CAMbrella
Professor George Lewith
University of Southampton
CAMbrella

CAMbrella – A pan-European research network for Complementary and Alternative Medicine (CAM)

Start: 1 Jan 2010

Duration: 3 years

Consortium: 16 participants from 12 European countries

Coordinator: Klinikum rechts der Isar, Munich Centre for Complementary Medicine Research - WW (Wolfgang Wiedenhammer and Dieter Melchart)

Funding: max 1.5 Mio € EC contribution (No. 241951)
## CAMbrella - history

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Year</th>
<th>Event</th>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>Lobbying to bring CAM into FP7</td>
<td>2007</td>
<td>First ad-hoc meetings Nov06/Jan07</td>
<td>2010</td>
<td>From Kick-off to final conference</td>
</tr>
<tr>
<td>2005</td>
<td>Paving the way</td>
<td>2008</td>
<td>Deadline proposal Dec08</td>
<td>2011</td>
<td></td>
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<tr>
<td>2006</td>
<td></td>
<td>2009</td>
<td>Result of review process Apr09</td>
<td>2012</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Grant Agreement Oct09</td>
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</tbody>
</table>
CAMbrella

Objectives

To develop a proposal for consensus on a series of definitions for the terminology for CAM.

To understand and evaluate the patient demands for CAM and its use in Europe and in relation to the rest of the world.

To review current legal status of CAM in Europe.

To explore the needs and attitudes of the EU citizens with respect to CAM.

To develop a roadmap and strategy for research and CAM delivery in the EU.
CAMbrella –
The consortium
WP1: CAM terminology and definitions

WP2: Legal status and regulations

WP3: Needs and attitudes of citizens

WP4: CAM use – patients’ perspective

WP5: CAM use – providers’ perspective

WP6: CAM research – the global perspective

WP7: Review of CAM research methodology + Roadmap for European CAM research

WP8: Dissemination and communication
WP1 Objectives – Bernard Uehleke, Zurich

Identifying and analyzing the existing terms and definitions of CAM.

Providing a core set of CAM disciplines and methods being used in Europe and an additional list of country specific CAM disciplines for individual EU member states.

Preparing a preliminary pan-European definition of CAM.
• A polyglot, pluralistic and transcultural Europe.

• Single therapies or whole systems?

• Approaches that are ‘imported’ into the EU as well as being indigenous and traditional.

• Medical procedures some of which are now integrated within our healthcare systems such as acupuncture and osteopathy.
Our working definition

- CAM utilised by European citizens represents a variety of different medical systems and therapies based on the knowledge, skills and practices derived from theories, beliefs and experiences used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illnesses. CAM therapies have been mainly used outside conventional health care, but in many countries some therapies are being adopted, taught or adapted by conventional health care.”
WP2 Objectives – Vinjar Fonnebo, Tromso

To review and describe in all 27 EU member and 10 associated states:

The legal and regulatory status of CAM.

The governmental supervision of CAM practices.

The reimbursement status of CAM practices and medicinal products.

The regulation of CAM medicinal products.

To review at EU level:

The status and obstacles relating to EU-wide regulation of CAM practices and medicinal products.
Regulation of health care in Europe

The EU has repeatedly confirmed that it is up to each member state to organize and regulate their health care system.
CAMbrella WP2 Methodology

Data were collected from 39 countries by:

1. Communicating with the Ministries of Health, Law or Education, governmental representatives, and members of national CAM associations.
2. Searches in the national web sites/databases as well as EUROPA and EUR-lex to identify official legal documents.
3. Direct dialogue with European CAM associations/coalitions, CAMbrella members and stakeholders.
4. Face-to-face meetings with the Ministries of Health and CAM practitioners representing organizations.
European CAM legislation

General CAM legislation

- **11** CAM law
- **6** General CAM legislation in health laws
- **22** No general CAM legislation
  (Note: CAM treatments may be regulated.)
The only common factor we have found across all 39 nations is the amazing ability they have demonstrated of structuring legislation and regulation differently in every single country, no matter how small the size of the population.
Consequences for European patients

