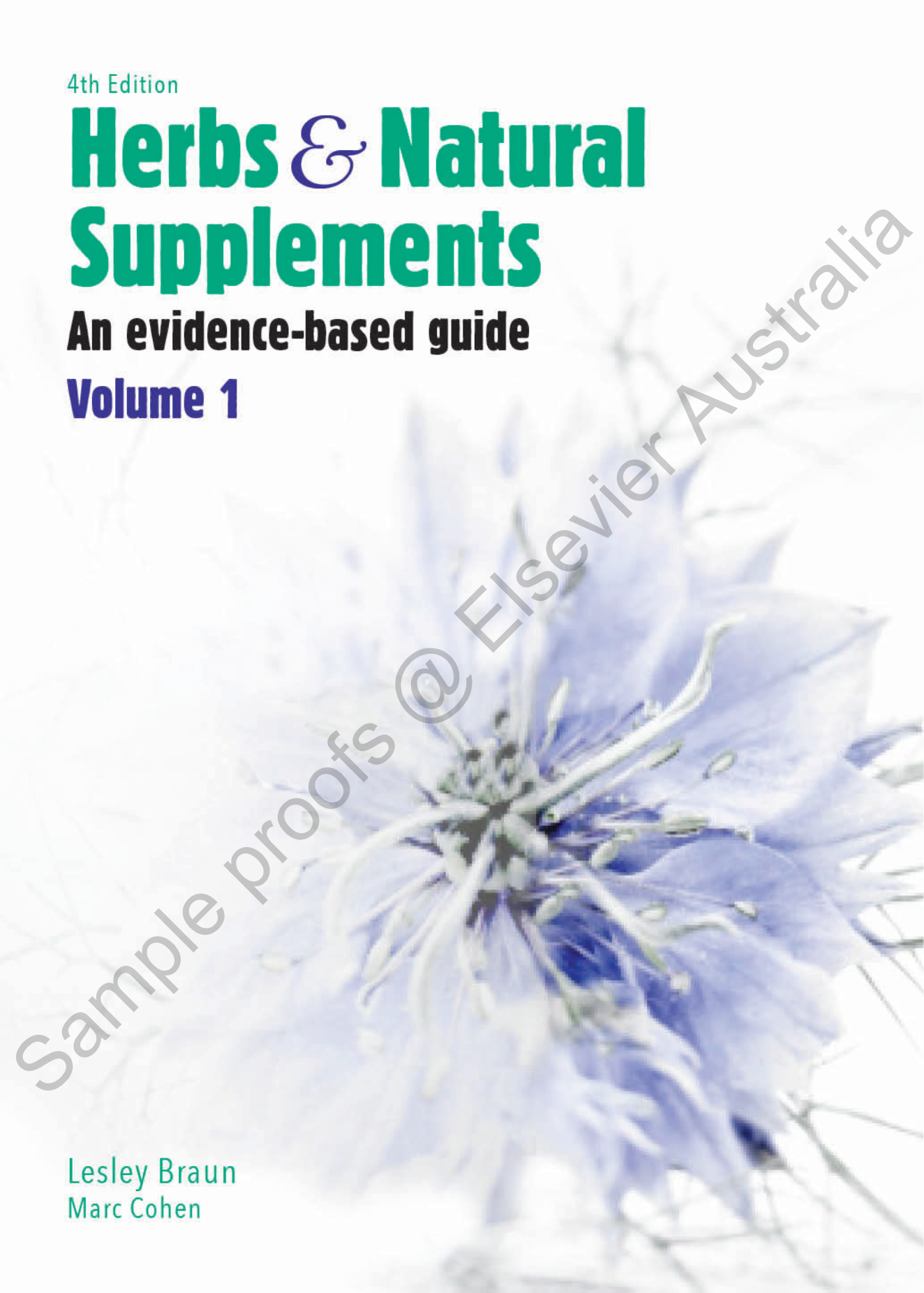
4th Edition

Herbs & Natural Supplements

An evidence-based guide

Volume 1



Lesley Braun
Marc Cohen

CHAPTER 6

INTRODUCTION TO THE PRACTICE OF INTEGRATIVE MEDICINE

Throughout history, every civilisation and culture has developed its own form of medicine. The rise of modern technology and scientific enquiry have added new therapeutic techniques, products and services to the range of traditional therapies. Thus, within today's pluralistic, multicultural and increasingly globalised societies, the wisdom and therapeutic interventions of many different traditions are becoming available. While it is impossible for any practitioner to have access to, or even know something about, the many hundreds of therapeutic interventions available, it is possible to incorporate some of the key principles into today's conventional healthcare practice. This leads to the practice of integrative medicine (IM), which attempts to define and embrace these principles.

The practice of IM is more than simply an expansion of conventional medical practice to include 'complementary therapies', such as mind–body techniques, acupuncture, herbs, nutrients and body work (for example, massage and manipulation). It involves:

- a focus on the whole person: the interplay between the physical, emotional, spiritual and psychological states
- individualised treatment plans tailored to meet the needs of the person
- the development of a therapeutic partnership between the patient and practitioner as a fundamental part of the healing process
- a primary focus on prevention, health enhancement and addressing predisposing, exacerbating and sustaining causes of disease
- integration of the best available, evidence-based, safe and ethical therapies from different traditions.

As such, IM forms the basis for clinical decision making and improving patient outcomes, by providing each patient with effective and compassionate care and healing on many levels. IM is increasingly being acknowledged as 'best practice'; however, it requires some fundamental shifts in the way healthcare is delivered, and has not yet become widely implemented (Cohen 2005a). For example, the use of complementary medicines is an integral part of IM practice, yet this use raises many issues for medical practitioners, particularly those who have not received training in how to use them. Some of the questions are:

- What can reasonably be expected by providing integrative care?
- What are the safety issues?
- Which therapies are cost-effective?
- What advice should be given to patients in the absence of definitive evidence?
- Which therapies or products are useful for which conditions and which patients?

