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Doctor communication quality and Friends’ attitudes influence complementary medicine use in inflammatory bowel disease

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Abstract

AIM: To examine the frequency of regular complementary and alternative therapy (CAM) use in three Australian cohorts of contrasting care setting and geography, and identify independent attitudinal and psychological predictors of CAM use across all cohorts.

METHODS: A cross sectional questionnaire was administered to inflammatory bowel disease (IBD) patients in 3 separate cohorts which differed by geographical region and care setting. Demographics and frequency of regular CAM use were assessed, along with attitudes towards IBD medication and psychological parameters such as anxiety, depression, personality traits and quality of life (QOL), and compared across cohorts. Independent attitudinal and psychological predictors of CAM use were determined using binary logistic regression analysis.

RESULTS: In 473 respondents (mean age 50.3 years, 60.2% female) regular CAM use was reported by
INTRODUCTION

The use of complementary and alternative medicine (CAM) is widespread in inflammatory bowel disease (IBD), rates ranging from 31% to 74% in studies across Europe[1-3], Australasia[4,5], and North America[6]. Studies examining the efficacy and safety of these treatments in IBD are heterogenous and controlled data limited[7], thus it is difficult for physicians to advise patients regarding these potentially deleterious agents. However, the ongoing consumer demand for alternatives to conventional therapy means that IBD physicians need to be alert to CAM use, its associated behaviours and underlying health beliefs that may influence conventional IBD care.

Approximately three quarters of CAM taking IBD patients do not discuss its use with their IBD physician[8], thus there is a need to identify surrogate markers or predictors of use that may prompt discussion about CAM during routine consultation.

Predictors previously established fall into demographic, clinical and attitudinal categories. Independent demographic predictors of CAM use include younger age[1,5,9], female gender[1,5,9], higher educational level[5,9], income and employment[5,9], and middle social class at birth[5]. Clinical predictors are more controversial[10,11], but have included Crohn’s disease[9], longer disease duration[12], medication type[1,13], active disease[14], the experience of adverse effects of conventional medication[12,14,15], and a concurrent diagnosis of irritable bowel syndrome (IBS)[16].

Some studies however, have suggested that health attitudes and behaviours are more important than demographics in influencing CAM use[15,17], and there has been recent enthusiasm to identify attitudinal and behavioural predictors as these factors are potentially modifiable. Data regarding such predictors are more limited and heterogenous but suggest that a need for control over disease[17], desire for a holistic approach[17], lack of confidence in the IBD physician[17], poorer therapeutic relationships[18], and vegetarianism[5] are associated with CAM use. CAM use has also been suggested as a marker of psychological or social distress[16].

Disparity in findings between different studies may relate in part to cultural differences in IBD populations, as suggested by an Italian study which demonstrated regional variations in CAM type chosen, despite similar rates of use across the cohorts[14]. An Australian diabetes study suggested an effect of health care setting on CAM use frequency, reporting private health insurance as an independent predictor of CAM use[19].

In IBD patients in Australia, whilst overall frequency and potential ethnically based differences in CAM use have been previously examined[20], attitudinal and psychological predictors of its use are unexplored, as is the effect of the health care setting on CAM uptake.

MATERIALS AND METHODS

Subject selection and recruitment

IBD patients from three different care settings in two distinct geographical locations in Australia were invited to participate. This method has been reported previously[20].

The first cohort came from a metropolitan public teaching hospital based specialist IBD Service...
at Flinders Medical Centre (FMC). This is a large, government funded hospital, offering secondary/tertiary care for a local regional population of 341000 with a Gastroenterology inpatient and outpatient service, and IBD nurses available to patients within working hours.

The second cohort consisted of IBD patients in an overlapping area, receiving their care via a metropolitan Private Practice setting. These patients were under the care of one of four male general Gastroenterologists with extensive experience in managing IBD, without attachment to a specialist IBD unit, or access to IBD specialist nurse support.

