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An exploratory typology of provider responses that encourage and discourage conversation about complementary and integrative medicine during routine oncology visits

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Abstract

OBJECTIVE—To characterize how providers respond to patient mentions of complementary and integrative medicine (CIM) during routine oncology visits.

METHODS—Ethnographic methods were used over a two and a half year period with 82 advanced cancer patients and their providers across four oncology clinics. Participant observation fieldnotes were analyzed using Discourse Analysis.

RESULTS—CIM was mentioned in 78/229 (34%) of the total observed visits. Patients initiated talk about CIM (76%) more than providers (24%). Patients mentioning CIM may indicate a preference for or interest in non-pharmacological adjunctive treatment options. Providers' responses *inhibited* further talk in 44% of observations and *promoted* talk in 56% of observations.

CONCLUSION—How providers respond may indicate their willingness to discuss a range of treatment options and to collaboratively engage in treatment decision-making. Provider responses that inhibited CIM conversation passed on the opportunity to discuss patient interests, and responses that promoted further conversation helped counsel patients about appropriate CIM use. Promoting discussion did not require additional time or extensive knowledge about CIM.

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PRACTICE IMPLICATIONS—Providers can facilitate high quality communication without endorsing C_{IM} to help patients make treatment decisions and to evaluate C_{IM} appropriateness and safety in ways that are responsive to patient preferences and values.

An exploratory typology of provider responses that encourage and discourage conversation about complementary and integrative medicine during routine oncology visits

Keywords

Complementary; Alternative; Integrative Medicine; Cancer; Provider-Patient Communication; Ethnography; Discourse Analysis; USA

1.0 Introduction

Complementary and integrative medicine (C_{IM}) use in the US remains steady, with an estimated 40% of adults regularly using one type of C_{IM} treatment. Among cancer patients, some studies report as much as 91% of people with cancer using at least one form of C_{IM} during treatment. (1) The National Center for Complementary and Integrative Health (NCCIH) defines C_{IM} as an “array of health care approaches with a history of use or origins outside of mainstream medicine.” (2) The most popular modalities include natural products, including herbs and nutritional supplements, deep breathing, meditation, chiropractic, and massage. (3) In studies of C_{IM} communication, cancer patients may tell their oncologists about using C_{IM} more often than in other health conditions. (1, 4, 5) However, despite these studies, advanced cancer patients may still be hesitant to disclose C_{IM} use to providers during clinical visits. While C_{IM} use is not necessarily contraindicated, communication about C_{IM} is an important way for providers to monitor safety related to C_{IM} use (6-8) and to facilitate patient-centered care. (9-11)

Patient-centered care is health care that is respectful of individual patient preferences, values, and needs. (12) Philosophically, patient-centered care places patients at the center of their care to ensure that patient values guide all clinical decisions. (13) Effective communication has been characterized as the cornerstone of patient-centered care (14) and is associated with improved quality of life and treatment adherence. (15) Collaborative health communication leads to improved patient understanding of treatment regimes and motivation to follow treatment plans, (16) and an increased therapeutic alliance. While patient-centered care is premised on being responsive to patient values and preferences, (12) research has shown that providers often inaccurately gauge patient health beliefs (17) and can make decisions based on false assumptions of patient preferences. (18)

Prior research suggests that cancer patients expect their oncologists to have at least basic knowledge of C_{IM}. (19) However, cancer patients have numerous barriers to C_{IM} communication. People with chronic illness, especially cancer, do not disclose C_{IM} use due to perceptions that providers will not be receptive to C_{IM} treatments; (20) providers do not ask; (21) providers do not have the skills or relevant information necessary for talking about C_{IM}; (22) and patients anticipate a negative response or that their provider will not know about C_{IM} treatment. (23) Providers are similarly hesitant to discuss C_{IM}, despite the fact that providers report that discussing C_{IM} may enhance the working provider-patient

relationship. (24, 25) However, providers do not always believe that talking about CIM is relevant to the clinical visit, (21) and many oncologists do not feel they have the skills and information necessary to discuss CIM. (21, 22)

Methodologically, prior studies typically employ self-reported measures, such as surveys and semi-structured interviews, to investigate whether a conversation about CIM occurred, (26, 27). However, conclusions drawn from self-reported measures are limited. While prior studies suggest that discussing CIM may increase communication quality, prior studies offer few details for how to do so. Direct observation can overcome these limitations. (28, 29) Few observational studies of CIM communication have been conducted in primary care (30, 31) and oncology, (32, 33) and to our knowledge no prior study has used direct observation to study CIM communication in oncology visits with advanced cancer patients. This is significant because observational data can be used to better understand the content and structure of actual conversations about CIM in naturally occurring medical visits. Building on the previous literature, this exploratory article analyzes how providers and patients talk about CIM by asking the following research questions:

RQ1: How do oncologists respond to patient preferences about CIM use during routine oncology visits?