- Where can high-quality complementary and alternative medicine (CAM) products be obtained?
- Which practitioners or modalities should patients be referred to use, and when, how and for what reasons should referrals be made?
- Where can reliable information about CAM be found, and what pathways are there for further study?

These are core issues in any healthcare practice and are not specific to the use of complementary medicines or even to the practice of IM. The practice of IM, however, poses additional challenges to medical practitioners, both professionally and personally. It requires being prepared to learn about new and different treatment systems, traditions and ways of thinking, and recognising the advantages and limitations of both complementary and conventional medicine and the potential benefits of combining them. It also requires adopting a collaborative approach with patients and a variety of different healthcare professionals, while allowing old beliefs to be challenged and re-evaluated. Furthermore, the practice of IM challenges medical practitioners to develop their intuition, empathy and compassion, address their own health and personal growth, and become role models for their patients and the wider community.

From a practical perspective, IM takes extra time. Time is needed to keep up to date with the changing evidence base, as well as to establish a rapport with and holistic understanding of patients and then apply the principles of IM to address their needs.

HOLISM AND THE INDIVIDUAL

In their professional training, medical practitioners study the biological, psychological and social aspects of health, as well as the signs, symptoms and pathophysiology of specific illnesses, to achieve an understanding of health and disease in a clinical context. This knowledge base must be updated and modified with new knowledge provided by new scientific evidence and cumulative clinical experience. Although consideration of the best available evidence is an important dimension of clinical practice, scientific data are often based on a group of observations that give statistical information about research populations, but which may not provide definitive information about what will happen to any individual patient in certain circumstances.

Each human being is unique and presents in a specific clinical context in which the outcome will be determined by personal attributes, such as attitudes, education and understanding, as well as by genetics, physiology, past experiences, socioeconomic and cultural circumstances, available resources and lifestyle. Accounting for individual differences is an essential aspect of the art of medicine and a cornerstone of many ancient systems of medicine.

Chinese medicine, Ayurvedic medicine and Western herbal medicine all have sophisticated systems of categorising people according to their different physiological and psychological characteristics in order to guide treatment selection. In comparison, modern Western medicine has been slow to accept and use this individualistic approach, preferring to standardise treatment approaches through clinical guidelines and protocols. The fields of pharmacogenomics and nutrigenomics, which have emerged out of the Human Genome Project, are beginning to provide a scientific rationale for individualising treatments. These new fields emphasise two factors: individualised response to medicines and nutrients, and the roles of dietary and genetic interactions in patient health.

The practice of IM combines both ancient and modern knowledge, and takes a holistic perspective that recognises health involves physical, psychological, social, spiritual and environmental dimensions. This is in line with increasing patient expectations to have the accompanying social and psychological aspects of their illness addressed, not just their presenting symptoms (Jonas 2001). Thus the practice of IM requires careful history-taking and physical examination, which may include obtaining information from different philosophical perspectives, together with astute and appropriate investigations, and obtaining other information from relatives or carers.

Accounting for individual factors takes considerable time, yet this time is well spent because there is mounting evidence to suggest a direct relationship between consultation

length and the quality of care. Longer consultations are likely to result in better health outcomes and better handling of psychosocial problems, fewer prescriptions, more lifestyle advice and lower costs, less litigation and more patient and doctor satisfaction (Cohen et al 2002).

THERAPEUTIC RELATIONSHIPS

Although amassing personal information about a patient is a time-consuming process, it is an extremely valuable one, not only for the information gleaned but also because it facilitates the development of rapport, respect and trust, thus laying the foundation for the therapeutic relationship. The development of close and meaningful relationships with people in a clinical context is one of the great challenges of holistic or integrative practice. It is also one of the most powerful therapeutic tools clinicians have and may be more important than any specific treatment modality.

The therapeutic relationship is a profound and sacred one, acknowledged since ancient times and codified in the Hippocratic oath, which has specific phrases that dictate the principle of doctor–patient confidentiality, as well as the responsibility of clinicians to exercise a duty of care.

A therapeutic relationship is established with the specific intention of healing, and the act of establishing such a relationship, in which intuition and empathy are valued alongside information and evidence, may be therapeutic in itself. Simply articulating one's personal story and expressing traumatic experiences to a sympathetic listener can help people make connections and better understand the causes and implications of their disease, as well as providing much needed psychosocial support.

Healthcare professionals commonly see people at their worst: when they are in pain and/or feeling sick, scared, sleep deprived and fearful of the possible implications of an illness. The constant stream of 'sick people' can make it easy to start differentiating patients by their illnesses; however, thinking of people in terms of their highest level of functioning may be more productive. To this end, some of the most important questions a practitioner can ask are: 'What makes you happy?' or 'What makes you feel alive?' The answers to these questions can provide valuable insight into an individual and form the basis for a more meaningful relationship than the answer to the question: 'What is the problem?'

Developing rapport, trust and a holistic understanding of patients' lives is one of the most important elements in IM, because it places practitioners in a better position to allay their patients' fears, adequately address the issues of most concern, and help to reduce the burden of stress that accompanies virtually all illness. A holistic understanding of a person also enables clinicians to recommend treatments that are more likely to be successfully integrated into a patient's social and cultural environment, thus improving efficacy and compliance. Furthermore, a sound therapeutic relationship provides the camaraderie and sense of therapeutic adventure necessary to underpin a partnership model of health and provides a solid foundation for clinical decision making.

PRACTITIONER WELLBEING

Healthcare professionals experience significant mental, physical and spiritual demands during the course of everyday practice. In addition, personal stress can influence the ability to deliver effective care, establish therapeutic relationships and maintain good health. Over time, exposure to multiple stressors can lead to physical and emotional exhaustion, or burnout, with its accompanying physical and psychological burden (Dunning 2005).