1. A wide diversity of available treatments and providers
2. For similarly labeled treatments; an unpredictable level of professional competence.
3. Different systems of authority regulation of quality of services provided.
4. Unpredictable system of reimbursement for services provided.
5. Limited and complex opportunities for complaints.
Consequences for European patients

Every aspect of the current situation can be a threat to patient safety
Consequences for European CAM practitioners

1. Serious concerns with regard to the predictability, quality and safety of health care delivery to European citizens.
2. The establishment of collegial common ground is very challenging.
Consequences for European CAM practitioners

The current situation can be a threat to patient safety
Consequences for European CAM researchers

1. Practices and practitioners are not comparable across national boundaries
2. Any observational or experimental study will therefore be generalizable only within a narrow national or cultural context.

This can be a threat to patient safety
Physiotherapy

- Regulated profession and EU registered: 29
- Regulated profession - not EU registered: 9
- Regulated treatment - not regulated profession: 0
- No therapy-specific regulation: 1
“When patients cross European borders in search of CAM treatment, they may encounter substantial differences in the professional background of apparently identical CAM providers. They may also face a completely different reimbursement system, and if the treatment they undergo results in unwanted adverse or side effects they will be differently safeguarded depending on which state they are in. Every aspect of the current situation can thus be a threat to patient safety. In post-modern Europe where patient choice in health care is seen as a core value, this confusing European market makes any informed treatment-seeking very challenging”.
Patient safety

Patient information
Attitudes and needs regarding CAM among EU citizens. WP3 Johanessen USD

Aims

• To identify stakeholders and indicators for needs for CAM
• To establish an overview of needs and attitudes towards CAM in Europe

Methods

• Stakeholder workshop (Croatian Federation of Natural Medicine, Danish Consumer Council, Denmark, Riga Stradins University, Tuscan General Directorate of Health, )
• Literature review
A workshop with stakeholders

Decision on prioritized areas of enquiry

- Independent and easily accessible **information** about CAM, based on available evidence to support informed decision making
- **Quality of care**, comprising services, practitioners and products
- Equal **access** to services, including considerations of distance to services, waiting times and costs/reimbursements

After the workshop: Collection of names and contact points for additional stakeholders
A systematic review of research based literature

Transforming the prioritized areas into a systematic literature search strategy

- **Search terms** - Synonyms for *citizen, need, and attitude* + CAM + Europe
  Additional keywords identified during the search

- **Major databases** - Pubmed, Web of Science, CINHAL, AMED, PsycINFO

- **189 papers** were included
  150 reporting on quantitative studies
  36 reporting on qualitative studies
  2 systematic reviews
Information about CAM: Needs and attitudes

Citizens’ main sources of information

• Social networks, often based on personal experience
• Biomedical professionals
• Print and broadcast media

Spectrum of disclosure of CAM use to biomedical professionals

• A spectrum of disclosure from very low to high
• Depending on the MDs practice of and attitude to CAM
Access to CAM: Needs and attitudes

Citizens express a need for

• Increased CAM provision
• Provision of CAM in public health services
• Diversity of CAM provision and providers
• More research into CAM

Citizens experience barriers of

• Financial costs
• Biomedical professionals’ attitudes to CAM
• Limited CAM provision, and provision of particular CAMs only in public health service
Quality of Care: Needs and attitudes

Citizens value certain aspects of the practice of CAM

- The CAM provider-patient relationship
- The approach underpinning CAM practice, such as person-centred care, personal involvement in care
- CAM is perceived to be safer than biomedicine

Citizens ensure quality and safety of CAM provision and products through

- Use of diverse strategies: such as experiences from social network, professional registration and CAM qualification
- Reliance on regulatory systems and biomedical endorsement
Conclusions from the literature review

Citizens’ core attitudes and needs regarding CAM

- CAM is seen to consider ‘the whole person’ and to be safer than biomedicine
- Availability of impartial, reliable and trustworthy information about CAM
- Wider access to and choice of CAM provision and providers within public health care
- Clear regulatory and educational frameworks of CAM
WP4 Objectives – George Lewith, Southampton

Address the prevalence of CAM use in Europe.

Identify the major conditions treated with CAM.

Explore the reasons why patients choose CAM.

