



late the authors for having drawn attention to this issue. Future research should rely not on meta-analyses of a small number of dated studies, but on careful analyses of routinely collected hospital separation data by researchers who are experienced in using administrative data, combined with detailed re-abstractation studies supplemented with expert clinical opinion.

*Ms. Bains is a Research Associate with the Health Information Partnership, Eastern Ontario Region, Kingston, Ont. Dr. Hunter is Director of the Health Information Partnership and an Assistant Professor with the Department of Community Health and Epidemiology, Queen's University, Kingston, Ont., and the Department of Epidemiology and Community Medicine, University of Ottawa, Ottawa, Ont.*

The Health Information Partnership is funded by the Ontario Ministry of Health. The views expressed in this article are the authors' and do not necessarily reflect the position of the Ministry.

Competing interests: None declared.

## References

1. Lazarou J, Pomeranz BH, Corey PN. Incidence of adverse drug reactions in hospitalized patients: a meta-analysis of prospective studies. *JAMA* 1998;279(15):1200-5.
2. Abraham C, Taylor P. Drug reactions kill thousands: researchers. *Globe and Mail* [Toronto] 1998;Apr 15:A3.
3. World Health Organization. *Manual of the international statistical classification of diseases, injuries, and causes of death*. Geneva: WHO; 1977.
4. Statistics Canada. *Mortality—summary list of causes, 1990*. Ottawa: Minister of Industry, Science and Technology; 1993.
5. Statistics Canada. *Mortality—summary list of causes, 1991*. Ottawa: Minister of Industry, Science and Technology; 1994.
6. Statistics Canada. *Mortality—summary list of causes, 1992*. Ottawa: Minister of Industry, Science and Technology; 1995.
7. Statistics Canada. *Mortality—summary list of causes, 1993*. Ottawa: Minister of Industry, Science and Technology; 1996.
8. Mittman, Liu BA, Iskedjian M, Bradley CA, Pless R, Shear NH, et al. Drug-related mortality in Canada (1984–1994). *Pharmaco Drug Saf* 1997;6:157-68.

**Reprint requests to:** Ms. Namrata Bains, 221 Portsmouth Rd., Kingston ON K7M 1V5

# Discussing complementary therapies: There's more than efficacy to consider

Tracy Truant, RN, MSN; Michael McKenzie, MD

‡ See related article page 365

In this issue (page 365) Dr. Neill A. Iscoe and colleagues identify evidence of efficacy, questions of cost and the potential for toxicity as important factors for physicians to discuss with cancer patients who are considering the use of complementary therapies.<sup>1</sup> Dr. Elizabeth Kaegi's decision-making tool for patients, published in *CMAJ* last year, conveyed much of the same information and stimulated a heated debate in the journal.<sup>2-4</sup> No matter what position they take on the issue, it is likely that most physicians would concur with Iscoe and colleagues' statement that "Whatever transpires, the physician should continue to provide support and comfort to the patient and his family through this difficult time." The ability to provide that support and comfort depends on an understanding of the patient's perspective, not least with respect to complementary therapies.

Research on patients' decisions about complementary therapies is still in its infancy, and such research involving patients with prostate cancer has yet to be done. What we know so far comes from qualitative studies involving pa-

tients with other types of cancer; these have shown that such decision-making is complex and is influenced by many factors, of which physicians need to be aware. One of us (TT) conducted a study in which 16 women with breast cancer, at varying points along the disease trajectory and from various cultural backgrounds, were interviewed to determine how they made decisions about using complementary therapies. Qualitative analysis of their accounts revealed a dynamic three-phase process of decision-making that was closely linked with the trajectory of their illness. This and other studies have shown that, rather than being based solely on statistical data about treatment outcomes, decisions about both complementary and conventional therapies often reflect lifestyle preferences as well as beliefs about health and illness.<sup>5-7</sup> Other factors that influence decisions include the quality of the relationship with the health care provider as well as the patient's preferred role in making decisions, desire for control, physical status and degree of fatigue, prospects for cure and the need to sustain hope.<sup>5,8-12</sup>





The desire to regain control and to maintain hope are the 2 most frequently cited reasons for considering and using complementary therapies.<sup>5,10,13-15</sup> A diagnosis of cancer changes one's life forever, imposing multiple losses, unrelenting uncertainty and high levels of stress, leading to a sense of loss of control.<sup>16,17</sup> The use of complementary therapies may be empowering for some cancer patients and may foster hope; this in turn may lead to an improved sense of well-being and some alleviation of anxiety and depression.<sup>18,19</sup> Complementary therapies may be used in different ways and for different reasons at various points during the disease process as patients try, evaluate and modify therapies to suit their beliefs, lifestyle and perceptions of their disease status.<sup>5</sup>

Patients' satisfaction with their relationship with the health care provider has been found to be an important factor in determining whether they discuss their current or potential use of complementary therapies.<sup>5,20</sup> Patients who disclose their interest in complementary therapies are more likely to use them safely. Some patients never disclose their use for fear of losing control or getting a response that shatters their beliefs and hopes.<sup>6</sup> Nevertheless, it has been shown that patients are more likely to discuss complementary therapies if they perceive their health care providers to be interested in their beliefs about health and illness and in understanding the impact that the diagnosis and treatment of cancer has had on them.<sup>5,21</sup> Physicians who want to be able to counsel patients about using complementary therapies should show respect for the patient's beliefs and values, ensure that the patient remains involved in health care decisions and bear in mind that patients use these therapies for a variety of reasons.

