

# Virtual Mentor

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## JOURNAL DISCUSSION

### Fairness in the Context of CAM

Hannah L. Kushnick

**Vaught W. Complementary and alternative medicine: the physician's ethical obligations. In: Snyder L, ed. *Complementary and Alternative Medicine: Ethics, the Patient, and the Physician*. Totowa, NJ: Humana Press; 2007. Biomedical Ethics Review Series.**

There are a few oft-voiced objections to learning about, testing, and keeping an open mind about CAM. As Wayne Vaught points out in his piece “Complementary and Alternative Medicine: The Physician’s Ethical Obligations,” they tend to revolve around several main generalizations: CAM providers are unscrupulous or ignorant and therefore unworthy of being treated with respect; CAM practices are dangerous because they are untested or not supported by high-quality evidence; CAM practices do not merit testing because they are inherently unscientific. Vaught addresses each of these with aplomb.

Before beginning the main portion of the argument, he pauses to dispatch the notion (more popular among CAM advocates than detractors) that CAM needs a different bioethics than that employed by conventional medicine. He points out both that the principles at the heart of conventional Western-derived bioethics are widely applicable (even outside of the realm of medicine) and that much of conventional-medicine bioethics is already asking questions that extend beyond its stated principles (e.g., what does it mean to be culturally competent and how can physicians become so?) [1]. He also mentions that some CAM organizations are making fruitful use of conventional principles in their codes of ethics, for example [2].

Then he turns to three possible obligations physicians could have in regard to CAM: (1) a duty (to the patient) to ask patients about CAM, (2) a duty (to CAM practitioners and proponents) to promote the scientific study of CAM, and (3) a duty (to both) to integrate CAM into conventional care. His arguments about the first are fairly straightforward, and can be summed up by the idea that “the need to learn about common forms of CAM stems from a similar obligation physicians have to understand environmental risks and lifestyle choices” [3]. In short, a physician’s choice to discuss or not discuss CAM should have nothing to do with his or her stance about the treatments themselves. Vaught’s discussion of the third duty makes mention of the integration of chiropractic—a system based on theories that definitely conflict with scientific ones—into care as an example of how such integration can

benefit patients. He points out that proponents of integrative medicine “focus...on the [efficacy of the] method itself, not the underlying theory” with good results [4].

The more unusual argument is about what physicians owe to their not-quite-colleagues. Vaught makes the interesting point that physicians have an ethical obligation not *only* to patients but to CAM practitioners to promote justice, which is to say fairness. Fairness entails avoiding generalizations about either CAM practitioners or medical doctors: “misrepresentation is not limited to CAM. Some [conventional, licensed] physicians have been guilty of fraud and misrepresentation” [5].

So what does the unfairness look like? Vaught expresses concerns that some arguments against testing CAM practices scientifically lead to a double standard of evaluation, “raising the bar of evidence for CAM providers while applying a lower standard of evidence [required] to justify...use of more conventional treatment” [6]. He points out, quite rightly, that those who deride CAM techniques *because* they are not based on scientifically accepted mechanisms are saying that “it is not just the lack of studies that [make CAM dangerous], but the very nature of the practices themselves that deem them unworthy of consideration” [7]. Vaught explains that this argument rests on two substantial assumptions:

(a) that all valid knowledge will prove coherent with some characteristic of established contemporary science, and (b) that the likelihood that a claim will eventually have this coherent relation to contemporary science can be judged on the basis of present knowledge....The most obvious difficulty with the argument is that the failure of a CAM provider to provide a scientifically supportable biological mechanism for a given treatment modality does not, in itself, render the treatment unworthy of clinical consideration. It may merely point to the limitation of our current state of scientific knowledge [8].

He goes on to remind readers that CAM treatments aren't the only ones that can be dangerous—a number of FDA-approved conventional treatments (e.g., arthritis drugs) have been pulled from the market when longitudinal trials (and lawsuits or news reports, I might add) show harmful side effects [9]. Vaught makes the extremely cogent point that *not every treatment* in conventional medicine is supported by high-quality evidence, and thus physicians are “forced” to rely on less-tested treatments—and the mechanisms by which many conventional treatments work, even one as widely popular and trusted as aspirin [8], remain in question—just as they do for many CAM treatments.

This would-be double standard applies to behavior, in addition to evidence. A willingness to experiment with things that aren't completely certain is central to the culture of conventional medicine. The behavior that CAM detractors argue would be irresponsible with regard to CAM is outright encouraged within conventional

medicine. Vaught gives two examples: hazardous lifesaving treatments and off-label use of drugs. He relates the story of a medical team that, in a last-ditch effort to save a teenage girl with a severe case of rabies, subjected her to a highly dangerous and untested treatment—a medically-induced coma and an experimental drug cocktail—and were “praised because their gamble paid off” [6].

He elucidates some similarities between these ER heroics and their more mundane cousin, off-label prescribing. His considerations of physicians’ reasons for prescribing drugs for a purpose other than the one for which they’ve been approved echo probable reasons for administering CAM treatments: “it may be that a physician has had success with it in the past [or]...there may not be an approved pharmaceutical to treat a specific condition...or...age group” (e.g., the drug is used in pediatrics even though it was not tested on children) [10]. These ideas point to other reasons CAM is sought and administered.

The more extreme version of a condition for which there is no FDA-approved treatment is a condition that is not on the medical map. Vaught notes that “patients also may wish to include CAM modalities when they [have] conditions that are not recognized by, or may seem bizarre to, conventional providers” [11]. These things may be considered “bizarre” if the patient uses the language of religious traditions that are not mainstream in America (e.g., the example Vaught gives: soul loss). Even if described in less supernatural language, they may still be dismissed as merely “vague” or “chronic.” This seems to point to the need to *do something* to respond to these conditions, whether that’s giving them consideration in conventional medical terms or allowing CAM treatments for them to coexist with medical treatments for medically recognized conditions.

Also, as Vaught points out, in some circumstances (e.g., chronic pain), a CAM treatment is *much* less invasive than the alternatives, which is to say it “it limits or makes pharmaceutical intervention [and their side effects] unnecessary” [4]. This is an important distinction—the dialogue about chronic conditions appears to focus primarily on conventional treatments’ lack of success and on the frustration of dealing with chronically ill patients, not on the invasiveness of the treatments. The idea that *limiting* pharmacological treatment should be a goal of mainstream medicine is notable.

Though, as Vaught cautions, “the fact that physicians must sometimes resort to unproven therapies does not legitimize the use of every unproven therapy” [10], he draws these parallels to show that CAM and conventional medicine have much in common and as such should be treated similarly. “If,” he says, the “restrictions [skeptics advocate putting on CAM] were applied equitably [to conventional medicine], physicians would lose a wide range of conventional treatment modalities” that are supported by low-quality or case-report evidence [9]. Physicians, he argues, “treat CAM unfairly...when they leave a patient with the impression that *all* conventional therapies have been tested for safety and efficacy” [5; italics mine] or tar all CAM practices with the same inappropriately broad brush. In short, physicians

“should not hold CAM to standards that conventional medicine is itself unable to achieve” [10].

### References

1. Vaught W. Complementary and alternative medicine: the physician’s ethical obligations. In: Snyder L, ed. *Complementary and Alternative Medicine: Ethics, the Patient, and the Physician*. Totowa, NJ: Humana Press; 2007: 49. Biomedical Ethics Review Series.
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Hannah L. Kushnick is the associate editor of *Virtual Mentor*.

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