**Integrative Palliative Care**

Complementary medicine in oncology

Eran Ben-Arye, MD, Yifat Katz, RN, MA, Daphna Wolf, DCO, and Noah Samuels, MD

**Edith**, a 27-year-old, had recurrent invasive ductal carcinoma of the breast, which metastasized to the chest wall, skin, lung, and bones. Her oncology nurse referred her to the complementary and integrative medicine (CIM) service, which is located in a conventional oncology department. Edith complained of many concerns related to quality of life (QOL), such as fatigue with a feeling of heaviness, generalized pain with reduced sensation in both legs, constipation, disturbed taste sensation, mouth sores, insomnia, and facial swelling, which prevented her from going out with friends. She hoped that the CIM program would empower her and help with her physical functioning. She said, “I feel that I alone must bear the burden of the disease on my shoulders, so as not to ‘break’ those around me; I am the responsible adult at home.”

**Martha**, a 59-year-old author with metastatic colon cancer, had “persistent thoughts about dying” and a sense of “disconnectedness from the Spring of Creation.” She suffered from painful ulcerating subcutaneous metastases and was scheduled for home hospice care.

**Dora**, a 79-year-old widow with recurrent metastatic breast cancer, suffered from chemotherapy-induced peripheral neuropathy with an abnormal sense of touch of the lower limbs and left shoulder and temporomandibular joint pain, limiting her ability to chew. She suffered from a disturbed sense of taste, decreased appetite, nausea, weight loss, and fatigue, and looked forward to dying to end her suffering. She stated, “I do not find any purpose in life.” However, after her treatment had been changed (from paclitaxel [Taxol®] to docetaxel [Taxotere®]), her symptoms decreased and her QOL improved, as did her perception about living. “At present, I do not really want to die,” she said.

**The Integrative Setting**

Patients are referred by oncologists, oncology nurses, and psycho-oncologists, and undergo a consultation by an integrative physician (IP) dually trained in CIM and supportive cancer care. IP consultations and CIM treatments are provided free of charge to patients undergoing chemotherapy. The IP addresses expectations and QOL-related concerns, and designs CIM treatment plans with patients. The treatment plan and goals are sent to the referring oncology care provider and to the patient’s primary care physician (Ben-Arye, Israely, Baruch, & Dagash, 2014). CIM treatments are provided weekly by a multidisciplinary team of four IPs, two nurses, three paramedical practitioners (i.e., a psycho-oncologist, a clinical dietitian, and an occupational therapist), and seven nonmedical practitioners (i.e., spiritual care providers, a music therapist, acupuncturists, and a manual and movement therapist). All CIM practitioners are trained in supportive cancer care.

**KEYWORDS**

palliative care; Paula method; quality of life; integrative medicine; oncology nursing

**DIGITAL OBJECT IDENTIFIER**

10.1188/17.CJON.290-293
the CIM service. Katz, a RN with a master’s degree in public administration, works in a specialized wound-care clinic. She has extensive training in traditional Chinese medicine and joined the service as part of a pilot project examining the integration of CIM-trained RNs in supportive cancer care. She incorporates CIM treatments, such as acupuncture and herbal and nutritional counseling, into her care and uses her skills in wound care when needed.

Wolf, a CIM practitioner, has degrees in geography and history but left her job in the film industry at age 26 years, following a stroke. She began to study complementary medicine, focusing on natural medicine and cranial osteopathy, as well as the Paula and Feldenkrais methods, manual therapies originating in Israel during the 1950s and 1960s. Katz and Wolf bring different and varied backgrounds, as well as paradigms of care, to the management of patients undergoing chemotherapy.

During a staff meeting, Katz and Wolf discussed the biologic, psychological, social, cultural, and spiritual challenges and treatment options for their patients. The two often have different opinions, although they agreed that Edith, Martha, and Dora required interventions to address their physical pain and emotional distress (see Table 1). Katz preferred to focus on concerns and treatment goals that had been discussed during the IP consultation, primarily insomnia (Edith), wound care (Edith and Martha), and difficulty chewing and impaired physical functioning (Dora).

Katz recommended that Edith receive conventional wound care in conjunction with CIM treatments. Katz used silver-sulfadiazine bandages to debride the ulcerated skin lesions, while providing acupuncture and other CIM modalities. Later, Katz became Martha’s case manager when she began home hospice care.