RQ2. What interactional behavior promotes or inhibits CIM discussion? RQ3. How do discussions about CIM demonstrate patient-centered care?

2.0 Methods

Routine oncology visits between people with advanced cancer and their oncologists were observed between April 2011 and November 2013 as part of a longitudinal ethnographic study to understand treatment decision-making among cancer patients. Data were collected at a large, academic medical center in the Western US. Observations took place at four clinics according to the original site of cancer diagnosis and included breast, melanoma, genitourinary, and gastrointestinal clinics. Participants were 105 physicians, nurses, advanced practice nurses, fellows, and residents, 36 caregivers, and 82 advanced cancer patients. Patients were initially identified through chart review and confirmed with input from their primary oncologist as having metastatic cancer diagnosis and ease with communication in English. The study methodology and sample characteristics are described separately. (34, 35)

Our interdisciplinary team included two experts in health communication (CJK, EYH), an epidemiologist (LT), a health policy researcher (DD), and a team of fieldworkers. All study team members were highly trained in ethnographic and observational methods to document relevant aspects of decision-making during routine patient visits, including CIM communication. The University of California, San Francisco institutional review board approved this study.

The research team spent 2-3 days per week observing routine medical visits between patients, caregivers, and oncology staff using standardized ethnographic methods (28) to document four oncology clinics. During observations, fieldworkers used small notebooks to

record detailed descriptions of activities, clinical processes, and social actions, including communication between providers and patients. Guidelines for fieldnotes included separating one's thoughts and assumptions from what is observed; describing activities in the order in which they occur; and recording speakers' exact words as much as possible. (36) After each observation, fieldworkers expanded handwritten fieldnotes into full-length typed texts that included relevant contextual information, including date, time, clinic environment, and participants. During weekly meetings, fieldworkers discussed observation experiences that occurred during the previous week. Early in data collection, fieldworkers noted that cancer patients frequently mentioned CIM modalities during oncology visits, which lead to systematic documentation of CIM discussions between patients and providers throughout data collection.

We use discourse analysis (DA), a qualitative research methodology with a history of studying health communication, (37-41) as our analytic approach. DA uses textual data, such as transcriptions of audiovisual recordings or ethnographic fieldnotes, to discern routine practices of social interaction and language use. (42) Prior studies have successfully used fieldnote texts to capture sensitive provider-patient interactions in situations where recording may be obtrusive or otherwise objectionable. (43-45)

We used a multi-step process to construct our analysis. First, we identified common CIM terms from two prominent national websites, NCCIH (2) and the Office of Cancer Complementary and Alternative Medicine (OCCAM). (46) Next, we imported all fieldnote texts into ATLAS.ti (v7.1), a software suite for managing qualitative data. (47) The list of identified CIM terms were put into ATLAS.ti to search for paragraphs, the analytic unit, containing any *identified* CIM term. CIM terms not in the original list were iteratively added to create a comprehensive inventory presented in Table 1.

Next, drawing on prior research, (30) we created an original coding scheme illustrated in Figure 1. The codebook characterizes (1) who initiated the CIM term; (2) the type of response it received; and (3) whether the response *inhibited* or *promoted* discussion in subsequent talk. DA employs linguistic features as evidence to determine the social effects of conversational interaction. (39, 42) Once segments were identified, we used structural criteria for classifying provider responses according to 1) whether providers engaged in additional talk about CIM; and 2) providers' evaluative stance towards CIM was positive, negative, or neutral. (30) Responses were coded as *inhibiting* if a provider either did not further talk about CIM or only engaged in a short exchange. Responses were coded as *promoting* if a provider engaged in an extended exchange that engaged in further talk about CIM.

Two experts in health communication (CJK, EYH) independently coded 10% of the identified paragraphs of the fieldnote texts. Differences in code application were resolved through discussion, resulting in refinement of code definitions and inclusion/exclusion criteria, and we independently coded an additional 10% of identified paragraphs. We then assessed intercoder reliability using a prevalence- and bias-adjusted *kappa* to adjust highly and rarely occurring code attributes. (48) The resulting score was above 0.8 indicating a high level of reliability. Finally, the remaining paragraphs were independently coded.

