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Integrating Complementary and Conventional Symptom Management in a Cancer Center

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Historically, patients undergoing treatment for cancer have sought complementary care in addition to conventional medical care. In 1990, David Eisenberg's team published a study in the *New England Journal of Medicine* that surprised physicians (Eisenberg, 1998). The study revealed that 34% of Americans were using complementary and alternative medicines (CAM); but, even more surprising, 60% of the users were not informing their physicians that they were doing so. Interestingly, the study found that CAM was not replacing conventional therapies; rather, it was used in addition to conventional, physician-provided therapies. When Eisenberg and colleagues replicated the study in 1997, CAM use had increased to 41% of the population. However, patients still were not revealing CAM use to their physicians. For the purposes of these studies, complementary therapies were defined as those not taught in medical school. From these studies and our clinical observations, we knew that patients and families were interested in CAM. This article will describe the unique blending of conventional and complementary care for pain and symptom management in a National Cancer Care Network (NCCN)-designated, comprehensive cancer center.

Historical Perspective

The Dana-Farber Cancer Institute Pain and Symptom Management Service was a nursing consult service from the early 1990s until 1997. With the addition of a medical director with experience in anesthesia pain management in 1997, the service became a combined medical and nursing consult service that worked collaboratively with primary oncology nurses, physicians, social workers, and other staff to manage symptoms related to cancer and its treatment. The service provided care for ambulatory and hospitalized patients including patient assessment; education for patients, families, and staff; and pharmacologic and nonpharmacologic management of symptoms related to disease and treatment side effects. Careful titration of medication doses to maximize comfort and minimize side effects was an integral part of the pharmacologic management. More invasive techniques for pain management, such as spinal analgesia and nerve blocks, also were available through collaboration with an anesthesia-based pain service. Although pain was the most frequent reason that patients used the service, the staff also commonly managed nausea and vomiting, anxiety, constipation, fatigue, insomnia, and wound care. An adult nurse practitioner (NP) experienced in oncology nursing and pain and symptom management performed most of the consults and follow-up care.

In 1998, a decision was made to expand the service to include complementary therapies. This decision reflected growing patient and family interest in complementary therapies and the desire of medical and nursing clinicians and administrators to meet the patient demand for these therapies within the context of existing professional services. Because nursing has a long history of a uniquely holistic perspective of health care, seeking an advanced practice nurse (APN) to provide complementary therapies under the auspices of the Pain and Symptom Management Service seemed appropriate.

Nursing's role always has been to support the healing process. In 1859, Florence Nightingale wrote in her *Notes on Nursing* that "nature alone cures . . . and what nursing has to do is put the patient in the best possible condition so that nature can act upon [the person]" (Nightingale, 1970, p. 74–75). In the Commonwealth of Massachusetts, this legacy was continued, when, on September 10, 1997, the Board of Registration in Nursing issued Advisory Ruling 9801, "Holistic Nursing and Complementary Therapies," authorizing the use of complementary therapies in the practice of nursing to meet goals of ". . . increased comfort, relief of pain, relaxation, improved coping mechanisms, reduction or moderation of stress, and an increased sense of well being." This ruling provided the basic description of complementary therapies that would be offered through the Pain and Symptom Management Service. Specifically, these therapies included massage as a nursing intervention, therapeutic touch (TT), Reiki, reflexology, imagery, hypnosis, and other therapies, such as Shiatsu, aromatherapy, and music therapy (Board of Registration in Nursing, 1997).

Synchronizing the Nursing Roles Within the Service

Because of the disparate backgrounds of its APNs—one was an adult oncology NP specializing in pain and symptom management and the other was a pediatric NP and licensed family counselor functioning as an APN providing complementary therapies—the nursing roles on the service were clearly delineated. However, each was open to, and appreciative of, the expertise and clinical experiences of the other. As a result, a synergistic and collaborative practice developed. Depending on patient needs, intrateam consults were common. The oncology NP used relaxation response, imagery, and Reiki as appropriate to augment more conventional symptom-management interventions. The complementary-care APN provided symptom assessment and frequently recommended conventional symptom management referrals.