Wolf’s approach to healing provides the CIM team with a different paradigm of care, combining her knowledge and experience while providing a unique perspective on patients’ concerns that need to be addressed. Her integration of the Paula and Feldenkrais methods with movement therapies was important to Edith, who expressed a need for physical touch to relieve pain. Dora and Martha reported a reduction in symptoms following their session with Wolf, which addressed symptoms like feelings of stiffness, while also providing an environment of “spiritual healing.” Wolf was also able to help Edith and Martha talk about

"Patients reported improved quality of life and functioning, in a manner that was more synergistic than additive."

### Table 1

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>Treatment goals</th>
<th>CIM treatment modalities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KATZ</strong></td>
<td><strong>CIM PRACTITIONER</strong></td>
<td><strong>EDITH</strong></td>
</tr>
<tr>
<td>Care of ulcerated skin metastases, followed by treatment of pain, fatigue, and insomnia</td>
<td>Wound care, serving as case manager in homecare hospice</td>
<td>Improving jaw pain and chewing function</td>
</tr>
<tr>
<td>Alleviating pain and need for physical touch; later, address emotional and spiritual concerns.</td>
<td>Reducing neck stiffness; later, address emotional and spiritual concerns.</td>
<td>Releasing TMJ spasm and pain, enabling chewing of solid food</td>
</tr>
<tr>
<td><strong>WOLF</strong></td>
<td><strong>CIM PRACTITIONER</strong></td>
<td><strong>EDITH</strong></td>
</tr>
<tr>
<td>Alleviating CIPN, fatigue, constipation, and anxiety</td>
<td>Relieving pain and easing emotional suffering</td>
<td>Alleviating CIPN, pain (legs, left shoulder, and TMJ), despair, taste alteration, appetite loss, fatigue, and insomnia</td>
</tr>
<tr>
<td><strong>INTEGRATIVE PHYSICIAN</strong></td>
<td><strong>CIM PRACTITIONER</strong></td>
<td><strong>EDITH</strong></td>
</tr>
<tr>
<td>Alleviating CIPN, fatigue, constipation, and anxiety</td>
<td>Relieving pain and easing emotional suffering</td>
<td>Alleviating CIPN, pain (legs, left shoulder, and TMJ), despair, taste alteration, appetite loss, fatigue, and insomnia</td>
</tr>
</tbody>
</table>

CIM—complementary and integrative medicine; CIPN—chemotherapy-induced peripheral neuropathy; TCM—traditional Chinese medicine; TMJ—temporomandibular joint
their emotional concerns. All women felt that Wolf had given them the tools and exercises with which they could cope with toxicities related to chemotherapy and cancer-related symptoms.

**The Need for Dually Trained Practitioners**

Katz and Wolf believe that two are better than one. Their collaboration had a significant impact on the treatment of Edith, Martha, and Dora, all of whom were suffering physically, emotionally, and spiritually. The treatment goals were both pragmatic and tangible (e.g., pain management), and the patients reported improved QOL and functioning, in a manner that was more synergistic than additive.

Concepts dominating traditional approaches to medicine, such as yin and yang, suggest that two opposing qualities may complement each other. Wolf and Katz were required to “translate” their vocabulary of care when discussing their treatment strategies. Both therapists described their counterpart’s contribution as a “broadening of outlook,” as was apparent in their treatment of the three patients (see Table 2).

Edith experienced the collaborative approach as a three-way “reflective mirror,” representing herself and her two CIM practitioners. This approach helped her overcome the difficulty of accepting the idea that emotional and spiritual concerns are valid and important outcomes. Wolf taught Edith breathing exercises, which helped her during her final days. Katz and Wolf accompanied her as case managers at the end of her life.

Martha had been hesitant about using CIM; acupuncture and mind–body therapies challenged her understanding of medical care. However, the collaboration between Katz and Wolf, created an environment of trust and safety, enabling her to address her sense of disconnectedness. The therapeutic process addressed body, mind, and spirit. She experienced relief from her painful ulcerating skin lesions and also got to explore beyond the physical symptoms.