3.0 Results

Of the 229 observed routine oncology visits, 78 (34%) had one paragraph in which a participant mentioned at least one CIM term. Patients typically initiated talk about CIM (n=59 or 76%) compared to providers (n=19 or 24%).¹ This analysis focuses on patient-initiated CIM talk because when patients initiate talk about CIM, they topicalize what they see as relevant to their own cancer care. Our findings are used to construct a typology that shows the social effects of provider response to patient-initiated CIM topics illustrated in Figure 2.

Responses that *inhibited* conversation about CIM occurred in 26/59 (44%) of observed visits and were associated with a shift to other talk or medical activities unrelated to CIM. Responses that *promoted* conversation about CIM occurred in 33/59 (56%) of observed visits and were associated with more substantive discussion about CIM. Overall, this suggests that providers may not recognize that when patients topicalize CIM during a medical visit, they actively participate in their own care by raising topics relevant to their treatment and well being. We argue that when patients initiate talk about CIM, they may simultaneously seek physician advice and indicate a preference for or an interest in non-pharmacological treatment options. In the following sections, we describe how providers' responses inhibit or promote further discussion that may dismiss or address patient concerns. Excerpts are anonymized and edited for clarity.

Provider responses that inhibit CIM conversation

When patients mentioned CIM, two types of provider responses impeded further talk about CIM, implying that CIM discussions are not relevant to oncology visits. We observed two response patterns that failed to address patient concerns about CIM, disattention and unexpanded acknowledgment. Disattention was the most common provider response (36%) and was defined as a response in which a provider does not give an overt verbal response at a place where a response would be normatively anticipated. Disattentive responses impeded further conversation about CIM by shifting to another activity rather than continuing talk about CIM, as the following extract illustrates:

In this extract, the patient's caregiver announces that acupressure and guided imagery help manage unwanted side effects of radiation therapy. She stresses how effective this CIM treatment is, which the patient independently affirms, "it really does help." While the physician appears to actively listen, at the conclusion of the couples' talk, he provides no discernable response, but rather shifts to another activity, typing into the electronic medical record (EMR). Prior literature in medical settings has shown that good news announcements normatively require a response, especially when coupled with emotionally sensitive, such as severe symptoms, because the response helps to ratify a positive side to a negative experience. (38) Further, upgrades after an announcement strongly encourage a recipient response, which is noticeably absent in this case. Throughout the dataset, when physicians disattended CIM talk, patients may not know whether the physician heard or understood

¹Providers initiated CIM talk primarily in the context of medication reconciliation and history taking. However, provider-initiated CIM talk resulted in both discussion (n= 13 or 16%) and non-discussion (n= 6 or 8%).

their contributions and physicians routinely neglected the opportunity to address patient preferences about CIM by shifting to another medical activity, such as typing in to the EMR.

A second response pattern that prevented further communication about CIM was unexpanded acknowledgment (9%). This response was defined by responses in which a provider gave a brief verbal response, such as okay, before shifting to another activity. The following extract illustrates a typical unexpanded acknowledgement response:

As part of the physical examination, the patient announces that she has been using unspecified oil on a recent surgery incision that causes her skin to turn yellow. When the physician asks for more information, the patient names a CIM product, sea buckthorn oil, and the source from which she learned about it, Dr. Mehmet Oz, a physician and host of a popular television talk show that promotes various CIM modalities. After a pause, the patient positively assesses the appearance of the scar as “a huge difference”. In response, the physician provides a brief, but unexpanded verbal acknowledgement, “Yeah, I agree,” before shifting to another activity, the physical examination. Throughout the dataset unexpanded acknowledgments verbally respond to the patient's mention of CIM in a short, usually affirmative response, but immediately shift to another activity that minimizes further conversation about CIM.