For some practitioners, there is a perceived pressure to symbolise perfect health and be invulnerable to disease. As a result, there is the temptation to avoid indications of ill health in themselves and their colleagues and a failure to see the need for self-care. The practice of IM compels clinicians to address their own health and lifestyle, explore their emotional life and develop self-care routines to maintain wellbeing and prevent disease. In addition, the therapeutic relationship developed with patients can be nurturing for the practitioner, with rewards that flow in both directions (Cohen 2005b).

In advocating a holistic view of health, the practice of IM can also motivate practitioners to become more involved in broader community, public health and global issues, such as social justice, fair trade, environmental

preservation, regeneration and sustainability, as well as spiritual, ethical and philosophical debates and pursuits.

INTUITION, BEDSIDE MANNER AND PLACEBO

Medicine is an art informed by science, yet with so much recent attention being given to scientific evidence, it is easy to forget the importance of intuition and clinical experience. A holistic understanding of a patient, together with empathy and compassion for a patient's circumstances, adds important information to any clinical encounter. It is likely that the best and most inspired practice occurs when the practitioner's academic knowledge, clinical experience and intuitive understanding of the individual merge to provide a picture of the clinical situation as a coherent whole, known as the 'Gestalt' approach.

Developing an intimate therapeutic relationship and integrating rational and intuitive knowledge enlists the full capacity of the practitioner. It may also be the best way to tap into patients' unconscious healing processes and elicit the 'placebo response'. The placebo effect is often considered a source of bias and a scientific distraction that research methodology must minimise; however, the placebo response is ubiquitous and cannot be avoided in the clinical setting.

All interventions have a non-specific therapeutic action, in addition to their purported activity, and the best clinicians will always use their 'bedside manner' to harness the 'placebo response' and enhance the therapeutic benefits of any specific intervention. Herbert Benson suggested that the placebo response is based on a good therapeutic relationship, as well as positive beliefs and expectations on the part of the patient and practitioner, and, furthermore, can yield beneficial clinical results and be a powerful adjunct to therapy. Benson, who coined the term 'the relaxation response' in reference to meditation, further suggested that the placebo response should be renamed 'remembered wellness', and that it may be one of medicine's most potent assets because it is safe, inexpensive and accessible to many people (Benson & Friedman 1996).

In addition to the use of rapport, empathy, compassion, trust, confidence and intimacy, an integral part of a good bedside manner is the appropriate and thoughtful use of touch. Touch pulls together psychological and bodily experiences and is important in relationships between people in general, and the therapeutic relationship in particular. It is a basic human need that enhances communication and builds trust. A simple handshake to acknowledge each other's presence or hand-holding when bad news is delivered can provide important and reassuring support that goes beyond words. The therapeutic power of touch has been recognised and practised throughout history: for example, through the art of massage, which, when provided by trained a practitioner, can produce substantial therapeutic effects, enhance a person's sense of wellbeing and promote a sense of calm and peace.

BIAS IN MEDICAL DECISION MAKING

How do people make decisions and how do they choose between different treatment options? Decisions are made using 'heuristics', or general rules of thumb, which reduce the time and effort required. Normally this method yields fairly good results; however, there are times when they lead to systematic biases (Plous 1993). In these situations, assumptions are made and information is neglected, downplayed or overplayed, or based on what is easily recalled. In healthcare, unrecognised bias of this nature can have dire repercussions, affecting a clinician's ability to diagnose and treat effectively and a patient's ability to make good choices.

It is both normal and human to have a range of biases that influence the types of treatments that are considered appropriate, based on the individual's personal, ideological, religious, ethical, cultural, educational and philosophical ideals and experiences. Good clinicians are aware of their personal biases and will openly disclose those that may influence a patient's care. In some cases, this is easier said than done. Stating known or potential bias can be particularly sensitive when the practitioner has strongly held religious beliefs that may limit their practice or determine their attitudes to different therapies, as well as when it comes to declaring commercial interests.

Healing is a human vocation that arises from the desire to do the best for humanity. The

patient–practitioner relationship, however, is not only a therapeutic one, it is commonly a commercial one. Healing is a business that sustains the personal lives of individual practitioners and drives the healthcare and pharmaceutical and industries, which are among the biggest industries in the world. In 2002 the combined profits for the top 10 drug companies in the Fortune 500 list were greater than those of all the other 490 companies combined (Angell 2004).

One important source of bias that is becoming increasingly recognised concerns the millions of dollars spent by the pharmaceutical industry in a bid to influence doctors' decision making. The seemingly unlimited marketing budgets and provision of gifts, luxuries and educational events has forced the medical profession to attempt to limit these sorts of inducements (Studdert et al 2004). The extent of the industry's influence is vast and has not always been obvious. In her book on the pharmaceutical industry, Marcia Angell, a former editor-in-chief of the *New England Journal of Medicine*, states:

> *Over the past two decades the pharmaceutical industry has moved very far from its original high purpose of discovering and producing useful new drugs. Now primarily a marketing machine to sell drugs of dubious benefit, this industry uses its wealth and power to co-opt every institution that might stand in its way, including the US Congress, the FDA, academic medical centers, and the medical profession itself.*
>
> **Angell 2004**

Not only are doctors subject to the influence of the pharmaceutical industry, they may also have other pecuniary interests that could bias their clinical decision making, such as commercial interests in pathology companies and their own clinical dispensaries.

