COMPLEMENTARY, ALTERNATIVE, AND INTEGRATIVE MEDICINE

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Week 18

Educational Objectives:

1. Define complementary and alternative medicine (CAM). Identify the differences between CAM and integrative medicine
2. Appreciate the history and relationship between medical discrimination and attitudes towards CAM among both patients and providers
3. Cite the available evidence surrounding the benefits and limitations of applying CAM to primary care practice
4. Formulate a standardized patient-centered approach to guiding discussions with patients regarding CAM

CASE ONE:

Mr. M is a 40-year-old African American accountant with a medical history notable only for back pain who presents to establish care at your clinic. He admittedly has not seen a doctor for "many years," but he sees a chiropractor for back pain monthly and has occasionally seen a naturopath, a provider educated in CAM. He presents now for a "checkup" given a recent diagnosis of diabetes mellitus in his mother. He is originally from London and moved to Connecticut when he was 15 years old. He shares that for most of his life his family utilized "alternative" types of medicine, which is his primary source of healthcare to date. However, he became worried about his own health with his mom's recent diagnosis. He reports overall good health with a successful accounting business. Aside from St. John's wort and a probiotic he is on no other medication.

Questions:

1. **What are the definition and origins of CAM? What new distinctions are being made between CAM and integrative medicine?**

2. **What are the characteristics of patients who are most likely to use CAM? Why is it important for health care providers to be familiar with CAM?**

3. **What approach do you use to inquire about Mr. M's CAM treatments and history? What are the non-disclosing clues Mr. M has given?**

CASE ONE CONTINUED:

Mr. M expresses gratitude for your inquiries and openness, as he has had many negative experiences with previous providers. He shares that he and his family's use of CAM was dismissed on many occasions even though it is an important part of their heritage. He is currently open to both CAM and conventional forms of medicine. He reports occasional anxiety and depression, for which his naturopath started St. John's wort over a year ago, with significant improvement. Otherwise, his review of systems is negative. He was also referred six months ago to his chiropractor for his back pain, which has not helped as much, although his naturopath encourages him to continue. He started the probiotic for overall "gut health," but denies any gastrointestinal symptoms or antibiotic history.

4. **What are the current evidence-based CAM therapies that can be applied to primary care practice? How would you respond to Mr. M's current use of complementary therapy? Are there any other CAM-based suggestions or alternatives you would consider?**

CASE ONE CONTINUED:

Mr. M's blood pressure is 118/70, HR 66, SpO2 100%. His baseline labs show a hemoglobin A1c of 5.9%, fasting triglyceride level of 200, and LDL of 180. His CBC and BMP were normal. Mr. M is wondering what role CAM can play in management of his prediabetes and abnormal lipid panel. His ASCVD 10-year risk is 2.1%.

5. **What specific recommendations would you give to Mr. M? What role can CAM play in initial therapy?**

CASE ONE CONTINUED:

Mr. M decides to hold off on starting a statin or fish oil because he would like to try lifestyle modifications first. He returns to your clinic for a three-month follow-up visit. He has since had two sessions with a nutritionist and started cooking his meals based on a Mediterranean diet and glycemic management diet. He has even begun cooking some meals with his mother to help her with her diabetes. His repeat labs today show hemoglobin A1c 5.3%, LDL 120, and fasting triglycerides 130. His review of systems is negative. He has stopped taking the probiotics and has increased his exercise with physical therapy, which has also improved his back pain. You congratulate Mr. M and decide to follow up with him every three months for maintenance of improvements and re-evaluation of the plan.

CASE TWO:

T is a 56-year-old gender-nonconforming journalist of East African descent diagnosed with heart failure two months ago. Past medical history includes type 2 diabetes, GERD, anxiety, class 2 obesity (BMI 39 kg/m^2), and OA. They are currently taking feverfew, ginseng, yohimbine, and bitter melon, all prescribed by their naturopath without issue. T's naturopath recently recommended coenzyme Q10 given the new diagnosis; however, they are beginning to worry about the safety and efficacy of their current CAM regimen.

6. **What resources are available to determine the safety and efficacy of CAM therapies? How would you counsel T regarding the therapies?**

CASE TWO CONTINUED:

T states they will continue to follow up with their cardiologist, however they decide that they do not want to stop any of their CAM because they feel all the therapies have benefited them thus far. They appreciate your suggestions; however, they have encountered many providers attempting to stop their naturopathic medications for the last 15 years and T feels there has been a lot of negative bias towards these treatments.

7. **How do you discuss CAM when there is discordance between provider and patient treatment goals?**

CASE TWO CONTINUED:

You share your concerns regarding T's decision, and they share that their cardiologist had similar concerns. The cause of the new heart failure is CAD and T tells you the cardiologist decided to hold off on initiating daily aspirin, however recommended initiation of guideline-directed medical therapy (GDMT) but T declined. You ask T for permission to contact their naturopath and they agree, and you document the discussion, taking care to forward your note to T's cardiologist. T's naturopath expresses sharing similar concerns about T continuing the ginseng and feverfew and agrees that GDMT should be started. At your next appointment T appreciates the discussion that was had between their providers and shares they have since started their GDMT and stopped feverfew and bitter melon but have continued coenzyme Q10 and ginseng.

Primary References:

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Additional References:

1. Schofield P, Diggens J, Charleson C, Marigliani R, Jefford M. Effectively discussing complementary and alternative medicine in a conventional oncology setting: Communication recommendations for clinicians. Patient Education and Counseling. 2010;79(2):143-51.
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4. Lazar JS, O'Connor BB. Talking with patients about their use of alternative therapies. Primary Care: Clinics in Office Practice. 1997;24(4):699-714.
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Sheba Ebhote is originally from Brooklyn, New York, and is of Afro-Caribbean descent. She graduated from New York Medical College in 2021 and completed residency training in Internal Medicine-Primary Care at Yale New Haven Hospital in 2024 with a distinction in Race, Bias & Advocacy. She also completed the POCUS Superuser Track. Sheba is currently completing a Chief Residency Year for the Internal Medicine-Primary Care Residency Program and her scholarly interests include developing curricula surrounding health inequity and advocacy for residents, POCUS, and mentorship of historically underrepresented groups in medicine.

Knowledge Questions:

1. **What are some strategies that can be used to effectively discuss CAM with a patient?**

    a. Be transparent about what you don't know
    b. Listen for "non-disclosing clues"
    c. Ask questions
    d. It is not appropriate to discuss CAM at multiple visits
    e. All except d

2. **All of the following correctly match a first-line CAM therapy with its indication EXCEPT:**

    a. Exercise – anxiety
    b. Fish oil – hypertriglyceridemia
    c. Coenzyme Q10 - heart failure
    d. Probiotics – antibiotic-associated diarrhea
    e. None of the above is a first line therapy

3. **There are reputable sources for patients and physicians to determine safety of CAM therapies.**

    a. True
    b. False