Provider responses that promote CIM conversation

When patients mentioned CIM, providers also gave responses that promoted further conversation, which affirmed patient concerns about CIM. Providers articulated positive, neutral, and negative evaluative stances in response to patient mentions of CIM. Approximately one quarter of providers' responses promoted further conversation by adopting a clearly positive stance (15%) that affirmed the patient's CIM use, as the following extract illustrates:

The patient announces using an “angel prayer” to support her concurrent biomedical treatments. When the provider gives a positive response, it encourages the patient to provide additional information that leads to further discussion of the other CIM modalities the patient uses. Note that the positive response encourages the patient to disclose her training and expertise in CIM as an important part of her ongoing treatment decisions. Positive provider responses encouraged further conversation about CIM throughout the dataset, and frequently led to spontaneous patient disclosures related to other treatment preferences and values regarding various standard and nonstandard treatment options.

Approximately half of providers' responses that promoted further conversation adopted a neutral stance (27%) about patients' CIM use. Neutral responses are characterized by provider contributions that suggest CIM is neither harmful nor helpful in managing a patient's health and may hedge a clearly positive or negative stance about CIM use. The following extract illustrates an interaction in which a provider informs the patient about cannabis, a controversial CIM treatment:

The patient's son asks about what the family can do to help support his father's eating habits while he undergoes chemotherapy. The physician answers with advice to help guide the

patient's dietary choices. The son asks specifically about medication that might stimulate the patient's appetite. When the physician does not support a stimulant, the patient jokingly mentions increased appetite as a side effect of cannabis. The physician takes the joke seriously by first saying that he “is not opposed to medical marijuana,” and, second, cautions against smoking, but recommends eating cannabis. The physician ends the discussion by mentioning that he cannot prescribe cannabis, and shifts to another activity, arrangement making for the patient's continued biomedical treatment. The physician's response is neutral because although he is not opposed to medical cannabis, he does not explicitly recommend it. Finally, the physician may subtly discourage the patient not to add cannabis because “I think we have enough to work on.” Rather, the physician provides medically informed information and leaves the patient to decide whether to use cannabis on his own. Throughout the dataset, providers use neutral responses to hedge a clear positive or negative stance about patient CIM use. Neutral responses often maintain relative equipoise that combines both positive and negative stances about CIM use that ultimately provides patients additional information to encourage decision-making deliberation outside the medical visit.

Finally, approximately one quarter of providers' responses that promoted further conversation adopted a negative stance (13%) that recommended against patients' CIM use, as the following extract illustrates:

The patient announces that he has incorporated various CIM modalities, including dietary modifications including macrobiotics and “some homeopathic stuff.” When the patient asks if these changes may make a difference for his illness, the physician discourages reliance on stringent diets alone to moderate Prostate-Specific Antigen (PSA) increases. The physician shifts the conversation to the possible psychological risk of strict diet change and recommends a more moderate “heart healthy” diet. Throughout the data, providers' negative responses orient to CIM as unhelpful due to concerns about safety, biomedical treatment interactions, and issues related quality of life. Even though negative responses typically dissuade patients from CIM use, provider responses address patient preferences in ways that help patients to navigate overall treatment decisions.

4.0 Discussion and Conclusion

4.1 Discussion

This exploratory qualitative study uses direct observations of routine oncology visits between providers and patients with advanced cancer to create a typology for how providers respond to patient-initiated mentions of complementary and integrative medicine (CIM). Prior literature has shown that patient CIM use and provider-patient communication are significant aspects of care for advanced cancer patients. (4, 5, 49) Our findings corroborate prior studies showing that CIM talk occurs in roughly one-third of routine oncology visits conversations and that patients typically initiate conversations about CIM. (30, 33) How providers respond results in distinct interactional outcomes. Our typology shows that provider responses inhibiting further conversation (disattention and unexpanded acknowledgment) may convey that CIM is not perceived as directly relevant to patient care and may disregard patient interest in CIM. Responses that promote further conversation (positive, neutral, or negative) acknowledge that patients are active participants in making

treatment decisions and demonstrate collaboration in helping to guide those decisions according to patient values and preferences. These findings lead to several implications.

