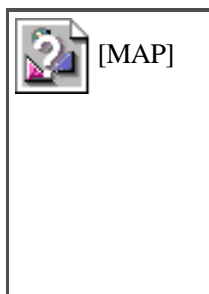




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PERSPECTIVE

Advising Patients Who Seek Alternative Medical Therapies

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David M. Eisenberg, MD

Alternative medical therapies, such as chiropractic, acupuncture, homeopathy, and herbal remedies, are in great public demand. Some managed care organizations now offer these therapies as an "expanded benefit." Because the safety and efficacy of these practices remain largely unknown, advising patients who use or seek alternative treatments presents a professional challenge. A step-by-step strategy is proposed whereby conventionally trained medical providers and their patients can proactively discuss the use or avoidance of alternative therapies. This strategy involves a formal discussion of patients' preferences and expectations, the maintenance of symptom diaries, and follow-up visits to monitor for potentially harmful situations. In the absence of professional medical and legal guidelines, the proposed management plan emphasizes patient safety, the need for documentation in the patient record, and the importance of shared decision making.

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From Beth Israel Deaconess Medical Center, Boston, Massachusetts. For the current author address, see [end of text](#).

Alternative therapies can be defined as medical interventions that are neither taught widely in U.S. medical schools nor generally available in U.S. hospitals (1). Examples include chiropractic, acupuncture, massage, and homeopathy. In 1993, my colleagues and I reported that an estimated 60 million Americans used alternative medical therapies in 1990 at an estimated cost of \$13.7 billion, that the estimated number of annual visits to providers of alternative medicine (425 million) exceeded the number of visits to all U.S. primary care physicians (388 million), and that more than 70% of patients who acknowledged using alternative therapy never mention edit to their physicians (1). These data generated considerable attention and debate and suggest that an "invisible mainstream" exists within the U.S. health care system (2). Little is known, however, about the safety, efficacy, mechanism of action, and cost-effectiveness of individual alternative treatments.

In the past 3 years, the lay press has reported a national trend: third-party payers who provide alternative therapies in the form of "expanded benefits" (3-11). Most recently, the Oxford Health Plan began a program whereby chiropractic, acupuncture, and naturopathy became available to the Plan's 1.5 million subscribers as paid benefits (12, 13). This trend poses a predicament for physicians: how to responsibly advise patients who use or seek alternative therapies in the face of inconclusive evidence about the safety and effectiveness of these therapies.

This unavoidable challenge is not without risk. Questions of professional liability are valid. The reality is that no case law directly answers the question, "Will I be sued if I knowingly comanage a patient who sees an alternative therapy practitioner and experiences a bad outcome from that therapy?" Although physicians have been prosecuted for malpractice when they have personally delivered alternative treatments, no cases have involved conventionally trained physicians who have advised patients about alternative medical therapies.

The other extreme involves the risk of not asking about alternative therapies known to be dangerous. In 1996, the media reported deaths from overdoses of *Herba ephedra* (herbal ephedrine), known in Chinese herbal medicine as ma huang (14, 15). A death attributed to pennyroyal, an herb commonly available in health food stores, was recently reported in the medical literature (16). As more patients use over-the-counter herbs, botanicals, and

supplements, physicians should discuss such practices with their patients, if only to safeguard their health.

Undoubtedly, talking with patients about alternative therapies requires additional skills and time. Yet, is this responsibility significantly different from exploring patients' use of alcohol or drugs, exposure to abuse, or preferences for cardiopulmonary resuscitation? Each is critically important to maintaining health and respecting patient values, and each takes time.

I propose a step-by-step approach whereby medical providers and patients can proactively discuss alternative medical treatments. These suggestions emphasize patient safety, the need for documentation in the patient record, and the importance of shared decision making.

Asking the Unasked Question

I suggest that after completing routine questioning to identify patients' chief symptoms, medical providers begin a conversation about alternative therapies with some version of the following question: "Patients with (chief symptom) frequently use other kinds of therapy to find relief. For example, some patients use chiropractic, massage, herbs, vitamins, etc. Have you used or thought about using any of these or other therapies for your chief symptom, or for other reasons?"

Because one third of all alternative therapy use seems to be associated with health promotion and disease prevention (1), providers should also ask about a patient's use of alternative therapy in this context. This inquiry can be assimilated into questions about lifestyle and health risks.

