An Integrative Approach to Addressing Clinical Issues in Complementary and Alternative Medicine in an Outpatient Oncology Center

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Complementary and alternative medicine (CAM) is popular among patients with cancer and often is used in conjunction with conventional medicine, mostly without the knowledge or guidance of healthcare professionals. The popularity of CAM has brought into sharp focus clinical issues such as the lack of disclosure and concern about interactions among dietary supplements, prescribed medications, and diseases. Those clinical issues underscore the need for a coordinated approach to integrate CAM therapies safely into conventional medicine. This article describes how an integrative CAM program in an outpatient oncology center addresses some of the clinical issues. The CAM program uses a nurse specialist to interface between CAM and conventional medicine. An interesting aspect of the CAM program is the provision of patient consultation and the creation of an individualized complementary therapies plan.

At a Glance

✦ A complementary and alternative medicine (CAM) program is created to address challenging clinical issues that result from the steady increase in CAM use.

✦ The goal of a CAM program is to integrate CAM therapies into conventional medicine, thus addressing some of the clinical issues such as communication gaps among CAM users, healthcare providers, and CAM practitioners.

✦ A special feature of the CAM program is the provision of an individualized patient consultation by a nurse specialist. The end result of the consultation is a complementary therapies plan, based on established standards of practice, for the patient to use.

Use of complementary and alternative medicine (CAM) among the general population, and patients diagnosed with cancer in particular, has increased steadily since the 1980s. Many of the therapies are used in conjunction with conventional medicine; consequently, several challenging clinical issues have surfaced that must be addressed. The issues include the lack of disclosure of CAM use by patients to their providers (Eisenberg et al., 1998; Yates et al., 2005), concerns about safety and efficacy surrounding CAM therapies (Henderson & Donatelle, 2004), and lack of knowledge about CAM on the part of patients and healthcare providers (HCPs) (Kreitzer, Mitten, Harris, & Shandeling, 2002; Rosenbaum, Nisly, Ferguson, & Kligman, 2002).

In response to these challenges, an outpatient oncology center created an institutional committee of physicians, nurses, and other providers to investigate how best to meet the demands for CAM and to address these clinical issues. The outcome was the development of a CAM program that gained the full support of administrators, physicians, nurses, and social workers. The goal of the CAM program is to integrate complementary therapies into conventional medicine practice. In a newly developed role, a nurse specialist (NS) who is knowledgeable in CAM and conventional medicine was assigned to further develop and manage the CAM program. The ability of the NS to navigate between CAM and conventional medicine facilitates integration and bridges the gap between patients, other providers, and CAM practitioners. A special feature of the CAM program is the provision of an individualized patient consultation by the NS. This approach is unique because the consultation provides a forum for patient education about CAM, the beginning of an invaluable therapeutic relationship, and the creation of an individualized complementary therapies plan (CTP).

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Defining Complementary and Alternative Medicine

In 2005, the Institute of Medicine (IOM) offered a composite definition of CAM.

Complementary and alternative medicine (CAM) is a broad domain of resources that encompasses health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the dominant health system of a particular society or culture in a given historical period. CAM includes such resources perceived by their users as associated with positive health outcomes. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp or fixed (p. 19).

This definition takes key elements in the field of CAM into consideration, such as differing healthcare practices, beliefs, and theories; patients’ perspective of perceived health benefits; and the recognition that the boundaries between the different systems are fluid and have the potential for change. Several classifications of CAM exist. The National Center for Complementary and Alternative Medicine (2005) suggested five categories: (a) alternative medical systems such as traditional Chinese medicine, (b) mind-body interventions such as meditation, (c) biologically based therapies such as herbs, food, and vitamins, (d) manipulative and body-based therapies such as massage, and (e) energy therapies such as Reiki.

Complementary and Alternative Medicine Use by Adults With Cancer

The prevalence of CAM use in the general population gradually increased from 1990–2004, a trend that is captured collectively in several large national studies (Barnes, Powell-Griner, McFann, & Nahin, 2004; Eisenberg et al., 1993, 1998; Ni, Simile, & Hardy, 2002). Estimated CAM use by patients with cancer in a systematic review of 26 published studies in 13 countries showed an average prevalence of 31% and a range of 7%–64% percent (Ernst & Cassileth, 1998). This is consistent with the different studies undertaken in the United States that documented usage ranging from 28% (Burstein, Gelber, Guadagnoli, & Weeks, 1999) to 91% (Henderson & Donatelle, 2004; Yates et al., 2005).

