

## Editorial

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# Integrating Complementary Medicine in Palliative Care: A Call for an Inter-Disciplinary Collaboration

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The interplay between complementary medicine and palliative care, both of which emphasize a patient-centered approach in order to improve quality of life-related concerns, is extremely important in the oncology setting. The integration of evidence-based complementary medicine therapies within conventional palliative care can expand the available treatment options, especially for chemotherapy-induced toxicities for which conventional medicine options are often limited. The integration of complementary medicine in palliative care may also provide an opportunity to address the bio-psycho-social-cultural-spiritual perspectives of care among those patients and caregivers for whom traditional medicine plays an important role in their health belief model. This integration should evolve as an inter-disciplinary process, as opposed to the intra-disciplinary approach which is being taken in most oncology settings. The inter-disciplinary approach recognizes the variance in approach to patient care, while facilitating a multi-disciplinary approach and enabling specialists from both domains to provide care based on their clinical expertise as well as their perceived health-belief models of care.

Over the past four decades a paradigm shift has been occurring, in which patient-centered care has become the focus of palliative medicine. Palliative care is taking place throughout the oncology setting, which recognizes the importance of addressing concerns related to the patient's quality of life (QOL), and not only outcomes related to survival or other disease-centered parameters. Palliative medicine provides therapeutic options which can reduce the level of suffering among patients and their caregivers, while addressing bio-physical, psychological, social and spiritual needs.<sup>1</sup> Improving QOL may, in turn, lead to a reduction in the use of medical services,<sup>2</sup> and may even impact outcomes such as survival rates among patients undergoing treatment.<sup>3</sup> In light of these findings, the American Society of Clinical Oncology guidelines recommend that “combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden”.<sup>4</sup> The World Health Organization (WHO) has also addressed the importance of palliative care, and provides recommendations for the provision of these therapeutic options as part of standard care.<sup>5</sup> Yet despite the widespread recognition of the importance of palliative care in the oncology setting, the WHO guidelines are often not being implemented, either because palliative care therapies are not recommended as part of the treatment protocol or because they are not being integrated into standard medical practice.<sup>6</sup>

Complementary medicine (CM) includes a wide range of non-conventional therapies, such as traditional and systematic medical approaches; the use of herbal and non-herbal supplements; and diverse methods of mind-body-spiritual, nutritional-based and manual-movement therapies. CM use is widespread among patients with advanced cancer, with as many as 70% reporting this practice before, during and following active treatment.<sup>7</sup> Many patients using CM

believe that these therapies can prolong survival, enhance QOL, reduce chemotherapy-induced toxicities, and increase levels of energy and function.<sup>8-11</sup> For many patients with advanced cancer QOL is severely impaired, and the treatment options provided for this indication by conventional medicine is often limited in its effectiveness.<sup>12</sup> As a result, many patients and their caregivers seek out “natural” remedies, frequently with the goal of curing their cancer, this despite the lack of any evidence as to their effectiveness and with a potential for adverse effects, including interactions with conventional oncology drugs.<sup>13</sup>

Integrative medicine is a concept of care which sees as its goal the integration of CM as part of standard conventional care. Integrative oncology seeks to supplement conventional supportive and palliative care, further enhancing patient QOL.<sup>14</sup> Integrative oncology services have become part of an increasing number of leading cancer centers, and are typically headed by integrative physicians (IPs). The IP is an MD with dual training in complementary medicine and supportive care, working in a multidisciplinary team which includes CM practitioners who are either physicians, nurses or other health care practitioners, as well as non-medical practitioners of CM.<sup>15</sup> Integrative oncology treatments are individualized and patient-tailored, while at the same time following the findings of evidence-based research regarding their effectiveness and safety. Much research has been conducted supporting both of these aspects of CM care, which include explanatory (randomized controlled trials) as well as pragmatic (non-controlled or observational) studies. This research has found a number of CM modalities to be effective and safe for a number of QOL-related concerns, such as the reduction of pain syndromes and improving mood with therapeutic massage<sup>16</sup>; reducing cancer-related fatigue, chemotherapy-induced nausea and vomiting (CINV), anxiety and dyspnea with acupuncture<sup>17-19</sup>; and beneficial effects of herbal products such as ginseng for CRF and ginger for CINV.<sup>20,21</sup>

Integrative oncology emphasizes the importance and centrality of communication between the IP and the “circle of care” which includes the patients themselves and their caregivers, as well as the health care professionals responsible for their care (oncologist, nurse-oncologist, psycho-oncologist, family physician and others). Maintaining open and non-judgmental communication between these parties is essential in establishing an effective and safe environment for the patient-tailored intervention. Such a plan needs to correspond with the concerns of patients and their caregivers, as well as addressing their expectations and willingness to undergo new and often unfamiliar treatment modalities. In addition to being tailored to individual needs and expectations, the integrative treatment plan needs to consider the social-cultural-religious context of the patient’s health belief model. This is especially true in regions such as the Middle East, where collective values often take precedence over those of the individual.