The physician and patient must feel comfortable with how the question is asked. Two caveats are worth considering: 1) The neutrality with which this question is asked influences the honesty of the answer, and 2) there is no need to refer to the "other therapies" as "alternative," "complementary," or "unorthodox." Such labels may be perceived as judgmental, thereby inhibiting disclosure and discussion.

Patients who are interested in exploring alternative therapies do so for diverse reasons: 1) They seek health promotion and disease prevention; 2) conventional therapies have been exhausted; 3) conventional therapies are of indeterminate effectiveness or are commonly associated with side effects or significant risk; 4) no conventional therapy is known to relieve the patient's condition; and 5) the conventional approach is perceived to be emotionally or spiritually without benefit. Whether or not patients use or seek advice about an alternative therapy, they are likely to be pleased when their physician cares enough to ask.

Prerequisites

Detailed discussion about alternative therapy should not occur until the patient 1) has undergone a complete conventional medical evaluation, including diagnostic assessment and, where indicated, referral to consultants; 2) has been advised of conventional therapeutic options; and 3) has tried or exhausted conventional therapeutic options or refused these options for reasons documented in their record. Professional advice on the adjunctive or exclusive use of alternative therapy without a complete diagnostic evaluation is irresponsible and does not serve the patient's best interest.

A Step-by-Step Strategy

Consider a patient with intermittent low back pain for whom nonsteroidal anti-inflammatory medications, physical therapy, regular exercise, and avoidance of heavy or improper lifting have not adequately reduced chronic or recurrent pain. The following approach (Figure 1), guided by the principle "do no harm" and its corollary, "monitor for unintentional side effects," can be considered:

1. Ask the patient to identify the principal symptom.

Back pain is the principal symptom.

2. Maintain a symptom diary.

Assist the patient with a daily symptom diary to be used for baseline assessment and evaluation of subsequent alternative (or conventional) therapeutic interventions. A scale from 0 ("no back pain") to 10 ("the worst pain imaginable") is recommended. Patients should be reminded that because accurate recall of discomfort, fatigue, and other symptoms is difficult, daily logs are essential.



Figure 1:

Proposed process for managing alternative therapy.
(File Size: 12 Kbytes)

3. Discuss the patient's preferences and expectations.

Many patients come prepared to discuss opinions or powerful anecdotes from friends or family members. The discussion often focuses on the reasons patients seek alternative treatment or their desire to avoid conventional therapies. Patients with low back pain, for example, may incorrectly assume that surgery is their only conventional option.

If patients wish to pursue alternative therapy but lack strong preferences for specific therapies, encourage shared responsibility for investigating options further. Various texts are available to both patients and conventional medical providers. These offer information on multiple alternative therapies (17-32) or focus on single treatments (33-43). Conventional practitioners might consider attending continuing medical education courses on this topic (44-46). In our hypothetical example, the patient opts to pursue acupuncture.

4. Review issues of safety and efficacy.

It is the conventional provider's professional obligation to monitor therapies with potential or documented toxicity, including herbal preparations (47-73), dietary regimens (74, 75) and supplements (76-79), medicinal agents delivered by injection (80), intravenous infusion (such as chelation therapy [81]), and certain forms of spinal manipulation (82-89). Advise patients that the absence of documented toxicity for herbs, supplements, or chemical preparations does not equal safety. Notions that "natural" substances are inherently safe are false (90). Snake venom is "natural" but deadly (91); poison oak and ivy contain "natural" urushiols that cause severe contact dermatitis (92). Examples of potentially toxic herbs include sassafras (55), chaparral (69), and germander (73). Reference books (93-95) and online resources (96) (Appendix 1) are available to investigate the relative safety of individual herbs and supplements.

Reviewing the current medical literature fails to provide unequivocal documentation of the safety or efficacy of the overwhelming majority of alternative therapies (85, 87, 89, 97-102). Notable exceptions include spinal manipulation for acute low back pain (103), acupuncture for nausea (104), and behavioral and relaxation techniques for chronic pain and insomnia (105). Adverse events attributable to acupuncture have been reported (106, 107) but are rare (108-112). The risk for transmission of infectious organisms can be reduced to almost zero by using disposable needles.