The complementary-care APN began seeing patients at their request with the knowledge of their oncologists. Specifically, the role of the complementary-care APN was to provide educational consults and individualized therapeutic interventions to address chief complaints and the patient's needs, values, experiences, and overall condition. The APN provided complementary therapies that in-

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cluded many of those listed in the nurse practice act, including relaxation response, guided imagery, TT, and Reiki (see Figure 1). In addition, the Pain and Symptom Management Service added yoga and mindfulness meditation to the list of available therapies because of the complementary-care APN's training and background in these areas.

At the same time that these complementary healing modalities were offered to patients through the Pain and Symptom Management Service, staff education, including theoretical and experiential components, was initiated. The purpose of these educational programs was to ensure that staff had personal experience and a beginning level knowledge of the theory and research supporting each of the complementary therapies that were being offered to patients. For staff interested in incorporating some of these therapies into their clinical practice, additional training classes and ongoing mentoring were made available.

Complementary Therapies

The **relaxation response**, first described by Herbert Benson (1975), involves the repetition of a word, sound, prayer, thought, phrase, or muscular activity. The relaxation response incorporates passive return to the repetition when distracted (Benson). The purpose of the relaxation response is to quiet the mind and the body and reduce stress.

Guided imagery, visualization, and hypnosis have long been a part of holistic nursing care. **Guided imagery** is a conscious thought process facilitated by a skilled clinician that invokes and uses the senses of vision, hearing, smell, taste, and touch, as well as movement and position. Conversely, **visualization,** which involves the same conscious thought process, is performed by an individual without being "guided" by another person. By engaging all of the senses through guided imagery or visualization, a person can change the subjective experience of a given situation so that he or she experiences less stress, anxiety, or pain. **Hypnosis** is similar to the relaxation response and guided imagery but goes a step further. It is a highly focused internal state of attention that elicits the relaxation response and allows one to be more receptive to specific therapeutic suggestions for healing or change (Dossey, Keegan, & Guzzetta, 2000).

Mindfulness meditation is the process of purposefully paying attention to what is happening right here, right now (Hanh, 1975). Patients are invited to enter more fully into the experience of the present moment, rather than intentionally being guided away from or distracted from their experiences. This is achieved by first learning to pay attention to the physical sensation of each inhalation and exhalation as it happens. The focus of attention then can be shifted from the breath to thoughts, sounds, sensations, or emotions. In this process, one can develop a sense of being a witness or compassionate observer of one's own experience without being drawn into the drama of what may have happened in the past or could possibly happen in the future (Kabat-Zinn, 1994).

Relaxation response
Therapeutic touch
Mindfulness meditation
Guided imagery/visualization
Reiki
Yoga

Figure 1. Complementary Therapies Offered Through Pain and Symptom Management Service

Therapeutic touch is a form of energy healing that has been adapted from ancient healing arts and used by nurses in hospital and ambulatory settings since the 1970s (Krieger, 1979). **Reiki** is another form of energy healing that nurses have used more recently (Olson & Hanson, 1997). Both TT and Reiki are ancient forms of healing that involve energy exchange from the practitioner to the receiver. This flow of energy has the effect of eliciting the relaxation response to support the healing process in the person receiving the treatment (Krieger; Macrae, 1988; Olson & Hanson).

Yoga is another ancient art that has potent healing possibilities. When doing yoga, one uses a combination of breath awareness and breath control with meditation, movement, and chanting to facilitate deep healing of mind-body-spirit (Feuerstein, 1998).

