

Guest Commentary

Ethical Issues In Alternative Medicine

By David Edelberg

Imagine it is 1990 and you're a primary care physician listening to a patient explain that instead of continuing with chemotherapy for her breast cancer, she has decided to see other healers. She says it's "nothing personal," but the chemotherapy hasn't been working and the oncologist is offering little hope. Therefore, she's selected a bioenergetic healer, a nutritionist, and a doctor in Chinatown who will try some herbs and acupuncture.

The resistance you may feel explains why the *New England Journal of Medicine* survey (Eisenberg et al. 1993) three years later commented how patients rarely inform physicians about their use of alternative medicine. You mention to her the lack of scientific evidence that such treatments work, the untrained practitioners, the fact that even if the treatment is effective, it could be dangerous. You tell there is still a chance the chemo will work, and that she might be missing her last chance.

She leaves the office and some weeks later you realize she

hasn't returned. When you call her at home, she is cool to you and doesn't answer when you inquire whether she is still going to those . . . healers.

It is now 1996. For three years a groundbreaking survey has demonstrated that every third American uses a form of alternative medicine and the numbers are thought to be significantly higher. Medical schools are offering electives in alternative medicines; physicians are adding acupuncturists, massage therapists, chiropractors to their staffs. Colleagues are studying homeopathy, Reiki, herbal medicine, and traditional Chinese medicine. Insurance companies, under the pressure of the marketplace and always exploring cost reduction, are exploring reimbursement for alternative medicine benefits. The legislative body has mandated that health insurers cover unconventional therapies.

You, of course, are the same physician in the opening paragraph, now six years older. Managed care's entry into the market has increased your workload and may have affected your income. There is more paperwork and you're thinking of discouraging your son from medical school because medicine is not the joy it once was.

Patients are talking to you about different treatments: "The orthopedist you sent me to for my back hasn't helped much and the medicines make me sick. I'd like to try chiropractic."

The patient's managed care coverage requires you to sign the referral form. You know nothing about chiropractic but rather than lose a patient, you sign the form. Later, when asked for referrals to an acupuncturist and queried if homeopathy is a covered benefit, you realize again how medicine is changing. In medical school, all this was dismissed as unscientific quackery. Can you, in good conscience, allow your patients to venture into these realms unprotected? For the first time since you paused over your first Do Not Resuscitate order, you realize you're facing significant ethical dilemmas here.

First, let's address the issue of quackery — the deliberate intent to defraud. Even the A.M.A., which historically has wanted to guard the unwary patient from health cheats, acknowledges that deliberate fraud is rare. When the organization has been critical, as in the A.M.A.'s *Reader's Guide to Alternative Health Methods* (Zwicky et al. 1993), alternative healers are described as sincere but unscientific and deluded. However, the A.M.A.'s stance has softened

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considerably in recent years. The A.M.A.'s *Encyclopedia of Alternative Medicine*, which may guardedly recommend therapies provided that a conventionally trained physician is in the wings, will be published in 1997.

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So you sign a referral to the acupuncturist and wonder if you're doing the right thing. As with any referral, you will assume ultimate responsibility for the patient's well-being. Is this what your life has become — authorizing referrals to the sincere but deluded? After all your years of scientific training, do you actually refer a patient to someone who believes that invisible energies can be manipulated by inserting needles in the skin (acupuncture), or that healing energies to affected organs can be released through spinal manipulation (chiropractic) or any of the almost two hundred other unconventional therapies?

Was the A.M.A. justified in its desire to protect the patient? Aren't you morally obligated to provide safe healing using the tools of rational science? A homeopathic remedy, which is a substance so diluted with water as to contain no molecule of the original material in the solution,

defies scientific sense. The Reiki practitioner's hand held an inch above the patient's skin allegedly manipulating the patient's subtle energies seems on a par with voodoo. Should a conventional physician allow himself to be involved in this at all?

At one time, Medical Practice Acts licensed physicians to engage in the healing arts. The concept of licensing, created during the mid-nineteenth century, turned into a powerful economic tool meant to doom alternative medicine. Now, as many states license these other healers and allow them limited access to third party reimbursement, physicians must face the fact that this sincere but deluded healer is now legally a quasi-colleague in health care.

Of serious consideration here are basic patient rights. Cannot an informed patient select her treatment of choice without admonishment or denial of access to other therapies? Cannot the other healer, fully trained and appropriately credentialled, perform his professional services without castigation? Cannot a conventionally trained physician become versed in an alternative therapy and offer this to his patient as part of his professional armamentarium? This last scenario is especially challenging as state boards have revoked the licenses of doctors for such issues, even without patient complaints. My own state, Illinois, can arrest a nationally certified acupuncturist doing acupuncture on the

charge of practicing medicine without a license (a felony), yet allows an M.D. without acupuncture training to buy needles, call himself an acupuncturist, and bill insurance for reimbursement.

These ethical issues of scientific worth, protection of the patient, and the rights of both patient and practitioner have merited a good deal of consideration since the 1993 survey. Although ethical dilemmas invite debate rather than provide answers, I, as medical director of a center of both conventional and physician-supervised alternative medicine, can only offer a personal perspective.

The first question asks "Is alternative medicine scientific?" and a positive answer is meant to calm physicians reluctant to refer patients to the land of non-science. By the standards of people currently in charge of science, the answer is that at present there is evidence proving scientific worth of many fields of alternative medicine. Most of the negativity conveyed during medical school was opinion and not actual fact. Unfortunately, most conventional studies have focused on disproving the worth of alternative therapies, which served little useful purpose. *Alternative Medicine — What Works* (Fugh-Berman 1996), a book for both patients and health care professionals, addresses these issues, the author having researched peer-reviewed medical journals for studies testing

unconventional techniques. Many more studies were available than anyone thought. This book is a starting point for the concerned physician and offers some guidance in an emotionally difficult area.