Identify a standardised questionnaire for CAM use in at least 3 European languages; the I-CAM-Q.
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Methods

• Using NCCAM CAM definition.


• All general population peer reviewed cross-sectional and population-based cohort studies in all ages in all languages.

• Dual review.
Quality assessment

• STROBE criteria.
Figure 1
Flow of information through the different phases of the systematic review.

5451 studies identified through database searching

4308 studies after duplicates removed

187 full papers retrieved, assessed for eligibility via inclusion/exclusion flow chart

148 additional studies identified by colleagues

Excluded 2246 not at all relevant to CAM and
1875 CAM but not at all related to CAM prevalence

29 non-English papers excluded—not available.
72 excluded—did not meet flow chart inclusion criteria

5 extra studies from citation tracking included studies

91 studies initially included

4 papers excluded at analysis by statistician as data not available

87 studies included in final analysis
CAMbrella

Outcomes

• 87 studies included
• Methodology and reporting poor, e.g. no definition of CAM
• CAM prevalence varied widely (0.3 – 86%)
• CAM users mainly women
• Dissatisfaction with conventional care
• Musculoskeletal problems
• The OTC versus consultation issue
Figure 2
Prevalence of any CAM use at any time.
## CAMbrella

<table>
<thead>
<tr>
<th>Therapy</th>
<th>No of Studies</th>
<th>EU Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herbal medicine</td>
<td>31</td>
<td>5.9 – 48.3%</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>25</td>
<td>2 – 27%</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>17</td>
<td>0.4 -20.8%</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>14</td>
<td>0.44 – 23%</td>
</tr>
<tr>
<td>Reflexology</td>
<td>11</td>
<td>0.4 – 21%</td>
</tr>
<tr>
<td>Nutritional Supplements</td>
<td>28</td>
<td>Unclear</td>
</tr>
</tbody>
</table>
Conclusions

• Poor data quality
• Data available from less than ½ EU States
• Comprehensive data from 5 or 6 States
• What is CAM?
• Some therapies widely used
• Need for coherent, comprehensive and rigorous prospective data collection
WP5 Objectives – Klaus Von Ammon, Bern

Review literature addressing the provider’s perspective of CAM use in Europe.

Identify the health problems for which CAM is utilised.

Explore how CAM research and the relevant evidence base are integrated into CAM practice.

Describe the impact of research results on health care practice.
Doctors and CAM practitioners in the EU

EU citizens 493,100,000

Total number of registered conventional doctors 1,498,750
95 Doctors per 100,000 inhabitants

178,000 non medical and 150,000 medical practitioners provide CAM
65 CAM providers per 100,000
### CAM Practitioners per Discipline - Table 1.1

<table>
<thead>
<tr>
<th>CAM discipline</th>
<th>non-medical practitioners</th>
<th>physicians (MD)</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>acupuncture</td>
<td>16,380</td>
<td>80,000</td>
<td>96,000</td>
</tr>
<tr>
<td>homeopathy</td>
<td>5,800</td>
<td>45,000</td>
<td>50,800</td>
</tr>
<tr>
<td>herbal medicine/phytotherapy</td>
<td>29,000</td>
<td>??</td>
<td>&gt;29,000</td>
</tr>
<tr>
<td>reflexology</td>
<td>24,600</td>
<td>?</td>
<td>&gt;24,600</td>
</tr>
<tr>
<td>naturopathy (GER: NHV)</td>
<td>7,300</td>
<td>15,000</td>
<td>22,300</td>
</tr>
<tr>
<td>antihomotoxicology</td>
<td>20,000</td>
<td>??</td>
<td>&gt;20,000</td>
</tr>
<tr>
<td>humoral / drain-off therapy</td>
<td>17,000</td>
<td>?</td>
<td>&gt;17,000</td>
</tr>
<tr>
<td>kinesiology</td>
<td>7,600</td>
<td>??</td>
<td>&gt;7,600</td>
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<tr>
<td>shiatsu</td>
<td>7,400</td>
<td>?</td>
<td>&gt;7,400</td>
</tr>
<tr>
<td>orthomolecular therapy *</td>
<td>7,000</td>
<td>??</td>
<td>&gt;7,000</td>
</tr>
<tr>
<td>* vitamins</td>
<td>Subtotal</td>
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<td>282,600</td>
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## CAM Practitioners per Discipline - Table 1.2

