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Integrating Complementary and Conventional Symptom Management in a Cancer Center

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Historically, patients undergoing treatment for cancer have sought complementary care in addition to conventional medical care. In 1990, David Eisenberg's team published a study in the *New England Journal of Medicine* that surprised physicians (Eisenberg, 1998). The study revealed that 34% of Americans were using complementary and alternative medicines (CAM); but, even more surprising, 60% of the users were not informing their physicians that they were doing so. Interestingly, the study found that CAM was not replacing conventional therapies; rather, it was used in addition to conventional, physician-provided therapies. When Eisenberg and colleagues replicated the study in 1997, CAM use had increased to 41% of the population. However, patients still were not revealing CAM use to their physicians. For the purposes of these studies, complementary therapies were defined as those not taught in medical school. From these studies and our clinical observations, we knew that patients and families were interested in CAM. This article will describe the unique blending of conventional and complementary care for pain and symptom management in a National Cancer Care Network (NCCN)-designated, comprehensive cancer center.

Historical Perspective

The Dana-Farber Cancer Institute Pain and Symptom Management Service was a nursing consult service from the early 1990s until 1997. With the addition of a medical director with experience in anesthesia pain management in 1997, the service became a combined medical and nursing consult service that worked collaboratively with primary oncology nurses, physicians, social workers, and other staff to manage symptoms related to cancer and its treatment. The service provided care for ambulatory and hospitalized patients including patient assessment; education for patients, families, and staff; and pharmacologic and nonpharmacologic management of symptoms related to disease and treatment side effects. Careful titration of medication doses to maximize comfort and minimize side effects was an integral part of the pharmacologic management. More invasive techniques for pain management, such as spinal analgesia and nerve blocks, also were available through collaboration with an anesthesia-based pain service. Although pain was the most frequent reason that patients used the service, the staff also commonly managed nausea and vomiting, anxiety, constipation, fatigue, insomnia, and wound care. An adult nurse practitioner (NP) experienced in oncology nursing and pain and symptom management performed most of the consults and follow-up care.

In 1998, a decision was made to expand the service to include complementary therapies. This decision reflected growing patient and family interest in complementary therapies and the desire of medical and nursing clinicians and administrators to meet the patient demand for these therapies within the context of existing professional services. Because nursing has a long history of a uniquely holistic perspective of health care, seeking an advanced practice nurse (APN) to provide complementary therapies under the auspices of the Pain and Symptom Management Service seemed appropriate.

Nursing's role always has been to support the healing process. In 1859, Florence Nightingale wrote in her *Notes on Nursing* that "nature alone cures . . . and what nursing has to do is put the patient in the best possible condition so that nature can act upon [the person]" (Nightingale, 1970, p. 74–75). In the Commonwealth of Massachusetts, this legacy was continued, when, on September 10, 1997, the Board of Registration in Nursing issued Advisory Ruling 9801, "Holistic Nursing and Complementary Therapies," authorizing the use of complementary therapies in the practice of nursing to meet goals of ". . . increased comfort, relief of pain, relaxation, improved coping mechanisms, reduction or moderation of stress, and an increased sense of well being." This ruling provided the basic description of complementary therapies that would be offered through the Pain and Symptom Management Service. Specifically, these therapies included massage as a nursing intervention, therapeutic touch (TT), Reiki, reflexology, imagery, hypnosis, and other therapies, such as Shiatsu, aromatherapy, and music therapy (Board of Registration in Nursing, 1997).

Synchronizing the Nursing Roles Within the Service

Because of the disparate backgrounds of its APNs—one was an adult oncology NP specializing in pain and symptom management and the other was a pediatric NP and licensed family counselor functioning as an APN providing complementary therapies—the nursing roles on the service were clearly delineated. However, each was open to, and appreciative of, the expertise and clinical experiences of the other. As a result, a synergistic and collaborative practice developed. Depending on patient needs, intrateam consults were common. The oncology NP used relaxation response, imagery, and Reiki as appropriate to augment more conventional symptom-management interventions. The complementary-care APN provided symptom assessment and frequently recommended conventional symptom management referrals.

The complementary-care APN began seeing patients at their request with the knowledge of their oncologists. Specifically, the role of the complementary-care APN was to provide educational consults and individualized therapeutic interventions to address chief complaints and the patient's needs, values, experiences, and overall condition. The APN provided complementary therapies that in-

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