First, when patients initiate talk about CIM, they may demonstrate a preference for or an interest in adjunctive non-pharmacological treatment options. Prior research has shown that patients employ communication strategies, including as leaving a gap of silence after a treatment recommendation (50) or asking questions about CIM treatment options, (30) as ways to actively participate in medical visits. When patients initiate topics during medical visits, they demonstrate through their verbal contributions what is important to them. When patients articulate their concerns indirectly may display caution, particularly when raising concerns about non-standard treatment options. Patient communication behavior demonstrates what patients see as relevant to their care and offers clues to treatment preferences and values. Findings from this article suggest a testable hypothesis that patients may use communication strategies to suggest treatment preferences and values. This is significant because while patient-centered care is premised on being responsive to patient values and preferences, prior research provides little guidance for measuring the relationship between patient preferences and communication behavior during medical visits. (12)

Second, provider responses to patient-initiated CIM talk has implications for how treatment decisions may be interactively negotiated during medical visits. Providers have various options to respond in *interactionally sensitive* ways to the concerns and priorities of a recipient according to her or his stage of illness. (51) How a provider responds can encourage or discourage communication that might help collaboratively assess CIM safety as part of an ongoing treatment regime. When providers establish boundaries around what may and may not be worth discussing, such as CIM treatment options, patients may simply choose not to discuss certain aspects of their care with their providers. In nearly half the cases of patient-initiated CIM talk in our data, providers passed on the opportunity to inquire about the values and preferences those mentions embody. This chilling effect may negatively impact the therapeutic alliance and may ultimately lead to an explanation for why providers misjudge patient health beliefs (17) and preferences. (18) While prior research has suggested that effective communication is the cornerstone for patient-centered care, (52) providers have an ethical responsibility to treat patient contributions as legitimate, regardless of whether they agree or disagree with the substance of those topics. Discussion about CIM treatment need not take up significant time during the visit, (30) and the consequences of not addressing patient concerns may have both immediate and long-term consequences on overall quality of care and the therapeutic alliance over time.

Third, our findings may be useful for future quantitative survey research. This study may provide an empirical basis for refining quantitative measures to increase the sensitivity of CIM communication based on interactionally meaningful distinctions. (53) For example, rather than asking if CIM was discussed during a routine visit, future questions can ask how providers responded when they initiated a topic like CIM use and whether the response resulted in further talk or not. These questions can be validated using audiovisual recordings to assess perceptions of patient-centered care based on how provider responses inhibit or promote conversation. This type of measure might be used to gauge the quality of communication about an expanded range of treatment options for people with chronic

illness, including advanced cancer. Increasing measurement accuracy may lead to a more precise understanding of CIM at the population level, which can eventually lead to more accurate correlations between communication behavior, clinical care, and health outcomes.

This study has several limitations. First, ethnographic fieldnotes are limited in their ability to represent nuances of communication, such as intonation, pauses, and other details of speech. While audiovisual recording can document these communication behaviors in detail, ethnographic fieldnotes have the advantage of documenting the rich longitudinal context within which interactions among providers, patients, and caregivers take place both inside and outside the medical visit. Second, the original study was designed to examine patient treatment trajectories longitudinally, but not to study CIM communication specifically. However, because the presence of CIM communication was apparent in early fieldwork, participant observers systematically gathered data on CIM communication patterns. Finally, because this was an ethnographic study, we do not have access to contextual aspects of the provider-patient relationship that lead up to our observed conversations, the types of treatment that were and were not appropriate for each patient's care, and the health outcomes associated with inhibiting or promoting further conversation about CIM. While all participants were diagnosed with stage 4 cancer, differences in cancer site, disease progression, and treatment options may have influenced providers' responses in ways our approach was not able to discern. However, future research can use these findings to discern how communication behavior, such as inhibiting or promoting conversation about CIM, may be the result of these clinical factors and may result in different health outcomes.

4.2 Conclusion

While health care providers are experts in clinical aspects of medical care, they may be less aware of how their communication behavior actively shapes the medical visit. CIM use is widespread among cancer patients, and providers should be comfortable eliciting and discussing which modalities patients use. Patients frequently initiate talk about CIM, which they believe is highly relevant to the oncology visit, but providers' responses determine whether discussion of CIM will or will not ensue. While patients do not expect their providers to be experts in CIM, they may expect their providers to minimally address their interest in CIM. Providers can facilitate high communication quality of CIM without endorsing CIM use to help patients make treatment decisions and to evaluate CIM appropriateness and safety without adding additional time to routine medical visits.