COMPLEMENTARY MEDICINE PRODUCTS

Several thousand complementary medicine products are now available on the market, the vast majority of which are available without prescription. Choosing the best product, correct dose and time-frame for use, and having realistic expectations of the treatment, are just some of the factors that healthcare practitioners must consider before recommending a specific product (Table 6.1). These factors, which are addressed in further detail in the monographs and chapters of this book, must be considered in the light of each individual patient's circumstances, including their condition and comorbidities, renal and hepatic function, personal preferences, financial resources and their ability to self-monitor their condition.

Complementary medicines in Australia are regulated in the same way as pharmaceutical medicines, and are evaluated for quality and safety; however, seemingly similar products will vary with respect to their efficacy and supporting scientific evidence. Most complementary medicines are available over the counter (OTC) through pharmacies, health food stores and supermarkets; however, there are also certain complementary medicines that are available as practitioner-only products. These are prescribed and dispensed only by a CAM practitioner; they can have different potencies and formulations from those available OTC and include extemporaneously compounded herbs that require time, specific knowledge and expertise to dispense. Clearly, making product choices can be confusing, and clinicians should be encouraged to become familiar with the products available and eventually identify a group of favoured products they feel confident in prescribing.

There are many good reasons for including complementary medicines into routine practice (Table 6.2). Medicines that are supported by good evidence of efficacy and safety, or which offer advantages over conventional medicines in terms of cost-effectiveness, should be considered an essential part of routine clinical practice. Indeed, there could be seen to be an ethical imperative for considering the use of such complementary medicines, as not to do so would deprive patients of potentially safe and effective treatments (see Table 6.3 and specific monographs for further details).

COST EFFECTIVENESS OF CAM

In October 2005 a report titled *The role of CAM in the NHS* examined whether treatment approaches not normally funded by the National Health Service (UK) could provide

TABLE 6.1 FACTORS TO CONSIDER WHEN RECOMMENDING A COMPLEMENTARY MEDICINE

PRODUCT FACTORS	COMMENTS
Mechanism/s of action	How well established are these? Do they seem plausible?
Evidence and expectations	Is it likely to achieve treatment goals? In what time-frame? Do not rely on label claims alone. Consider the type of evidence available for this particular indication. For herbs also consider: extract and plant part/s tested. For nutrients: consider chemical form and bioavailability.
Dose and administration route	Ensure these are correct for the specific indication.
Frequency, timing and ease of use	Reduced frequency improves compliance. Consider timing, such as before, during or after meals.
Quality control standards	Not all countries impose high quality control standards on the manufacture of complementary medicines; e.g. the USA. In Australia, only use products with AUST L or AUST R numbers on the label.
Combination products or single entities	For combination products, consider dosage and potential synergy of individual ingredients.
Potential to induce adverse reactions	Consider potential likelihood of adverse reaction and consequence (see Chapter 7 for more information).
Potential to induce interactions	Are harmful, beneficial or neutral interactions possible? Should the product be avoided, used only under professional supervision, or actively prescribed? (Use METOPIA algorithm in Chapter 8.)
Contraindications	Take special care with high risk groups (see Chapters 7 and 10 for more information).
Storage	Consider sensitivity to light and heat, need for refrigeration, and shelf-life.
Cost	Compare cost with that of other treatments — medicinal and non-medicinal.
Availability	Is it available OTC or only from a practitioner?

TABLE 6.2 REASONS FOR USING COMPLEMENTARY MEDICINES

Efficacy — will alleviate symptoms of disease, reduce exacerbation or present a cure.
Safety — present a safer treatment option than other therapies.
Cost — when they provide lower cost treatment options.
Adjunct — if the efficacy and/or safety of other interventions can be improved with adjunctive use.
Prevention — when they provide safe prevention strategies in at-risk populations.
Enhance health — increase sense of wellbeing and quality of life.
Enlists patients' involvement in their own healthcare.

some financial relief, while retaining good quality patient care (Smallwood 2005). The report, commissioned by HRH Prince Charles, involved an assessment of the scientific evidence, interviews with experts, such as researchers, policymakers and healthcare professionals, and case studies to draw together published and experiential information, financial data and economic forecasting.

The report suggested that acupuncture may provide costs benefits in general practice when used for musculoskeletal conditions or as an adjunct to conventional treatment for lower back pain, migraine and stroke rehabilitation. With regard to herbal medicine, the enquiry identified several OTC herbal medicines such as St John's wort, phytodolor, Echinacea, *Ginkgo biloba*, devil's claw, hawthorn, horse chestnut and saw palmetto that provide potential cost savings to the government, while offering similar or greater benefits than pharmaceutical treatments. More recently, a report on the cost effectiveness of complementary medicines produced by the National Institute of Integrative Medicine (NICM) in Australia suggested that 'millions in healthcare costs could be saved without compromising patient outcomes if complementary medicines were

TABLE 6.3 EXAMPLES OF HERBS AND NATURAL SUPPLEMENTS WITH PROVEN EFFICACY

HERB/NATURAL SUPPLEMENT	PROVEN EFFICACY
Chaste tree	Premenstrual syndrome
Cranberry	Urinary tract infection prophylaxis
Fish oils	Cardiovascular disease prevention; lipid-lowering
St John's wort	Depression
Ginkgo biloba	Dementia
Glucosamine sulphate	Osteoarthritis: symptoms and disease progression
Hawthorn	Chronic heart failure (New York Heart Association classes I–II)
Honey	Infection control/wound healing
Horse chestnut	Chronic venous insufficiency
Kava kava	Anxiety
Peppermint	Irritable bowel syndrome
Probiotics	Preventing antibiotic-induced diarrhoea
Pygeum	Benign prostatic hypertrophy (BPH)
Saw palmetto	BPH
Tea tree oil	Topical infections

more widely used' (Access Economics 2010). This report, which examined the direct costs associated with the use of selected therapies supports the conclusions of the UK study by suggesting that acupuncture, St John's wort, fish oils and phytodolor all offer potential cost savings when used for selected conditions.

