

Move into hospital sector another sign of complementary medicine's growing popularity

Anita Elash

In brief

GROWING DEMAND HAS LED SOME CANADIAN HOSPITALS to offer alternative therapies to patients, even though many physicians still question their efficacy. Anita Elash visited Toronto's Sunnybrook Health Science Centre, where staff physicians have been debating the issue. One physician said hospitals have no choice but to offer the treatments. "If you believe in the primacy of patients making their own decisions and you believe in the fundamental of informed consent, you cannot deny them access to this treatment."

En bref

LA DEMANDE A POUSSÉ LES HÔPITAUX DU CANADA à offrir des traitements parallèles aux patients, même si beaucoup de médecins doutent encore de leur efficacité. Anita Elash a visité le Centre des sciences de la santé Sunnybrook de Toronto, où les médecins membres du personnel débattent de la question. Un médecin a déclaré que les hôpitaux n'ont pas le choix : ils doivent offrir les traitements. «Si l'on croit au droit fondamental des patients de prendre leurs propres décisions et si l'on croit au droit fondamental au consentement éclairé, on ne peut leur refuser l'accès à ce traitement.»

When a patient asks Dr. Georg Bjarnason about complementary therapies — and as an oncologist he gets asked a lot — he keeps his answer simple. First he claims ignorance, and then he explains that if he believed there was evidence alternative methods could help he would offer them himself.

"It's a sensitive issue," says Bjarnason, who practices at the Sunnybrook Health Science Centre in Toronto. "For someone who has metastatic disease, I only have so much to offer. They probably understand they are going to die, so it is understandable they would want to explore some of these things."

When a reporter asks Bjarnason about complementary therapies, however, his answer is less benign. "I think you're fooling the individual by claiming activity that has not been proven," he says. "And whoever is doing it is acting unethically."

Views like his aren't hard to find among medical staff at Sunnybrook. Even so, their patients may soon be able to find the complementary treatments they want on one of the hospital's wards. Sunnybrook's President's Council, which makes rulings on issues of hospital philosophy, is putting the finishing touches on a policy that would allow professional staff, chaplains, social workers and volunteers to use techniques such as aromatherapy, iridology, reflexology and magnetic therapy as part of a patient's regular care. Although none of these treatments has been proved effective by scientific standards and many doctors consider them quackery, Sunnybrook's vice-president of professional affairs says the hospital has no choice but to offer them.

"Whether I believe a therapy such as therapeutic touch is useful is irrelevant," says Dr. Donald Livingstone. "If you believe in the primacy of patients making their own decisions and you believe in the fundamental of informed consent, you cannot deny them access to this treatment."



Features

Chroniques

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Dr. Donald Livingstone: "you cannot deny patients access to these treatments"



To a limited extent, Sunnybrook already allows its staff to provide complementary treatments. About 75 employees, including around 50 nurses, are trained in therapeutic touch — a treatment in which practitioners' hands are waved a few centimetres over patients' bodies in an effort to smooth their energy fields. Nurses, who routinely use the technique as a comfort measure for patients in the palliative care, oncology and orthopedic wards, say the results are remarkable.

Oncology practice leader Tracey Das Gupta, a registered nurse trained in therapeutic touch, says patients who are agitated or in pain usually calm down within a few minutes of treatment. The nurses also seem to benefit. Das Gupta says they find the treatment so soothing they often perform it on one another to relieve stress.

The practice has grown without a policy to govern it, and so has the hospital's acceptance of it. "If a nurse is trained in therapeutic touch, it is part of the nurse's skill set," says Livingstone. However, the need to formalize arrangements for therapeutic touch and other complementary therapies became apparent in 1996 when Livingstone was inundated with "a slew" of alternative practitioners who wanted to set up shop at the hospital. "I had clinics practically knocking down my door," he says. "Many, I think, were looking for market share."

It was hard to send them away, because Sunnybrook's patients had been asking for the treatments. Although Livingstone does not know how often alternative or complementary therapies are requested at Sunnybrook, he does know demand is growing. According to Statistics

Canada's 1994 national health survey, at least 15% of adults surveyed used such therapies in the previous year. A 1996 survey of families with children who were treated for cancer at British Columbia Children's Hospital revealed that 41% supplemented patient care with therapies such as relaxation and imagery, massage, therapeutic touch and herbal teas.

For Livingstone, the main issue is patient autonomy. Three years ago Sunnybrook adopted a corporate philosophy of "patient-centred care" in an effort to erase the paternalism that has ruled hospitals. Today, its doctors no longer offer advice: they offer information and the chance for patients to make their own decisions. "If I prevent patients from making the decision of their choice, then I am imposing my belief on them and I believe that is wrong," says Livingstone. Even so, the hospital recognized that it would need rules to control alternative practitioners.

Livingstone says the proposed policy strides the middle ground between autonomy and quality care. Patients can get the service, but the proposed policy's main provisos — that the practitioner be properly trained and governed by a professional body and that the patient not be charged for the service — protect them and the hospital from self-interested charlatans.

Still, the strategy has raised serious concerns among medical staff. After a lengthy discussion last December, members of the Medical Advisory Committee (MAC) unanimously rejected the policy. According to Livingstone, they argued that it could be mistaken as an endorsement for unproven therapies. "We have 600 physi-

When complementary medicine moves to hospital, ethical issues tag along

As patient demands for alternative treatments increase, so do the ethical dilemmas facing physicians. Often, there seems to be no good choice. Staff at the Vancouver Hospital recently faced the issue firsthand when the family of a Chinese man who had been severely burned in an industrial accident insisted he be given an injectable drug commonly used in China. The treatment was meant to improve his general health, but pharmacologic tests showed it could also cause neurologic damage. Although the physician in charge agreed to the treatment, he refused to administer it on the grounds that hospital rules prohibit the use of unapproved medication.

