PLUS ÇA CHANGE? THE CASE FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE CHARITIES

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Introduction

This article has been written in response to the Charity Commission review of Complementary and Alternative Medicine Charities (CAM). It seeks to demonstrate CAM's public benefit and efficacy and sets out legal safeguards on their position as charities. Its authors are a charity lawyer and a CAM practitioner whose arguments complement and support each other.

Many CAM charities have been registered by the Charity Commission over the years. Following the threat by the Good Thinking Society to apply for judicial review of the Charity Commission's actions if it continued to register CAM charities, the Commission opened a consultation titled: 'The use and promotion of complementary and alternative medicine: making decisions about charitable status'. This article looks at the position of such charities; both those applying to be registered and those already registered. It is argued that if the Charity Commission refuses to register or removes from the register CAM charities, it would be open to legal challenge. The Charity Commission will also be open to challenge if it attempts to use its *cy-près* powers to apply CAM charitable property for other purposes.

Additionally, it is argued that assertions that the evidence base for CAM is scientifically inadmissible, or even entirely lacking, revolved around a definition of

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evidence that uniquely serves the pharmaceutical and medical industries and unfairly disadvantages CAM, whose methodology is predicated upon alternative philosophical and epistemological foundations. The authors call for qualitative findings, from subjective narrative and ethnographic research, to be admitted to the evidence base alongside quantitative 'gold standard' clinical trials, and for a pluralistic approach to evidence to be embraced as part of a politically and socially responsible commitment to the real-life needs of patients.

Key themes also explored include the basis upon which public benefit is assessed and the alignment of beliefs within religion both in charity law and human rights. This is especially true when complementary medicine forms part of a religious practice, as is the case for many religions which practice faith healing.

The Charitable Basis of CAM

As a starting point, it is necessary to explain the charitable basis for CAM. The Charities Act 2011 lists as one of the description of charitable purposes: 'the advancement of health and the saving of lives'.[1] The original reference to health in the Charitable Uses Act 1601 referred to the maintenance of sick and maimed soldiers and mariners and the relief of the aged and impotent. There was a subsequent categorisation of charitable purposes into four heads, these being:[2] the relief of poverty; the advancement of education; the advance of religion and a fourth head of other purposes beneficial to the community. Health largely fell within the fourth head but could fall within the first three too. Those falling within the old fourth head included homeopathy,[3] herbalism,[4] yoga,[5] acupuncture,[6] osteopathy,[7] clinical nutrition,[8] and vegetarianism.[9] Some promote physical health,

1 Charities Act 2011, s 3(1)(d).

2 Per Lord MacNaghten in *Income Tax Special Purposes Commissioners v Pemsel* [1891] AC 531.

3 See Homeopathy: Medicine for the 21st Century. Registered Charity Number 1124711.

4 The Herb Society Limited. Registered Charity Number 1071779.

5 Yoga for Heart and Education Trust. Registered Charity Number 1124041.

6 British Medical Acupuncture Society. Registered Charity Number 1057942.

7 London School of Osteopathy. Registered Charity Number 1085391.

8 Heart Empowerment Through Nutrition. Registered Charity Number 1116097.

9 The Vegetarianism Charity. Registered Charity Number 294767. See Robert Meakin, *Charity in the NHS: Policy and Practice* (Jordans 1998) 64.

and some, such as meditation, promote mental health.[10] Some provide education[11] (the old second head) and/or promote research.

The first three heads of charity were presumed to be charitable, whereas in the case of the fourth head (other purposes beneficial to the community) there was a need to prove public benefit.[12] Following the Charities Act 2011,[13] there is no presumption that any charity is for the public benefit.[14]

In any event, for over thirty years, the Charity Commission's general approach to the registration of such charities has been to require them to submit evidence that their methods are efficacious.[15]

The Charity Commission Review

In response to a challenge by the Good Thinking Society (GTS),[16] which threatened to apply for judicial review of the Commission if they did not remove homeopathic charities from the register or conduct a full review of CAM charities generally with a view to seeing if they provide public benefit based on scientific evidence, the Charity Commission opened a consultation titled: 'The use and promotion of complementary and alternative medicine: making decisions about charitable status'.[17] The consultation is about the type of evidence that should be required by the Charity Commission and not about the following matters:

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10 Charities Act 2011, s 3(2)(b) defines 'health' as including the 'prevention or relief of sickness, disease or human suffering'. Psychological healing has been accepted as charitable. See *Re Osmund* [1944] Ch 206.

11 Ibid.

12 *National Anti-Vivisection Society v IRC* [1948] AC 31, 65 per Lord Simmonds. Note that there is a debate about whether there was a presumption of public benefit. This is discussed in Robert Meakin, 'Taking the Queen's Shilling: The Implications for Religious Freedom for Religions Being Registered as Charities' (2017) 178 Law and Justice 63.

13 Charities Act 2011, s 3(2).

14 If, indeed, there ever was such a presumption. See Mary Synge, *The 'New' Public Benefit Requirement: Making Sense of Charity Law?* (Bloomsbury 2015).

15 See *New Age Healing Trust* [1975] Ch Comm Rep 22, paras 68-69. This is consistent with the approach taken in *National Anti-Vivisection Society v IRC* [1948] AC 30, 65.

16 www.goodthinking.org Charity Commission Consultation on CAM charities.

17 Charity Commission – 13 March 2017. https://www.gov.uk/government/consultations/consultation-on-complementary-and-alternative-medicines

- Whether or not CAM therapies in general, or any particular CAM therapies, are effective.
- What evidence may exist in support of or against the efficacy of any particular CAM therapy.
- Whether or not any particular organisation should be, or should continue to be, registered as a charity.
- The Commission's approach to registering charities generally.

In other words, the Commission is making it clear that it retains the right to decide in respect of these matters, as opposed to giving this right to the general public. Despite these exclusions, however, it would be surprising if the outcome of the consultation did not have an impact on organisations seeking to become registered charities and on the continuing registration of existing charities. Although the Commission says that it is not consulting on whether CAM therapies generally or in particular are effective or on what evidence exists in support of or against this proposition, those issues will be critical to whether a CAM charity will be recognised by the Charity Commission as providing sufficient public benefit to be charitable. For this reason, this article explores these issues further.

Evidence in Support of CAM Providing Public Benefit

Following the Charities Act 2011,[18] there is no presumption that any charity is for the public benefit. Public benefit must therefore be demonstrated.[19] This section debates what kind of evidence should be examined when determining this question. It is a crucial question which will, in many cases, determine whether an institution is regarded as charitable.