Dora’s journey had more of a physical nature, and the CIM treatments addressed the symptoms of pain, stiffness, disturbed taste sensation, decreased appetite, and constipation, which had not responded to other therapeutic options, either conventional or complementary. The collaborative efforts of Katz and Wolf provided Dora with significant relief, and they offered step-by-step guidance on the bridge toward healing.

Addressing patients’ symptom burden in collaboration with other healthcare professionals is an important aspect of oncology care; it can support professionals reporting compassion fatigue and promote professional growth (Back, Deignan, & Potter, 2014). As “wounded healers” (Hankir & Zaman, 2013), healthcare professionals need to enrich their dialogue on treatment, sharing their understanding of patient needs while trying to fill the half-empty therapeutic “glass.” In this way, oncology providers can help soften the difficult challenges of cancer care and enhance compassion.

**Implications for Nursing**

Oncology nurses can be trained in CIM, enhancing the supportive care services provided in their workplace and creating a dialogue and mutual understanding with nonmedical CIM practitioners to promote patient health and well-being.

---

**TABLE 2.**

**PRACTITIONER-PERCEIVED CONTRIBUTIONS OF OTHER PRACTITIONERS TO PATIENT CARE**

<table>
<thead>
<tr>
<th>PRACTITIONER</th>
<th>PATIENT</th>
</tr>
</thead>
</table>
| **Katz** | (Wolf) contributed acupuncture by adding touch and movement modalities, which augmented CIM treatments and reduced specific symptoms (e.g., constipation).<sup>*</sup> | **“Supporting me emotionally as Martha’s condition deteriorated; providing practical tips to alleviate the patient’s pain”**
| | | **“Better management of significant TMJ pain and severe constipation”**
| **Wolf** | “Coprofessional reflection and a tridimensional dialogue with Edith, enabling emotional support” | **“The harmonic collaboration with Yifat tempered Martha’s apprehension toward the medical team [and] helped Martha feel embraced by two attentive practitioners in the room.”**
| | | **“Stiffness characterized not only the TMJ but also the patient’s approach to therapy. Together, we managed to . . . [alleviate] intense TMJ pain that . . . affected appetite and constipation.”**
| **Integrative physician** | “The coupling of [Katz] with [Wolf] produced a shared case managing which resulted in both nonspecific [e.g., empathy and reduced anxiety] and specific effects [e.g., constipation relief] from possible synergistic effects between acupuncture and manual treatments.” | **“The main contribution of the two practitioners was important in bridging the gap in communication between the medical team and the patient. This gap intensified as treatment moved from the oncology department to homecare hospice. Although pain and wounds were the initial presenting concerns, the joint treatment of [Wolf] and [Katz] enabled Martha to better deal with spiritual suffering.”**
| | | **“The collaboration between the two practitioners helped the patient overcome severe and debilitating quality of life–related concerns that were not addressed by either conventional pain management or acupuncture. TMJ relief was very likely due to synergism between several CIM modalities and practitioners.”**

<sup>*</sup>CIM—complementary and integrative medicine; TMJ—temporomandibular joint.
Conclusion
Collaboration of conventional CIM practitioners (e.g., integrative nurses) with nonmedical CIM practitioners can result in a synergy that better addresses patients’ biologic, physical, emotional, and spiritual concerns in supportive cancer care settings.

Eran Ben-Arye, MD, is the director of the Integrative Oncology Program, Yifat Katz, RN, MA, is an RN, and Daphna Wolf, DCO, is an integrative practitioner, all at the Lin Medical Center of Clalit Health Services in Haifa; and Noah Samuels, MD, is the medical director of the Tal Center for Integrative Oncology at the Sheba Medical Center in Tel Hashomer, all in Israel. Ben-Arye can be reached at eranben@netvision.net.il, with copy to CJONEditor@ons.org.

The authors take full responsibility for this content and did not receive honoraria or disclose any relevant financial relationships.

REFERENCES

DO YOU HAVE AN INTERESTING TOPIC TO SHARE?
Supportive Care provides readers with information on symptom management and palliative care issues. Length should be no more than 1,000–1,500 words, exclusive of tables, figures, insets, and references. If interested, contact Associate Editor Ashley Leak Bryant, PhD, RN-BC, OCN®, at ashley_bryant@unc.edu.