knowledge, clinical experience and sound judgement ensures they usually get it right.2 GPs have expressed as ‘informed empiricism’, (RPinsent, personal communication, 1980) rather than an exclusively linear-rational model of evidence-based care.7,4 They are aware of the shaky evidence base for much conventional practice.

Ernst’s sometimes limited and selective use of evidence does not help. An example from his book Trick or Treatment5 is the risk of stroke incorrectly attributed to chiropractic manipulation of the cervical spine.34 Whereas the impressive level of benefit reported in the Bristol model is what we use, even though it may not always be appropriate.34

A regrettable consequence of Ernst’s polemical style is to polarise attitudes to CAM when rapprochement would be more fruitful. At its worst, it encourages clinicians to denigrate CAM to patients expressing interest, compromising the therapeutic relationship and perhaps prompting them to become conventional medicine ‘abandoners’ (GLewith, personal communication, 2009).

This unbalanced presentation of the CAM debate distracts from the exploration of what can be learned from unorthodox approaches (placebo or otherwise), that enable self-regulation and enhance wellbeing, truly complementing the achievements of orthodox methods. I have contributed to Vickers’s critique of CAM,4 but the paradigm problem he dismisses in Ernst’s quotation undoubtedly has practical consequences.

The type of revolution that Kuhn described when he introduced the concept, a metanoia, really is needed if medicine is to evolve, rather than merely advance on the same narrow front.34 As David Haslam wrote, ‘We use the medical model because the medical model is what we use, even though it may not always be appropriate.‘

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REFERENCES


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