

# Exploring complementary & alternative medicine use by patients in

## residential hospice care in British Columbia

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### Background

Use of complementary and alternative medicine (CAM) by terminally-ill patients and those nearing end-of-life is increasingly common. Yet, there is limited information about CAM use by Canadians in residential hospice care settings. A pilot study was conducted in Vancouver, British Columbia in order to explore hospice patient use and openness to CAM, and which complementary therapies they are most interested in having available to them while in residential hospice care.

### Methodology

**Interviews with patients.** A short, interview-based questionnaire was developed to investigate in a sample of patients in residential hospice care: (a) prior and current use of CAM; (b) interest in using CAM while in hospice care; (c) reasons for use and interest in CAM; and, (d) whether a significant other (spouse, other family member or friend) would also be interested in receiving CAM, and their openness to sharing a CAM intervention with one another. Basic patient demographic data were also obtained.

**Sample.** Our convenience sample included eligible patients from nine hospice sites located in the Metro Vancouver region of BC. Eligibility criteria for participation were that the patient be 19 years of age or older; be able to communicate in either English, Cantonese, Mandarin, Punjabi or Hindi; and be able to consent to their own participation.

At each site, a hospice staff contact assisted with recruitment. Written consent was obtained. An interview took approximately half an hour to complete. Recruitment and data collection occurred over a 10-month period.

**Analysis.** Interview data were entered into an Excel spreadsheet and coded for analysis. Descriptive statistics were used to report percentages of CAM use/interest across the sample. Types of CAM identified by participants and stated reasons for CAM use were coded and summarized.

This study was approved by the Research Ethics Boards of the University of British Columbia/Providence Health Care and the Fraser Health Authority.

### Acknowledgements

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### Results

In total, 48 patients participated (see Table 1). A majority (79%) reported prior experience with CAM and 56% were current users. When asked if interested in receiving CAM while in hospice care, 81% said, 'yes.' All 39 participants who reported interest in CAM stated it should be provided alongside other medical treatment. Approximately 48.7% felt their significant other would also be interested in receiving CAM, and about half of these reported personal interest in sharing the experience with that person.

Table 1: Participant Profile

Participant Characteristics	Total % (n)
<b>Sex</b>	
Male	35% (17)
Female	65% (31)
<b>Age</b>	
<65	48% (23)
65-74	21% (8)
75+	31% (15)
<b>Ethnicity</b>	
Caucasian	76% (36)
Non-Caucasian	25% (12)
<b>Marital status</b>	
Married/common-law	33% (16)
Single/widowed/divorced	67% (32)
<b>Diagnosis</b>	
Cancer	85% (41)
Non-cancer	15% (7)
<b>TOTAL</b>	<b>100% (48)</b>

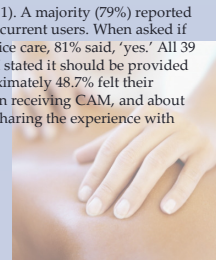
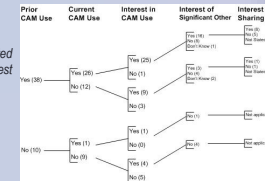


Figure 1 illustrates CAM use/interest as reported by participants. Reasons were relatively stable across prior use, current use and interest in using CAM. The two most often stated reasons for interest in CAM were: (1) 'For relaxation and well-being' and (2) 'Pain relief'.

Figure 1: Participants reported CAM Use/Interest



### CAM types reported by participants for use & interest in using

Table 2: Most frequently reported CAM types by participants

CAM Types	Ranking based on 5 most frequently reported*		
	Prior	Current	Interest
Acupuncture	***	**	**
Chiropractic care	*		**
Energy therapies (Reiki, Therapeutic Touch)	***	***	****
Massage therapy			*****
Meditation (breathing techniques)	****	****	***
Music therapy		***	*
Natural health products			
Spiritual and religious healing	*****	*****	

\*Note: Ranking (most to least)

Table 2 illustrates the 5 most frequently reported CAM types by participants.

Participants reported relatively consistent use and interest in energy therapies and meditation. There was high expressed interest in massage therapy although it was not frequently identified for prior or current use. Spiritual/religious healing was most frequently reported for prior and current use.

### Discussion

Unlike a previously reported study,<sup>1</sup> this pilot found a majority of hospice patients were receiving CAM. The difference between the studies may be due to several reasons, including: (1) Potential under-reporting of CAM use in patient records or disclosure of use by patients to care providers. In contrast, our study focused directly on the patients' perspective; and, (2) The prevalence of CAM use reported in our study may reflect relative openness towards CAM in BC compared to the national average.

In our study, nearly 25% of current non-users expressed interest in receiving CAM, suggesting a potential unmet demand for CAM (and in particular, massage therapy) by hospice patients in a sample of BC hospices.

CAM use/interest may be associated with prior experience using CAM before being admitted into hospice

or other factors that shape a person's views and use of CAM, such as age, gender, cultural background, and interpersonal factors including attitudes and advice from family/friends and health care providers.

As family physicians play a central role in CAM use and referral,<sup>2</sup> we also explored potential congruence between therapies identified in our study and those considered 'acceptable' by physicians.

Prior research suggests acupuncture, chiropractic care, massage therapy, and spiritual and religious healing are 'acceptable' complementary therapies, whereas reflexology, naturopathy, Reiki, and homeopathy are among the 'least acceptable'/clinically useful from the physician's perspective. Generally speaking, our findings were found to align with a CAM classification system based on Albertan family physicians' ratings of effectiveness.<sup>3</sup>

However, we note several challenges in comparing patients and physicians' CAM perspectives: (1) CAM definitions vary between studies making it difficult for meaningful comparative analysis.

(2) Physician characteristics, including knowledge/education of CAM, often influence personal attitudes and behaviours toward CAM use and may, in turn, impact ratings of CAM effectiveness and advice given to patients.

(3) Situational factors, like patient diagnosis and stage of illness, can also affect physician recommendations on CAM use.<sup>4</sup>

(4) Care setting characteristics and policies may also shape patient attitudes toward CAM use. For example, music therapy, massage therapy and therapeutic touch are already commonly provided in Canadian hospice/palliative care settings<sup>5</sup> and therefore may be viewed more positively than other CAM therapies.

Moreover, a hospice's organizational policies; available staff/volunteers and funds for CAM delivery; and CAM exposure/interest among hospice care team members (e.g., nurses, social worker), may also sway which therapies are of interest/use by hospice patients.

Research is still needed to explore potentially competing interests/epistemologies of the various stakeholders regarding CAM use, as well as the central question of its effectiveness for providing relief and comfort. Professional reflections and dialogue between hospice care staff and CAM practitioners may also help to foster more open communication with patients regarding CAM.

As this was a small pilot, a study with a larger, representative sample is still needed.

### Conclusions

Our findings suggest high interest in using CAM in a small convenience sample of patients in residential hospice care. This pilot highlights substantial opportunities for further empirical and conceptual work to broaden our understanding of the potential role of CAM in the holistic care of Canadians nearing end-of-life.

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### Further Information

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