DISPENSING PRODUCTS

The choice whether or not to stock and dispense products is a complex one, with ethical, commercial and practical issues to be considered. Many medical practitioners may feel it is unethical to profit from the sale of products they prescribe (Cohen et al 2005), but the direct dispensing and selling of complementary medicines by doctors is in line with the sale of products by other registered healthcare professionals such as veterinary surgeons, pharmacists, podiatrists, physiotherapists and optometrists. These healthcare professionals dispense advice and sell products in the same consultation, as do CAM practitioners, such as naturopaths, herbalists and traditional Chinese medicine (TCM) practitioners.

The direct dispensing of products provides practitioners with some assurance of patient compliance and promotes the use of correct dosage, administration forms and extracts. This may be particularly important for herbal products. Direct dispensing is also convenient for patients and gives them the confidence that a practitioner who is aware of their history and current needs has directed them to the best treatment. If a decision to dispense products is made, this should obviously be done in an ethical manner, and treatment plans must always be dictated by the best interests of the patient.

ETHICAL CONDUCT

The issues of ethical practitioner conduct have their basis in the Hippocratic oath, which acknowledges the inherent inequality of the practitioner–patient relationship and the responsibility of the doctor to use this to improve the health of their patients, who may be vulnerable and who entrust themselves to medical care.

The ethical conduct of doctors has since been explored by various professional associations and colleges such as the Australian Medical Association and Royal Australian College of General Practitioners. The standards of ethical conduct (AMA 2004) include:

- always acting in the best interests of patients
- not exploiting patients for any reason
- respecting the patient's right to make their own decisions and to accept or reject advice about treatment or procedures
- ensuring patients are aware of fees, and that healthcare costs are openly discussed and direct financial interests disclosed.

These standards also apply to IM, and the sale of complementary medicines must conform with these principles, insofar as the interests of the patient are the foremost consideration and patients are fully informed about the nature, benefits, risks and costs of any proposed treatment, as well as any financial interests of the practitioner. Patients also need to be aware that they have the right to accept or reject any advice (AMA 2004).

INFORMED CONSENT

The ethical precepts of informed consent and the respect for patient autonomy compel healthcare practitioners to inform their patients about the range of appropriate treatments available, their associated costs and risks, and to respect the right of patients to make their own decisions. In practice, this can be problematic, as it remains unclear how much information practitioners are expected to know themselves and how much patients require.

This issue is addressed by by the joint position statement on complementary medicine made by the Royal Australian College of General Practitioners (RACGP) and the Australasian Integrative Medicine Association (AIMA):

> *General practitioners require a basic understanding of natural and complementary medicine and should receive sufficient training in their undergraduate, vocational and further education to enable them to include natural/complementary medicines with proven safety and efficacy in their practice, and to discuss issues with their patients on an informed basis.*
>
> *The key principle of evidence based medicine should be the basis of evaluating natural and complementary medicines and their use by the medical profession. It should also be the basis of any collaborative relationships between general practitioners and complementary therapists.*
>
> **RACGP/AIMA 2004**

Based on this statement it would seem reasonable that all general practitioners need to know enough about widely available complementary therapies to use safe and effective, evidence-based therapies where appropriate, and to avoid predictable adverse events and interactions induced by commonly used complementary therapies. It has further been argued that doctors have an ethical and even a legal obligation to become familiar with this area and open a dialogue with their patients about complementary treatments to provide quality care and address safety concerns (Brophy 2003).

Unfortunately this is a difficult task, as most medical schools give little or no time to teaching about evidence-based complementary therapies, and the opportunities for vocational and postgraduate medical education about CAM remain limited. As a result, having ready access to quality, evidence-based, independent information sources is essential to guide clinicians when making healthcare decisions or faced with patient enquiries about CAM.

EVIDENCE-BASED MEDICINE

The idea that practitioners need to refer to evidence is the basis of evidence-based medicine (EBM), which has been described by Sackett et al (1996) as: 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients'. These authors go on to state:

> *The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care.*

This statement acknowledges that, in practice, for most treatment decisions the conclusive evidence simply does not yet exist, and the best available evidence may simply be clinical experience or anecdotal reports. It is also clear that each practitioner and patient must seek out the necessary information they require, and interpret this evidence in the light of each individual situation.

EVIDENCE IN PRACTICE

EBM adds another dimension to the art of medicine and requires clinicians to review the evidence of safety and efficacy for the therapy under consideration, as well as to understand the inherent limitations of the available evidence and its relevance to a specific situation. It also involves weighing up the evidence for a number of different therapies, which includes

an assessment of their costs and risks versus their potential benefits (see PEACE mnemonic in Chapter 1).

In the specific case of CAM, a growing number of treatments have been subject to scientific investigation, with over 6000 RCTs identified and made available through the central Cochrane Library. Although this is encouraging, many therapies do not yet have established evidence and some remain difficult to assess under controlled conditions (e.g. massage). In practice, this should not preclude them from being viable treatment options, but it can place some limitations on use. Ultimately, clinical decision making should be guided by the evidence available (Fig. 6.1).

- When there is evidence of efficacy and safety for CAM, it should be recommended to patients where appropriate and included as part of standard care.
- When the efficacy of a treatment is unknown, due to insufficient investigation or inconclusive results, and there are no apparent safety concerns, patients deciding to use these therapies should be supported and supervised. It is prudent to set specific therapeutic objectives and time-frames, and to monitor for potential adverse outcomes.
- When there is evidence for a lack of effect, use should be discouraged, especially if there is the potential to induce adverse effects.

This approach is summarised by the four Ps: **P**rotect, **P**ermit, **P**romote and **P**artner (Jonas et al 1999). Thus, practitioners need to protect their patients by ensuring the safety and cost effectiveness of treatments, permit therapies that are safe and inexpensive, even if their efficacy has not been conclusively proven, promote proven practices and partner with patients and other complementary therapists (Jonas 2001) (Table 6.4).