Summary

This section discusses the implications of GTS' challenge to the Charity Commission in terms of issues pertaining to the question of evidence. It has already been noted above that the consultation does not concern itself with whether or not CAM is effective, or with the nature or value of existing evidence for or against the efficacy of CAM. Nevertheless, the challenge from GTS proceeds directly from an assumption that there is no evidence, or that such evidence as exists is not sufficiently robust. Therefore, part of the focus of this section will be to address the question of the evidence base within CAM, and to compare it with the biomedical/pharmaceutical model that is invoked in comparisons between

18 Charities Act 2011, s 3(2).

19 See Synge (n 14).

CAM and biomedicine. The case will be made for a pluralist approach to research methodology, which challenges the prevailing model used by medical science, upon which the GTS challenge is tacitly predicated. It will be argued that, through the exclusive advocation of this model, there is a present danger that self-elected spokespeople for the mainstream in medicine are intent on building a 'monoculture' that seeks to suppress alternative perspectives.

Following on from this, the political and ethical dimensions of a situation in which the legitimacy of personal choice in health care is endangered by this initiative will be explored from the point of view of globally emerging ethnographic and cultural contexts in health care, and a case will be put that, irrespective of the evidence base, marginalisation or suppression of CAM therapies may do active harm.

In pursuing these objects, it will be necessary to draw upon relevant discussions in the philosophy and theory of science in order to contextualise the notion of 'science' itself and to put the case for an inclusive, pluralist approach to the problem of evidence.

Background

In 2000, the House of Lords Select Committee on Science and Technology put out a 'call for evidence' to the CAM professions, in preparation for a groundbreaking review of CAM practice in the UK.[20] The ensuing report was controversial, in that it stratified the sector into three groups, based upon the perceived value of the evidence gathered. It is interesting in the present context to comment briefly on the rationales given for the allocations that appear in each of the three groups.

Although those in Group 1 (Acupuncture, Chiropractic, Herbal Medicine, Homeopathy and Osteopathy) are ostensibly selected owing to their level of 'professional organisation', in the commentary we find the following observation: '… it may be damaging to the better-established CAM professions and disciplines to group them with those which have no evidence base. We understand these views and it is for this reason that we propose the grouping given above'.[21] This clearly indicates an 'evidence hierarchy' which places pre-eminence on the selected professions and by implication relegates those in Groups 2 and 3 to a lesser status. With regard to Group 3, the following assessment appears:

> … it is our opinion that the therapies listed in our Group 3 cannot be supported unless and until convincing research evidence of efficacy based upon the results of well-designed trials can be produced. Such evidence must be capable of showing that the effects of any therapeutic discipline

20 UK Parliament (2000) House of Lords – Science and Technology – *Sixth Report*.

21 Ibid, 2.4.

> are superior to those of the placebo effect. It is our view that for those therapies in our Group 3, no such evidence exists at present.[22]

It was not lost on proponents of the culturally specific healing practices of Traditional Chinese Medicine, Ayurveda and Tibb Medicine, whose modalities were included in Group 3, that this consigns not just practices, but entire cultural and traditional systems, to a 'dilemma of incommensurability' from which it will be difficult to rescue them without exposing, and then deconstructing, the assumptions that lie behind these judgements. We shall return to the cultural implications of this at a later point, but it is important to understand that it is precisely the *incommensurability*, not just of heath care modalities themselves, but of the systems of thought which underpin them, which is at the heart of the reasons for their rejection by the mainstream: in other words, these modalities are predicated upon different *thought systems*, and therefore cannot be submitted to any meaningful comparison with the orthodox scientific canon.

Hence, direct call for trials demonstrating clinical effects 'superior to those of the placebo effect' circumscribes the allowable evidence to that which confirms to this particular scientific context, embodied in the so-called 'gold standard' model for clinical trials: the randomised, double-blinded, placebo-controlled trial (RCT), upon which, it is supposed, evidence based medicine must exclusively rest.

An additional and recently emerging irony of the report has been that one of the disciplines in the pre-eminent Group 1, Homeopathy, has become the most severe casualty in the 'evidence war' to date, resulting most recently in its expulsion from NHS facilities that have been established for several decades.[23] This is despite the fact that there have been several RCTs conducted for homeopathic treatments, many of which demonstrate its effectiveness. In this regard, commentators such as Simon Singh (Good Thinking Society) and Guardian columnist Ben Goldacre[24] have been at the forefront of a campaign to discredit homeopathy, which is crucially evident in the challenge that generated the consultation that is the *raison d'etre* of this article. This campaign has deployed a polemic that has never been subjected to exhaustive public scrutiny, even though it has been cogently deconstructed elsewhere.[25]

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22 Ibid, 2.7.

23 UK Parliament (2010) House of Lords – Science and Technology – *Evidence check 2: Homeopathy*.

24 See e.g. Goldacre, B (2007) *A kind of magic*. https://www.theguardian.com/science/2007/nov/16/sciencenews.g2

25 Loughlin, M (2007) Style, substance, newspeak 'and all that': A commentary on Murray et al (2007) and an open challenge to Goldacre and other 'offended' apologists for EBM *Journal of Evaluation in Clinical Practice*, *13*, 517–521.

Theoretical underpinnings

All research proceeds from a set of assumptions about reality – a theoretical perspective – from which is derived a *methodology*, which is a set of rules governing how we conduct our investigations.[26] The theoretical perspective that underlies science, as we are given to understand it, is *positivism*, which is the view that reality exists and conforms to certain rules which enable us to make predictions about what it will do, independently of whether we observe it. This in turn is informed by an *epistemology*, which is a set of ideas about knowledge and how we gather it. The epistemology that is partnered with positivist science is called *objectivism* – it regards reality as objective, and hence discoverable, knowable and measurable. It is beyond any consideration of consciousness, individual perception, or subjectivity. It is absolute.

