National Institute of Medical Herbalists

Council members views

PSA Consultation Feb 2020

Accredited Register: Summary of questions

Question 1: Do you agree that a system of voluntary registration of health and social care practitioners can be effective in protecting the public?

The UK Government has told us that this is the case.

The National Institute of Medical Herbalists has historically supported the statutory regulation of herbal practitioners. The Walker report on the regulation of herbal medicines and practitioners (2015) found that the case for statutory regulation of herbal practitioners could not be made, and suggested that voluntary accreditation with the Professional Standards Authority would effectively address any concerns raised over protection of the public.

Whilst proper recognition of our members as safe and effective providers of healthcare services continues to be a prime objective of the Institute, the current absence of any clear route to our preferred option of statutory regulation – decided primarily on the recommendations of the Walker report – suggests that a government report commissioned to answer this very question also supports the view that voluntary registration is effective in protecting the public.

Successful adoption of voluntary assurance schemes for a wide variety of other occupations provide reassurance to potential customers and clients that appropriate standards are being observed and that there is provision for any complaints or other concerns to be addressed on their behalf by such schemes. This model is clearly shown to be effective for these associations and registers, who will undoubtedly share with us the safety and protection of the public as one of their core values.

The issue here seems to be related to the successful promotion and recognition of such registers which will drive membership and improvement of standards, and not inherently related to the voluntary nature of the registers themselves.

Question 2: How do you think the Authority should determine which occupations should be included within the scope of the programme? Is there anything further you would like us to consider in relation to assessing applications for new registers?

The Authority should determine this by carefully establishing and considering the entire breadth and depth of the work undertaken by those in occupations seeking to join the programme, and not by merely focussing on a proposed evidence base judged by criteria specified by those working outside of the occupation being considered.

The Institute feels that when determining those occupations related to health and care to be included in the programme, it is vitally important to consider all three tenets of the original definition of evidence based medicine in their widest sense:

"A systematic approach to clinical problem solving which allows the integration of the best available research evidence with clinical expertise and patient values."

Sackett DL, Strauss SE, Richardson WS, et al.(2000) *Evidence-based medicine: how to practice and teach EBM*. London, UK: Churchill-Livingstone.

We believe that the Authority should consult all stakeholders and consider their views when determining those occupations to be included in the scope of the programme. We feel that both practitioner values and patient choices should be properly identified, highlighted and acknowledged in this process.

In the case of our own organisation, members of the National Institute of Medical Herbalists are trained in many conventional clinical skills, and are educated to degree standard (level 6) in several disciplines which support and underpin conventional medical practice. This training takes place only in teaching programmes which are authorised by our own Accreditation Board according to the professional, educational, and ethical standards of the Institute. Qualification as an accredited herbal practitioner typically takes between 3 to 5 years to complete, and will involve at least 500 hours of supervised training in a clinical setting, as well as formal written and clinical assessments.

Our members offer a personalised, comprehensive, holistic and patient-centred approach to wellbeing that is both complementary and integrative to conventional healthcare strategies. We support both patients and mainstream healthcare providers in many ways that are known to improve patient outcomes.

These might include highlighting appropriate preventative medical strategies, the recognition and raising of awareness of previously unrecognised health concerns, potential medication related issues, or patient safeguarding matters – and perhaps most importantly – **empowerment of our patients through personalised and professionally supported self-management approaches to help them appropriately and independently achieve many of their own healthcare needs**.

We strongly believe that, provided patient safety is assured, patient choice should always be respected and encouraged. Our members work with their patients in many ways that are often not appreciated by those who are unfamiliar with the work of herbal practitioners. As well as undertaking a detailed medical, social and personal history before formulating a rational healthcare management plan, they are also trained and experienced in guiding their patients through discussions of health issues involving lifestyle choices, dietary advice, the proper use of dietary supplements, stress management concerns, and health benefits provided by wider engagement with the natural world. This might include spending healing time in nature, working with living plants, or simple self-help strategies using medicinal plants from nature as source materials.

This well-established approach extends way beyond simply issuing a prescription for a herbal product, and embodies many elements that are now gaining wider recognition through their promotion as effective mainstream healthcare options in terms of social prescribing and therapeutic strategies around reconnection with nature.

The National Institute of Medical Herbalists advocates both patient choice and patient centred care. Patient centred care has been defined as:

"Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."