Complementary therapies with rigorous evidence for efficacy and safety that do not require specialised skills or expertise to implement should be considered part of mainstream practice and used by all healthcare practitioners, whereas other therapies/medicines with less rigorous evidence or requiring specific expertise may be more appropriately used by those with a special interest and/or appropriate training. Therapies that have evidence for a lack of efficacy and safety should be abandoned along with the long list of useless and harmful therapies that have been discontinued throughout medical history.

FIGURE 6.1 Paradigm of clinical decision making (Based on Renella & Fanconi 2006, adapted from Cohen & Eisenberg 2002)

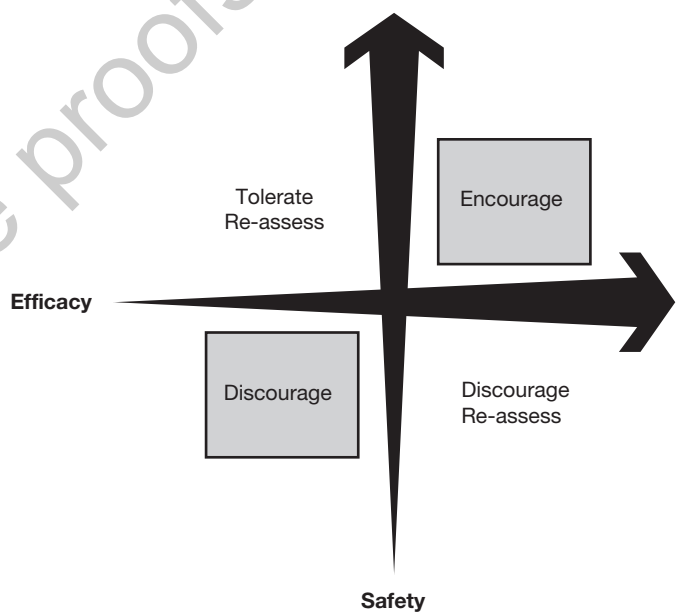


TABLE 6.4 PRINCIPLES FOR ADVISING THE USE OF COMPLEMENTARY THERAPIES

STATUS OF EVIDENCE	SPECIAL SKILL/TRAINING REQUIRED	SPECIAL SKILL/TRAINING NOT REQUIRED
Strong evidence for quality, safety and cost-effectiveness	*Promote and partner with therapist* Encourage/recommend/implement therapy. *OR* Refer to appropriate practitioner and/or consider obtaining required skills (e.g. acupuncture).	*Promote and partner with patient* Encourage/recommend/implement therapy. Consider as part of standard practice (e.g. dietary modification).
Insufficient or inconclusive evidence for quality, safety and cost-effectiveness	*Permit and partner with therapist* Continue therapy with caution and monitor patient in collaboration with other practitioner if necessary. *OR* Consider more appropriate therapies.	*Permit and partner with patient* Continue therapy with caution and monitor patient. *OR* Consider more appropriate therapies.
Strong evidence against quality, safety and cost-effectiveness	*Protect and partner with patient* Discourage use. Discuss reasons and desired outcomes and consider more appropriate therapies.	

A MULTIDISCIPLINARY, COLLABORATIVE APPROACH

It remains unclear which therapies should be considered within the domain of every doctor and which should be considered areas of special interest or the exclusive domain of CAM practitioners. It is clear however, that the practice of IM requires a multidisciplinary approach with collaboration and communication between the different practitioners who are aware of their own limitations and who have declared interests and expertise. It is also clear that whether or not doctors are prepared to personally use CAM, all doctors need to be prepared to discuss their use and inform patients of viable evidence-based options, as well as assess the likelihood of safety issues or interactions.

OPEN COMMUNICATION

Effective communication and teamwork is essential for the delivery of high-quality, safe patient care: communication failure is an extremely common cause of inadvertent patient harm.

Numerous surveys have shown that patients commonly combine CAM with conventional medical treatments, outside the knowledge of their various healthcare providers. This may be particularly true in hospitals, where it has been found that while almost 50% of surgical patients take complementary medicines in the perioperative period, 80% are not asked about this use (Braun et al 2006). It is also estimated that more than 50% of users of CAM do not disclose this use to either their hospital doctors (Braun et al 2006) or their GPs (MacLennan et al 2002). In addition, many treatments are patient-initiated without professional advice.

According to a review of 12 studies, patients do not disclose use of CAM to their medical practitioner for reasons that can be grouped into three main themes (Robinson & McGrail 2004).

1. Concerns about eliciting a negative response, disapproval and rejection. Patients fear they will be persuaded to cease use and the practitioner will not continue to provide patient care.
2. Patients believe that the practitioner does not need to know about CAM use because it is irrelevant to the biomedical model of treatment; their practitioner is ignorant about CAM and would not be able to understand why it is being used or be able to contribute useful information about it.
3. Not being asked about CAM use or perceiving practitioner disinterest in the topic. (This has proved to be more significant in preventing discussion than previously thought [Braun et al 2006].)

It is therefore not unusual for there to be little coordination between patient-initiated and clinician-initiated treatments, which can result in suboptimal 'integrative care' and potentially unsafe outcomes.

As the popularity of CAM continues to grow, medical practitioners in the community and hospital settings will keep coming into contact with patients who are using, or considering using, these treatments, making the issue of communication and competence in dealing with CAM-related issues more urgent. Asking patients about possible use of complementary medicines may seem daunting; however, it is a necessary measure to promote patient safety. It also provides an opportunity to gain insight into a patient's beliefs and attitudes, as well as their willingness to be involved in their own healthcare.

