Complementary practitioners' views of treatment for inflammatory bowel disease

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A substantial number of patients with inflammatory bowel disease use complementary therapies to manage their disease, including chiropractic and herbal therapies. The objective of this study was to explore whether providers of these therapies see patients with inflammatory bowel disease and recommend therapies, and to determine their opinions about the treatments that they recommend. The study sample comprised 66 chiropractors, 19 pharmacists, 16 herbalists and 15 health food store employees in Calgary, Alberta. A structured questionnaire containing two patient scenarios (a patient with active ulcerative colitis and a patient with inactive Crohn's disease) was completed either by an in-person interview or by a mailed questionnaire. Most respondents had seen patients with ulcerative colitis, and at least 80% of each group except pharmacists (only 10%) would treat these patients or recommend treatment. Almost all chiropractors used spinal manipulation, whereas herbalists and health food store employees suggested a wide range of different treat-

ments. Chiropractors rated their treatment as moderately effective; herbalists and health food store employees viewed their recommendations as very effective. The results with respect to the second scenario were very similar. The wide range of treatment recommendations by practitioners, who differ greatly in terms of skills, knowledge and experience, has important implications for physician-patient communication, information provision and education regarding complementary and alternative therapies.

Key Words: *Alternative medicine; Complementary medicine; Inflammatory bowel disease*

Point de vue des autres justificateurs de soins de santé face au traitement des MII

RÉSUMÉ : Un nombre substantiel de patients atteints de maladie inflammatoire de l'intestin (MII) utilisent des traitements d'appoint pour gérer leur maladie, y compris des traitements chiropratiques et la phytothérapie. L'objectif de cette étude est de mesurer si les spécialistes

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de ces médecines «alternatives» voient des patients atteints de MII et recommandent des traitements et de sonder leurs opinions au sujet des traitements recommandés.

L'échantillon de l'étude comprenait 66 chiropraticiens, 19 pharmaciens, 16 phytothérapeutes et 15 employés de magasins d'aliments naturels de Calgary en Alberta. Un questionnaire structuré renfermant deux scénarios de cas (un patient atteint de colite ulcéreuse évolutive et un patient atteint de maladie de Crohn en rémission) ont été administrés soit au moment d'une entrevue face à face ou ont été envoyés par la poste. La plupart des répondants avaient vu des patients atteints de colite ulcéreuse et au moins 80 % de chacun des groupes, sauf les pharmaciens (seulement 10 %), se disaient prêts à traiter ces patients ou à leur recommander des

traitements. Presque tous les chiropraticiens utilisaient des manipulations de la colonne vertébrale alors que les phytothérapeutes et les employés de magasins d'aliments naturels suggéraient une vaste gamme de traitements différents. Les chiropraticiens ont qualifié leur traitement de modérément efficace, les phytothérapeutes et les employés de magasins d'aliments naturels ont perçu leurs recommandations comme très efficaces. Ces résultats, en ce qui a trait au deuxième cas, ont été très semblables. La vaste gamme de traitements recommandés par ces praticiens qui diffèrent considérablement sur le plan de leurs habiletés, de leurs connaissances et de leurs expériences, a d'importantes implications sur le rapport médecin-patient, sur la communication de renseignements et l'éducation au sujet de traitements d'appoints et de «médecines douces».

Complementary and alternative medicine has not been well defined. A variety of terms ('unconventional', 'unproven', 'unorthodox') have been used to describe therapies or approaches that are not considered part of standard medical practice in the Western world. Complementary and alternative medicine includes a wide range of therapies. Some of these therapies offer systems of assessment and treatment, and others complement conventional treatment with various supportive techniques. Some have well-developed regulatory structures, while others are fragmented professions with little interdisciplinary agreement regarding regulation.

Complementary and alternative treatments are commonly used by patients with chronic diseases, including inflammatory bowel disease (IBD) (1-3). IBD often lowers the quality of life and the level of psychosocial functioning, and the most effective treatments have common side effects that may limit their acceptance by patients. For many patients, conventional treatments are not successful at achieving disease remission or even lesser treatment goals. Therefore, it is not surprising that the main, but not the only, reasons for using complementary therapy are the avoidance of side effects and the ineffectiveness of conventional treatment (1). Other reasons are dissatisfaction with conventional medicine (2,4), and the need to be in control of the disease and its management (3).

The types of therapies reported in the different studies vary. This variation probably reflects the different descriptions of complementary and alternative therapies used in the questionnaires, as well as what is locally available and cultural preferences. However, herbal therapies (eg, aloe vera, ginseng, cat's claw and slippery elm) and physical therapies such as chiropractic medicine appear to be among the more commonly used complementary treatments. Such treatments are also mentioned in resources for IBD patients. (eg, 5). Herbal therapies are available from a variety of sources, including herbalists, health food stores and pharmacists. Patients often do not discuss their use of complementary therapies with their physicians (1,6). This may mean that patients rely on health providers other than their physicians to guide them in their choice of therapies. Because little is known about the perspective of health practitioners other than physicians on IBD treatment, we

explored whether such practitioners see patients with IBD, whether and how they treat (or recommend treatment to) these patients and, if so, their opinions about the treatments that they recommend.