The demography of CAM users remains consistent over time. Almost all studies showed that a significant number of patients with cancer have a higher level of education and socioeconomic status. CAM users are more likely to be female and use more than one CAM therapy in conjunction with conventional medicine. Reasons for CAM use are the belief that these therapies can (a) boost immune function, (b) prevent cancer and/or improve quality of life, (c) increase the feeling that patients are more in control and play an active role in their own care, and (d) palliate symptoms of cancer treatment (Richardson, Sanders, Palmer, Greisinger, & Singletary, 2000; Sparber et al., 2005).

Preferences for CAM therapies vary. Several studies report a high prevalence of the use of prayer, dietary supplements (Hann, Baker, Denniston, & Entrekin, 2005; Lengacher et al., 2002), massage (Kao & Devine, 2000; Morris, Johnson, Homer, & Walts, 2000), and relaxation techniques (Henderson & Donatelle, 2004). The use of dietary supplements is estimated to be particularly popular in patients with breast, gynecologic, and prostate cancers (Lengacher et al.; Swisher et al., 2002; Wilkinson et al., 2002).

Clinical Issues in Complementary and Alternative Medicine for Cancer

Communication

Nondisclosure of CAM use by patients with cancer has been well documented, with studies reporting rates from 40%–70% (Ashikaga, Bosompra, O’Brien, & Nelson, 2002; Yates et al., 2005). Reasons given for nondisclosure on the part of patients were “it wasn’t important for the doctor to know” (61%) and “the doctor never asked” (60%) (Eisenberg et al., 2001). Yates et al. suggested two other issues surrounding nondisclosure: (a) Patients do not see CAM’s potential to affect their standard cancer treatment, and (b) patients did not perceive the therapy they were using as CAM. Other possible reasons are feared disinterest or negative response by the provider or the view that the discussion is a poor use of time (Powell, Dibble, Dall’Era, & Cohen, 2002; Tasaki, Maskarinec, Shumay, Tatsumura, & Kakai, 2002). Additionally, discrepancy exists between the documented prevalence of CAM use and what HCPs believe the prevalence to be among their patients (Kao & Devine, 2000; Richardson, Masse, Nanny, & Sanders, 2004; Rosenbaum et al., 2002). That patients do not reveal CAM use to HCPs is a particular concern because the safety and efficacy of some CAM therapies are not yet fully known.

Safety and Efficacy of Dietary Supplements

Dietary supplements are vitamins, minerals, amino acids, herbs, or botanicals. An estimated 16%–20% of patients use dietary supplements in conjunction with prescription medication (Kauffman, Kelly, Rosenberg, Anderson, & Mitchell, 2002). Studies suggest that a significant number of patients use supplements without the guidance of an HCP because they often are perceived as natural, harmless products that have no side effects (Henderson & Donatelle, 2004; Richardson et al., 2004). Dietary supplements contain active ingredients and may not have undergone methodologically sound scientific testing. The lack of scientific data is compounded further by the current lack of requirement for companies to produce safety and efficacy data prior to marketing.

Additionally, the possibility of herb-vitamin-drug interactions exist. In this regard, data support that some herbs, when used concurrently with prescription medications, can lower the effectiveness of the medications. A common example is St. John’s Wort, which has been shown to lower the efficacy of irinotecan, warfarin, and indinavir (Piscitelli, Burstein, Chaitt, Alfaro, & Falloon, 2000). Data also support the possibility of herb-cancer interactions. Black cohosh, which has estrogenic properties, may adversely affect hormone-sensitive cancers such as breast and ovarian cancers (Natural Medicines Comprehensive Database, 2005).

Of equal gravity is that some herbs or vitamins, when given in doses higher than recommended, have been proven either ineffec-
tive or potentially harmful. An example of the former is megadose vitamin C, which has been the subject of two randomized trials that did not support the claim that the vitamin could cure cancer (Creagan et al., 1979; Moertel et al., 1985). An example of the latter is laetrile, which has been shown to have toxic side effects and failed to demonstrate benefit in a phase II clinical trial (Moertel et al., 1982). The combination of the previously mentioned concerns and the high prevalence and use of dietary supplements underscores the critical need for the education of patients and HCPs who need to be knowledgeable about the pertinent issues in cancer care and how best to advise their patients.