The third cohort consisted of IBD patients cared for via Royal Darwin Hospital (RDH), a public hospital in a very remote location in Northern Australia. When this study was conducted, IBD care in Darwin was undertaken predominantly by general practitioners (GPs) and general surgeons, with no specialist gastroenterologist residing in Darwin, and no IBD nurse. The nearest tertiary hospital is in Adelaide, SA, more than 3000 kilometres away.

Potential subjects were identified from IBD databases/hospital records in each location and mailed a questionnaire. Reminder letters were sent to non-responders after one and three months.

**Questionnaire content**

The opening section of the questionnaire sought demographic details including age, gender, disease type, indigenous, relationship and employment status as well as current or previous history of smoking.

In the following sections, A-D, participants answered questions assessing: (1) views regarding conventional IBD medications; (2) views regarding CAM; (3) quality of Life; and (4) psychological and personality traits. Where possible, validated instruments were used as described below.

IBD-specific CAM use was assessed by asking subjects to rate the frequency with which they use complementary or alternative medicine to treat IBD on an ordinal Likert scale. A dichotomous variable was then generated whereby “yes” responses encompassed those describing their use as “often” or “very often”, and “no” included responses “sometimes”, “rarely” and “never”.

Medication Adherence was assessed using the Morisky 4 item Self Report Measure of Medication Taking Behaviour [21,22], examining predominantly dose omission, and covert dose reduction (CDR), the tendency to take less than prescribed of IBD medication without prescriber awareness was assessed as a dichotomous variable (yes/no) based on answer to the question “I take less than prescribed of my IBD medication without telling my doctor”. This has been previously reported [20].

Free text responses regarding attitudes towards IBD medication and dose modification were encouraged.

Other non-standardised attitudinal statements were put to subjects, seeking their views regarding IBD treatment beliefs and attitudes. Some Likert data were collapsed into categories “yes” and “no” for data presentation, but analysed as non-normalized data or continuous data using factor scores for regression analysis.

Anxiety and Depression were measured using the Hospital Anxiety and Depression Scale [23], higher scores indicating higher levels of anxiety or depression. Quality of Life was measured using the reliable and valid Short Inflammatory Bowel Disease Questionnaire [24].

The Spielberger State-Trait Personality Inventory [25-27] was used to assess and compare depressive symptoms, anxiety, anger and curiosity between cohorts in both the immediate (state) and long term (trait or personality characteristic).

**Statistical analysis**

Comparisons between cohort means and medians were performed using the Kruskal Wallis test for non-normally distributed values, and two tailed t test or ANOVA for normally distributed values. Pearson’s χ² or Fisher’s exact test were applied as appropriate for categorical data.

Significant or trend associations at univariate level (P < 0.10) determined which variables were included in regression analyses, along with demographic factors.

Additional continuous variables summarising themes across the questionnaire were generated using principal component analysis for ordinal data using M Plus software (V5.2), for the purpose of data reduction. An oblique (oblimin) rotation was used of 37 of the 55 Likert scale items assessing all aspects of IBD treatment. An examination of the Kaiser-Meyer Olkin measure of sampling adequacy suggested the sample was favourable (KMO = 0.618). When loadings less than 0.4 were excluded, the analysis yielded an 8 factor solution. Scores for each of these 8 factors were normally distributed.

Binary logistic regression was used to assess predictors of CAM use as a dichotomous dependent variable, adjusting for age, gender, employment and relationship status.

A P value of < 0.05 was considered statistically significant. Apart from factor analysis, statistical calculations were performed using IBM SPSS Statistics for Windows, version 22, 2013 (IBM Corp). The statistical methods for this study were reviewed by Dr Reme Mountifield of Flinders Medical Centre, South Australia.

**RESULTS**

**Demographic data**

Response rates to the survey differed between cohorts, with 337/612 (55.1%) of FMC and 91/180 (50.5%) of SA private invitees participating, compared
with 35/100 (35%) in Darwin ($P < 0.0001$). Non respondents did not differ from respondents by gender ($P = 0.2$), but there was a trend toward non respondents being younger than respondents (mean age 43.7 vs 50.3 years, $P = 0.065$) Darwin subjects were more likely be current or previous smokers, and to receive a disability support pension. This population has been previously reported[20]. Demographic data are summarised in Table 1.

