Alternative Therapies and Public Health: Crisis or Opportunity?

In 1994, Jennifer Jacobs, MD, MPH, contacted the national office of the American Public Health Association (APHA) about procedures to start a new organizational component of the association and to schedule time for an organizational business meeting at the 1994 annual meeting. The result was a new Special Primary Interest Group (SPIG) that, after much discussion at the annual meeting, was eventually named Alternative and Complementary Health Practices (A. Trachtenberg, oral communication, 2002). The term "health practices" was chosen to reflect a neutral stance on whether such practices might be therapeutic, preventive, or even harmful.

At the 1994 meeting, about 30 members elected the new SPIG's first cochairs, Jennifer Jacobs and Alan Trachtenberg, MD, MPH, who at that time was also directing the National Institutes of Health (NIH) Office of Alternative Medicine. Lawrence Kushi, ScD, was elected the SPIG's first program chair. From 1995 to the present, the SPIG has presented an interesting and well-attended scientific program at every annual meeting and has grown to over 200 primary members.

The public health imperative for the study of these health practices was their sheer prevalence, which had been brought to major public attention by the survey by Eisenberg et al. in the *New England Journal of Medicine*.[1] Members of the new SPIG assumed that some practices would be helpful, some harmful, and some merely an unnecessary expense, and that sound clinical research was required to separate the wheat from the chaff. However, we recognized that a public health approach to alternative health practices would also require a larger view, one that incorporates cultural competence as an important value in primary health care. For instance, if a health center was providing community-oriented primary care for a particular community, the health practices, beliefs, and traditions of that community might need to be addressed to ensure adequate medical utilization and compliance by members of the community, as well as to provide for community input, participation, and self-governance of health care. The new SPIG was aware of the World Health Organization's (WHO) traditional medicine initiative,[2] which sought to incorporate traditional tribal healers into the public health infrastructure around the world, as well as the practice at many Indian Health Service units of finding creative ways to provide space and even positions for tribal healers.

ALTERNATIVE IN THEIR ORIGIN

Therapies and other health practices seem to have been labeled "alternative" in the Western biomedical setting because they came from outside that setting. They are alternative primarily in their origin. Therapies like surgery, psychotherapy, and the early antibiotics came from within our own Western biomedical tradition and predated the advent of evidence-based medicine. Some have since been confirmed by rigorous methodology, but many have not.[3] Likewise, new technologies such as intrapartum fetal monitoring may emerge from within our own biomedical culture and become widespread, despite an absence of rigorous data on benefits.

The arts of medicine and public health policy have often required that practitioners make their best educated guess as to what to do, even in the absence of adequate data. Doing nothing may be even worse, or may be unacceptable to the patient or to the public. Such educated guesses, made with the best of intentions, will clearly reflect cultural and individual biases.

Other biomedical cultures, many as scientifically oriented as our own, have made very different decisions than we in the United States have about the incorporation of what we call alternative therapies into national health programs. (Some would say that the fact they these countries *have* national health programs, while the United States still does not, suggests a certain superiority of these nations' general approaches.) For instance, phytomedicines (herbal preparations) and even homeo-

pathic "drugs" are routine and well-regulated parts of physician prescribing in many European countries.[4] In France, acupuncture is just another medical specialty, like surgery or psychiatry. In Japan, traditional herbal combinations are highly regulated and have gained a substantial clinical trial database for safety and efficacy.

Thus, even among our economic and scientific peers, the United States stands out as a medical culture uniquely resistant to the use, or even the study, of therapies that come from outside the Western biomedical context. In the developing world, of course, traditional (or, for us, "alternative") health care is the most commonly available type, and this is the rationale for the WHO's traditional medicine initiatives.

COMPLEMENTARY IN THEIR USE

The term "complementary" was originally coined by the British to refer to therapies that worked by complementing or enhancing the patient's intrinsic healing mechanisms. This recognized a vitalistic commonality to many alternative therapies such as acupuncture, herbs, and homeopathy. In the United States, the term has grown to refer mostly to the way such therapies are generally used by the American public—as adjuncts to conventional medical care, rather than as substitutes or complete alternatives. By increasingly voting with their feet[5] and their wallets, the public, rather than traditional "investigator-initiated" scientific curiosity, has driven the research in this area in the United States.

The Office of Alternative Medicine (now the National Center for Complementary and Alternative Medicine) was formed as part of the NIH by the Senate committee with authority over the NIH budget, despite objections from within the NIH and much of the biomedical community. Nevertheless, the public health of our nation is better served by such scientific attention than by these health practices being ignored or marginalized as scientifically uninteresting or trivial. This special issue of the Journal is well suited to addressing this uniquely public health–oriented approach to alternative therapies.

CAVEAT EMPTOR

One of our paramount duties as public health professionals in this area is to ensure adequate consumer protection. The challenge, however, is to protect consumers without restricting their choices in a way that will be intolerable to too large or to too influential a part of our citizenry. Clearly, consumer education is a key element of such consumer protection in a democratic society. But if consumers are to be able to rely on the advice of their physicians and other conventional health professionals, we must ensure that these professionals are adequately knowledgeable. When a consumer brings articles (sometimes biomedical articles found through MEDLINE) to a medical visit and sees those articles ignored or rejected out of hand, it is often clear that the rejection is based not on a carefully considered medical opinion but more probably on unfamiliarity or even bias. Such consumers may then opt for self-care and select alternative health products on their own (the bulk of dietary supplement sales), or they may seek professional consultation with an alternative provider, such as a naturopath, acupuncturist, or (some would say) chiropractor. This is of particular concern when patients use botanical medicines or other "dietary supplements," which, taken without a physician's knowledge, can sometimes have profound interactions with prescribed medications.[6] However, the attention that these consumers are now paying to diet and other aspects of their health might be a powerful motivator for positive behavioral changes.

CARPE DIEM

The alternative and complementary health care being chosen by consumers is therefore not subject to many of the regular rules and safeguards that have applied in the conventional practice and technology of medical and pharmaceutical care. In the chaotic marketplace that has emerged, turf wars, competing guild interests, and commercial considerations have been the predominant determinants of what is presented to the public. Variation from state to state is much wider than in conventional health care, and there is considerable need for national leadership. Such leadership could come from the public health community, which may be able to serve as "honest broker" between orthodox biomedical professionals, a suspicious public, and at least the part of the alternative health community that aspires to an evidence-based approach and to the values of public health and preventive medicine. While rigorous clinical and basic research, which is the jurisdiction of the NIH, is absolutely necessary to resolve these issues, it will not by itself address the various needs and demands of the public.[7] Standards, professional development, continuing medical education, clinical education, and perhaps even regulations and the coordination of state and local jurisdictions with relevant federal agencies will be required.

The Chinese character for "crisis" contains the figure for "opportunity" as well as that for "danger." Alternative therapies present both of these aspects. The public health community must rise to this challenge by seizing the opportunity as well as working to ameliorate the danger. ■

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