Despite the difference in their fundamental conceptual paradigms, integrative oncology and palliative medicine share an approach which emphasizes the bio-psycho-spiritual and patient-centered aspects of patient care. Both recognize the importance of the need for continuity of care, which begins from the moment the cancer is diagnosed, through active treatment and finally advanced cancer and end of life care. Both employ multi-disciplinary teams which include physicians, nurses, psycho-oncologists and other paramedical professionals in palliative care, and non-medical CM practitioners in integrative oncology. What, then, separates these two paradigms of care? How is the role of the IP different from that of the palliative care specialist? And finally, should the two domains exist separately in an inter-disciplinary framework, or should they co-exist within the same intra-disciplinary setting?

Both palliative medicine and integrative oncology need to choose between specializing in one domain or maintaining a more broad and general perspective. The specialist approach tends to focus on the specifics, analyzing medical challenges from a top-to-bottom perspective which is atomistic and reductionist. In contrast, the generalist approach contemplates a more horizontal and inter-disciplinary view. Interestingly, many IPs and palliative care specialists come from specialties with a more generalist orientation, such as family and internal medicine, geriatrics and others. Indeed, IPs and palliative care specialists share a more peripheral and holistic perspective when addressing QOL-related aspects of care. In addition to their conventional medical education, IPs chose to undergo additional CIM training which requires them to internalize medical philosophies which are not taught in medical schools and which often challenge conventional medicine concepts of care. Many IPs have also taken courses in CM treatments such as acupuncture, homeopathy, mind-body and other techniques, in order to better understand the tools available. As such, the IP should not be viewed merely as a CM practitioner with technical knowledge (e.g., acupuncture). Rather, IPs and their team of CM practitioners should be seen as providing a non-conventional understanding on the meaning of health vs. disease, as well as on the meaning of healing vs. medical management and treatment, especially for QOL-related concerns.

In order for an effective and true integrative process to take place, it is our belief that integrative oncology should take place in an inter-disciplinary model with palliative medicine care, and not one that is intra-disciplinary. We acknowledge the temptation to combine the two approaches. After all, an oncologist can become familiar with the use of herbal medicine; a psycho-oncologist can provide meditation and spiritual care; a palliative care specialist can insert acupuncture needles at designated points; and nurses can be trained in massage therapies such as reflexology. In practice, however, such a generalist approach is unlikely to succeed. The need for specialization in general fields of medicine is reflected in the establishment of subspecialty training in fields such as palliative medicine and psycho-oncology, and this should be the case for integrative medicine as well.

Collaboration between IPs and palliative care specialists needs to be recognized for the many advantages which result from adopting an inter-disciplinary approach. This collaboration can be synergistic, with each discipline providing a solution for the other's "blind spots", significantly increasing the impact on QOL-related outcomes. The differences between these two paradigms of care are their strength, especially since both are committed to the same therapeutic goals. The IP consultation and CM treatments can supplement palliative care in cases where the conventional approach is not able to provide the necessary relief, as well as where there is an expectation regarding the patient's health belief model. Collaboration between IPs and palliative medicine specialists may reduce the "burnout" which results from work with palliative care, inducing a process of post-traumatic growth. And finally, palliative care specialists and IPs need to see each other as essential to patient care, enriching each other and advancing an inter-disciplinary collaboration within their joint medical institution.