The New Look of the Service

After incorporating these healing modalities, the types of referrals that the Pain and Symptom Management Service received began to change. Although the service continued to offer ways for patients to optimize pharmacologic and conventional nonpharmacologic interventions for pain, nausea and vomiting, and other symptoms, the number of requests for complementary care, either separately or in combination with conventional care, increased monthly during the first year of the integrated service. During the first year, the Pain and Symptom Management Service had a total of 2,736 patient contacts, which included new patient consults and follow-up for active patients. Of these, about 1,600 were for conventional pain and symptom management and nearly 1,200 were specifically for complementary care. This referral trend reinforced what previous studies have reported regarding the use and acceptance of the integrated service by patients, families, and providers (see Figure 2).

Types of Consults

In 1999, most of the complementary care consults (25%) were requests for help with reduction of stress and for training in the relaxation response. Another 24% of patients specifically requested "energy work" in the form of TT or Reiki. Some asked for "that touch-not-touch stuff that helps you feel better," and "you know, that energy treatment that relaxes you." In addition, staff received specific requests for guided imagery (10%). Some patients wanted resources and references, others wanted to experience guided imagery, and still others requested an audiotape be made specifically for them to use during treatments or at home. Fifteen percent of patients requested assistance with anxiety related to their diagnosis or treatments. Some patients requested specific interventions including meditation (5%), yoga (2%), herbs (1%) or help with insomnia (1%). Two percent wanted nonpharmacologic interventions for pain control (see Table 1). Another group of patients (10%–15%) requested information about complementary care in general. Examples of these patient requests included

- "I have a diagnosis of cancer. What do I need to know about in terms of complementary care? What's out there?"
- "I'm getting chemotherapy, and I've heard acupuncture might be helpful."
- "I'm a little bit worried about just going out and signing up with somebody for some sort of complementary care. What do I need to know? How can I find somebody who is competent? Is there anybody who has done any research on any of this?"

Patients often were surprised that such requests triggered a more complete assessment

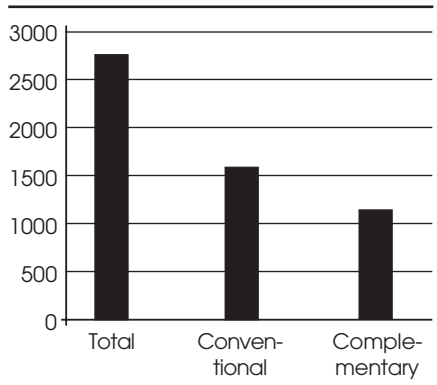

Figure 2. First Year Contacts for Integrated Service (1999)

Table 1. Reasons for Referrals for Complementary Therapies (1999)

Therapy	%
Stress reduction/relaxation	25
Therapeutic touch	24
Anxiety	15
Complementary care inquiry	15
Guided imagery/visualization	10
Meditation	5
Pain control	2
Yoga	2
Herbs	1
Insomnia	1

from a holistic nursing perspective. Some questions asked during the complete assessment included: How many hours a night are you sleeping? How is your diet? How would you rate your stress? Do you feel like you are depressed? What kind of exercise are you getting? What kinds of things are different in your life now?

Patient response to the blended care was enthusiastic, resulting in increased referrals specifically for complementary care from medicine, nursing, social work, nutrition, and patients themselves. Patient self-referrals often were based on word of mouth and came from the community at large. A case study illustrates the benefits of this integrated care model.

Case Study

The following case study demonstrates how both complementary and conventional interventions were used to relieve pain and enhance symptom management. A 35-year-old male with angiosarcoma metastasized to the liver at the time of diagnosis was admitted with a pericardial effusion and referred to the Pain and Symptom Mmanagement Service because of severe back pain, nausea, and anxiety.

He was evaluated by both the conventional and complementary-care NPs. Recommendations for pharmacologic management of his symptoms included initiation of oxycodone SR 20 mg every 12 hours as a background analgesia, with oxycodone 10–15 mg every three hours as needed and rofecoxib (Vioxx®, Merck & Co., Whitehouse Station, NJ) 25 mg four times a day for liver capsule pain and chest wall pain from pleural effusions. Prochlorperazine (Compazine®, GlaxoSmithKline, Research Triangle Park, NC) 15 mg spansules every 12 hours was recommended for nausea, and lorazepam 0.5–1 mg every six hours as needed was recommended for anxiety.