4.3 Practice Implications

Our findings have practical implications for the clinical care of people with advanced cancer. Providers have an ethical responsibility to learn about CIM because patients are increasingly using these treatments to complement their biomedical care. Because patients often may not overtly express their treatment preferences, providers need tools to become sensitized to indirect communication strategies patients use to indicate their interests, values, and preferences. When a patient or caregiver mentions CIM during a clinical visit, providers have a range of possible response options that can either discourage or encourage further conversation about CIM. Our typology expands health care providers' available repertoire for giving *interactionally sensitive* responses. For example, when patients topicalize a CIM

treatment, rather than providing an unexpanded acknowledgment that passes the opportunity to holistically discuss patient treatment options, providers can briefly acknowledge the patient's interest and explicitly defer the conversation about other forms of treatment to a more appropriate time. Our findings suggest that disattentive responses may be the least patient-centered, which should only be used to prioritize urgent medical problems. Similarly, responses that promote further conversation do not necessarily have to endorse CIM. However, promoting conversation can be more appropriately used to address patient preferences and to help providers monitor appropriateness, safety, and efficacy of a full range of cancer treatments, which may enhance the overall therapeutic alliance.

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Highlights

- Patients raise topics that are important to them during medical visits.
- Advanced cancer patients initiate conversation about CIM more than providers.
- Providers have a range of response options when patients raise CIM as a topic.
- How topics are raised may indicate patient treatment preferences and values.

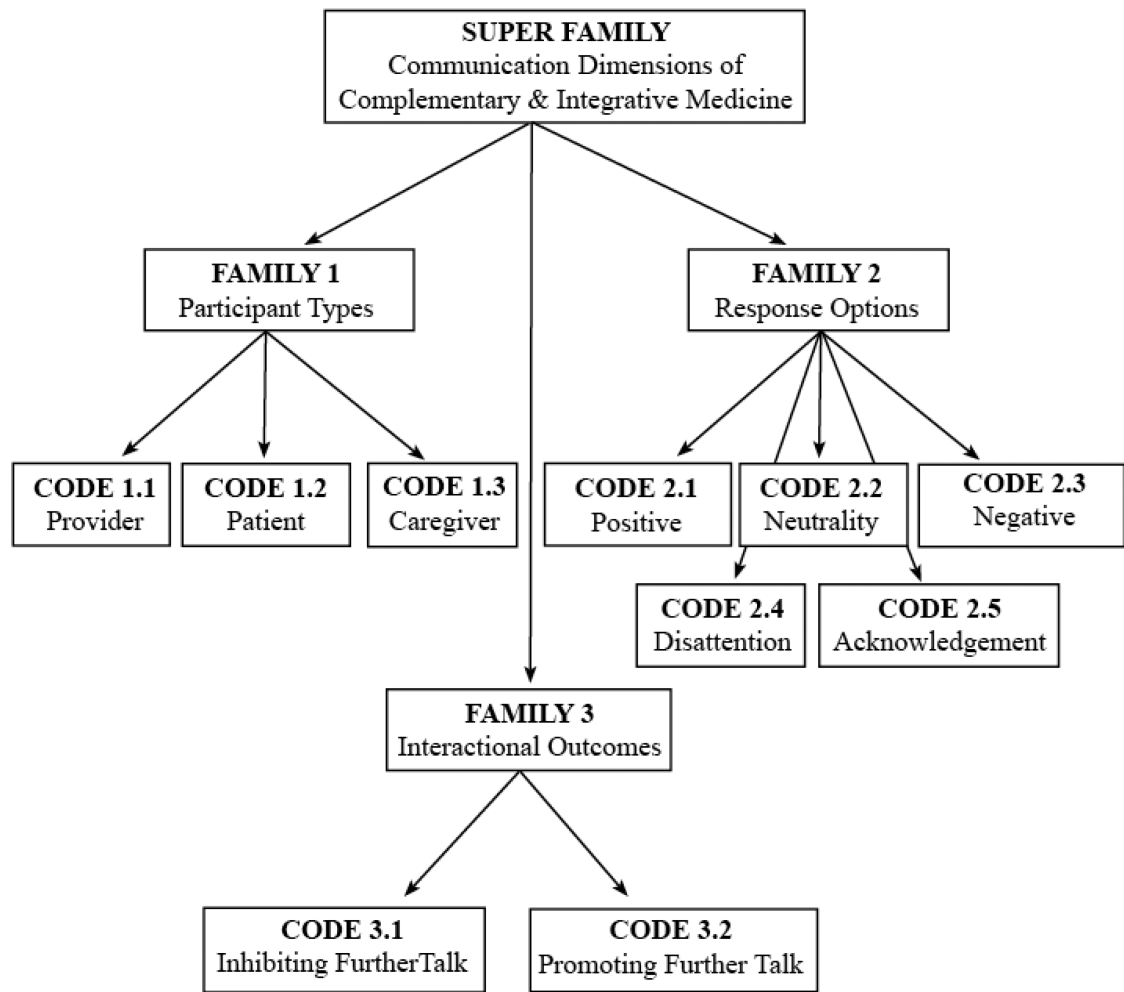


Figure 1.
Graphical representation of the coding scheme for CIM communication.