## REFERENCES

1. The National Consensus Project for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care. 3<sup>rd</sup> ed. 2013; <http://www.nationalconsensusproject.org/>. Accessed September 19, 2016.
2. Ferris FD, Bruera E, Cherny N, et al. Palliative cancer care a decade later: Accomplishments. The need, next steps – from the American Society of Clinical Oncology. *J Clin Oncol*. 2009; 27: 3052-3058. doi: [10.1200/JCO.2008.20.1558](https://doi.org/10.1200/JCO.2008.20.1558)
3. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med*. 2010; 363(8): 733-742. doi: [10.1056/NEJMoa1000678](https://doi.org/10.1056/NEJMoa1000678)
4. Smith TJ, Temin S, Alesi ER, et al. American Society of Clinical Oncology provisional clinical opinion: The integration of palliative care into standard oncology care. *J Clin Oncol*. 2012; 30(8): 880-887. doi: [10.1200/JCO.2011.38.5161](https://doi.org/10.1200/JCO.2011.38.5161)
5. World Health Organization. WHO Definition of Palliative Care. Web site. <http://www.who.int/cancer/palliative/definition/en/>. Accessed September 7, 2016.
6. Lee RT, Ramchandran K, Sanft T, Von Roenn J. Implementation of supportive care and best supportive care interventions in clinical trials enrolling patients with cancer. *Ann Oncol*. 2015; 26(9): 1838-1845.
7. Shen J, Andersen R, Albert PS, et al. Use of complementary/alternative therapies by women with advanced-stage breast cancer. *BMC Complement Altern Med*. 2002; 2: 8. doi: [10.1186/1472-6882-2-8](https://doi.org/10.1186/1472-6882-2-8)
8. Correa-Velez I, Clavarino A, Eastwood H. Surviving, relieving, repairing, and boosting up: Reasons for using complementary/alternative medicine among patients with advanced cancer: A thematic analysis. *J Palliat Med*. 2005; 8(5): 953-961. doi: [10.1089/jpm.2005.8.953](https://doi.org/10.1089/jpm.2005.8.953)
9. Paul M, Davey B, Senf B, et al. Patients with advanced cancer and their usage of complementary and alternative medicine. *J Cancer Res Clin Oncol*. 2013; 139(9): 1515-1522. doi: [10.1007/s00432-013-1460-y](https://doi.org/10.1007/s00432-013-1460-y)
10. Naing A, Stephen SK, Frenkel M, et al. Prevalence of complementary medicine use in a phase 1 clinical trials program: The MD Anderson Cancer Center Experience. *Cancer*. 2011; 117(22): 5142-5150. doi: [10.1002/cncr.26164](https://doi.org/10.1002/cncr.26164)
11. Hlubocky FJ, Ratain MJ, Wen M, Daugherty CK. Complementary and alternative medicine among advanced cancer patients enrolled on phase I trials: A study of prognosis, quality of life, and preferences for decision making. *J Clin Oncol*. 2007; 25(5): 548-554. doi: [10.1200/JCO.2005.03.9800](https://doi.org/10.1200/JCO.2005.03.9800)
12. Correa-Velez I, Clavarino A, Barnett AG, Eastwood H. Use of complementary and alternative medicine and quality of life: Changes at the end of life. *Palliat Med*. 2003; 17(8): 695-703. doi: [10.1191/0269216303pm834oa](https://doi.org/10.1191/0269216303pm834oa)
13. Ben-Arye E, Mahajna J, Aly R, et al. Exploring an herbal "wonder cure" for cancer: A multidisciplinary approach. *J Cancer Res Clin Oncol*. 2016; 142(7): 1499-1508. doi: [10.1007/s00432-016-2175-7](https://doi.org/10.1007/s00432-016-2175-7)
14. Deng GE, Cassileth BR, Cohen L, et al; Society for Integrative Oncology Executive Committee: Abrams D, Rosenthal D, Sagar S, Tripathy D. Integrative Oncology Practice Guidelines. *J Soc Integr Oncol*. 2007; 5(2): 65-84. doi: [10.2310/7200.2007.002](https://doi.org/10.2310/7200.2007.002)

15. Ben-Arye E, Schiff E, Zollman C, et al. Integrating complementary medicine in supportive cancer care models across four continents. *Med Oncol*. 2013; 30(2): 511. doi: [10.1007/s12032-013-0511-1](https://doi.org/10.1007/s12032-013-0511-1)
16. Kutner JS, Smith MC, Corbin L, et al. Massage therapy versus simple touch to improve pain and mood in patients with advanced cancer: A randomized trial. *Ann Intern Med*. 2008; 149(6): 369-379.
17. Molassiotis A, Bardy J, Finnegan-John J, et al. Acupuncture for cancer-related fatigue in patients with breast cancer: A pragmatic randomized controlled trial. *J Clin Oncol*. 2012; 30(36): 4470-4476. doi: [10.1200/JCO.2012.41.6222](https://doi.org/10.1200/JCO.2012.41.6222)
18. Barton DL, Liu H, Dakhil SR, et al. Wisconsin Ginseng (*Panaxquinquefolius*) to improve cancer-related fatigue: a randomized, double-blind trial, N07C2. *J Natl Cancer Inst*. 2013;105(16): 1230-1238. doi: [10.1093/jnci/djt181](https://doi.org/10.1093/jnci/djt181)
19. Minchom A, Punwani R, Filshie J, et al. A randomised study comparing the effectiveness of acupuncture or morphine versus the combination for the relief of dyspnoea in patients with advanced non-small cell lung cancer and mesothelioma. *Eur J Cancer*. 2016; 61: 102-110. doi: [10.1016/j.ejca.2016.03.078](https://doi.org/10.1016/j.ejca.2016.03.078)
20. Arslan M, Ozdemir L. Oral intake of ginger for chemotherapy-induced nausea and vomiting among women with breast cancer. *Clin J Oncol Nurs*. 2015;19(5): E92-E97. doi: [10.1188/15.CJON.E92-E97](https://doi.org/10.1188/15.CJON.E92-E97)
21. Rithirangsiroj K, Manchana T, Akkayagorn L. Efficacy of acupuncture in prevention of delayed chemotherapy induced nausea and vomiting in gynecologic cancer patients. *Gynecol Oncol*. 2015; 136(1): 82-86. doi: [10.1016/j.ygyno.2014.10.025](https://doi.org/10.1016/j.ygyno.2014.10.025)