<table>
<thead>
<tr>
<th>CAM discipline</th>
<th>non-medical practitioners</th>
<th>physicians (MD)</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>subtotal (CAM 1-10)</td>
<td></td>
<td></td>
<td>282 '600</td>
</tr>
<tr>
<td>manual therapies</td>
<td>4'900</td>
<td>??</td>
<td>&gt; 5'000</td>
</tr>
<tr>
<td>(chiropractic, osteopathy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>anthroposophical medicine</td>
<td>--- (D: 20)</td>
<td>4 '500</td>
<td>4 '500</td>
</tr>
<tr>
<td>oxygen / ozone therapy</td>
<td>3 '000</td>
<td>??</td>
<td>&gt; 3 '000</td>
</tr>
<tr>
<td>Kneipp therapy (GER)</td>
<td>2 '500</td>
<td>?</td>
<td>&gt; 2 '500</td>
</tr>
<tr>
<td>neural therapy (Huneke)</td>
<td>---</td>
<td>1 '500</td>
<td>1 '500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>178 '000</strong></td>
<td><strong>150 '000</strong></td>
<td><strong>295 '100</strong></td>
</tr>
<tr>
<td><strong>Total per 100 '000 (population)</strong></td>
<td><strong>33</strong></td>
<td><strong>30</strong></td>
<td><strong>63</strong></td>
</tr>
</tbody>
</table>

General Practitioners (GP)
Total per 100 '000 (population)
Maps – Most Provided Disciplines

Acupuncture (all countries)

Homeopathy Provision by MD and Non-Medical Practitioners per 100'000 Inhabitants (EU 27+12)

Herbal Medicine Provision by MD and Non-Medical Practitioners per 100'000 Inhabitants (EU 27+12)

Reflexology Provision by MD and Non-Medical Practitioners per Inhabitants (EU 27+12)

Naturopathy Provision by MD and Non-Medical Practitioners per 100'000 Inhabitants (EU 27+12)
WP5 – CAM Provision: Conclusion

CAM provision in Europe requires

- transparent harmonisation of CAM training, continuous medical education and certification,

- publicly accessible standards of regulation and registration for both, therapists and products

- prospective and controlled comparative state-run studies of public demand, outcome and cost-effectiveness at a nation-wide or EU level
WP6 Objectives – Torkel Falkenberg, Karolinska Institutet

Map the international position and status of CAM within health care policy.

Incorporate experiences from countries in which CAM R&D is integrated and publicly supported (US/Canada), while exploring its use as Traditional Medicine (TM) in developing countries (China/India).

Understand of the pros and cons of CAM R&D internationally.

Risks of over-harvesting medicinal plants, and protection of traditional inherited knowledge of traditional medicine used within CAM.

How might the EU might relate to international developments.
Aim

The aim of this study was to analyse global research and development (R&D) strategies for traditional medicine (TM) and complementary and alternative medicine (CAM) across the world to learn from previous and on-going activities.
Material and Methods

- Fifty-two representatives within CAMbrella nominated 43 key international stakeholders (individuals and organisations)
- 15 of these were prioritised
- Information from policy documents including mission statements, R&D strategies and R&D activities were collected in combination with personal interviews
Data was analysed using the principles of content analysis
Results

• The analysis showed that stakeholders vary greatly in terms of capacity, mission, and funding source (private/public)

• Stakeholders’ engagement ranged from comprehensive R&D investments and public communication agendas to membership-financed networks
## Results