Institute of Medicine (U.S.).(2001). *Crossing the quality chasm: a new health system for the 21st century.* Washington, D.C., USA: National Academy Press.

There are a variety of reasons why patients may choose to engage with herbal practitioners for their healthcare needs, and these patient values should also be carefully examined when considering those occupations to be included in the programme.

Member experience suggests that in the case of medical herbalists some examples of these reasons might include:

- A wish to explore additional treatment options alongside conventional management strategies to support, optimise or enhance the effectiveness of both approaches

- Unsatisfactory past experiences, lack of availability, or difficulties in engaging with conventional practitioners for help with a particular problem

- Perceived lack of acceptable or effective conventional management options for a given medical condition or concern with an aspect of wellbeing

- Help with unwanted symptoms associated with conventional treatments that are otherwise proving difficult to overcome

- Specific patient healthcare choices based on personal preference or a need to engage with healthcare systems that reflect and respect the identified cultural, spiritual or ethnic backgrounds and values of individual patients.

It should also be noted that members of the National Institute of Medical Herbalists are bound by a code of ethical practice which clearly states their responsibilities to recognise the limits of their professional competence, work in collaboration with conventional healthcare providers, and to advise patients to seek other forms of medical treatment where herbal medicine is not thought to offer the most appropriate means of treating their problems.

Question 3: Do you think that moving from an annual to a longer cycle of renewal of accreditation, proportionate to risk, will enable the Authority to take a targeted, proportionate and agile approach to assessment? Do you think our proposals for new registers in terms of minimum requirements are reasonable?

The National Institute of Medical Herbalists supports the move to a longer cycle of renewal of accreditation. We also support the idea of clearly defined minimum

requirements for accreditation, but would need further details of these requirements before responding fully.

We do not support the introduction of a pre-assessment fee or charges for additional audit activities as we feel that these would be significant disincentives for professions to join or remain in the programme. For some of the smaller subscription based registers this might create significant cash flow difficulties where such expenses had not been anticipated and could not be quantified in their annual budgets.

Question 4: Do you think accreditation has been interpreted as implying endorsement of the occupations it registers? Is this problematic? If so, how might this be mitigated for the future?

Endorsement of patient safety should be the prime concern of voluntary accreditation.

Any other interpretations of such endorsement made by individuals, organisations, or pressure groups with agendas hostile to complementary therapies should be effectively and robustly managed by the Authority without recourse to mitigating such accusations, or penalising individual registers by requesting access to bodies of evidence based on methodologies, criteria and models of healthcare other than those which are appropriate to the registers themselves.

Question 5: Do you think the Authority should take account of evidence of effectiveness of occupations in its accreditation decisions, and if so, what is the best way to achieve this?

No, we feel that this is counterproductive and discriminatory.

In the case of those professions offering complementary therapies we see this as an extremely complex and contentious question.

The National Institute of Medical Herbalists believes that it is counterproductive to the effective voluntary accreditation of complementary therapies to seek evidence of the effectiveness of their work based solely on research models and criteria emphasised and adopted by many mainstream medical bodies to the exclusion of other, equally valid sources of evidence.

Seeking criteria to endorse the efficacy of any particular complementary treatment modality should be relevant and appropriate to the work of the practitioners themselves. If examined by the Authority, registers should be allowed to fully embrace the cultures, traditions, shared wisdoms, values and professional experiences of their members, which should be based on their own practice of health care. These may be different from mainstream medical practice, but still valid, widely accepted, effective, supportive, integrative, complementary and entirely compatible with other practices, although not necessarily evidenced in exactly the same ways.

Providing evidence of effectiveness for a particular complementary medical modality raises the issue of how recognition of its efficacy can be established using the same benchmarks and criteria used elsewhere to provide the standards for conventional medical practice. Such standards are often constrained by particularly narrow interpretations of the concept of evidence based medicine. There may be an undue focus on laboratory trial data at the expense of considering the other equally valid components of clinical experience and patient values.

Much attention is paid to the so-called 'gold standard' of the double-blinded randomised placebo-controlled trial. Growing concerns within the research community itself over many aspects of such trials cannot be ignored. These concerns include inherent bias, lack of representational sample populations, doubtful relevance to real-life health situations – particularly in individualised medicine, and undue commercial pressures on research teams to achieve positive outcomes with potential withholding of economically undesirable data and results.