METHODS

A series of small-scale studies were conducted by medical students as fulfillment of their requirement to conduct a research project in the undergraduate medical program, and by a summer student, based on a general protocol developed by the senior authors. Four groups of practitioners who provide or recommend complementary health care were selected – chiropractors, herbalists, pharmacists and health food store employees. These are professions that provide or recommend the types of therapies most commonly used by IBD patients and that vary with respect to training and degree of controversy in the eyes of conventional health care practitioners. A structured questionnaire was developed based on two vignettes describing a patient with active ulcerative colitis and one with inactive Crohn's disease (Appendix 1). Vignettes were chosen to describe different types of patients with IBD to make sure that all respondents had a common understanding of the type of patient. These vignettes were developed by one of the authors and were reviewed by four other gastroenterologists. The questions assessed whether practitioners were seeing these patients, whether they would treat them (or suggest treatment) and, if so, what treatment was offered, their opinions about the effectiveness of this treatment and their referral practices. Sociodemographic information consisted of age, sex, education and type of practice.

The questionnaire was piloted and reviewed by key informants of each practitioner group. Changes were made according to the key informants' suggestions. The most important difference in the questionnaires was the inclusion of a sentence in the vignettes stating that the patient "has lower back discomfort of a mechanical nature without neurological signs or symptoms"; this statement was only included in the chiropractors' questionnaire because the key informants indicated that they would otherwise not treat these patients. A second difference was that the vignettes for pharmacists were modified to ask about herbal therapies, rather than alternative, natural medicines. The

TABLE 1
Demographic characteristics of four groups of health providers

Characteristics	Chiropractors (n=66)	Pharmacists (n=19)	Herbalists (n=16)	Health food store employees (n=15)
Age, years (mean $\pm$ SD)	41 $\pm$ 9	37 $\pm$ 10	45 $\pm$ 10	37 $\pm$ 12
% Male	80	45	56	7
Years in practice (mean $\pm$ SD)	12 $\pm$ 9	14 $\pm$ 11	11 $\pm$ 11	4 $\pm$ 2

TABLE 2
Treatment characteristics of patients with active ulcerative colitis by four health practitioner groups

Characteristics	Chiropractors (n=66)	Pharmacists (n=19)	Herbalists (n=16)	Health food store employees (n=15)
Number who have seen these patients (%)	54 (82)	14 (74)	14 (88)	12 (80)
Average number of patients/month	2	1	1	1
Number who recommend treatment (%)	64 (97)	2 (10)	15 (94)	14 (93)
Number who would refer patients to other practitioners (%)	56 (85)	16 (84)	3 (19)	5 (33)
Mean effectiveness*	2.7 (56)	2.5 (2)	1.7 (14)	1 (8)

*On a scale from 1 (very effective) to 5 (not effective) – numbers in parentheses correspond to the number of participants who responded to the question

method in which the questionnaires were administered was also based on the advice of the key informants. Chiropractors had a strong preference for a mailed questionnaire. The other practitioners were interviewed in person.

A questionnaire was mailed to a random sample of 100 chiropractors in Calgary, Alberta. The response rate was 66%. Twenty-six herbalists were approached; they were local members of the Canadian Association of Herbal Practitioners and herbalists listed in the *Yellow Pages*. Sixteen herbalists (62%) agreed to participate in a personal interview. All (n=22) head pharmacists at local Shoppers Drug Mart stores were approached; 19 (86%) took part in a personal interview. Finally, a convenience sample of 15 employees of 15 different local health food stores took part in a personal interview. Stores that offered a limited range of health care products were excluded.

Data analysis was descriptive using summary measures to describe the practices and opinions of the different groups of practitioners. Due to differences among the groups and variations in data collection, no statistical tests were used to compare the groups.

RESULTS

Table 1 presents the sociodemographic characteristics of the four different groups. Questions regarding education, training and practice were different for each of the four groups. Forty-five per cent of chiropractors received a doctor of chiropractic medicine degree from the Canadian Memorial Chiropractic College, Toronto, Ontario, and 37% from the Palmer Chiropractic College in the United States. Fifty-two per cent were in solo practice, and 75% of

those indicated that they were associated with other health care professionals. Of the 19 pharmacists, 16 graduated in Canada. Nine of 16 herbalists had a university degree; three of these were physicians. Nine herbalists indicated that they had special training as herbalists. While 13 herbalists were members of a professional organization, only four were licensed. However, 11 indicated that they were in favour of licensing their profession. Five health food store employees had a university degree, and four indicated that they had a certificate in massage therapy or herbalism. The remaining 11 health food store employees had no formal training with respect to the products sold in the store.