The methodology that this gives rise to is almost invariably *quantitative*; that is, concerned with empirical – measurable – outcomes. The relevance of this to clinical research in medicine is immediately obvious: the kind of evidence that we are concerned with here is that of how many people taking a certain drug, or receiving a certain treatment, will 'get better'? The terms of measurement are also objective: the assumption is that we are dealing with 'real' pathologies that have measurable dimensions – blood counts, viral loads, hormone levels, functional capacities, tumour size, etc. Even when taking on subjects such as mental illness, where subjective markers such as the level of anxiety or the severity of depression are at issue, research proceeds by assuming that these experiences can be assessed objectively and establishes industry-standard measuring scales in order to quantify them.[27]

However simple and authoritative this may sound, in practice it rarely is. Reality rarely consents to fall into such neat categories, or give tidy, uncomplicated results. In order to establish credibility, Crotty argues, scientific findings themselves are often simply beliefs dressed up as truths: 'Many of the so-called 'facts' that serve as elements of these theories … have been quite purposefully contrived and introduced as mere heuristic and explanatory devices'.[28] If this is true, the objections levelled at CAM by the scientific sceptics sail dangerously close to an intellectual double standard, and serve only to reinforce the glass ceiling that determines who shall, or shall not, be accepted in the evidence stakes.

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26 Crotty, M (2015) *The foundations of social research: meaning and perspective in the research process*. London: Sage.

27 Hamilton, M (1959) The assessment of anxiety states by rating. *Br J Med Psychol*, *32*, 50–55.

28 Crotty (n 26) 30.

The answer to the dilemma posed to alternative medicine systems in this situation must therefore at least partly consist in the task of investigating and validating alternative methodologies and theoretical perspectives. At present, these are perceived to be oppositional to, and incommensurable with, the prevailing notion of science.[29] In approaching pluralism in research methodology, there is a need to declare the assumptions that lie behind all research, but also a need to avoid the automatic assumption that one type of evidence is necessarily better than another – for example, the favoured RCT model over 'anecdotal' (or narrative) data. There must be recognition that both sets of data are valid within the terms that define them, and that they each serve different, and quite specific, ends. This is what it will take to rescue CAM from the incommensurability bestowed upon it by the current culture of scientific monism.

Critiquing evidence based medicine (EBM)

The phrase 'evidence based medicine' was coined in 1996 by Sackett et al, who defined it as: 'The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients … integrating individual clinical expertise with the best available external clinical evidence from systematic research'.[30] Originally intended as a manifesto for a new rigour in medical practice, the phrase has been polemicised – not to say weaponised – by the so-called sceptics. However, it has never been regarded as unproblematic.[31] In fact, it was long recognised by the originators of the EBM paradigm that strict objectivity in clinical practice was difficult to maintain, seen in the fact that levels of agreement between clinicians, particularly in diagnostic findings, is typically found to be low.[32]

In an early essay on 'narrative medicine' in a standard health care context, Greenhalgh discusses the role of subjective clinical judgement within the context of evidence based practice, and argues that all *objective* data must inevitably be run through the *subjective* lens of the clinician's experience and his or her engagement

29 Kielmann, K (2012) The ethnographic lens. In L Gilson (Ed), *Health policy and systems research: a methodology reader* (pp 235–237); Hollenberg, D (2006) Uncharted ground: Patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care settings. *Social Science & Medicine*, *62*(3), 731–744.

30 Sackett, DL, Rosenberg, WM, Gray, JA, Haynes, RB, & Richardson, WS (1996) Evidence based medicine: What it is and what it isn't. *BMJ (Clinical Research Ed)*, *312*(7023), 71–2.

31 Goldenberg, MJ (2006) On evidence and evidence-based medicine: Lessons from the philosophy of science. *Social Science & Medicine (1982)*, *62*(11), 2621–32; Harari, E (2001) Whose evidence? Lessons from the philosophy of science and the epistemology of medicine. *The Australian and New Zealand Journal of Psychiatry*, *35*(6), 724–30.

32 Sackett, DL, Haynes, RB, Guyatt, GH, & Tugwell, P (1991) *Clinical epidemiology: a basic science for clinical medicine*. London: Little Brown.

with the stories of individual patients.[33] Nevertheless, in declaring that such a focus does not require 'an inversion of the hierarchy of evidence', neither is it explicitly stated that objective evidence and subjective evidence should be given equal weight.

Challenges to the hierarchy of evidence must necessarily critique the top tier, in terms of both theoretical and political power bases. In this regard, there is considerable commentary on EBM in the literature from both sides of the fence, and whilst it is necessary to admit that it is beyond the remit of this article to encompass all positions, or to give an in-depth account of the historical debate, it is certainly relevant – since CAM is being challenged to meet the evidential standards of the orthodoxy – to suggest that we subject these standards to some scrutiny.

Falkenberg calls for a 'non-hierarchical view on evidence based medicine', partly in order to facilitate the introduction of CAM therapies into an integrative medical field, but also to reframe research methodologies as selective pathways designed to answer different types of questions.[34]

Loughlin argues that EBM hails from the logical positivist movement of the Vienna Circle philosophers in the early 20th century, a significant feature of whose legacy is the decoupling of epistemology from ethics.[35] He further suggests that these theoretical foundations open up a pathway by which EBM can be appropriated by vested interests and used as an ideological tool for 'management' purposes, citing 'so-called management science':

> Management theory becomes an 'ideology' in the sense intended by Marx: a system of ideas that functions to provide a rationalization for the interests of certain groups over others (in this case, guaranteeing them control of organizations) but which serves to obscure those interests (rendering them 'hidden from sight') and coming, over time, to appear self-evident (sheer 'common sense') to naïve participants within the colonized discourse.[36]

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33 Greenhalgh, T (1999) Narrative based medicine: narrative based medicine in an evidence based world. *BMJ (Clinical Research Ed)*, *318* (7179), 323–5.

34 Falkenberg, T (2011) From traditional medicine to integrative care – A global research perspective: Keynote lecture, Complementary and Alternative Medicine Strategies, Training, Research and New Developments (CAMSTRAND) Conference 2011, Southampton, UK *European Journal of Integrative Medicine*, *3*(2), e103.

35 Loughlin, M (2006) The future for medical epistemology? Commentary on Tonelli (2006), Integrating evidence into clinical practice: an alternative to evidence-based approaches *Journal of Evaluation in Clinical Practice* 12, 248-256. *Journal of Evaluation in Clinical Practice*, *12*(3), 289–291.

