

“Administration” of complementary and alternative medicines (CAM) in public hospitals

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Drug interaction between St. John's wort and cyclosporine

GW Barone *et al*, *Annals Pharmacotherapy* 2000



CASE REPORT: A 29-year-old white woman who received a cadaveric kidney and pancreas transplant, with stable organ function and stable cyclosporine concentrations began self-medicating with St. John's wort. After taking St. John's wort supplements for four to eight weeks, her cyclosporine concentrations became subtherapeutic; this was associated with organ rejection. Four weeks after stopping St. John's wort, her cyclosporine concentrations again became therapeutic. Subsequent to this rejection episode, she has developed chronic rejection and now has returned to dialysis.

Due to CYP3A4 induction, with increasing elimination of these drugs

Case history, 12/6/07

Mr TP, Chronic Fatigue Syndrome. Taking 4 CM preparations including Adrenotone® at a dose of 2 tabs bd

Adrenotone contains 3.6 g/tab liquorice extract (tdd 14.4 g)!



WATAG considered “complementary medicines” as a policy matter between 2001-03, at a time of increasing public awareness of alternative forms of treatment.

- What IS a “complementary medicine”
- Is there a problem requiring a policy framework?
- Do CAMs have any clinical value?
- Do patients have a “right” to use CAMs in hospital? If so, how should these rights be accommodated?

Laissez-faire?

Quasi-prescription on drug chart?

Intermediate position eg entry in case notes?

“Medication reconciliation”

“Complementary (alternative, herbal) medicines”

Compounds other than registered (AUST R) drugs used by a patient for therapeutic purposes regardless of the existence of a formal efficacy claim.

- Herbal remedies, including aromatherapies etc
- Homeopathic remedies
- “Ethnic” medicines (eg traditional Chinese remedies)
- Essential oils, vitamins, minerals, supplements

Risks of approving CAMs

- Compromise patient safety

ADR with registered medicines, intrinsic toxicity, poor efficacy

- Promotion and practice of unscientific therapeutics/medicine
- Lending support to quack compounds
- Increase potential legal liability

WATAG discussion document and Draft Review positions

- Complementary medications do not represent best practice.
- Patients right to bear and use CAM is not infringed, except that CAM can be withdrawn if there is a safety concern
- Provision for patients to disclose CAM use and for counselling in the use. Fact of discussions to be documented in patient notes
- Hospital staff not to condone, promote, or administer CAMs except to withdraw for safety reasons
- Record fact of CAM use on the (pre-NIMC) medication chart and discharge letter, for information only

- ADRs to be reported as for prescription drugs
- CAMs to be returned to patient on discharge
- Medication history form and information sheet developed
(*similar to current moves under medication reconciliation*)
- Hold *status quo* until legal opinion obtained

Feedback: generally, less tolerant

Is the service *responsible* for use of CAMs?

Use of “complementary medicines” should not be condoned;
assigns implicit legitimacy

Medical Directors Forum “*refused to be involved*” in a system
permitting continued access while in hospital

Strong disagreement from WCHS, which had developed its
own policy (not divulged, not on the WCHS website)

Comments on CAM to be placed in notes, not drug chart. **Now
no provision for “general treatment” on NIMC**

Prohibition should be *broader*.

Role of traditional bush medicines should not be compromised

Administrative progress

Referred to OCMO 2004.

Last record of file activity in Legal Branch, 2005.

Matter caught up in preparation of legislation for Chinese medicine practitioners (not yet enacted) and related matter of Chinese herbal remedies.

ie rate of progress is glacial but apparently without controversy (suggesting relative unimportance?)

Summary

Herbal remedies and CAM are unscientific, generally without efficacy, and potentially dangerous or toxic.

The “right” to maintain access to them while a patient in a public hospital is weak.

Consideration to maintain supply on patient request, and permission if bland, with a compulsory note preferably on the drug chart, is probably workable.

The official policy has stalled.