Risk is also associated with manipulation of the cervical spine (82, 83, 87-89). Other treatments with potential significant risks include some single herbs; some Chinese "patent" remedies manufactured overseas that routinely include various herbs and are occasionally adulterated with steroids or lead (68); high-dose vitamins and minerals, radical diets, certain deep-tissue massage; and any substance administered intravenously.

Relatively low-risk therapies include homeopathy, most forms of massage, prayer, guided imagery, spiritual healing, hypnosis, and relaxation techniques. Two caveats are worth noting: 1) Any therapy can cause "indirect toxicity" if it results in a delay of a proven treatment, and 2) there is a risk for perceived blame and failure among patients who, expecting a "cure" as a result of mental or spiritual exercises, do not experience the desired result (113). Thus, thinking of alternative therapies in terms of relative risk or benefit is reasonable.

Indirect toxicity is exemplified by documented drug-drug interactions. Examples include the potentiation of calcium channel blockers by grapefruit juice (63) and decrease in the bioavailability of digoxin in the presence of guar gum consumption (48). Given the potential for unintended drug-drug interactions, patients who take prescription medications, especially drugs with known toxicity to the liver or kidneys (such as chemotherapeutic agents), should be cautioned about, if not dissuaded from, simultaneously using herbs, supplements, and other substances with poorly studied pharmacologic activities. Perhaps the most common, vexing example involves the patient who is receiving chemotherapy or radiation therapy and considers the consumption of herbs, high-dose vitamins, or supplements before or during treatment. These substances may, hypothetically, inhibit or potentiate the activity of conventional therapeutic agents. Physicians must warn patients about unintended drug-drug interactions and the prospect of not knowing which substance is responsible. In general, a strategy that uses one therapeutic intervention at a time, at least until a therapeutic plateau is reached or a reasonable period of monitoring elapses, should be discussed and documented in the record.

5. Identify a suitable licensed provider.

Patients may have already identified a provider by word of mouth or informal referral. Physicians should emphasize that alternative therapy providers are licensed by state governments and commonly maintain professional malpractice insurance. Licensure laws and the scope of practice guidelines regulating individual practices vary by state (114)



Figure 2:

State licensure of
alternative medicine
practitioners.

(Figure 2) and are subject to frequent change. Patients should review the professional credentials of any prospective alternative provider. Ideally, this information should be documented in the patient's record.

6. Provide key questions for the alternative therapy provider during initial consultation.

When patients are being counseled about use of alternative therapy, providing the following questions to ask the alternative medical provider is helpful: 1) Is the provider's belief in the effectiveness of the therapy (for example, acupuncture) based on clinical experience with similar patients? If so, is it possible to speak to such a patient? 2) Of what will the therapy consist? What is the recommended frequency of therapy? 3) How many weeks will pass before the patient and provider can decide that the therapy is or is not beneficial? 4) What is the cost per session, with or without medication, and the anticipated total cost for the specified time period? Is third-party reimbursement available? 5) Are there potential side effects? 6) Is the provider willing to communicate diagnostic findings, therapeutic plans, and follow-up with the patient's primary care provider or subspecialist? Are there any limitations to this communication?

Ideally, the physician should obtain patients' permission to release relevant information (including information on the use of prescription medications) to the alternative therapy provider in order to offer accurate historical information and avoid conflicting recommendations.

7. Schedule a follow-up visit (or telephone call) to review treatment plan.

Topics to be addressed during this session include 1) the alternative practitioner's responses to the questions outlined above; 2) potential risks or toxicity, particularly those involving therapies taken orally, intramuscularly, or intravenously; and 3) recommendations that directly conflict with those of the conventional provider. An extreme example is the recommendation that a patient delay or forego surgery, chemotherapy, or radiation therapy for a potentially treatable malignant condition.

8. Follow up to review the response to treatment.

This should occur after a "reasonable" period (usually 4 to 8 weeks). By the time this follow-up session takes place, patients usually have decided whether or not to continue the alternative therapy. If the therapy was effective, the patient's positive experience constitutes a beneficial clinical outcome and provides anecdotal evidence that this therapy (or, one might argue, the *provider* of this therapy) may be helpful to others with similar problems. If the therapy was ineffective, the patient and physician together can review other alternative and conventional therapeutic options. Regardless of the perceived efficacy or lack thereof, patients who pursue an alternative therapy while being monitored by their physician tend to feel "listened to" and enjoy a degree of perceived safety that they might otherwise be denied.