Scenario I (active ulcerative colitis)

Table 2 shows how the different groups of practitioners would approach a patient with active ulcerative colitis. Practitioners who had not seen these patients also responded to the questions about treatment by indicating how they would treat these patients if they saw them. The five most common treatments identified by chiropractors were spinal manipulation (97%), exercise review and counselling (52%), nutritional review and counselling (50%), stress factor review and counselling (48%), and soft tissue therapy (35%). The most common reasons for treatment were to remove nerve irritation caused by subluxation (92%), to restore normal spinal biomechanics (90%) and to control symptoms (30%). The majority of chiropractors would not treat these patients in isolation but would refer them to other health providers. They would most commonly refer patients to general practitioners (43%), followed by naturopaths (39%) and gastroenterologists (26%).

TABLE 3
Characteristics of proposed treatment of patients with inactive Crohn's disease by four health practitioner groups

Characteristics	Chiropractors (n=62)*	Pharmacists (n=19)	Herbalists (n=16)	Health food store employees (n=15)
Number who have seen these patients (%)	49 (79)	16 (84)	13 (81)	12 (80)
Average number of patients/month	1	<1	1	1
Number who recommend treatment (%)	60 (97)	5 (26)	15 (94)	14 (93)
Number who would refer patients to other practitioners	41 (66)	11 (58)	3 (19)	1 (6)
Perceived mean effectiveness†	2.9 (53)	2 (1)	1.9 (14)	1.6 (5)

*Four chiropractors did not respond to this section of the questionnaire; †On a scale from 1 (very effective) to 5 (not effective) – numbers in parentheses correspond to the number of participants who responded to the question

Only three pharmacists knew of herbal treatments for this type of patient (psyllium, peppermint oil and chamomile), and two of them would recommend these treatments to such a patient. The majority of pharmacists would refer these patients to a physician. Pharmacists were also asked whether they would recommend herbal treatments for general gastrointestinal symptoms, including diarrhea, heartburn, nausea, constipation, flatulence and vomiting. Eleven pharmacists would recommend treatments, but only when symptoms are mild or moderate. They were most likely to recommend treatment for nausea and constipation.

The 15 herbalists who would recommend treatment would most commonly suggest dietary assessment and counselling (n=15), herbal treatment (n=14), lifestyle factor assessment and counselling (n=9), and acupuncture (n=8). Other treatment strategies were mentioned only once or twice. Herbalists were also asked which herbal therapies (up to two) they would recommend. A wide range of herbal treatments was listed; only goldenseal and *huang lian su* (*Coptis chinensis*) were mentioned twice. Several treatments consisted of specific concoctions for this type of patient (eg, Robert's formula [NF Formulas, USA], Zheng Qi Wan formula, UCj3 formula, and other unspecified formulas). The most important reasons for using these herbs and herbal formulas were to heal the bowel (n=9) and to reduce bowel inflammation (n=8). Three herbalists would refer patients to other health professionals – two to a general practitioner and one to a naturopath.

Three health food store employees had not seen this type of patient. Five would recommend that the patient see a physician due to the presence of blood in the stool. Health food store employees recommended a wide range of products. The most commonly mentioned products were aloe vera (n=7), acidophilus (n=5), and bulking agents such as psyllium and flax seed (n=5). Other products mentioned were digestive enzymes, vitamins (A, C and E), minerals and other herbs. Most often, the indication for treatment was described as 'digestive problems'. Other indications

that were mentioned included ulcers and 'used for everything'. In addition to products, some employees recommended dietary changes (n=3) or iridology (n=2) to diagnose candida and to reveal stress levels (both of which were thought to be underlying causes of ulcerative colitis). Two employees indicated that they had to check their books first to see what should be recommended in such a case. Health food store employees were also asked how they obtained knowledge about treatments for IBD. All employees said that they read books. Half of them referred to *Prescription for Nutritional Healing* (7). Eight attended seminars sponsored by product companies, natural health magazines or the health food store head office. Some referred to their personal experience, training with a herbalist or the media.

Scenario II (inactive Crohn's disease)

Table 3 shows how the different groups of practitioners would approach patients with inactive Crohn's disease. Recommended treatments identified by chiropractors and reasons for treatment were very similar to those mentioned for scenario I. Chiropractors would most commonly refer patients to naturopaths (35%), general practitioners (18%) and nutritionists (16%).

While five pharmacists said that they would recommend treatment for this patient, none of them knew what they would recommend. One pharmacist indicated that he knew of a specific treatment (chamomile) for this type of patient but that he would not recommend it. Fifty-eight per cent of pharmacists would refer the patient to a physician.