36 See Loughlin (n 25).

To add to this, the shortfall of ethical standards in informing evidence based practice necessitates an alternative approach which 'recognizes that variation in practice is something natural and to be expected (rather than something problematic which requires explaining away)'.[37]

We should certainly question the ethics of a situation in which a problematic definition of evidence should be forced upon alternative practices and traditional medicine as a *sine qua non* for acceptance or validation. This is not to question the necessity for an evidence base, but it certainly casts doubt on the future of acceptance criteria for evidence. No matter that proponents of EBM may see their practice as resting entirely on objective evidence, the reality may be very different.[38]

Amongst the most carefully reasoned critiques of the shortcomings of the objectivist paradigm in medicine is that presented by Harari, who observes: 'there are, in effect, as many 'worlds' as there are viable constructions of 'it'… Each particular construction proceeds according to its own rules and is interpreted according to the system that determines the rules of construction'.[39] In the context of medicine, and especially from Harari's specific standpoint, that of psychiatry, the conclusion is forceful:

> Intellectual flexibility, tolerance of ambiguous and discordant information obtained by different methods from differing viewpoints and at different conceptual levels, the judicious yet knowingly fallible, theory-derived construction, selection and interpretation of observations and empathically derived experiences typify the scientific method and is congruent with a form of clinical practice that is scientific, therapeutic and ethical.[40]

Medical interest in qualitative and ethnographic research has been on the agenda since the beginning of the 21st century.[41] Leung argues that 'in general practice, qualitative research contributes as significantly as quantitative research, in particular regarding psycho-social aspects of patient-care, health services

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37 See Loughlin (n 35).

38 Charles, C, Gafni, A, & Freeman, E (2011) The åevidence-based medicine model of clinical practice: Scientific teaching or belief based preaching? *Journal of Evaluation in Clinical Practice*, *17*, 597–605.

39 Harari, E (2001) Whose evidence? Lessons from the philosophy of science and the epistemology of medicine. *The Australian and New Zealand Journal of Psychiatry*, *35*(6), 724–30, 725.

40 Ibid, 729.

41 Savage, J (2000) Ethnography and health care. *BMJ (Clinical Research Ed)*, *321*(7273), 1400–2.

provision, policy setting, and health administrations'.[42] The recent initiatives on the part of the World Health Organization (WHO) seem to signal that mainstream healthcare is at last beginning to take on board earlier criticisms that have observed a lack of theory or engagement in contextual issues affecting patients in medical care.[43] In particular, they begin to take on board that such an engagement, in tandem with enhancement of communication and attention skills, can directly and indirectly contribute to quantitative improvements in outcomes in health care and management.[44] It could therefore be said that the absence of such an approach within EBM would be a serious shortcoming.

In a report from the first meeting of the WHO Expert Group on the cultural contexts of health and wellbeing in 2015, the following statement appears:

> The conventional hierarchy of evidence drawn upon to inform evidence-based policy privileges randomized control trials, case control trials and other statistically valid forms of quantitative data. However, such a hierarchy has been recognized to shut down access to the subjective meanings of experiences, the contextual nature of knowledge production and the dominant discourses that inform both policy and research orientations.[45]

Although contributors to emerging WHO policy are by no means uniformly convinced of the need to challenge the 'hierarchy of evidence', this does represent the beginnings of a shift in the overarching management of health policy towards broader evidential criteria.

Greenhalgh's project of narrative medicine is currently under discussion in the Health Evidence Network (HEN), coordinated by the WHO Regional Office for Europe under the umbrella of the European Health Information Initiative.[46] Starting from The Lancet's groundbreaking review of the impact of culture on

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42 Leung, L (2015) Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care*, *4*(3), 324–7.

43 McKinley, RK, & Middleton, JF (1999) What do patients want from doctors? Content analysis of written patient agendas for the consultation. *The British Journal of General Practice : The Journal of the Royal College of General Practitioners*, *49*(447), 796–800.

44 Ibid; Fong, J, & Longnecker, N (2010) Doctor-patient communication: A Review. *The Ochsner Journal*, *10*, 38–43.

45 World Health Organization (2015) *Beyond bias: exploring the cultural contexts of health and well-being measurement*. Copenhagen.

46 Greenhalgh, T (2016) *Cultural contexts of health: The use of narrative research in the health sector*. Health Evidence Network Synthesis Report 49, The Health Evidence Network.

health,[47] and in the context of the recent WHO focus on qualitative evidence, Greenhalgh's report itself acknowledges that 'an overly technocratic approach, while superficially rigorous, could overshadow the crucial process of interpretation and judgement'.[48]

Nonetheless, non-positivist and qualitative theoretical perspectives still occupy a precarious position in orthodox medicine, and practice almost certainly lags behind the best available theory in this regard. Commentaries that bring out the dissatisfactions that this can engender in the relations between physicians and their patients shed light on the social context in which patients are turning to CAM practitioners because of the perception that person-centred care is more securely embedded in CAM practice than it is in orthodox medical practice.[49]

The problem for CAM is that in society, as in mainstream science, the default position seems to require that any difference of opinion must automatically be resolved in favour of those who uphold a positivist/objectivist standpoint. Furthermore, practices that do not uphold, or at least have difficulty in applying the principles of objectivism, are likely to be characterised as 'pseudoscience' and 'potentially dangerous quackery',[50] and their proponents as malevolent charlatans attempting to mislead a gullible public. The premise that 'science' (an overarching term for which no clear definition is publicly seen) is tacitly regarded as above question, is taken for granted in many of these communications, rendering them in fact little more than polemical diatribes in defence of an assumed superiority. As polemics go, however, they hold significant sway over government bodies and public hearts and minds alike, and threaten serious damage to alternative systems – which is precisely what they are intended to achieve: polemic, after all, is a weapon of war. Thus 'science' itself, in declaring its absolute and sole claim to truth, runs the risk of becoming, in Waitzken's words, 'an ideology that is distinguished by the belief that it is beyond ideology'[51] – a stance which is at best hypocritical, and at worst authoritarian and repressive.

47 Napier, D, Ancarno, C, Butler, B, et al (2014) The Lancet Commissions – Culture and Health. *The Lancet*, *384*, 1607–1639.

48 See Greenhalgh (n 46) 2.

49 Cant, S, & Sharma, U (1998) Reflexivity, ethnography and the professions (complementary medicine) Watching you watching mewatching you (and writing about both of us). *The Sociological Review*, *2* (6), 244–263; Jackson-Main, P (2013) *Professionalism and rapport: A critique of the 'Practitioner as Medicine.'* University of Central Lancashire.

50 Singh, S (2017) *Welcome to Good Thinking*. Good Thinking Society.

51 Waitzken, H (1993) *The Politics of Medical Encounters: how patients and doctors deal with social problems*. Connecticut: Yale University Press.