9. Provide documentation.

Conventional providers are encouraged to build a record of the clinical encounters, conversations, and advice that lead to all treatment decisions.

Patients Who Already Use Alternative Therapies

Such patients may not wish to discuss these alternative practices; this should be recorded in their medical records. For patients who welcome this conversation, the physician's challenge is to explore whether the patient and alternative provider are willing to follow the steps discussed above. Refusal on the part of either party should be documented in the patient's record.

Patients Who Reject Conventional Diagnosis or Therapy

A more challenging situation involves the new patient who currently uses an alternative therapy (or wants a referral) but refuses conventional evaluation. Patients have the right to forego conventional treatment, but this choice does not constitute a right to obtain a referral or tacit medical approval for alternative therapy in the absence of a diagnosis.

Physicians might convince such patients that an "integrated" approach is in their best interest. If patients refuse this advice, they are best served by the unequivocal message that requests for referral to an alternative provider are unreasonable and cannot be met. Physicians facing this predicament should follow accepted professional guidelines for referring patients to another physician. Under no circumstances should a conventional medical provider feel professionally obligated to make or support referrals to alternative therapy providers in the absence of a thorough medical evaluation.

Discussion

Discussions about the use of alternative medicine are primarily influenced by patient preference, perceived need for alternative interventions, and anecdotal evidence that the therapy *may* provide relief and long-term benefit or be toxic. Together, patients and providers must acknowledge that as long as information on the efficacy and toxicity of alternative therapies remains inadequate, advice will remain imperfect and a matter of judgment.

As with all good care, the patient's wishes should not override a physician's professional judgment. If the physician believes that an alternative therapy is unsafe or inappropriate, patient requests for it should not be endorsed. Perhaps the question each clinician must ask is, "Would I let a family member follow this course of action?" Patients, I believe, want their physician's opinion, even if it is a blunt "I wouldn't be comfortable watching a family member do this." If, however, little evidence suggests that risks outweigh potential benefits and the physician is willing to monitor the patient, it is often appropriate to pursue alternative treatment.

By implementing the proposed strategy, physicians and patients may disagree about which alternative therapy is safe and potentially effective. I believe that this kind of disagreement is extremely valuable. Kassirer (115) commented that

the patient should be given the benefit of the doubt when important decisions are contemplated. The physician initially should assume that the patient is capable of becoming a full partner in the decision-making process and encourage active participation. This means the patient will have to assume more responsibility for outcomes of medical decisions and the physician will have to relinquish some....

Kassirer concludes that

when discussing details with the patient, physicians should disclose whatever uncertainties exist. Most patients are not horrified to learn that a considerable body of medical information is fuzzy and uncertain. Neither do they fail to comprehend that some tests and treatments are risky, that some treatments are not always efficacious, and that on occasion the treatment may turn out to be worse than the disease.

Physicians and patients should dare to disagree, especially about therapies for which scientific support is anecdotal, equivocal, or preliminary. Often, the most sensitive barometer of a relationship is the ability to resolve disagreement. A rabbi commented that when providing premarital counseling, she always asks the couple, "Tell me *how* you disagree. I'm not interested in what you disagree about, but rather *how* you work through your disagreement." The manner in which the patient and physician wrestle with disagreements about therapeutic choices helps define their relationship and its value to each party.

We as a profession must address the challenge of discussing alternative therapies with our patients and put an end to the "don't ask, don't tell" approach that characterizes communication in this area. These discussions are opportunities for shared decision making and "relationship-centered care" (116). No patient should feel that their medical journey is to be taken alone or according to some stealth trajectory, invisible to their conventional providers. The delivery of medical care, like the experience of illness, is best viewed as a journey shared.

Appendix 1. Selected Information Resources on Herbs and Supplements

Research Databases

**U.S. Department of Agriculture
Agricultural Genome Information System**
<http://probe.nalusda.gov>

Free access to 80 000 records on herb taxonomy and the use of herbs worldwide, developed by Dr. James Duke. Other available databases include a WAIS (wide-area information server)-based subset of Agricola.