Nurses also refused after the Registered Nurses Association of British Columbia advised them against doing it. The family eventually agreed to give the injection, but because they were not properly trained the man

struggled and had to be held down each time he got a needle.

Alister Browne, ethics care consultant at the Vancouver Hospital, says the real difficulty was that the patient received suboptimal care. He agrees that medical staff are obliged not to cause harm by administering treatments that have unknown benefits and could be damaging, but argues that refusing alternative care can put patients at just as much risk. "You're put in the position of somebody harming themselves," he says. "For [doctors and nurses] to watch this happen exposes them to just as much ethical and legal liability as if they had given him the drug themselves." Browne says the best solution is to do away with rules that prohibit the use of alternative medications. The change would leave patients and doctors free to make conscientious decisions about a treatment.



cians here and virtually all of them are scientists. . . . Their problem is how to reconcile what is basically an unregulated therapy against stuff that has usually gone through a high degree of evaluation."

A revised version of the policy, which will eventually be presented to the MAC for information, will likely indicate that Sunnybrook neither endorses nor condemns the treatments, but simply wishes to respect patients' wishes.

That is unlikely to mollify critics like Bjarnason. "It re-

mains equally unscientific and unproven no matter who is administering it. If anything happens to a patient we still have to answer for it, so I don't think it is in our interest to do anything of unproven value."

Others are concerned about whether Sunnybrook can afford to provide complementary treatments. Medical oncologist Neill Iscoe says funding cuts have already made it difficult to provide treatments that are well understood and accepted. Allowing staff to use unproven therapies

Changing demographics increasing demand for complementary medicine

Wendy Charbonneau's life fell apart after her jaw was shattered in a car crash 3 years ago. The accident forced her to quit her job as a kindergarten teacher; she also had surgery and became addicted to morphine. Today, she credits therapeutic touch — a complementary therapy that involves waving hands a few centimetres above a patient's body — with restoring at least a semblance of normalcy to her life. Her concentration and self-esteem have improved and she has been weaned off most painkillers.

"I feel I have more inner strength to try things," she says. "I would not have been able to get this far without therapeutic touch." Nor would she have tried the treatment if it had not been available — free of charge — at the Toronto East General Hospital.

"Having it in the hospital gives me confidence in the treatment," she says. "It is a lot more professional and trusting and if you have a complaint you can take it to the hospital board."

Toronto East General set up its therapeutic touch clinic 3 years ago after receiving requests from nurses. Now, administrators plan to open several more clinics for complementary and alternative treatments. Colin Goodfellow, the hospital's director of strategic operations, says available therapies will include Chinese and ayurvedic medicine and acupuncture; they will occupy "at least" a wing. Some practitioners will be independent and simply rent space, while others will be paid by the hospital and see patients referred by physicians.



Colin Goodfellow: "This is the number-one thing people believe we should be doing."

The hospital board decided to open the clinics in response to patient demand. Goodfellow says this has been increasing because patients are better educated. As well, changing demographics mean the hospital's catchment area includes more people from non-Western cultures that employ alternative types of medicine. "This is the number-one thing people believe we should be doing that we are not doing," he adds.

Goodfellow admits his toughest job will be to get physicians on board. He hopes to defuse the opposition by locating general practitioners' offices next to alternative medicine clinics so that they can "work in tandem" from the beginning. Early indications are that doctors will support the strategy as long as complementary caregivers operate under strict controls.

"We recognize [complementary therapy] does have a role to play," says Dr. Haig Basmajian, the chief of staff. "The big area of concern will be to ensure the treatments do have benefits, that there is monitoring and that nobody is harmed." Members of

the Medical Advisory Committee (MAC) have asked management to draft regulations governing the new clinics.

Gastroenterologist Frank Dicum, an MAC member, says he will support the clinics as long as the hospital spells out the conditions they can treat. He also wants patients to undergo screening to rule out serious illnesses that could be treated conventionally.



could constrain resources even more. "We cannot be all things to all people," he says. "If it is being treated as an entitlement, I am concerned."

Nor does everyone accept the premise that patient demands should outweigh professional judgement. "Personal autonomy is not an endless request for whatever one wants," says Eric Meslin, a former staff bioethicist at Sunnybrook.

He agrees that physicians must respect patients' decisions but argues that if they don't set strict limits hospitals could be left without solid arguments against measures that may harm patients. "Certain types of demands are unreasonable," he says.

The question of what constitutes valid scientific evidence remains one of the biggest barriers in the battle for mainstream acceptance of complementary therapies. However, Meslin says the argument that complementary therapies have not been validated "is not a strong one." He says many mainstream treatments, both medical and

surgical, have never been validated by standard studies either.

Dr. Charles Weijer, a general practitioner turned bioethicist at Toronto's Mount Sinai Hospital, says the best way to assess complementary therapies is to stop trying to measure biologic effect. Instead, researchers should consider a package of outcomes such as symptom improvement, pain control and control over nausea and vomiting. "Some treatments, like laser acupuncture, do lend themselves well to study," he says. "But with alternative medicine, outcomes are holistic and diffuse. It is much more difficult to measure holistic well-being."

Whatever their approach, most physicians agree that solid research into complementary treatments can only benefit health care by either confirming their importance or finally laying them to rest. However, Sunnybrook does not intend to contribute to the research, even after it adopts its new policy on complementary therapy.

Livingstone says it doesn't have the money. ?

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