Ethics and ethnography

In this section, we will argue that the marginalisation of alternative, ancient and traditional healing practices at the behest of a hierarchy of knowledge that unequivocally and exclusively demands a certain kind of evidence, based on the prevailing, unexamined and undeclared objectivist theoretical perspective, is not only deeply unethical, but also unsustainable.

Barry notes that 'calls for 'gold standard' randomised controlled trial evidence, by both biomedical and political establishments, to legitimise the integration of alternative medicine into healthcare systems, can be interpreted as deeply political',[52] whilst Sagli pulls fewer punches in talking of the need to counteract 'the illegitimate consequences of biomedical authority when plans for integration are designed'.[53]

Kaptchuk and Miller, exploring the possible relationship configurations between the orthodoxy and CAM, argue strongly for pluralism, rather than either opposition or integration, commenting that: 'The philosophical, epistemological, and practical differences between mainstream medicine and CAM systems defy coherent integration'.[54] But pluralism would only work in a culture of mutual respect and a non-hierarchical approach to knowledge, and one of the problems with this is that, whereas in the non-positivist worldview, truth is not singular, and all versions have equal validity, in an objectivist science, this is quite clearly not the case, and it is this assumption of absolute veracity that is precisely at issue here.

Searches for qualitative data in CAM practice bring up a preponderance of studies dealing with indigenous or ethnic usage, and frequently conclude that the potential loss of these modalities might have serious consequences for the populations concerned. These concerns highlight the desirability, not to say the necessity, of preserving vital systems of traditional diagnostic and therapeutic knowledge, for

52 Barry, CA (2006) The role of evidence in alternative medicine: Contrasting biomedical and anthropological approaches. *Social Science & Medicine*, *62*(11), 2646–2657, 2646.

53 Sagli, G (2010) The contested reality of acupuncture effects: measurement, meaning and relations of power in the context of an integration initiative in Norway. *Anthropological Notebooks*, *16*(2), 39–55, 39.

54 Kaptchuk, TJ & Miller, FG (2005) What is the best and most ethical model for the relationship between mainstream and alternative medicine: Opposition, integration, or pluralism? *Academic Medicine*, *80*(3), 286–290, 288.

fear of counting the cost in terms of the attrition to end-users of available health care services.[55]

Such ethnographic studies as have been conducted in the 'developed world', frequently highlight the fact that scientific validity is not high on the list of reasons why patients choose CAM.[56] Sagli also confronts this issue in her survey of acupuncture delivery in the context of Norwegian public health care, which she characterises as fundamentally an issue of power relations, wherein patients' subjective reports of the benefits of treatment are typically discounted.[57]

A detailed survey of the experiences of naturopathic practitioners in an Australian integrative health care context found that true integration, together with mutual understanding and respect, is frequently lacking.[58] This failure of integration was seen in poor or reluctant communication, doctors appropriating naturopathic modalities without having understood them properly, and medical bias on the part of GPs, and it was observed to impact negatively on patients themselves, obscuring the benefits of the naturopathic treatments that patients were receiving.

This configuration supports powerful political and economic realities. Hollenberg and Muzzin's incisive critique of integrated medicine (IM) sees the growing global monopoly of biomedicine as a post-colonial phenomenon ('Euroscience'), and casts IM as part of the history of illegitimate appropriation of indigenous knowledge, which has its roots in historical European colonial encroachment across the globe.[59] In particular, the fact that biomedicine's insistence upon the supremacy of the RCT methodology is 'part and parcel of the pharmaceutical industry's drug approval system' is, in their post-colonial analysis, an automatic

55 Chander, MP, Kartick, C & Vijayachari, P (2015) Herbal medicine & healthcare practices among Nicobarese of Nancowry group of Islands - an indigenous tribe of Andaman & Nicobar Islands. *Indian Journal of Medical Research*, *141*, 720–744; Davids, D, Blouws, T, Aboyade, O, Gibson, D, De Jong, JT, Van't Klooster, C, & Hughes, G (2014) Traditional health practitioners' perceptions, herbal treatment and management of HIV and related opportunistic infections. *Journal of Ethnobiology and Ethnomedicine*, *10*(1), 77; Porqueddu, T (2017) Herbal medicines for diabetes control among Indian and Pakistani migrants with diabetes. *Anthropology & Medicine*, *24*(1), 17–31.

56 Cant & Sharma (n 49); Little, CV (2009). Simply because it works better: Exploring motives for the use of medical herbalism in contemporary UK health care. *Complementary Therapies in Medicine*, *17*(5), 300–308.

57 Sagli (n 53).

58 Wardle, J, Steel, A, Lauche, R. & Adams, J (2017) Collaborating with medicine? Perceptions of Australian naturopaths on integrating within the conventional medical system. *Journal of Interprofessional Care*.

59 Hollenberg, D, & Muzzin, L (2010). Epistemological challenges to integrative medicine: An anti-colonial perspective on the combination of complementary/alternative medicine with biomedicine. *Health Sociology Review*, *19*(1), 34–56.

disqualifier from the claim to be 'the new arbitrator of health and healing'. The authors further argue that the monopoly of a purely objectivist epistemology has stultified science itself, citing Harding: 'Truth claims are a way of closing down discussion, of ending critical dialogue, of invoking authoritarian standards. They deny the possibility of continuing processes of gaining knowledge in the future'.[60]

Ethnographic data should arguably be in the front line of alternative perspectives from which to view the phenomenon of CAM, and has already been deployed in commentaries on CAM.[61] The question of whether CAM and CAM-users in the UK, or the 'developed world' generally, can position themselves as a distinct ethnographic grouping is an interesting one, which asks us to consider the extent to which coherent minority perspectives may be formulated within a macroscopic cultural identity that is defined epistemologically and politically by its dominant narratives. Any investigation into this must reach beyond distinct cultural subgroups (usually determined by ethnicity) and take on board also the rights and interests of any individual or group that entertains diverse beliefs and preferences in choosing health care.

An example of such an investigation in the case of herbal medicine (one of the 'big five' identified in the Select Committee on Science and Technology's Sixth Report mentioned at the start of this section) is Nissen's exploration of the concept of 'naturalness', predicated upon a 'feminist ethics of care'. Nissen attempts to define a subset within UK society founded upon a raft of ethical values that can, she argues, be located at the heart of herbal medicine, yet which are not purely medical in focus. As one respondent to Nissen's survey puts it, she chooses herbal medicine because it is 'congruent with the way I approach things'.[62] Nissen's vision of herbal practitioners and their patients as 'embedded in a … web of care that intertwines past, present and future, self and others, and local and global concerns'[63] suggests a widening of rationales for choosing herbal medicine, and CAM in general, which intersect with ethics on interpersonal, societal, political, ecological and global levels.