Although discussions about complementary therapies may enhance the therapeutic relationship, non-disclosure can indicate a serious deficiency in this relationship, for if patients are unwilling to discuss their use, it is also possible that they will not discuss other personal information that may have an impact on their health and medical treatment. Non-disclosure also refers to a lack of interdisciplinary communication. Although many patients would like to benefit from treatment and advice from both doctors and natural therapists, effective collaboration between these groups appears to be limited and it has been estimated that of the 44% of Australians who visit natural therapists, only 13% do so on the advice of their doctors.

INTERDISCIPLINARY COLLABORATION

True collaboration can only occur in an environment of shared respect and trust, and knowledge of what can be offered. In reality, both medical and CAM practitioners have several concerns about each other's practice, which must be addressed in order to achieve a good working partnership.

For medical doctors, there are concerns that CAM practitioners may put patients at risk of delayed or missed diagnosis and/or delay the use of more effective therapies (Cohen et al 2005). There is also concern that CAM practitioners might encourage patients to refuse use of 'proven' treatments in preference for 'unproven' ones, particularly in serious diseases such as cancer or HIV-AIDS. The promotion of implausible or untrue claims or unsafe complementary therapies that waste patients' time and money, or induce adverse events, is another source of apprehension.

Complementary therapists, on the other hand, may be concerned that medical doctors too readily prescribe symptom-suppressing drugs, yet do little to address underlying causes and support natural homeostasis through diet, lifestyle and preventive approaches. There is concern that patients may waste their time and money on treatments that exert significant side effects while providing limited benefits, and that medical practitioners may advise against the use of natural therapies because of fear, ignorance or arrogance. Furthermore, natural therapists may be concerned that their positions are being usurped by doctors who take on the use of natural and complementary therapies with little specific training and little consideration for their underlying philosophies and holistic considerations (Cohen 2001).

Many of these concerns are based on ignorance and misunderstanding between the practitioner groups and can be addressed through open and honest communication and formalised communication strategies, one of the most important of which is through the provision of formal correspondence in referral letters.

REFERRAL LETTERS

Referral letters are a standardised method of professional communication between practitioners. They involve both outgoing and incoming correspondence that sets out what has been done to date and any specific requests. Referral letters may request a second opinion, ask for help in patient management through a collaborative approach or transfer patient care (Table 6.5). Upon receiving a referral letter, professional courtesy and good patient care dictates that a practitioner sends a return correspondence, thanking the referring practitioner for the referral and stating the details of any procedures undertaken, new findings, clinical impressions or recommendations, as well as their rationale, and arrangements for follow-up. Such correspondence forms an essential part of professional collaboration and may also have legal status as part of the medical record and/or eligibility for funding or patient reimbursement. It also ensures that practitioners understand each other's expectations and goes far towards fostering goodwill and mutual respect.

TABLE 6.5 ELEMENTS OF A REFERRAL LETTER

ELEMENT	DETAILS
Professional letterhead	Referring practitioner's name Qualifications Practice address Phone number/fax/email Provider number if appropriate Date of referral
Practitioner and patient identification	Details of practitioner to whom referral is being made Patient identifying details: full name, date of birth, address, hospital UR (patient) number etc
Patient's history	Brief patient history including background, any special considerations, past history and present complaints Investigations, treatment to date, including current and/or proposed treatments pharmaceutical or complementary, rationale and expected outcomes including involvement of other practitioners Any psychosocial concerns
Reasons for referral	Detailed reasons for referral, including expected actions of other practitioner (e.g. second opinion, further investigation, specific intervention, help in case management, transfer of care etc)
Conclusion	Arrangements for follow up Referring practitioner's signature

Although effective communication is vital, there are still many issues that need to be resolved before interdisciplinary collaboration between complementary and conventional practitioners becomes the norm. These include the credentialling and regulation of CAM practitioners, differences in nomenclature between disciplines, equity of access in different healthcare settings, the requirements for evidence-based practice, appropriate funding models and medico-legal issues, including referrals and vicarious liability (Cohen 2004). Despite these obstacles the fruits of interdisciplinary collaboration are becoming evident, with the emergence of clinics in which doctors and natural therapists share premises and work together for the benefit of their patients. Currently this collaboration and drive towards IM seems to be in response to patient demand rather than driven by professional associations, government policy or the accumulation of supportive scientific evidence.

PATIENTS' RESPONSIBILITY

Patients now have unprecedented access to healthcare information, as well as unprecedented power to choose the type of services they receive. This power is further supported by the ethical principle of informed consent and respect for patient autonomy. With power, however, comes responsibility. Patients must therefore begin to accept the responsibility to become more informed and to be active participants in the decision-making process and the implementation of their healthcare. This responsibility also extends to implementing lifestyle interventions, as summarised by the SENSE approach (see Chapter 1). Thus in every encounter, whether patients are currently well, at risk of disease or have an established disease, practitioners should take the opportunity to enlist the patient's cooperation in implementing their own healthcare and discussing interventions that can be used to enhance health, prevent disease and complement the use of any disease-specific interventions.

PERSONAL AND PROFESSIONAL SATISFACTION

The role of the IM practitioner is particularly challenging and rewarding. It compels practitioners to develop multiple skills, be informed about many therapies, navigate between different information sources and practitioners, and keep an open mind. It also broadens the

capacity of practitioners to deal with a great variety of patient issues from a number of perspectives, thus providing continuous intellectual stimulation and both professional and personal satisfaction. To have people's confidence as a practitioner and to participate in their most emotionally charged moments, which may include both the beginning and the end of their life, is a great privilege, and sharing the triumphs and tragedies of individuals from different walks of life provides rewards that enrich both the professional and personal lives of practitioners.