An evaluation of complementary therapies revealed that the patient had a black belt in karate. For the first time in his life, he was not able to do any of the forceful movements, punches, and kicks he was used to doing. More devastating to him was the fact that he was so debilitated that he did not have the energy or ability to carry out his daily karate routine. Building on his background in karate, recommendations were made for modified, gentle yoga movements supported by breath. This allowed him to move fluidly in a conscious way, supported by breathing techniques, much as he had in karate. He found the yoga to be very useful, and it also reassured him that he could maintain some continuity in his usual daily practice.

He was interested in Qi Gong, an ancient Chinese practice that combines breath, movement, and meditation to enhance the flow of vital life energy in the body, but had questions about its form and practice. He requested and was given some references so he could explore this more on his own and decide whether it was something he wished to pursue. He also requested TT, saying, "I've heard that might help, and I want to try to reduce the amount of pain medicine I have to take. I don't like being sleepy." After his first TT treatment, he found that his pain was reduced, and he felt peaceful and calm. As a result, TT was incorporated into his treatment plan on a regular basis.

In the days after the complementary therapy interventions, he was able to reduce the amount of pain medication that he was taking. The nausea was alleviated to the point that he stopped antiemetics. He was able to use breathing techniques and yoga movements to control his anxiety episodes, which initially became fewer in number and less intense, and then disappeared completely. He articulated that the complementary therapy interventions allowed him to use less medication for pain, nausea, and anxiety. He was able to sustain these practices and continued to use minimal pharmacologic symptom control measures even as his disease progressed.

All patients may not do as well as this patient, but the case study illustrates the usefulness of combining conventional and complementary care interventions. Individualized and comprehensive therapeutic plans can improve quality of life for our patients.

Summary

One goal of oncology nursing is to help patients achieve the best possible quality of life. In the conventional care perspective, quality of life has four aspects: physical, emotional, social, and spiritual (see Figure 3). From the complementary care perspective, it is defined as harmony of body, mind, and spirit (see Figure 4). Integrating these perspectives of quality of life allows us to have a fuller and richer view of the patient, accentuating the core of his or her being: values, beliefs, and goals (see Figure 5). The Pain and Symptom Management Service has embraced this integrated view and, by doing so, has improved symptom management outcomes for patients and their families.

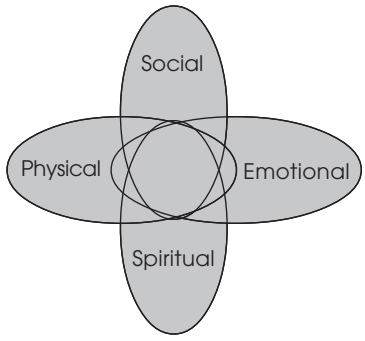

Figure 3. Conventional View of Quality of Life

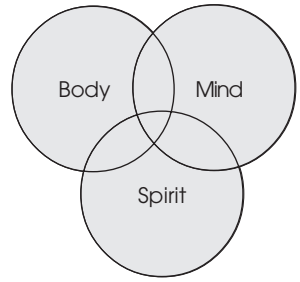

Figure 4. Holistic View of Quality of Life

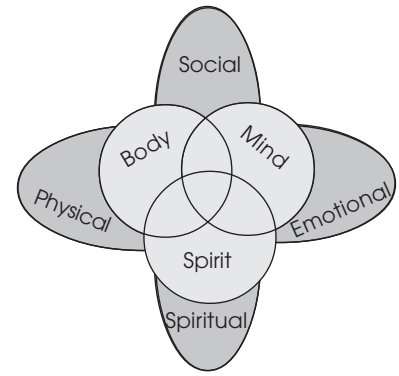

Figure 5. Integrated View of Quality of Life

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