We would also point out that particularly when using this type of research methodology, the absence of proof cannot be interpreted as proof of absence.

These considerations become particularly concerning when it is considered that a significant proportion of such work is funded either directly or indirectly by the manufacturers and developers of the very products being evaluated. Few complementary therapies have access to the levels of funding provided by the pharmaceutical industry enabling such large and well-publicised studies to take place.

We would strongly advocate that any proposed attempts to establish an evidence base for complementary medical modalities should consider other equally valid sources of evidence to support their validity, such as practitioner experience, cultural values and precedents, and sources of traditional knowledge, rather than insisting on evidence from unachievable and narrowly focussed large scale research projects of questionable value, or dismissing out of hand the methodologies or results of smaller projects undertaken with professional integrity by less well funded groups of researchers working in real life situations with their patients.

Question 6: Do you think that changing the funding model to a 'per-registrant' fee is reasonable? Are there any other models you would like us to consider?

Yes, we would support this model of funding.

The National Institute of Medical Herbalists has historically derived the majority of its working income from member subscriptions and would therefore feel that a funding model based on a 'per-registrant' fee is reasonable.

Question 7: Do you think that our proposals for the future vision would achieve greater use and recognition of the programme by patients, the public, and employers? Are there any further changes you would like us to consider?

Not necessarily, we believe that there are other considerations here.

Your proposals make no mention of any initiatives on your part to raise public or professional awareness and highlight the value of voluntary accreditation, or to promote the work of the professions that you are accrediting. Supporting and assisting these professions to attract additional patients and develop further career opportunities, perhaps working alongside or on behalf of conventional practitioners, would seem to us to be an essential part of achieving greater use and recognition of the programme by patients, the public, and employers.

Question 8: Do you agree that to protect the public, the Accredited Registers should be allowed to access information about relevant spent convictions?

Protection of the public is important, and the National Institute of Medical Herbalists feels that there may on occasion be particular circumstances where access to relevant spent convictions would help Accredited Registers to achieve this. We feel that it is essential that such powers are used appropriately, and only where protection of the public might justify their use.

It is worth noting that members of National Institute of Medical Herbalists are unable to apply for, or renew their membership without disclosing and confirming with us the details of any spent convictions, and our insurers require the same disclosure from our members before approving their policy.

From the information provided in your discussion document it would appear that such access will not be possible unless the members of registers suitable to be considered within the scope of the programme are recognised as having the status of providing 'healthcare' by means of legislative changes.

We strongly feel that should legislative changes be enacted to recognise a particular complementary therapy as providing 'healthcare' services, this should not be conditional on achieving accreditation. Recognition of healthcare provider status is inherent in the scope and methodology of the work of the practitioner, and is therefore not determined or defined by accreditation status with the Authority.

Question 9: Are there any aspects of these proposals that you feel could result in differential treatment of, or impact on, groups or individuals with characteristics protected by the Equality Act 2010?

We do feel that there is a risk that these proposals could be discriminatory to certain groups or individuals.

"*All patients should be supported and enabled to have a say in their care, according to their capabilities and wishes, and regardless of our age, gender, ability, ethnic origin, religion or belief, socio-economic situation, sexual/gender orientation, identity, expression or characteristics*."

European Patients Forum (2020) *Charter on Patient Empowerment* [Online] Available at https://www.eu-patient.eu/policy/campaign/PatientsprescribE/charter-on-patient-empowerment/ [Accessed 8th February 2021].

The World Health Organisation supports and recommends the integration of traditional medicines into national health systems, and has been instrumental in founding the Forum for Harmonization of Herbal Medicines.

World Health Organisation (2021) *Integrating traditional medicine into national health systems* [Online] Available at https://www.who.int/westernpacific/activities/integrating-traditional-medicine-into-national-health-systems [Accessed 7th February 2021].

The National Institute of Medical Herbalists promotes equality, diversity and inclusion in the study and practice of herbal medicine by its members. We strongly advocate that patients who identify themselves with particular ethnicities, races, religions, belief systems, spiritual philosophies, traditions, and ethical or ideological standpoints should have access to healthcare options that align with these identities. We feel that any move to exclude health and care options solely on the grounds of not being defined within conventional medical terms would therefore be discriminatory under the terms of the Equality Act 2010.

Question 10. Your name and/or the name of your organisation.