However, measuring the scientific worth of alternative medicine also asks, "What actually *is* science?" If acupuncture has been healing for four millennia, maybe Chinese medicine is a science unto itself. Not better, not worse, but different. Could it be that science, like the rest of reality, is simply a socially constructed phenomenon, a creation of whoever happens to be in charge? Walter Truett Anderson's *Reality Isn't What It Used To Be* (1990) separates our understanding of reality into three phases. The first, Pre-Modern, defines reality as the product of the prevalent power. A good example might be the attitude of the Inquisition toward nonCatholics ("Believe the reality that is or suffer the consequences). Until recently, conventional medicine's view of alternative therapies was distinctly pre-modern.

A later phase, which Anderson termed modernism, can be phrased as follows: Although I am the dominant thought-form (Christian/Jew, conventional physician), you (Buddhist, homeopath) are entitled to your belief system. Although I won't persecute you for your beliefs, in my heart-of-hearts, your system is simply wrong-headed." The current liberalism toward

alternative medicine is distinctly modern.

Anderson might ask us to consider alternative medicine in the light of the third and current phase, which he calls post-modern. Reality has shifted to being a socially constructed phenomenon, the product of the press, experts, television, and the like. There is no absolute reality, only the construct of someone in whom you've placed your faith. Science, too, is little more than a social construct. Although we value science to the point of adoration, perhaps the ethnoscience of the shaman and the Oriental acupuncturist, is as valid for them as the articles in *Scientific American* are for us. The very idea of science as a socially constructed phenomenon makes most health care conventional doctors squirm uncomfortably. However, to the holistically oriented alternative sciences, the current Western model, reductionistic and mechanical, feels inherently wrong. Trying to understand the essence of Chinese medicine by measuring the blood levels of endorphins after needle insertion is like trying to understand cathedralness by analyzing a chunk of Chartres in a laboratory.

The second question asks the conventional physician if she has a moral obligation to protect her patient from therapies that fall outside the range of her scientific point-of-view. My answer here is a strong yes, although at first, this seems

contradictory given my comments on postmodernism. However, I am not a post modernist; at the present time, I know only one scientific reality. The training of virtually all the two hundred fields of alternative medicine gives little attention to the dominant scientific point-of-view, which they term allopathic. The alternative medicine practitioner's working knowledge of physiology, anatomy, pathology, biochemistry, pharmacology, and the like, is extremely limited. Someone dealing with the patient needs to make a conventional diagnosis and be able to offer conventional therapy; say no when alternative medicine is inappropriate or dangerous, write a prescription for a life-saving drug, consult a specialist, or arrange hospitalization. That someone can only be a conventionally trained licensed doctor of medicine.

After years of working with alternative practitioners, I believe that working as a team, with a physician as leader, can dramatically and effectively improve health care in the twenty-first century. Without medical supervision, as paternalistic as this sounds, alternative medicine will never reach its full potential. The two modalities, conventional and alternative, need to work together in order to effectively guide the patient along a healing path. For mankind's chronic conditions, now a huge catalogue of ailments with which conventional medicine has little success, supervised

alternative medicine is safe, harmless, and can transcend the physician's limited therapeutic armamentarium.

The final issue, concerning rights of both patient and practitioner, was best answered two hundred years ago by Benjamin Rush, physician, signer of the Declaration of Independence, as first Surgeon-General of the United States. Dr. Rush wrote:

The Constitution of this Republic should make special provisions for Medical Freedom as well as Religious Freedom . . . To restrict the art of healing to one class of medicine and deny equal privileges to others will constitute the Bastille of medical sciences. All such laws are unAmerican and despotic. They are fragments of a monarchy and have no place in a Republic.

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Readers Respond ■■■

Those of us who are charged with ethical reflection are at times smothered by the use of ethical principlism. And yet as I read the articles and guidelines in the past *Bioethics Forum* [1996 12(3)], I believe that issues regarding not only health care decisions of the developmentally disabled, but all life decisions about, for, and with persons with developmental disabilities, require us to bring principlism to the forefront.

Because of the special concerns of persons with developmental disabilities, the resurrecting and utilizing of the basic ethical principles of autonomy, beneficence, nonmaleficence, justice, and fidelity will not simplify decision making, but in ways muddy the process. Questionable capacity makes for questionable self-determination. And in no other area of decision making have I witnessed the overwhelming impulse to be paternalistic in a well-intended, beneficent way. A subtle manipulation of reality is often paired with this beneficence. How could we burden persons in stories such as Russell (*BF* 12(3), 48) and Kenny (*BF* 12(3), 11) with the truth? Would not a piece of the truth be sufficient? Balancing beneficence and self-determination does not come naturally for health care professionals.

Concurrently, the notion of

justice ebbs and flows, depending on how we balance the needs of unique individuals with those of the majority. This is increasingly difficult when one person's needs so clearly outweigh other members, whether the system is a care plan, an institution, a state, or a family. From family experience, I know that the practice of justice in families with developmentally challenged persons involves sharing decision making, not only with one primary guardian or surrogate, but with an entire family system over the lifetimes of those involved. Multiple inputs appear overwhelming but are unavoidable in situations of such chronicity.

Ethical reflection is rarely an easy task, and in consideration of persons who are created a bit different from others, the reflection becomes more complex. In using the guidelines provided by the Task Force on Health Care for Adults with Developmental Disabilities, no matter what hat we wear, we must dust off some of the "good old" principles to find keys of integrity for the continuum of decision making that faces individuals, families, institutions, and communities with special needs.

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