Our knowledge of health and disease is far from complete, and healthcare practitioners regularly deal with uncertainty. The implementation of IM, however, recognises that compassion is always helpful and healing is always possible, even when curing is not (Rakel & Weil 2003). It also recognises that practitioners must endeavour always to do their best with what they have at any point in time and to be comfortable in the knowledge that their best will continually get better.

By fostering interaction, cross-disciplinary research, and collaborative care, redefined standards of care will emerge that are scientifically based and interdisciplinary in nature. The outgrowth of such a paradigm shift will change the legal and practice environment from one of fear to freedom.

Engler et al 2009

SUMMARY POINTS

- Taking time to develop a good therapeutic relationship may be therapeutic in itself and provides the best foundation for any other therapy.
- The integrative approach compels practitioners to develop an intimate understanding of their patients' lives, and to provide social support, understanding and compassion.
- The widespread use of complementary therapies compels doctors to discuss their use with patients and to do so on an informed basis and in a non-judgmental manner.
- All healthcare practitioners should have access to appropriate and independent information, so that they can provide sound advice and detect predictable interactions and safety issues.
- Healthcare practitioners need to be aware of their particular biases, limitations and financial interests, and to clearly state these to patients when patient care may be affected.
- Healthcare practitioners should attempt to make patients active participants in the decision-making process and the implementation of their own healthcare.
- Healthcare practitioners need to liaise with different practitioners in order to advise on and implement the most appropriate interventions.
- Complementary therapies/medicines with rigorous evidence for efficacy and safety that do not require specialised skill or expertise to implement should be considered as part of mainstream practice.
- When efficacy of treatment is unknown and there are no apparent safety concerns, patients deciding to use these therapies should be supported and supervised.
- Therapies/medicines with less rigorous evidence or requiring specific expertise may be more appropriately used by healthcare practitioners with a special interest and/or appropriate training.
- When there are differences in the supporting evidence and quality of different herbal extracts and other CAM, the recommendation of specific brands of CAM products may be appropriate.
- Compassion is always helpful and healing is always possible, even when curing is not.

REFERENCES

Access Economics. Cost effectiveness of complementary medicines, National Institute of Integrative Medicine (NICM), 2010. Available at: http://www.nicm.edu.au/research/health-economics/cost-effectiveness-of-cm-report/cost-effective-applications-of-cam.

AMA (Australian Medical Association). AMA Code of Ethics, 2004. Available at: www.ama.com.au/web.nsf/tag/amacodeofethics 21/7/14.

Angell M. The truth about drug companies. New York: Random House, 2004.

Benson H, Friedman R. Harnessing the power of the placebo effect and renaming it 'Remembered wellness'. Annu Rev Med 47 (1996): 193–199.

Braun L et al. Use of complementary medicines by surgical patients: undetected and unsupervised. In: Proceedings of the 4th Australasian Conference on Safety and Quality in Health Care, Melbourne. Canberra: National Medicines Symposium, National Prescribing Service, 2006.

Brophy E. Does a doctor have a duty to provide information and advice about complementary and alternative medicine? J Law Med 10.3 (2003): 271–284.

Cohen M. Interdisciplinary collaboration: obstacles and opportunities. J Aust Integr Med Assoc 17 (2001): 24–25.

Cohen M. CAM practitioners and regular doctors: is integration possible? Med J Aust 180.12 (2004): 645–646.

Cohen M. The challenges and future direction for integrative medicine in clinical practice. Evidence Based Integr Med 2.3 (2005a): 117–122.
Cohen M. Exploring emotions. In: Spa Asia [conference handbook], March/April 2005. 2005b: 100–101.
Cohen MH, Eisenberg DM. Potential physician malpractice liability associated with complementary and integrative medical therapies. Ann Int Med 136.8 (2002): 596–603.
Cohen M et al. Long consultations and quality of care. J Aust Integr Med Assoc 19 (2002): 19–22.
Cohen M et al. The integration of complementary therapies in Australian general practice: results of a national survey. J Altern Complement Med 11.6 (2005): 995–1004.
Dunning T. Caring for the wounded healer: nurturing the self. J Bodywork Movement Ther 10.4 (2005): 251–260.
Engler RJM et al. Complementary and alternative medicine for the allergist-immunologist: Where do I start? J Allergy Clin Immunol 123.2 (2009): 309–316.
Jonas WB. Advising patients on the use of complementary and alternative medicine. Appl Psychophysiol Biofeedback 26.3 (2001): 205–214.
Jonas WB et al. How to practice evidence-based complementary and alternative medicine: essentials of complementary and alternative medicine. Philadelphia: Lippincott, Williams & Wilkins, 1999: pp 72–87.
MacLennan •• et al. The escalating cost and prevalence of alternative medicine. Prev Med 35.2 (2002): 166–173.
Plous S. The psychology of judgement and decision making. Sydney: McGraw-Hill, 1993.
RACGP/AIMA. Joint Position Statement of the RACGP and AIMA. Complementary Medicine (2004).
Rakel D, Weil A. Philosophy of integrative medicine. In: Integrative medicine. Philadelphia: Saunders, 2003.
Renella R, Fanconi S. Decision-making in pediatrics: a practical algorithm to evaluate complementary and alternative medicine for children. European Journal of Pediatrics 165.7 (2006): 437–441.
Robinson A, McGrail MR. Disclosure of CAM use to medical practitioners: a review of qualitative and quantitative studies. Complement Ther Med 12.2–3 (2004): 90–98.
Sackett DLR et al. Evidence based medicine: what it is and what it isn't. BMJ 312.7023 (1996): 71–72.
Smallwood C. The role of complementary and alternative medicine in the NHS. London: FreshMinds, 2005.
Studdert D et al. Financial conflicts of interest in physicians' relationships with the pharmaceutical industry: self-regulation in the shadow of Federal prosecution. N Engl J Med 351.18 (2004): 1891–1900.