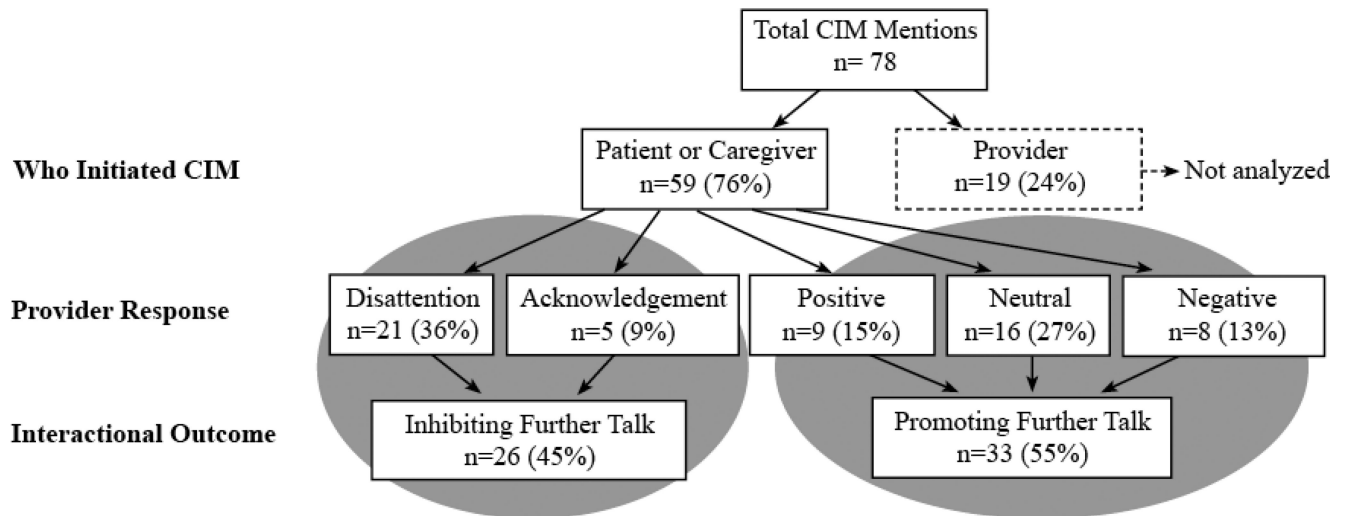


Figure 2. In response to patient initiated CIM talk, provider response determined the interactional outcomes of discouraging or encouraging further talk that have implications for the communication concepts of disclosure and discussion.

Table 1

Key terms were identified from the National Center for Complementary and Integrative Health (NCCIH) and the Office of Cancer Complementary and Alternative Medicine (OCCAM) at the National Cancer Institute (NCI) websites and ethnographic fieldnotes.

General Terms

*Gary Abrams, MD

Alternative (medicine)

Complementary (medicine)

Eastern (medicine)

Holistic

Home remedy

Integrative (medicine)

Natural

*Osher Integrative Cancer Center

Traditional (healer, medicine)

Mind-Body Medicine

Acupuncture

Biofeedback

Concentration

Deep Breathing

Guided Imagery

Hypnosis

Meditation

Yoga

Manipulative & Body-Based Practices

Alexander (technique)

Chiropractic

*Cleansing

*Detoxification

Feldenkrais (method)

Massage

Osteopathy

Pilates

Reflexology

*Relaxation

Rolfing

Trager (Psychophysical Integration)

Natural Products (NCCIH) Biologically Based Practices (NCI)

*Alkaline (e.g., water, food/diet)

*Apricot seeds

Botanical

*Cannabis

Diet

*Dispensary (e.g., Cannabis)

*Fasting

Herbs

*Juicing

*Macrobiotics

Marijuana, *Pot

*Mineral

*Mushroom

*Nutrition

Probiotics

*Raw (e.g., Raw foods diet)

Supplement (e.g., Dietary)

Vitamin (e.g., micro nutrients)

Energy Medicine

Energy

*Healer (e.g., spiritual, psychic, etc.)