NAPRALERT

College of Pharmacy
The University of Illinois at Chicago

Contact: Mary Lou Quinn
Phone: 312-996-2246
Fax: 312-996-7107
www.pmmp.uic.edu

Contains 124 000 scientific articles on the chemical constituents and pharmacology of plants (75% were published after 1975). Requires annual subscription fee for mediated searching plus a fee for each record retrieved.

Research Journals

Journal of Natural Products
American Society of Pharmacognosy
555 31st Street
Downers Grove, IL 60515
Phone: 708-971-6417

Journal of Ethnopharmacy
Elsevier Science Ireland, Ltd.
Madison Square Station, Box 882
New York, NY 10159
Phone: 212-989-5800

International Journal of Pharmacognosy
Swets & Zeilinger
400 Creamery Way, Suite A
Exton, PA 19341
Phone: 800-447-9387

HerbalGram, HerbClip
American Botanical Council
PO Box 201660
Austin, TX 78720
Fax: 512-331-1924
www.herbalgram.org/abcmission.html

Mediated Searching

Herb Research Foundation

1007 Pearl Street, Suite 200
Boulder, CO 80302
Phone: 303-449-2265
Fax: 303-449-7849
www.herbs.org

Hand searching of private library composed of 125 000 papers that cover a full range of botanical issues. Hourly fee for searching plus a per-page charge.

U.S. Department of Agriculture National Agricultural Library

Food and Nutrition Information Center
Phone: 301-504-5719
www.nal.usda.gov/fnic

National Institutes of Health Office of Dietary Supplements' public information service. No charge for telephone requests. Reference service hours are Monday through Friday, 12:30 to 4:30 p.m. Eastern Standard Time.

Lloyd Library

917 Plum Street
Cincinnati, OH 45202
Phone: 513-721-3707
www.libraries.uc.edu/lloyd

One of the largest comprehensive collections of books and serials on natural pharmaceuticals in North America. Searches are free, but a copy fee is charged for materials retrieved.

List of Associations

Herbnet

www.herbnet.com/associations.html

Extensive annotated listing of commercial, nonprofit, national, and regional organizations dedicated to the support of herbal medicine. Other resources available through Herbnet

include recent news and publications.

Appendix 2. Information Resources for State Licensing

Chiropractic

Federation of Chiropractic Licensing Boards

901 54th Avenue, Suite 101
Greeley, CO 80634
Phone: 970-356-3500
www.fclb.org/fclb

Homeopathy

National Center for Homeopathy

801 North Fairfax Street, Suite 306
Alexandria, VA 22314
Phone: 703-548-7790
www.homeopathic.org

Homeopathy is licensed in three states. Contact state licensing boards for general information.

Massage Therapy

National Certification Board for Therapeutic Massage and Bodywork

8201 Greensboro Drive, Suite 300
McLean, VA 22102
Phone: 800-296-0664
www.ncbtmb.com

Provides detailed information on state licensing and regulatory requirements and on individual certified practitioners. Certification is not consistently required for licensure. Not all massage therapists are nationally certified.

Acupuncture

No single acupuncture organization can provide information by telephone on a state-by-state basis. State boards of registration in medicine should be contacted for further information.

National Certification Commission for Acupuncture and Oriental Medicine (NCCA)

1424 16th Street NW
Suite 501
Washington, DC 20036
Phone: 202-232-1404

Book (cost, \$7.00) available that provides each state's licensing and regulatory requirements.

American Academy of Medical Acupuncture

5820 Wilshire Boulevard, Suite 500
Los Angeles, CA 90036
Phone: 213-937-5514
www.medicalacupuncture.org

Membership limited to allopathic and osteopathic physicians who have had 200 hours of acupuncture training.

Naturopathy

American Association of Naturopathic Physicians (AANP)

601 Valley Street, Suite 105
Seattle, WA 98109
Phone: 206-328-8510
www.infinite.org/Naturopathic.Physician

Naturopathy is licensed in 12 states and the District of Columbia ([Figure 2](#)). The AANP provides contacts for local licensing and regulatory boards and general information on naturopathy.

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Requests for Reprints: David M. Eisenberg, MD, the Center for Alternative Medicine Research, Beth Israel Deaconess Medical Center, 330 Brookline Avenue, Boston, MA 02215.

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