Complementary medicine: is it more acceptable in palliative care practice?

Allan Kellehear

ABSTRACT

- Some complementary health modalities have found a well-accepted place in palliative care.
- The interdisciplinary nature of palliative care underlies the common acceptance of complementary therapies in this field of care.
- The experience of the interdisciplinary approach in palliative care may presage current changes in attitude towards complementary therapies in other areas of medicine.
- Growing collegiality and interdisciplinary teamwork in healthcare is encouraging the medical profession to see beyond scientific reservations and view complementary modalities as providing supportive roles.

MJA 2003; 179: S46–S48

PALLIATIVE CARE makes a full-time occupation of the art of caring. For people whose disease is incurable but for whom health and hope remain important goals in life, palliative care meets the interdisciplinary challenge of care in the very shadow of death. It combines the best symptom management practices that scientific medicine can offer with a multidisciplinary approach to caring. It recruits the traditions of bedside medicine, counselling, pastoral care and community volunteer work, as well as social supports and public health services.

In these styles of care, the palliative approach goes a step or two further than many other branches of medical care. Palliative care has a working relationship with what has been variously called "alternative", "complementary" or "traditional" healthcare. How has this situation arisen in a broader culture of medical scepticism and resistance to complementary therapies, and are there lessons to be learnt regarding practice and attitude in the wider medical world?

Palliative care: the interdisciplinary imperative

Palliative care, having its formal origins in religious history, has had a pastoral and social dimension from its earliest inception. Modern palliative care services have continued this tradition, first through the pioneering work of Cecily Saunders in the United Kingdom[1] and later in the World Health Organization's philosophy of "whole-person care" and the acceptance of the natural inevitability of death and dying.[1] Whole-person care has been central to the mission and philosophy of palliative care. To assist a person to "die as they have lived" is to commit to a service approach that reflects the social, spiritual and psychological complexity of a life lived in community. The final physical illness is only one part — perhaps the health-related prompt to reorganising other aspects of a person's community life and identity at the end of life.

In this multidisciplinary context, medicine has become a vital but equal player among other acknowledged contributors to quality of life at the end of life. Effective physical

Palliative Care Unit, Faculty of Health Sciences, La Trobe University, Melbourne, VIC.

Allan Kellehear, PhD, Director, and Professor of Palliative Care.

Reprints will not be available from the author. Correspondence: Professor Allan Kellehear, Palliative Care Unit, Faculty of Health Sciences, La Trobe University, 215 Franklin Street, Melbourne, VIC 3000. a.kellehear@latrobe.edu.au

management is crucial to quality care of the dying person, but so, too, is the spiritual care from pastoral workers or the comfort and support gained, for example, from music therapists or companion animals.[2-5]

Complementary health practices such as aromatherapy, massage or music therapy have been accepted and integrated into palliative care because the practice of medicine in this specialty happens alongside a multidisciplinary culture of practitioners. In many other healthcare occupations, complementary therapy is seen not as a rival, "unscientific" service provider, but rather as an adjunct provider within the special and limited area of social, psychological or spiritual support.

The interdisciplinary approach has transformed the attitude of practitioners and the practice of medicine in the field of palliative care. The recognition by medical leaders of the social and spiritual elements of care at the end of life has been facilitated by a necessary commitment to interdisciplinary practice. This historical journey in end-of-life care is now being repeated in the parallel journey that the wider medical profession is currently undergoing.

The medical profession is revising and debating its own transition from an identity of "medical care provider" to one of "healthcare provider". In other words, medicine is beginning to see itself as simply one profession working alongside an ever-broadening number of other professions within public health, most of whom share the same social goal of support.

Medicine and the "alternatives"

Outside the field of palliative care, the medical profession has a long history of antipathy and resistance towards complementary healthcare. As late as the 1980s, the Royal Australian College of General Practitioners produced a defensive and critical examination of complementary medicine, attributing its popularity principally to the media being more interested in "headlines" than "accuracy".[6] A 1986 British Medical Association report equated complementary medicine with primitive superstition.[7]

But just a few years later, attitudes from peak medical bodies and writers demonstrated important changes. In 1993, the British Medical Association began to advocate "collaboration" with complementary medicine and issued a call for greater organisation and controls for its practitioners.[8] Maddocks, in a tempered and considered review of complementary medicine, advocated better working relationships between the medical profession and complementary practitioners and suggested that each could learn from the other.[9]

Nevertheless, one characteristic of medical discussions about complementary medicine has endured over the years — the adversarial language used by the medical profession in depicting complementary practitioners. Medicine has frequently painted itself as scientific, safe, proven and "realistic". Complementary medicine is often portrayed as unproven, unscientific and dangerous, and its practitioners have been labelled purveyors of false hope.