An understanding of the issues that are important to a particular patient considering complementary therapies will better enable physicians to ensure that their use is safely integrated with conventional treatment. Such an understanding will also contribute to efforts to address the needs of the "whole person," which is the essence of effective palliative care. In situations such as the case example given by Iscoe and colleagues, insights gained from an exploration of the patient's beliefs about health and illness will help the physician not only to assist patients in making decisions about complementary therapies but also to plan for future needs and ensure continuity of care. Moreover, helping patients to discuss their perceptions of a loss of control can bring to the surface questions and issues that might otherwise not be raised.

Although Iscoe and colleagues' article, along with much of the medical literature on complementary therapies, focuses on issues of efficacy, a great deal more goes into a patient's decision about using complementary ther-

apies. Understanding the factors that are important to the patient places the physician in a better position to give advice and to gain insights that can be crucial to the provision of effective palliative care.

*Ms. Truant is Regional Oncology Nurse Leader, Education and Practice, at the British Columbia Cancer Agency, Vancouver Cancer Centre, Vancouver, BC. Dr. McKenzie is Radiation Oncologist, Radiation Therapy Program, at the British Columbia Cancer Agency, Vancouver Cancer Centre, and Clinical Associate Professor with the Division of Radiation Oncology, University of British Columbia, Vancouver, BC.*

Competing interests: None declared for Dr. McKenzie; Ms. Truant has received foundation grants and a studentship for research in this area.

## References

1. Iscoe NA, Bruera E, Choo RC. Prostate cancer: 10. Palliative care. *CMAJ* 1999;160(3):365-71.
2. Kaegi E. A patient's guide to choosing unconventional therapies. *CMAJ* 1998;158(9):1161-5.
3. Tannock IF, Warr DG. Unconventional therapies for cancer: a refuge from the rules of evidence? *CMAJ* 1998;159(7):801-2.
4. Hoey J. The arrogance of science and the pitfalls of hope. *CMAJ* 1998;159(7):803-4.
5. Truant T. Complementary therapies: the decision making process of women with breast cancer [Master's thesis]. Vancouver: University of British Columbia; 1998.
6. Kelly-Powell ML. Personalizing choices: patients' experience with making treatment decisions. *Res Nurs Health* 1997;20:219-27.
7. Montbriand MJ. Decision tree model describing alternate health care choices made by oncology patients. *Cancer Nurs* 1995;18(2):104-17.
8. Cassileth BR. The social implications of questionable cancer therapies. *Cancer* 1989;63:1247-50.
9. Furnham A, Forey J. The attitudes, behaviors, and beliefs of patients of conventional vs. complementary (alternative) medicine. *J Clin Psycho* 1994;50:458-65.
10. Montbriand MJ, Laing GP. Alternative health care as a control strategy. *J Adv Nurs* 1991;16:325-32.
11. Wong-Wylie G, Jevne R. Patient hope: exploring the interactions between physicians and HIV seropositive individuals. *Qual Health Res* 1997;7(1):32-56.
12. Yates PM. Towards a reconceptualization of hope for patients with a diagnosis of cancer. *J Adv Nurs* 1993;18:701-17.
13. Yates PM, Beadle G, Clavarino A, Najman JM, Thomson D, Williams G, et al. Patients with terminal cancer who use alternative therapies: their beliefs and practices. *Social Health Illn* 1993;15(2):199-216.
14. Balneaves LG. Beliefs and treatment practices of women with breast cancer using alternative/complementary therapies [Master's thesis]. Winnipeg: University of Manitoba; 1996.
15. Montbriand MJ. Alternative therapies as control behaviors used by cancer patients. *J Adv Nurs* 1995;22:646-54.
16. Fryback PB, Reinert BR. Alternative therapies and control for health in cancer and AIDS. *Clin Nurs Spec* 1997;11(2):64-9.
17. Loveys BJ, Klaick K. Breast cancer: demands of illness. *Oncol Nurs Forum* 1991;18(1):75-80.
18. Ersek M. The process of maintaining hope in adults undergoing bone marrow transplantation for leukemia. *Oncol Nurs Forum* 1992;19:883-9.
19. Miller J. Hope-inspiring strategies of the critically ill. *Appl Nurs Res* 1989;2:23-9.
20. Post-White J, Ceronsky C, Krietzer MJ, Nicholson K, Drew D, Mackey KW, et al. Hope, spirituality, sense of coherence, and quality of life in patients with cancer. *Oncol Nurs Forum* 1996;23:1571-9.
21. Langner N, Clarke NJ, Kelly P, Bouchard G. The National Forum on Breast Cancer: a survey study [unpublished report]. Montreal; 1993.

**Reprint requests to:** Dr. Michael McKenzie, Radiation Therapy Program, British Columbia Cancer Agency, Vancouver Cancer Centre, 600 W 10th Ave., Vancouver BC V5Z 4E6; fax 604 877-0505; mmckenz@bccancer.bc.ca