Interestingly, Nissen clearly identifies the ethnicity of the sample represented in her survey as 'white, female and middle class', ostensibly expected for the geographical locus, but nonetheless making ethical choices that can be seen as fundamentally opposed to normative behaviour in the face of health care considerations.

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60 Ibid, 44.

61 See n 56.

62 Nissen, N (2015) Naturalness as an ethical stance: idea(l)s and practices of care in western herbal medicine in the UK. *Anthropology & Medicine*, *22*(2), 162–176, 162.

63 Ibid, 164.

In herbal medicine again, Little's intriguingly titled 'Simply Because it Works Better' turns its attention towards the reasons that patients choose to visit herbal medicine practitioners.[64] Little's study holds a particular value, since issues of effectiveness are revealed, significantly, to be a function of linguistic and logical compatibility with the beliefs and understandings of patients, as well as depending on issues arising within the therapeutic relationship itself, such as co-operation, empowerment, and the role of informal 'chat'. The author concludes that 'users show a preference for medical pluralism, selecting and integrating health care options creatively and thoughtfully to more adequately meet their needs in a unique and personalized way'.[65]

Studies such as these have begun to shed light on the phenomenon of CAM and have opened up a debate which we find reflected in front-line developments in the orthodoxy – such as those currently espoused by WHO – on the social, cultural and political contexts of health care choices. It may be argued still, by those who have difficulty in embracing pluralism in its raw form, that these things are a matter of belief, and that science, after all, deals with certainty. Even if we could uphold that as truth (and we have endeavoured in this article to argue against that view), would it be regarded as ethical, for example, to discriminate against *religious* practices, also based on belief, that are not commensurable with the official religion of the state? The answer is that it would not. We argue that the case of CAM occupies similar ethical dimensions, and that, especially in view of the existence of doubt regarding issues of truth and validity, the conscientious choice of individuals in selecting their preferred health care strategy is deserving of being upheld and protected in any fair and just society, including, by extension, charitable groups whose aim is to promote the welfare of their beneficiaries.

We might also ask the question, at a time when the sheer volume of demands on standard health care delivery is close to breaking the system altogether: is it scientifically or ethically sustainable to discourage practices which might offer our population valid solutions to real problems, on grounds of a conflict of ideology, and at the behest of a hegemony of largely corporate interests that may be contaminated by scientific, economic and political agendas?

Legal Limits on the Charity Commission

Even if our arguments on the benefits of CAM are not accepted, the Commission's position is difficult. Where an institution was a charity but is no longer so the Commission's powers of removal are limited. Where the institution's objects have

64 Little (n 56).

65 Ibid, 306.

ceased to be charitable due to the passage of time or a change in social circumstances its property can be rescued by a *cy-près* scheme.[66]

Cy-près

Section 62(1) of the Charities Act 2011 provides: 'Subject to subsection (3) below,[67] the circumstances in which the original purposes of a charitable gift can be altered to allow the property given or part of it to be applied cy-près are …'

Section 62(1)(e)(ii) of the Charities Act 2011 provides one of the circumstances for a *cy-près* application: 'Where the original purposes, in whole or in part, have, since they were laid down, … ceased, as being useless or harmful to the community or for other reasons, to be in law charitable …'

The common law basis for this statutory provision is the House of Lords decision *National Anti-Vivisection Society v IRC*.[68] In that case Lord Simonds looked, *obiter*, at the question of whether a charity which was once regarded as charitable could ever cease to be regarded as such. He contrasted this with an institution which, although mistakenly held by the Court to be so, was never charitable. Lord Simonds said: 'A charity once established does not die, though its nature may be changed'.[69]

In a later judgment, Lord Simonds added:

> I do not seek to qualify what I recently said in National Anti-Vivisection Society v IRC that there may be circumstances in which the Court will in a later age hold an object not to be charitable which has in earlier ages been held to possess that virtue. And the converse case may be possible. That degree of uncertainty in the law must be admitted. But I would ask your Lordships to say that it is only a radical change of circumstances, established by sufficient evidence that should compel the Court to accept a new view of this matter.[70]

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66 Charities Act 2011, s 62(1)(e)(ii). See also *National Anti-Vivisection Society v IRC* [1948] AC 31, 74 per Lord Simonds.

67 Ibid, s 62(3) reads as follows: 'Subsection (1) above shall not affect the conditions which must be satisfied in order that property given for charitable purposes may be applied *Cy-pres* except in so far as those conditions require a failure of the original purposes'.

68 *National Anti-Vivisection Society v IRC* [1948] AC 31.

69 Ibid, 74.

70 *Gilmour v Coats* [1949] AC 426, 443.

These passages indicate that once a charity has been established it cannot cease to be charitable because its objects have become dated and that it must be a 'radical change of circumstances' which causes the Court to think in terms of *cy-près*[71] application of a charity's property.

The *cy-près* doctrine is a trust law concept but these days many charities are incorporated. The Commission has questioned whether the property of a charitable company will be held for charitable purposes where, due to a change in social circumstances, its objects cease to be charitable.[72] This is because a charitable company does not hold its general property on charitable trusts[73] and therefore it could be argued that it would continue to hold its property beneficially for its non-charitable objects.

It is argued that the better view is that the Court would treat a charitable company's property as being dedicated for charitable purposes,[74] so that the result would be the same as if the property were held on charitable trusts; namely, that the directors would be under an obligation to apply for a *cy-près*[75] scheme. The issue does not arise in the case of Charitable Incorporated Organisations, where their property is held on trust.

The obligation to apply property *cy-près* where an institution was originally charitable but has ceased to be so due to the passage of time or a change in social circumstances will limit the Commission's power of removal because the property will continue to be applied for charitable purposes.

Distinguishing decisions of the Court

It is quite legitimate for the Court to distinguish an earlier decision of the Court. The basis for distinguishing a decision could be on the facts or relevance which might be due to the passage of time or a change of social circumstances. The advantage of distinguishing precedents is that it allows the Court to make a decision without necessarily disturbing the rights of existing donors and testators.

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71 Charities Act 2011, s 62(1)(e)(ii).

72 RR6 – Maintenance of an Accurate Register of Charities (2000) Annex E. See also James Dutton, 'Charitable Companies Ceasing to be Charitable' (2001) Vol 7 Issue 1 CL & PR 31.