However, for some time now, the alleged contrasts and perceived rivalry between mainstream and complementary medicine have not been reflected in reality. In the 1980s and 1990s, it was observed that complementary medicine relied on orthodox medicine for its props (eg, white coats, office designs and referral conduct).[10-12] Moreover, there is wide recognition from complementary practitioners of the effectiveness and value of orthodox medical treatments, especially in matters to do with accidents, emergencies and infections and for those very near death. In such circumstances, most complementary practitioners refer and defer to their orthodox medical colleagues.[11,12] Complementary practitioners also rely on orthodox medicine for screening procedures, often getting their diagnosis "second-hand" from patients. Most of their patients are either healthy people in search of better ways to maintain or improve their own health or people who are chronically or incurably ill — patients whom orthodox medicine itself struggles to help.

On the other hand, the medical profession is no "monolithic whole".[13] Medicine has many subgroups and cultures within its own ranks. The varying opinions of its members are reflected in the changing attitudes of the peak bodies that profess to represent medicine's views. A significant number of complementary treatment modalities (eg, acupuncture, vitamin and mineral therapy, and manipulation) are currently offered by orthodox medical practitioners.[10] Furthermore, a Monash University medical graduate survey revealed that 94% of recent Monash graduates planned to practise some form of natural therapy alongside conventional medicine.[14] Clearly, both attitudes to and relationships with alternative modalities of medicine are changing.

Medical practice as healthcare practice?

There is little doubt that complementary medicine is more acceptable in palliative care than in other areas of medicine. The reasons why palliative care has been at the forefront of this acceptance may shed light on the growing acceptance of complementary therapies in other areas of medicine.

From its early experiences of care for the dying, palliative care took for granted the necessity of placing patient values and lifestyle habits at the core of any design and delivery of quality care at the end of life. If the patient desired

complementary therapies, and as long as such treatments provided additional support and did not endanger the patient, they were considered acceptable.

The care of dying people is also one of the first areas of medical practice in which the profession found memorable lessons about scientific limits to its own power. It is also the interface of medical practice where the cutting edge of its bedside art explores the most creative possibilities. The limits to science and the possibilities in the art of caring within the medical profession are the first and most lasting impetus for interdisciplinary designs in healthcare. These are clearly seen in palliative care, but their possibilities for enhancing quality of life now stretch into all major areas of medicine.[15]

These kinds of social insights, obviously relevant to the broader healthcare system, have led to greater interest in, if not acceptance of, complementary medical practices. Now, interest in scientific evaluations in medicine embraces all types of treatments, not simply its own. For their part, complementary practitioners are taking a greater interest in professional regulation, scientific and social research, and training. Orthodox medicine renews and strengthens its interest in the interpersonal and interdisciplinary dimensions of communication, support, and the diverse social and cultural meanings and experiences of health itself.

The process (suggested by Maddocks[9]) of orthodox and complementary medicine developing closer working relationships and embracing opportunities to learn from one another is clearly under way. The field of palliative care — a field in which the goal is maximising patient comfort and wellbeing rather than finding a cure — may have been an important impetus for diplomatic progress between the two traditions of healthcare. It can still be a challenging, if not controversial, role model for professional development for the wider world of medicine.

Competing interests

None identified.

References

1. Kellehear A. Health promoting palliative care. Melbourne: Oxford University Press, 1999.
2. Palliative Care Australia. National palliative care services: a planning guide. Canberra: PCA, 2002.
3. Rydholm M, Strang P. Acupuncture for patients in hospital-based home care suffering from xerostomia. *J Palliat Care* 1999; 15(4): 20-23.
4. O'Connor M, Webb R. Learning to rest when in pain. *Eur J Palliat Care* 2002; 9: 68-71.
5. Ockleford E, Berryman J. Do companion animals have therapeutic value? *Eur J Palliat Care* 2001; 8: 75-78.
6. Royal Australian College of General Practitioners. Alternative medicine. Sydney: Preventive and Community Medicine Committee, NSW Faculty, RACGP, 1980.
7. British Medical Association. Report of the Board of Science and Education on alternative therapy. London: BMA, 1986.
8. British Medical Association. Complementary medicine: new approaches to good practice. London: BMA, 1993.
9. Maddocks I. Alternative medicine. *Med J Aust* 1985; 142: 547-551.
10. Easthope G. Healers and alternative medicine: a sociological examination. Aldershot, UK: Gower Publishing, 1986.
11. Willis E. Illness and social relations. Sydney: Allen and Unwin, 1994.
12. Pirotta MV, Cohen MM, Kotsirilos V, Farish SJ. Complementary therapies: have they become accepted in general practice? *Med J Aust* 2000; 172: 105-109.
13. Saks M. Professionalism and health care. In: Field D, Taylor S, editors. Sociological perspectives on health, illness and health care. Oxford: Blackwell Science, 1998: 174-191.
14. Healey K. Alternative medicine. Sydney: Spinney Press, 1998.
15. Rumbold B. Implications of mainstreaming hospice into palliative care services. In: Parker J, Aranda S, editors. Palliative care: explorations and challenges. Sydney: MacClennan and Petty, 1998: 3-20.

(Received 20 May 2003, accepted 15 Jul 2003) ❑