Health professionals rarely record history of complementary and alternative medicines

Nicole L. Cockayne,¹,² Margaret Duguid¹ & Gillian M. Shenfield¹,²
Royal North Shore Hospital, Clinical Pharmacology, ¹St Leonards, NSW, Australia; University of Sydney, ²Pharmacology, Sydney, Australia

Introduction

Complementary and alternative medicines (CAM) are widely used in Australia [1] (usually referred to as complementary medicines (CM) in Australia [2]) the USA [3] and UK [4]. A previous study in our hospital revealed that up to 52% of patients had used at least one CAM in the previous 12 months but fewer than 50% of them had informed their doctor [5]. CAM may include vitamins and minerals which can be prescribed for deficiency syndromes but, when used as self treatment, are often for nonspecific indications. Many herbal medicines may have serious adverse effects and can also interact with other medications such as anticoagulants, immunosuppressants and antidepressants [6]. The best described of these is St John’s wort, which has been shown to interact with a number of prescription medicines [7–9]. It is particularly important for CAM use to be a routine part of a medication history but even for conventional therapies doctors rarely take full histories [10]. Recent publications suggest that doctors do not consistently record CAM in patient charts [11]. A study in patients with prostate cancer found a high usage of CAM which had not been identified by conventional medication history taking [12].

Aims

To identify the completeness of documentation of Complementary And Alternative Medicine (CAM) use in hospital medical records of patients before and after an education programme.

Methods

Documentation of CAM in all parts of the medical records was compared to patients’ self-reported use. Data were collected for one month before and one month after an education programme for hospital staff.

Results

At baseline: 59 (58%) of 101 patients used 129 CAM in the month prior to admission; only 36 (28%) of the CAM were documented in the medical record. After education: 51 (54%) of 94 patients used 91 CAM in the month prior to admission; 40 (44%) of the CAM were documented in the medical record. After education, recording rates increased by 16% (95% CI: 3% to 29%) due to improvements by pharmacists (18%, 95% CI: 5% to 31%). 32 (54%) of CAM users at baseline and 29 (57%) of CAM users after education informed a health professional. The recording rates were only 23 (39%) and 28 (55%) respectively for patients in these two subgroups, being an improvement of 16% (95% CI: −2% to 34%).

Conclusions

Prevalence of CAM use among patients admitted to hospital is high, but documentation of usage is low. Strategies need to be designed to improve health professionals’ knowledge about the need to record history of CAM use.