<table>
<thead>
<tr>
<th>Name of stakeholder</th>
<th>Type of organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>China academy of Traditional Chinese Medicine, China</td>
<td>State funded department/institute</td>
</tr>
<tr>
<td>Federal Ministry of Health/Complementary and Alternative Medicine, Brazil</td>
<td>State funded department/institute</td>
</tr>
<tr>
<td>Natural Health Product Directorate, Health Canada, Canada</td>
<td>State funded department/ institute</td>
</tr>
<tr>
<td>Department of Ayurveda, Yoga &amp; Naturopathy, Unani, Siddha and Homoeopathy (AYUSH), India</td>
<td>State funded department/ institute</td>
</tr>
<tr>
<td>Central Council for Research in Ayurveda &amp; Siddha (CCRAS), AYUSH, India</td>
<td>State funded department/ institute</td>
</tr>
<tr>
<td>Korean Institute of Oriental Medicine, Korea</td>
<td>State funded department/ institute</td>
</tr>
<tr>
<td>National Center for Complementary and Alternative Medicine, National Institutes of Health, USA</td>
<td>State funded department/ institute</td>
</tr>
<tr>
<td>National Institute of Complementary Medicine (NCIM), Australia</td>
<td>State funded department/ institute</td>
</tr>
<tr>
<td>Japan Society of Oriental Medicine, Japan</td>
<td>Research organisation</td>
</tr>
<tr>
<td>Osher Program for integrative medicine, located centers in USA &amp; Sweden</td>
<td>Research organisation</td>
</tr>
<tr>
<td>Samueli Institute, USA</td>
<td>Research organisation</td>
</tr>
<tr>
<td>The Consortium of Academic Health Centers for Integrative Medicine (here referred to as IM consortium) (CAHCIM), North America</td>
<td>Research association</td>
</tr>
<tr>
<td>International Society for Complementary Medicine Research (ISCMR), International</td>
<td>Research association</td>
</tr>
<tr>
<td>Research Council for Complementary Medicine, international, UK based</td>
<td>Research association</td>
</tr>
<tr>
<td>World Health Organization, Traditional Medicine, international</td>
<td>Global health organisation</td>
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</table>
## Results: Top Funding Stakeholders

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Estab</th>
<th>Budget estimates</th>
<th>Finances external research</th>
<th>Own research</th>
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<tr>
<td>USA National Center for Complementary and Alternative Medicine (NCCAM), National Institutes of Health (NIH)</td>
<td>1998-</td>
<td>€101,260,265 (2011 Planned); €98,795,573 (2010); €93,352,232 (2009)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>INDIA The Department of Ayurveda, Yoga &amp; Naturopathy, Unani, Siddha and Homoeopathy (AYUSH)</td>
<td>1995-</td>
<td>€142,645,082 (2010-11) €127,699,902 (2009-10);</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>INDIA CCRAS (AYUSH)</td>
<td>1978-</td>
<td>€19,574,744 (2010-11) €20,342,381 (2009-10)</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Japan Society of Oriental Medicine (JSOM)</td>
<td>1950-</td>
<td>Official budget figures not found</td>
<td>Not found</td>
<td>Yes</td>
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<tr>
<td>CHINA China Academy of Traditional Chinese Medicine (CATCM)</td>
<td>1955-</td>
<td>Official budget figures not found</td>
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<td>AUSTRALIA National Institute of Complementary Medicine (NICM)</td>
<td>2007-09</td>
<td>€6,044,748 (2009)</td>
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<td>Yes</td>
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</table>
Results

Component efficacy

Biological mechanisms
Results

**Supported Research Areas**

- **Context, paradigms, philosophy and utilization**
- **Safety status**
- **Comparative effectiveness**
- **Component efficacy**
- **Biological mechanisms**

**Supported Research Areas**

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**S O C I E T Y**

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**L A B O R A T O R Y**
Results

• Among the larger investments, a common shift in R&D strategy was noted where a decade ago, research focused mainly on exploring **efficacy and mechanisms** while the majority of stakeholders today, emphasise the importance of a **broad spectrum of research including methodologies exploring context, safety and comparative effectiveness**
Research prioritisation

- Investments on research of popular, highly utilized CAM methods and areas, e.g. herbal products, traditional systems

- Investments on areas of heavy public health burden, e.g. long-term chronic conditions, pain, mental health problems
Conclusion

✧ The scarce European public investment in the field stands in stark contrast to the large investments found in Australia, Asia and North America

✧ An emerging shift to support a broader research repertoire, including qualitative and comparative effectiveness research

✧ The EU should consider these trends given the experiences and the substantial research funding committed by the included stakeholders
WP7 Recommendations – Benno Brinkhaus, Charite Institute Berlin

Identify consensus-based research strategies to investigate CAM prevalence and to develop a general research map for future clinical and epidemiological research.