### Frequency, demographic and clinical associations of regular CAM use

Many subjects (45.4% overall) reported regular use of CAM, with no significant difference in usage frequency between cohorts ($P = 0.594$) (Figure 1). Distribution of CAM type used is presented in Table 2, and was not significantly different between cohorts ($P = 0.626$). The regular use of more than one CAM type (i.e., physical as well as homeopathic methods) was reported by 64.5% of subjects.

Rates of CAM use were higher amongst younger (46.69 vs 53.41 years, $P < 0.001$), female (52.0% vs 35.5%, $P < 0.001$), and permanently employed (51.1% vs 37.4%, $P = 0.004$) subjects. However, CAM usage did not differ by disease type ($P = 0.394$), conventional medication pill burden ($P = 0.784$), smoking status ($P = 0.805$), or vegetarianism ($P = 0.256$) on univariate analysis.

### Attitudes towards CAM

Of the 206 subjects who reported regular CAM use, 52.5% felt that it was effective (worked “well” or “very well”), and 20.7% had obtained the therapy at consultation with an alternative practitioner rather than independently. The vast majority (83.3%) continued to use conventional IBD medications concurrently. Only half (54.1%) discussed their CAM treatment with their doctor, despite 87.6% of subjects reporting feeling comfortable doing so.

In contrast, of those reporting previous consultation with an alternative practitioner only 62.2% felt comfortable discussing conventional therapy with their alternative practitioner ($P < 0.001$), and 16.6% reported the CAM practitioner discouraged their use of conventional IBD medication. With regard to the consultation experience, 10.5% felt less intimidated by alternative practitioners than doctors, and 16.9% felt more informed about IBD by the alternative practitioner.

### Reasons for CAM use by free text response

Of the 194/206 (94.2%) subjects who offered reasons for their CAM use, 33.0% reported safety concerns regarding conventional medications. Subjects who elaborated further expressed the belief that “natural” CAM would enable them to reduce reliance on “chemical” conventional therapy and dose reduce or cease these medications. Seeking a holistic approach to health in some way was cited by 32.0%, and 20.6% report advice from family, friends, colleagues, religious advisors, or the internet as their main reason for use. The vast majority (83.3%) continued to consult with an alternative practitioner rather than “very well”), and 20.7% had obtained the therapy at consultation with an alternative practitioner ($P = 0.805$), or vegetarianism ($P = 0.256$) on univariate analysis.

### CAM use and treatment attitude associations-univariate analysis

Attitudinal and behavioural associations of CAM use on univariate analysis are presented in Table 3.
With increased CAM use, whilst personality type did not influence rate of use (Table 4).

**Independent predictors of regular CAM use**

After adjustment for age, gender, disease type and employment level, attitudinal and psychological predictors of regular CAM use using binary logistic regression analysis are shown in Table 5. This model explained a significant proportion of variance in low adherence rates (adjusted pseudo R squared 0.217, goodness of fit Hosmer Lemeshow P = 0.161).

After adjustment for demographics a trend was observed toward higher CAM usage amongst non-smokers (OR = 1.299, 95%CI: 0.993-1.698, P = 0.056).

Covert dose reduction, lower depression scores and subjects’ propensity to seek psychological help predicted CAM use, the latter factor analysis generated variable encompassing use of antidepressants, and consultations with counsellors, psychologists or psychiatrists (Table 5). Similarly, the factor analysis generated variable assessing dissatisfaction with doctor communication was an independent predictor of CAM use, and included satisfaction level with doctor relationship, doctor communication style, level of comfort in asking questions of doctor, and comprehension of information provided during consultation.

**DISCUSSION**

This study demonstrates the high frequency of CAM use amongst IBD patients in Australia, and suggests that such use occurs independently of health care setting and geography. Newly identified attitudinal and psychological risk factors include dissatisfaction with patient-doctor communication, CAM use by social contacts and lower depression scores. We confirm both the known demographic risk factors for CAM use and known behavioural associations such as covert dose reduction, psychotherapeutic support seeking, and adverse effects of conventional medications.

