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.