Lack of Guidance and Reliable Information

Studies looking at how patients obtain CAM information demonstrate that HCPs were sought less often (physicians [7%], nurses [9%], and CAM practitioners [18%]) than friends (75%), media (55%), and family (43%) (Swisher et al., 2002). The pattern of obtaining CAM information from non-HCP sources is consistent with that reported in other studies (Helft, Hudocky, & Daugherty, 2003; Sparber et al., 2000). CAM information obtained from poorly informed sources can be misleading and can create confusion and false hopes, leading patients to delay or refuse conventional therapy. Patients’ pattern of obtaining CAM information would suggest that their need for accurate and reliable information has not been met.

Addressing Clinical Issues in Complementary and Alternative Medicine Use

Patient Consultation and the Creation of an Individualized Plan

Upon referral to the newly established CAM program, patients complete a health assessment form that the NS reviews prior to the 45- to 60-minute consultation appointment (see Figure 1). Overall, the NS creates an environment that encourages open and meaningful discussions about CAM and is respectful of patients’ perspectives: cultural, psychosocial, and emotional well-being; and treatment choices. The best approach to the individualized consultation is one that creates the optimal conditions for establishing a therapeutic relationship that eases the healing process and enhances health and well-being. Emphasis is placed on creating a safe, respectful, and nonjudgmental environment via active listening and by showing care, compassion, kindness, and understanding (Mitchell & Cormack, 1998). The end result of the consultation is a better-informed patient and the beginning of an invaluable therapeutic relationship.

During consultations, the NS guides and educates patients. Per oncology center guidelines, the NS explains that CAM therapies are an adjunct to conventional medicine rather than an alternative approach. The NS inquires whether patients are using or are planning to use CAM and discusses these therapies in the framework of safety and efficacy data to support or discourage their use. When advising patients about CAM use, the NS supports the safe integration of CAM. Patients are encouraged to ask questions and report adverse events during their care. The NS accesses the most up-to-date resources, conducts literature searches, and ensures that the information patients receive about CAM is reliable and accurate in the creation of a CTP. Figure 2 outlines the consultation process.

Guidelines Used When Creating a Complementary Therapies Program: Risk Management

When creating a CTP and advising patients about CAM, guidance is modeled after the Hippocratic oath of “do no harm,” the IOM recommendation that the same standard for clinical efficacy be applied to CAM and conventional medicine (IOM, 2005), and Cohen and Eisenberg (2002). Although the following guidelines have not yet been developed into a formal written policy, they are used by the NS when advising patients about CAM use.

Recommend: Evidence of safety and efficacy is available. When CAM therapies fulfill the safety and efficacy criteria, they are said to be within the standard of practice or care. From the safety perspective, no documented life-threatening and permanent adverse events may be associated with the therapy. An example is the use of acupuncture for chemotherapy-related nausea and vomiting.

Reasonably acceptable: Evidence supports safety but is inconclusive regarding efficacy. When CAM therapies do not satisfy the efficacy criteria but meet the safety criteria, they are said to be below the standard of care. These therapies do not harm patients. Any documented adverse events are not life threatening. An example is the incorporation of dietary fat reduction in adults with cancer.

Discourage: Evidence indicates either ineffectiveness or serious risk. CAM therapies in this category have reliable documentation of a major adverse event that may be life threatening or permanently disabling in nature. An example is taking a vitamin or herb in higher-than-recommended doses in the absence of close monitoring by HCPs.
Working With the Healthcare Team

Bridging the Communication Gap

Once a CTP is developed, a copy is provided for the patient, the referring HCP, and medical record. The CTP is reviewed periodically and adjusted accordingly by the patient and the NS, thus encouraging the patient to be an active partner in his or her health and healing process. Ongoing communication is facilitated at formal weekly team meetings where information about patients is exchanged among the social worker, nutritionist, RNs, and NS, providing the opportunity to identify patients who require follow-up. Informal communication among the team occurs in person or via telephone as needed.

When patients are ready to implement the CTP, the NS refers them to CAM therapies that are offered at the oncology center, such as acupuncture, Reiki, Qi Gong, or yoga. For a more invasive treatment such as acupuncture, the NS obtains a medical clearance stating that laboratory results and the patient’s health status are at a level that would be safe to proceed with the CAM intervention. For interventions not offered in the oncology center, referrals are made to outside CAM practitioners. To ensure safe implementation and with the patient’s written permission, the NS communicates relevant health information between the conventional and CAM practitioners. In this manner, the CAM practitioners are included as valuable members of the healthcare team. Figure 3 shows an excerpt from a sample CTP plan. Working with CAM practitioners, though, raises concerns surrounding liability and credentialing. Although addressing those issues at length is beyond the scope of this article, a brief description as to how the author’s oncology center handles such issues is offered later.