The frequency of regular CAM use was slightly...
higher in our study population (45.4%) than reported previously in Australia[4], but within the range reported internationally[1,4,28]. Similarly to the Italian study assessing regional variation in CAM use[14], we found no difference in overall rates of CAM use between cohorts, but in contrast did not find regional variation in the type of CAM chosen either. Some variation in choice of CAM type is seen between populations globally, our predominantly Caucasian cohorts being comparable with New Zealand IBD subjects amongst whom herbs and vitamins were most commonly used[5]. Interestingly nearly two thirds of subjects used more than one type of CAM, however, overlapping physical and homeopathic methods and rendering further analysis by individual CAM type difficult.

Although the patient doctor relationship is known to affect CAM use[29], the more specific aspect of doctor communication quality as a predictor has not been previously reported. Subjects who were dissatisfied with the style of communication from their doctor, did not feel information was presented in a comprehensible way, or felt that the consultation environment did not encourage patient questions, were significantly more likely to use CAM after adjustment for other factors. A Canadian study found that the wish for a more active role in treatment decisions was associated with CAM use[17], and the desire for more information from doctors was predictive of use in an Italian cohort[30].

The significant influence of CAM use behaviours amongst social contacts on CAM uptake decisions in IBD individuals has also not been previously reported. In our study this was adjusted for age, gender, and employment level but not for other demographics which may be common across family members and confound the association. Such influence would not be surprising, however, given the effect of marital status, for example, on other medication taking behaviours such as adherence to conventional therapy in IBD[31]. A study of healthy adolescents found that social contacts exert significant influence over the decision to use CAM[32], and further work to investigate this in IBD populations is warranted, especially given the escalating influence of social media on everyday decision making.

Previously reported predictors including CDR of conventional medications, adverse effects of medications and increased QOL were confirmed in this study. Free text responses strongly suggested that IBD CAM users tend to reduce rather than omit doses of conventional medications on the assumption that CAM use will provide a “medication sparing” effect, the aim being to minimise adverse effects of conventional medications. This newly described phenomenon is the subject of a separate publication[30], which suggests that similar underlying health beliefs and desires drive both CAM uptake and CDR behaviour. Although abundant free text data from this study support this hypothesis, formal path analysis has yet to be undertaken to confirm the direction of causality in the association between CAM use and CDR.

Those subjects seeking psychological input such as counselling, psychologist or psychiatrist review, or antidepressant medication were significantly more likely to use CAM in this study, and this has been previously demonstrated in two European studies[1,13]. Free text responses suggested that CAM was not being prescribed by the psychological care provider, but rather both behaviours were the result of a desire for a holistic health approach with active ways of coping, and this has been previously reported[13]. This may be supported by our new finding that lower depression scores were associated with CAM use, perhaps indicating the presence of successfully treated depression in this population who may be more receptive to psychology.

Gastroenterologist awareness of CAM use was similar in our study to the 46% seen in a French web based study of IBD patients[30], but greater than that found elsewhere[3,8,33]. This communication gap may be contributed to by both consultation participants, a study examining CAM use in IBD patients from the physician perspective finding that only 8% of IBD physicians had initiated CAM conversations themselves, and only around 50% were comfortable discussing CAM with their patients[33].

The confirmation of previously reported demographic and attitudinal CAM predictors suggests that our study population is similar to others, and thus the results generalizable to some extent. The limitations of this study include the small amount of clinical information obtainable from subjects by self-report, including disease activity and response to conventional therapy. Additionally, comparisons between cohorts were hampered by the uneven group sizes and response rates across different treatment settings. Statistical analysis differentiating by CAM type is likely to be important but was not feasible in this study as most subjects (64.5%) reported using more than one therapy type. Also, the definition of CAM is not uniform across studies and in this case was defined as what subjects felt was outside of “conventional” therapy.

CAM use is highly prevalent and appears independent of care setting and geography in IBD, and its importance to patients is often under-recognised by physicians. The quality of patient doctor communication is a key determinant, and failure to actively address CAM use in consultation may promote patient “default” to other advice sources such as family, friends and other social contacts, which ultimately undermines the patient doctor relationship.

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