73 *Liverpool and District Hospital for Diseases of the Heart v AG* [1981] 1 Ch 193, 214 per Slade J.

74 *Re Vernon's Will Trusts* [1972] Ch 300.

75 Charities Act 2011, s 62(1)(e)(ii).

Two examples of this are *Re Scowcroft*[76] and *Re Bushnell*.[77] In *Re Scowcroft*, a gift for 'the furtherance of conservative principles and mental and moral improvement' was held to be charitable. However, in *Re Bushnell*, the testator created a fund to be used, *inter alia*, to engage lecturers and publish information to demonstrate 'that the full advantage of Socialised Medicine can only be enjoyed in a Socialist State'. Unlike in *Re Scowcroft*, the Court held that the dominant purpose of the objects was political rather than educational and that the testator was trying to promote his own theory through education. A similar approach of distinguishing precedents could be adopted by the Commission, although as the Commission is not a Court and has no law-making powers,[78] it would need to be confident that the Court would support its decision, otherwise it would be acting unlawfully.

If the Commission wished to refuse to register or to remove a charity from the register without using its *cy-près* jurisdiction to apply the property for other charitable purposes, it might try to distinguish a decision of the Court which supports charitable status by saying that it no longer thinks that the basis for the recognition of a CAM charity is relevant on the facts. However, there is a fine line between distinguishing decisions and claiming that a charity was never a charity as opposed to saying it was charitable but is no longer so. This was the case when the Charity Commission reviewed the charity status of gun clubs. The decisions of the Commission in relation to City of London Rifle and Pistol Club and Burnley Rifle Club[79] not to register these charities had implications for the many gun clubs already on the register. Following the publication of their Statement of Reasons,[80] the Commission issued a press release in which the then Chief Commissioner said: 'We shall now have to examine the position of clubs already on the register of charities'.[81]

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76 *Re Scowcroft* [1898] 2 Ch 638. See generally Jean Warburton, *Tudor on Charities* 9th ed (Butterworths 2003) 186-189.

77 *Re Bushnell* [1975] 1 WLR 1596.

78 *Rule v Charity Commissioners* (High Ct, 10 December 1979) [1979] Ch Comm Ann Rep 12-16. The Commission only has the powers set out in the Charities Act 2011 and other enactments.

79 Charity Commission, 'Statement of Reasons for the Commissioners' Decision to Disallow Applications for Charity Registration from the City of London Rifle and Pistol Club and the Burnley Rifle Club' (1993).

80 Ibid.

81 Charity Commission Press Release, 1 February 1993. The majority of rifle clubs are still on the register and it is unclear what their present position is.

In reaching its decision, the Commission had to go back to an antiquated case, *Re Stephens*.[82] The gun clubs which were investigated had objects to encourage skill in shooting by providing instruction and practice in the use of firearms to Her Majesty's subjects so that they would be better able to defend the realm through service in the armed forces. It had previously been thought, relying on *Re Stephens*,[83] that rifle clubs with such objects were charities. In *Re Stephens*,[84] a testator made a gift in his will to the National Rifle Association to form a fund to be called the Stephens Prize Fund 'to be expended by the Council for the teaching of shooting at moving objects in any manner that they may think fit, so as to prevent as far as possible a catastrophe similar to that at Majuba Hill'. The testator did not say that the gift should be restricted to soldiers and Kekewich J construed the gift as being for all Englishmen. It was mentioned in the judgment that it was a matter of English history that at Majuba Hill, during the Boer War, the English soldiers were defeated because their opponents were excellent rifle shots. The gift was held to be charitable because it promoted the security of the nation.

The Commission[85] pointed out two particular aspects of Kekewich J's judgment in *Re Stephens*[86] which, in its opinion, rendered it irrelevant as an authority in support of the clubs' application for registration:

(A) It was found that the object in the testator's mind was clear. He desired that Englishmen should be taught to shoot with these particular weapons which were used in war for the destruction of their enemies and their own protection; and

(B) It was found that what the testator meant was that accurate shooting was to be taught amongst Englishmen in general.

By contrast, the Commission found that the clubs' purposes were not to teach members of the public in general to shoot with those particular weapons which are used in times of war. It decided that modern warfare no longer depended on the expert shooting skills of soldiers in the way it had at the Battle of Majuba Hill. Modern warfare, the Commission thought, depended more on fully trained service personnel, familiar with the latest communications, equipment and technological weaponry, than on the competent single start shooter. Furthermore, it thought that the social and organisational changes affecting the recruitment and training of the

82 *Re Stephens* (1892) 8 TLR 792.

83 Ibid.

84 Ibid.

85 Charity Commission (n 79).

86 *Re Stephens* (1892) 8 TLR 792.

Armed Forces rendered the idea that rifle club members fulfilling the role of a semi-trained third line at times of war anachronistic.[87] The Commission decided that even if *Re Stephens*[88] was still good authority, it doubted that it extended beyond the individual circumstances surrounding the decision; namely the avoidance of another disaster along the lines of Majuba Hill. In any event, the Commission considered that there had been such a radical change in circumstances since that case that it was not bound to follow it.[89]

In reaching this decision, the Commission relied on the *dicta* of Lord Simonds in *National Anti-Vivisection Society* v *IRC*[90] and *Gilmour v Coats*,[91] discussed above. But these decisions are authority for the proposition that the Court can review its previous decisions in the light of changes in social habits and needs of a radical nature. They are not authorities which support the case for the loss of charitable status or removal in such circumstances. On the contrary, they are authorities which support the case for a *cy-près*[92] application of the property. The Commission was not saying that *Re Stephens*[93] was incorrectly decided; it was simply contending that, on the facts, it was no longer relevant. If this is correct, the proper course of action would be to make a *cy-près* scheme to modernise the objects[94] rather than initiating their removal.[95] However, the decision in respect of the gun clubs does illustrate the potential for the Commission to attempt to distinguish precedents on the facts in order to refuse to register charities or to remove charities affected by the passage of time. A similar approach in the case of CAM charities could be open to a challenge in the Charity Tribunal.

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87 Note that there was some evidence to the contrary: see Ch Comm Dec Vol 1 (1993) 7. For a criticism of the Commission's reasoning see Peter Clarke, 'The Charitable Status of Rifle Clubs: the Explosion Occurs' (1993/94) Vol 2 Issue 2 CL & PR 98.