Bridging the Education Gap

As part of the integration effort, the oncology center offers lectures and seminars on CAM topics such as traditional Chinese medicine, herbal medicine, meditation, and therapeutic massage. Patients, HCPs, and CAM practitioners are invited to attend. The educational activities, as well as information available on the Internet (see Figure 4), promote open dialogue among CAM practitioners, patients, and HCPs. Given time, the seminars likely will expand the knowledge base of all involved.

Creating Partnerships With Outside Agencies

Patients with cancer can incur significant out-of-pocket expenses despite possessing insurance. For many, a cancer diagnosis may jeopardize earning capacity. Most CAM therapies are not covered by insurance, although a new set of integrative healthcare codes may provide a national health information infrastructure in the future (ABC Coding Solutions, n.d.). Partnering with schools of bodywork or oriental medicine and nonprofit foundations is a potential avenue to gain low-cost access to CAM interventions such as Reiki, acupuncture, yoga, and massage. In the author’s CAM program, those services may be provided in the oncology center, thereby minimizing patient travel during active treatment.

Credentialing Complementary and Alternative Medicine Practitioners

A clear scope of practice and credentials are two important professional areas for practitioners. Credentialing is a way to protect...
patients from unsafe, inappropriate, or incompetent practices and to facilitate access to reasonably safe and effective therapies. HCPs such as physicians, advance practice nurses, and RNs with state licenses practice with appropriately defined scopes and have established mechanisms for credentialing. Not all CAM practitioners are certified, however, because their specialty areas may lack uniformity and an established credentialing process. Reiki and yoga practitioners do not have standard educational requirements, state licensing, or a defined scope of practice. Practitioners of acupuncture and oriental medicine and massage therapists are licensed in most U.S. states. The variations in licensure and credentialing present a challenge in the field of CAM and in the integration of CAM into conventional medicine.

To address this need, the oncology center’s department of medicine processes practitioners who have a state license (e.g., acupuncturists, massage therapists). In addition, when partnerships with outside agencies are generated, the respective attorneys review and sign the agreement. Reiki or yoga practitioners are interviewed to ensure competency using criteria such as the number of years they have been in practice, the number of training hours they received, and the characteristics of their practice. Following the review of reference letters, the practitioners attend an orientation fulfilling Joint Commission on Accreditation of Healthcare Organizations requirements and are supervised by the NS on a daily basis.

Patients are referred only to outside CAM practitioners who have been through a formal screening process involving a site visit and interview. Attention is placed on professionalism, attitude toward conventional medicine, cleanliness of the office, and helpfulness of the staff. These criteria are used to minimize liability and protect patients’ interests. The NS maintains a database of outside practitioners who have experience working with patients with cancer and have completed the formal screening process.

Challenges of an Integrative Approach

Difficult but not insurmountable challenges to an integrated approach to cancer care are differing practice beliefs, lack of a common medical language, and wavering support from conventional and CAM practice communities. Differences in practice beliefs between conventional medicine and CAM at times can appear to be a clash of two opposing paradigms (Kaptchuk & Miller, 2005). Researchers argue that pluralism is more suitable because it requires the cooperation of various systems where differences in approach and beliefs are recognized and respected.

Lacking a common language poses difficulties for conventional and CAM providers to fully understand what is meant by terminology. For example, a traditional Chinese medicine practitioner may describe a clinical condition as “counterflow stomach qi,” whereas a conventional provider could diagnose the same condition as “nausea and vomiting resulting from side effects of chemotherapy.” The NS, aware of the language difference, can interface between the two paradigms to aid in the practitioners’ understanding of one another and the patient. A formal way to address this problem in the CAM program is by obtaining an initial intake and subsequent progress report documenting a patient’s health status, which is available for HCPs to review in the medical record.

For an integrated CAM program to be successful, support from the institution and healthcare team is critical. The CAM program described in this article gained the necessary support as reflected in the referral pattern in its first year: 57% from physicians, 20% from an on-staff advanced practice nurse, and the remaining from RNs, social workers, and nutritionists. The positive trend in the referral pattern, together with continued demand by patients, continues to validate the need for the CAM program.

Conclusion

An effective approach was developed by an outpatient oncology center to encourage the safe integration of CAM therapies into cancer care and bridge a gap between CAM and conventional oncology communities. It has the unique feature of an NS who is knowledgeable in cancer CAM and conventional medicine and the development of a CTP for patients that works within the context of an oncology healthcare team based on established standards of practice.

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