Dr Philip Deakin, BSc Hons, BSc Hons, MB ChB, NMIMH, MCPP, MURHP.

President of the National Institute of Medical Herbalists

Question 11: How would you describe your organisation (or your own role if more relevant)?

My professional background includes an honours degree in physiology followed by medical and surgical degrees with subsequent vocational training for general practice. After spending 34 years working as a general practitioner for the NHS and providing unscheduled care services for Sheffield GP Out-of-Hours Collaborative, I retrained as a herbal practitioner and graduated with first class honours in Medical Herbalism. My wide medical experience and knowledge of herbal practice provide me with a well-developed understanding of issues within both the medical and herbal worlds around perspectives on integrated approaches to patient wellbeing.

As President of the Institute I am democratically elected by our members to represent their views and interests in upholding the Objects of the Institute:

"*To promote and encourage the study and practice, with a view to the relief of human suffering, of the art and science of* ***Medical Herbalism***"

The National Institute of Medical Herbalists (2021, adopted 2009, last amended 2018) *Memorandum and Articles of Association of the National Institute of Medical Herbalists* [Online] Available at https://nimh.org.uk/wp-content/uploads/2020/01/Mems-Arts-Bye-laws-Oct-18.pdf [Accessed 8th February 2021].

The National Institute of Medical Herbalists is the United Kingdom's leading professional body and voluntary regulator of herbal practitioners. It was first established as the National Association of Medical Herbalists in 1864 by a group of herbalists from the north of England. Today the Institute has members throughout the United Kingdom and internationally.

The Institute promotes the benefits, the efficacy and the safe use of herbal medicine. Our members treat thousands of patients every year. By choosing one of our members as their herbal medicine practitioner, patients can be confident of their high standards of training and professional conduct.

Our key activities:

- Maintaining a Register of individual members
- Setting the profession's educational standards
- Running an accreditation system for training establishments
- Maintaining mandatory programmes of professional development
- Providing codes of conduct, ethics and practice
- Operating complaints and disciplinary procedures
- Representing the profession, patients and the public through participation in external processes such as regulation of the profession and herbal medicine

- Ensuring that all Institute Members have professional indemnity, public liability and medical malpractice insurance

- Operating a comprehensive block insurance scheme

Performance Review: Summary of questions

As far as I can gather from the accompanying notes it appears that the questions on performance review are directed at those who wish to comment on performance review of professions that have **Statutory Regulation** of their activities.

We could choose to comment on these, but these questions are not central to our present application for voluntary accreditation

Question 1: Are there other concerns about the current performance review process that we have not identified here?

Question 2: Do you have any comments on our role or the broad approach that we take to performance review as we have set out here?

Question 3: Do you think we should continue to look at the regulators' performance against all of the Standards every year or could the scope of our reviews be more targeted?

Question 4: If we were to change our approach, are these the right factors for us to consider in determining the scope of reviews? Is there anything else we should be considering?

Question 5: If we implemented a system as described above, do you agree that there should be a presumption that the Authority should actively review all of the Standards at regular intervals? What do you think an appropriate timeframe would be?

Question 6: Do you agree that we should introduce monitoring processes as described above? Do you have any comments on these suggestions?

Question 7: Have we identified the right areas of our approach that we need to develop in this area? Is there anything else we should be considering?

Question 8: How could we best engage with stakeholders, to ensure that we are aware of key risks to public protection? Is there any other evidence that we should be seeking to inform our performance reviews?

Question 9: Should we retain the binary system or adopt a more nuanced approach?

Question 10: If we were to adopt a different approach, what alternative approach would you prefer and why?

Question 11: Would these changes support the regulators to learn from our work and that of other regulators, in order to better protect the public?

Question 12: Do you think thematic reviews would assist us in our scrutiny of the regulators and enhance our public protection role?

Question 13: Please set out any impacts that the proposals set out in this paper would be likely to have on your organisation or considerations that we should take into account when assessing the impact of the proposals.

Question 14: Are there any aspects of these proposals that you feel could result in differential treatment of, or impact on, groups or individuals based on the following characteristics as defined under the Equality Act 2010:

- **Age**
- **Disability**
- **Gender reassignment**
- **Marriage and civil partnership**

- **Pregnancy and maternity**
- **Race**
- **Religion or belief**
- **Sex**
- **Sexual orientation**
- **Other (please specify)**

If yes to any of the above, please explain why and what could be done to change this.