88 *Re Stephens* (1892) 8 TLR 792.

89 See Robert Meakin, *The Law of Charitable Status Maintenance and Removal* (CUP 2008) 63-65 for a discussion on the Decision of the Charity Commissioners for England and Wales; made 2 April 2001 relating to the Application for Registration as a charity by the General Medical Council, a decision of the Commission in which it outlined the circumstances where it considers itself entitled to disregard decisions of the Court.

90 *National Anti-Vivisection Society v IRC* [1948] AC 31, 74.

91 *Gilmour v Coats* [1949] AC 426, 443.

92 Charities Act 2011, s 62(1)(e)(ii).

93 *Re Stephens* (1892) 8 TLR 792.

94 Charities Act 2011, s 62(1)(e)(ii).

95 Ibid, s 34.

More recently, when considering applications for registration by the Plymouth Brethren,[96] the Commission refused to consider itself bound by a decision of the Court[97] that neither the practices of the Exclusive Brethren nor its doctrines suggested that the religion was contrary to the public interest. However, the Commission considered that the decision *Holmes v AG*[98] was not binding, as the presumptions of public benefit had played a part in the decision and, following the Charities Act 2006, this presumption had been abolished.[99] On that basis, the Commission considered itself entitled to take a fresh look at whether the Brethren were charitable for the benefit of the public. The Commission concluded that certain practices of the Brethren – such as 'shutting up' (the ostracism of those members who leave) and limitations put on younger people's education and social contact – were not for the benefit of the public.

If the Commission took the same approach with CAM charities, then we are confident that even taking a fresh look at the legal authorities would lead the Commission to decide that those CAM charities providing tangible and intangible benefits would be regarded as charitable. Failing that, as explained above, property could be rescued by a *cy-près* scheme.[100]

The non-justiciability principle

The Charity Commission is sailing into dangerous waters with this consultation if it is to decide whether to register charities or remove charities from the register, or, if amending charitable purposes, whether to create a global *cy-près* scheme that would transfer property from one charity to another where the CAM forms part of a religious practice. If this is to be the case, the Commission will need to bear in mind the principle of non-justiciability.

Religions and beliefs are now arguably given equal treatment both under charity law and under Article 9(1) of the European Convention on Human Rights.[101] The

96 Charity Commission for England and Wales, Preston Down Trust Application for Registration of the Preston Down Trust, Decision of the Commission, 3rd January 2014. Note that the Plymouth Brethren Church used to be called the Exclusive Brethren. Neither are connected to the Open Brethren, who are the larger Brethren Church.

97 *Holmes v AG* The Times, 11 February 1981. Note that the Court had also assumed the Brethren were charitable in *Rule v Charity Commissioners* (High Ct, 10 December 1979) [1979] Ch Comm Ann Rep 12-16.

98 Ibid.

99 Charities Act 2006, s 3(2).

100 Charities Act 2011, s 62(1)(e)(ii).

101 For commentary see Meakin (n 89) 142-152.

principle of non-justiciability means that the Court will not become involved in the internal regulation and determination of beliefs within religious organisations.[102]

In the context of charity law, it was expressed by Lord Reid in *Gilmour v Coats* as: 'No temporal court of law can determine the truth of any religious belief: it is not competent to investigate any such matter and it ought not to attempt to do so'.[103]

The Court has confirmed this principle in respect of its *cy-près* jurisdiction.[104] CAM forming part of a religious practice of a religious charity refused registration or removed from the register of charities or faced with a *cy-près* scheme could argue that the Commission is breaching the principle of non-justiciability.

Challenge to cy-près

That leaves the sixty-four-million-dollar question: if a CAM charity was no longer charitable, what would be the *cy-près* application? Is homeopathy regarded as akin to herbalism and clinical nutrition akin to vegetarianism and so on and so forth? Or would the application be to its conventional medicine counterpart? These are emotive and highly controversial issues which would almost certainly lead to a proposed *cy-près* scheme being challenged. The Commission will be wary of being drawn into such debates, especially as the Charities Act 2011 forbids it to make a scheme (not referred to it by the Court) which is contentious, which raises a special question of law or fact, or which for other reasons the Commission may consider more fit to be adjudicated on by the Court.[105] It is noteworthy that the consultation sidestepped the questions of whether CAM therapies are effective or of what evidence may exist in support of or against the efficiency of any particular CAM therapy.

Conclusion

Our position therefore may be summarised as follows:

1. It is deeply problematic to discard CAM on the basis that it fails to meet the standards of evidenced based medicine as they are currently formulated, when those standards are themselves problematic.

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102 See generally Russell Sandberg, *Law and Religion* (CUP 2011) 74-76.

103 *Gilmour v Coats* [1949] AC 426, 455.

104 *Varsani v Jesani* [1998] Ch 219 (CA) 235 per Morritt LJ quoting *Gilmour v Coats* [1949] AC 426 per Lord Reid.

105 Charities Act 2011, s 70(8)(a)(b).

2. Empirical research is also socially constructed but rarely declared or recognised as such. Although the medical orthodoxy is often considered to be 'objective', standing apart from any subjective or relativist interpretation, its claims to truth can be and have been challenged.

3. All so-called 'objective' evidence is inevitably filtered through the 'subjective' lens of the clinician's judgement and experience; this is in fact recognised in the original definition of 'evidence based medicine'.

4. Empirically measurable outcomes are only one of a number of important considerations in health care: there is widespread support for subjectivity and the inclusion of variables in research.

5. There is a clear and present danger that empirical science is vulnerable to appropriation for ideological ends, to provide 'evidence' on behalf of political and economic interests, and this may result in the marginalisation, suppression and eventual loss of valuable alternative resources.

6. The Charity Commission's position is difficult in law because even if the objects of CAM charities are no longer accepted as charitable, the appropriate course of action is to make a *cy-près* scheme to apply the property for other charitable purposes.

7. Even if the Charity Commission took a fresh look at the legal authorities supporting CAM charities on the basis that there was no longer a presumption of public benefit, we are confident that the evidence would support their continued registration.

8. We argue that the common law tradition of non-justiciability coupled with Article 9 which protects religions and beliefs will make it difficult to remove charities carrying out CAM practices which form part of a religious practice and belief.

9. A *cy-près* application of CAM charities' properties would be controversial and open to challenge.

In light of this, we argue, objections to the inclusion of CAM therapies within the jurisdiction of charitable enterprise are specious, inimical to the greater good of society, and ultimately unsustainable.