office tips

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Dr. Vernon Curran is assistant professor (medical education) with the faculty of medicine at Memorial University, and is this department's contributing editor.

A Question of Herbs

J.K. Crellin, PhD, LRCP, MRCS, professor, faculty of medicine, Memorial University of Newfoundland.

A recent survey showed that a substantial number of educators in Canadian medical schools agreed on the appropriate roles for physicians in complementary/alternative medicine (CAM).[1] These roles include:

1. Having a basic understanding of CAM practices used by patients;
2. Being willing to discuss CAM with patients;
3. Being able to identify safety risks; and,
4. Having a basic understanding of the evidence base of CAM.

Fulfilling these roles is easier said than done, given limited curriculum time, minimal exposure in CME, and the confusion of information about the safety and efficacy of CAM. This tip points out issues for critical appraisal that may help physicians develop such roles.

Assessing Historical Pedigrees of Herbs

In the context of insufficient or inadequate clinical trial data for the foreseeable future, the evaluation of efficacy and safety will continue to depend partly on historical and ethnographic data. There is widespread popular belief that the safety and efficacy of herbs rests on thousands of years of use in American aboriginal, traditional Chinese, and Western herbal medicine.

This is supported by many herbal authorities and occasional voices within the medical/pharmaceutical establishment. Additionally, some commentators also argue that since the majority of medicines and medical practices, prior to the '30s, can be dismissed as inert (any reputation is due to placebo action), then they must also be safe.

One issue behind the frequency and authority of such positive statements about historical safety is the tendency for these statements to go unquestioned. In fact, while critical evaluation, based on established criteria, is a hallmark of medical science, there is little such assessment of the historical record. While positive statements are eagerly culled from past and current sources, negative information is commonly overlooked, even though the latter may be based on the extensive experience of practitioners at a time when herbs were the mainstay of conventional therapy.

Despite the need to appraise critically historical pedigrees, little advice on approaches to this is available. One useful test of time, however, has been proposed (Table 1).

A systematic approach to evaluating any paper that proposes safety and efficacy on the

Table 1

Appraising Herbs

- A herb from a new geographic source may have different actions and unidentified incompatibilities with new drugs.
- A particular treatment may have no specific record despite a long history (*e.g.,* typical of many suggested herbs for hypertension).
- New routes of administration (*e.g.,* powders in capsules) may produce different actions.

Taken from: Ernst E, Barnes J: Methodological Approaches to Investigating the Safety of Complementary Medicine, Comple-mentary Therapies in Medicine, 1998; 6:115-121.

A Question of Herbs (cont'd)

basis of the historical record is necessary. A planned series of questions can be asked. A good example of an ancient theory still current is the Doctrine of Signatures which suggests the appearance of a plant indicates its therapeutic use (*e.g.,* lungwort) (Table 2).

Although it can be difficult for those unacquainted with herbs and their history to make judgments based on these points, one must ask such questions before acceptance of any statement that makes claims about the safety and effectiveness of an alternative treatment solely on the basis of history.

References

1. As presented by Verhoef M, Best A, Boon H: Plenary session "What our Future Doctors Need to Know About Alternative/Complementary Medicine," the Association of Canadian Medical Colleges/ Canadian Association for Medical Education/Association of Canadian Academic Health-care Organisations annual meeting.

Table 2
Evaluating Information

- Has information been culled from once widely used authoritative textbooks by authors who have evaluated the reputation of a herb when the herb was in common use?
- Does evidence exist that main-line, not incidental, uses of a herb over time have been determined?
- Are any secondary sources used authoritative (many currently employed are not)?
- Does the information provided link uses with particular modes of administration (*e.g.,* teas, powders, juices)?
- Is there supporting evidence from physicians (case notes written when the herb was in general use)?
- Has consideration been given to a reputation that is likely to rest more on theory than experience?
- Has there been an acknowledgement of placebo effects?

Doctors are people too!

Douglas Kirby, B.Comm, CA,
St. John's, Newfoundland.

Doctors are often viewed as income producing machines who are put on this earth to provide well, in terms of health, for everyone else.

When you start practising, you stop being a person and you become a doctor. Society's unwritten, but generally accepted rules, say a doctor has to provide a better than average lifestyle for his/her family.

New doctors naively dream about the future with stars in their eyes: big house, nice cars, and an Ivy League education for their children. They are not prepared, however, for the eventual realisation that someone (themselves) will have to labour for long hours in order to provide all those amenities.

Marketing and production "efficiency" experts promote programs that result in the physician working faster and harder. "Happiness is a million dollar practice," they say. "Build bigger offices and hire more staff. Extend office hours." Supply houses reinforce that position, especially when it includes buying new and more expensive equipment. Gross income becomes the doctor's indicator of

success, but certainly not happiness!

Unfortunately, even family and close friends will say, "What else would he/she do? He/she loves it," and, "He/she wouldn't know what to do with him/herself if he/she weren't practising."

Can anyone blame doctors when they forget they are people with needs like anyone else?

Some people are cut out to be doctors and others are not. They can't come to this realization, however, until they invest a lot of time and money to become a doctor. Then, if they find out they are not happy, they wonder what's wrong with them.

Doctors should try to get control of their lives. Don't live to practise, practise for a living! Establish your personal needs, set business and personal goals, then look at your practice and see what role it should play in your future.

If you want to try something else for a living, then try it. If you want to eliminate management stress or lighten clinical responsibilities, then take action. Don't sit around bemoaning the fact that you're unhappy—do something about it!

The author is not suggesting you compromise your future security and that of your family. He is suggesting there are ways to minimise the risk and give you a new lease on life. CME