Healing touch

Light therapy

Magnet therapy

*Prayer

*Polarity (therapy)

Reiki

*Shaman

Tai Chi

Therapeutic touch

Whole Medical Systems

Ayurveda/Ayurvedic

Chinese (Traditional Medicine)

Homeopathic

Naturopathic

Words identified only from fieldnotes are designated with an asterisk (*).

Table 2

Acupressure & Guided Imagery

Mrs. Tate reports that after Mr. Tate's whole-brain radiation, he had a series of *grand mal* seizures, but she recognized other, littler seizures before the big ones. From his wheelchair, Mr. Tate says that he can feel when the seizures come on. Mrs. Tate nods, "When they do, I massage a couple acupuncture points that are good for calming down the nervous system." She demonstrates the acupuncture point on her own hand for Dr. Scott and continues, "I hold that point and tell him to think of a happy place. It really helps." Mr. Tate says, nodding, "It really does help to minimize seizure severity." Dr. Scott quietly looks at the couple for a moment. Without responding, he swivels his chair, logs onto the medical record, and starts typing for several minutes. When Dr. Scott next speaks, he changes the topic, announcing that Mr. Tate has been on antibiotics for over 6 weeks, and he has had thrush since mid-April.

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Table 3

Sea buckthorn oil

Dr. Sims is in the process of doing a physical exam and tells Mrs. Allen, "Your weight is good." Mrs. Allen tells Dr. Sims that she's been putting an oil on the skin around a recent incision site. Dr. Sims comments that her skin is yellow. "It's not jaundice," says Mrs. Allen, "it's the oil." Dr. Sims asks, "What is the oil?" Mrs. Allen explains, "It's sea buckthorn oil. Dr. Oz says everyone should take it. You can rub it on, you can take it internally. [pause] I can tell there's a huge difference." Dr. Sims says, "Yeah, I agree," as she continues the physical exam by asking, "Do you feel like your energy's gotten better?" Mrs. Allen says, "Yeah. I've started taking Synthroid."

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Table 4

Prayer and Mushroom Extract

The nurse says that the patient, Mrs. Mack, seems to be doing well without too much side effects. Mrs. Mack says that she recites that her intention and her “angel prayer” when she takes the medication is that it goes only to the target. That practice worked for her chemo, she said. The nurse says, “Good for you. Where did you learn that?” Mrs. Mack explains that she’s a Reiki master. The nurse asks if she’s still doing the mushroom extract and the other alternative therapies, which Mrs. Mack affirms and continues by saying that she is an advanced practice nurse and has studied complementary medicine, and those things affect her decision-making. After a moment, the nurse shifts topics by noticing that Mrs. Mack’s calcium levels are low.

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Table 5**Medical Cannabis**

The patient, Mr. Burns, and his son discuss his difficulty with eating after three rounds of chemotherapy with Dr. Nash.

Son: What other kind of habits should we think about to keep him eating?

Dr. Nash: (looking at the patient) We want you to eat flavorful foods that you enjoy to keep you eating. I think you should drink and eat freely.

Son: Anything that can be done about his (lack of) appetite? Should we try an appetite stimulant?

Dr. Nash: I would not suggest a stimulant.

Mr. Burns: Marijuana always gave me the munchies. (joking)

Dr. Nash: I'm not opposed to medical marijuana. I wouldn't want you smoking, but cookies or brownies are OK. I can't prescribe it. For now, I think we have enough to work on. Do you have any other questions?

Mr. Burns and his son shake their heads "no." Dr. Nash moves onto discuss arrangements for the next stage of his treatment regime.

Table 6**Diet Changes and Homeopathy**

Mr. Lane recounts that he and his spouse have been doing a lot of diet changes, such as cutting out meat and dairy and eating brown rice, and some homeopathic stuff. Mr. Lane finally asks, “Will that make any difference do you think?” Dr. Rivera replies, “With some very strict diets the PSA increases less quickly, but these diets are very hard to maintain. They don’t affect just individuals, but whole families, which can be very disruptive. There’s also a big danger with adherence—when people don’t feel like they can maintain these diets, they begin to feel like they are complicit in making their cancer grow. What I don’t want is for you to feel guilty or feel like you’ve failed to control the cancer. What I can say is that a general “heart smart” healthy diet will go a long way without being too disruptive.” Dr. Rivera shifts topics by saying that PSAs typically increase for these types of tumors, so you should have a CAT scan and a bone scan after 12 weeks.

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