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Complementary therapy use: some new insights

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Up to 70% of the Australian population has used complementary medicines and other complementary therapies (CAM) either self-initiated or recommended by CAM practitioners. The most frequently consulted CAM practitioners are chiropractors, naturopaths and acupuncturists. In addition, general practitioners increasingly prescribe CAM or refer people to CAM practitioners. Significantly, people with diabetes are high CAM users: they also require regular, often complex conventional care. Risks of adverse events including medicine interactions increases as the number of medicines increases: once more than eight medicines are used there is a 100% chance of an interaction.

CAM users have been described as:
- Earnest seekers, who try many forms of treatment to manage intractable health problems.
- Stable users, who use one form of CAM to manage their health, or regularly use a combination of CAM therapies for a particular health problem.
- Eclectic users, who choose and use different therapies according to the particular problem and circumstance.
- One-off users who try a therapy or therapies but do not continue using them.

People with diabetes fall into all four categories and may move from one category to another at different stages of their disease. It is well documented that more than 57% of CAM users do not tell their conventional practitioners about their CAM use. Reasons for non-disclosure include concern about eliciting a negative response from conventional health practitioners (CHP), belief that CHP do not need to know, because CHP are not trained in CAM and would not understand, and, significantly, because CHP do not ask about CAM use.

Many studies show people frequently combine CAM and conventional care. For example, Then et al. (2000) found 51% of 3,106 surgical patients used vitamins before surgery and 21% used herbal medicines including Echinacea, Ginkgo biloba and Hypericum perforatum (St John's Wort). All these herbal medicines can interact with anticoagulant medicines and increase the risk of bleeding. Some CAM medicines interact with anaesthetic agents and others with glucose lowering medicines and cause hypoglycaemia.

Most data were collected in the community: there is less information about people's CAM use in hospitals, but information is beginning to emerge. Braun (2006) found almost 50% of surgical patients in an Australian hospital used CAM medicines in the perioperative period; 90% reported their CHPs did not ask about CAM use. It is not clear whether any of Braun's participants had diabetes.

Some US, UK and European hospitals provide CAM services such as acupuncture and massage. Interestingly, all 18 hospitals recently named as America's Best Hospitals provide some CAM. 15 of the 18 belong to the Consortium of Academic Health Centres for Integrative Medicine, a group of 36 US teaching hospitals that integrate CAM and conventional care. Integration is beginning to occur in some Australian hospitals.

We undertook a CAM point prevalence survey in a regional Australian hospital in 2010 and found a prevalence rate of 64.5%. High acuity areas such as intensive care and operating theaters were excluded. One hundred and sixty-five patients were interviewed: 55% female, 71% were aged over 50 years, and 73% indicated they used CAM at some stage, 55% were current CAM users, and 22% were using CAM in hospital. Twenty nine percent had diabetes, mostly type 2, and a mean duration of diabetes of nine years. The most frequently used CAM were vitamins and minerals (often prescribed by doctors), glucosamine, massage, chiropractic and herbal medicines. The majority, 81%, of CAM-users in hospital had informed the CHPs about their CAM use.

These factors suggest it is likely people with diabetes requiring inpatient and emergency care in Australia are currently using or recently used CAM and may be at risk of adverse events and/or unrecognised benefits. Thus, like other CHP groups, diabetes educators have a responsibility to ask about CAM use and provide relevant advice or counsel individuals using CAM to seek advice from a qualified CAM practitioner. It is also imperative that CAM use and, reasons for using and outcomes are documented in the care plan and communicated to the health care team.

Many people with diabetes use (continued on page 13>
CAM to maintain well-being and prevention, which suggests they are proactive and take personal responsibility for their health. Thus, it is essential to understand people’s beliefs, knowledge, and the cultural factors related to CAM use before developing care plans or providing CAM advice.

Diabetes educators need to have the required knowledge and competence to provide CAM advice and/or be able to direct the person to an appropriate information source. Having access to information about CAM/conventional and CAM/ CAM medicine interactions, how to identify such interactions, and what to do if they occur, is essential. Some useful resources were outlined in Dunning (2006). In addition, a portfolio of information about commonly used CAM can be a useful risk reduction strategy. Where possible, qualified CAM practitioners could contribute information to compiling such a portfolio.

Significantly, not all interactions are adverse. Beneficial interactions include being able to use fewer and/or lower doses of potent conventional medicines, using non-medicine options such as massage.

References