The 13 herbalists who would recommend treatment also recommended similar types of treatments as in scenario I. As for the previous scenario, a wide range of herbal treatments were identified, including specific concoctions made for the individual patient. Almost all herbalists would suggest different treatments for the patient in scenario II than for the patient with ulcerative colitis. More than 10 reasons for using these herbal treatments were given. The most common reason was to heal and regulate the bowel.

Health food store employees suggested a wide range of products, including acidophilus (n=3), aloe vera (n=3), and a wide range of other herbs, vitamins and minerals. Two employees would recommend a change in diet in addition to health food products.

DISCUSSION

While physicians' recommendations for IBD are rather uniform and consist of drug treatment, the four groups of health practitioners included in this study present very different perspectives. Chiropractors are consistent in their main treatment approach (spinal manipulation). In addition, many of them include lifestyle review and counselling in their management of IBD patients. Chiropractors appear very willing to provide concomitant care with physicians (complementary care). Generally, they believe that their treatment is moderately effective. Pharmacists have been suggested to be potential resources for patients with respect to herbal treatments and are encouraged by some companies (in particular the Shoppers Drug Mart chain) to undergo training in this field, which is provided in-house. However, they seem to defer the treatment of IBD to physicians and do not play a role in recommending treatment to IBD patients. Herbalists provide a wide range of individualized treatments and appear to work separately from physicians (alternative care). They generally consider their treatment to be effective. Finally, our results suggest that, while some health food store employees are interested in and have some knowledge of the treatment options for IBD, it is more appropriate to consider them as sales people than as health care providers. The high number of health food store employees providing treatment recommendations to this type of patient, and the source of information (7) they use, confirm the results of a recent study of the health information provided by health food store employees for a child with Crohn's disease (8).

The study results imply that patients with IBD who seek complementary and alternative therapies are confronted with a wide array of treatments. It is important to recognize that combining these treatments can pose risks to a patient's safety and wellness. Our study has shown that practitioners from the various groups differ greatly in terms of skills, knowledge and experience, and the evidence supporting the treatments that they recommend varies as well. In addition, just as there are risks involved in the use of conventional treatments, there are risks attached to complementary treatments. These risks include adverse effects; potential adulteration or contamination of herbal preparations; risk of nutritional deficiencies due to rigid, restrictive diets; and interaction effects between conventional and complementary treatments (9,10). It is not clear whether patients realize the risks involved and are aware of the vast differences in skills, training and experience of their practitioners, or whether they view physicians, chiropractors, herbalists and health food store employees as more or less the same. The role of health food store employees is particularly problematic because they may be perceived as health

APPENDIX 1

Two patient scenarios presented in a questionnaire designed to determine complementary health practitioners' views of the treatment of inflammatory bowel disease

Scenario I (chiropractor version)

A 45-year-old man comes to talk to you. He has general lower back discomfort of a mechanical nature without neurological signs or symptoms. He explains that he has a 15-year history of ulcerative colitis. He has currently been having increased symptoms over the past three weeks. Symptoms are loose stools six times per day, with some blood with each movement, urgency to pass stools and some lower abdominal crampy pain prior to bowel movements. He has no nausea or vomiting and he has not lost any weight. He is currently on no medications because he has had little success with prescription medicines. He wants to try alternative, natural medicines and asks whether you could help him.

Scenario II (chiropractor version)

A 30-year-old female tells you she has a history of lower back discomfort of a mechanical nature with no neurological signs or symptoms, and Crohn's disease. She last had significant symptoms four months ago at which time she was treated with oral steroids. She is now much better with only occasional cramps and diarrhea. She is currently not on any medication. She would like to try and prevent a future episode of the disease without using prescription medications.

providers, while they are trained to be informed sales people of nutritional supplements.

As long as conventional medicine does not provide efficacious IBD treatments that are free of side effects, patients will continue to look for treatments that complement conventional treatment or alternative treatments. In a previous study, we found that patients believed that their physicians would reject complementary therapy use, had little knowledge about and interest in these therapies, and did not take the time to discuss these therapies (11). To avoid patient risk and to overcome these beliefs, it is important that physicians and other health providers discuss the use of complementary therapies with their patients. Eisenberg (12) developed useful guidelines for physicians to advise patients who seek complementary therapies. Following these guidelines will ensure that patients receive the best integrated treatment for their IBD.

The results of these small exploratory studies are limited due to their sample size and the variations in study design. In addition, it is beyond the scope of this paper to assess the appropriateness and efficacy of the recommended treatments. However, the study illustrates that IBD patients may receive wide-ranging, often inconsistent, advice regarding disease management. Therefore, open communication between patients and providers about disease management is required to ensure patient safety.

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