Developing research methods and strategies for CAM that take into account the needs and attitudes of EU citizens and providers (funders and clinicians).

Developing research strategies and a road map to enable future CAM research regarding effectiveness, efficacy, cost effectiveness and safety.
• CAM Research Roadmap – background, aim and methods

• **Background**: CAM is highly prevalent within Europe; but: significant evidence gaps for CAM regarding prevalence, effectiveness, efficacy, safety and costs

• **Aim**: To provide a research roadmap for clinical and epidemiological research for CAM (*not* for basic science!)

• **Methods**: literature review WP 7, results of WP 1-6, expert workshop on CAM methods 2011, Consensus meeting 2012
CAM Research Roadmap – Our Vision for 2020

To establish an evidence base that enables European citizens and medical and non-medical healthcare providers to make informed decisions about CAM utilisation

This roadmap proposes a methodological and strategic research agenda for the field of CAM to address future European health care challenges
• CAM Research Roadmap – Main Topics

Citizens *
Prevalence *
Safety *
Effectiveness *
Context Factors *
CAM integration *
Research Funding
Research Infrastructure

Mixed Methods Approach
Key Area 1: CAM prevalence in the EU

- **Aim**: to develop a valid overview of CAM use in EU
- **Recommendation**: EU-wide approach to assess the prevalence of CAM using standard definitions
- **Methods**: observational and cross-sectional studies
  - develop a standardised methodology for surveys
  - avoid various forms of bias (e.g. recall bias)
Key Area 2: Needs and attitudes of citizens and providers

• **Aim**: to improve our knowledge about the availability of trustworthy information about CAM

• **Recommendation**: pan-European research program

• **Methods**: surveys, qualitative interview studies, mixed-methods approach
  - citizens’ and CAM providers perspectives on education, training and practices
  - inclusion of health economic aspects of CAM
  - respect local traditions, ethnic minority groups
• **Key Area 3: CAM safety**

  • **Aim**: gathering valid information about safety and the risk-benefit ratio of CAM

  • **Recommendation**: establish an European-wide monitoring and registration system

  • **Methods**: clinical trials, observational and CER studies, single case studies

    • clarification of the terminology
    • investigate CAM as a complex treatment
    • taking drug interactions into consideration
Key Issue 4: Comparative Effectiveness Research and Health Economic Evaluation

Aim: to support clinical and healthcare policy decision-making with data suitable research data

Recommendation: future research should investigate CAM in real world setting

Methods: Comparative Effectiveness Research (CER) / pragmatic clinical trials

- randomisation wherever possible
- health economic evaluations
- following guidelines of CER
Key Issue 5: Meaning / Context Factors in CAM

Aim: to understand to what extent the clinical effects of CAM treatments and conventional medicine (!) are due to meaning and context effects

Recommendation: clinical trials should try to differentiate specific effects from meaning and context effects

Methods: mixed methods approach including
  - qualitative studies
  - experimental studies to investigate the underlying mechanisms of CAM
WP8 Objectives – Bettina Reiter, Vienna

To foster communication within CAMbrella and between the consortium and CAM stakeholders including patient and public health care organizations

To establish, host and maintain a website as the common platform for CAMbrella

To identify CAM stakeholders and appropriate target audiences in Europe through which to disseminate information generated by the project.

To plan and organize the final CAMbrella conference. The proceedings of the conference will be published in an open access journal and on the website.
Contact details and further information

www.cambrella.eu

www.cam-research-group.co.uk
Acknowledgments

Consortium

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Dr Koldo Santos-Rey

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Jesper Madsen

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Prof Dr Gabriella Hegyi
Acknowledgments

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Prof Dr Gerard Delahaye

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Prof Dr Sorin Ursoniu
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Dr Johanna Hök (first author)

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Prof Dr Benno Brinkhaus (WP leader)
Dr Felix Fischer (first author)
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