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Research paper

Why cancer patients choose in-patient complementary therapy in palliative care: A qualitative study at Arokhayasala Hospice in Thailand

Benjawan Poonthananiwatkul[a], Rachel L. Howard[b], Elizabeth M. Williamson[b], Rosemary H. Lim[b,*]

[a] University of Reading School of Pharmacy, Whiteknights, Reading, Berkshire, UK RG6 6AP, Present address: Sirindhorn College of Public Health, Yala,Thailand
[b] University of Reading School of Pharmacy, Whiteknights, Reading, Berkshire RG6 6AP, UK

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ABSTRACT

Introduction: Cancer patients often choose complementary and alternative medicine (CAM) in palliative care, often in addition to conventional treatment and without medical advice or approval. Herbal medicines (HM) are the most commonly used type of CAM, but rarely available on an in-patient basis for palliative care. The motivations which lead very ill patients to travel far to receive such therapies are not clear. A qualitative study was therefore carried out to investigate influences on choosing to attend a CAM herbal hospice, to identify cancer patients' main concerns about end-of-life care.
Methods: Semi-structured interviews with 32 patients were conducted and analysed using thematic analysis. Patients were recruited from Arokhayasala, a Buddhist cancer hospice in Thailand which provides CAM, in the form of HM, a restricted diet, Thai yoga, deep-breathing exercises, meditation, chanting, Dhamma, laughter and music therapy, free-of-charge.
Results: The main factors influencing decision-making were a positive attitude towards HMs and previous use of them, dissatisfaction with conventional treatment, the home environment and their relationships with hospital doctors.
Conclusion: Patients' own perceptions and experiences were more important in making the decision to use CAM, and especially HM, in palliative cancer care than referral by healthcare professionals or scientific evidence of efficacy. Patients were prepared to travel far and live away from home to receive such care, especially as it was cost-free. In view of patients' previously stated satisfaction with the regime at the Arokhayasala, these findings may be relevant to the provision of in-patient cancer palliative care to other patients.

1. Introduction

Several reasons have been suggested as to why cancer patients use complementary and alternative medicines (CAM) [1–4] even whilst being treated with conventional medicine. A recent systematic review identified the most common reasons for using herbal medicines (HMs), the most prevalent type of CAM by cancer patients, which are taken mainly as self-medication [5]; patients hoped to improve physical symptoms, support emotional health, stimulate the immune system, improve quality of life, and relieve side-effects of conventional treatment. Surprisingly few studies cited achieving a longer life-span, and only one suggested dissatisfaction with conventional medicine, as reasons for using HMs [5].

The Arokhayasala Foundation at Wat (=temple) Khampramong is a Buddhist hospice that provides CAM, with a focus on HM, for in-patient cancer palliative care. 3638 patients have been treated since 2005 using general and individual HMs, a restricted diet, Thai yoga, deep-breathing exercises, meditation, chanting, laughter and music therapy and Dhamma (prayer and contemplation according to Buddhist philosophy) which comprises the temple regime [6]. Patients have reported perceiving benefit from this regime, although no clinical trial evidence was available to corroborate this [7]. This study aimed to explore reasons why cancer patients came to Arokhayasala, to clarify the reasons and concerns that lead them to travel far and live away from home in order to receive CAM palliative care. At Arokhayasala, HM is the main treatment but patients also appreciated the other activities of the temple regime, particularly the spiritual aspects, for enhancing quality of life [7].

* Corresponding author. Fax: +44 0 118 378 4703.
E-mail addresses: be036@hotmail.com (B. Poonthananiwatkul), Rachel.howard@onwight.net (R.L. Howard), e.m.williamson@reading.ac.uk (E.M. Williamson), r.h.m.lim@reading.ac.uk, rosemarylim@yahoo.com (R.H. Lim).

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Table 1
Patients purposively sampled for the study.

Experiences of the temple regime		Attitude towards HM in general n[a] (no. of patients responding to questionnaire)		
		Negative	Neutral	Positive
Type of experience perceived	Beneficial effect	0 (0)	6 (59)	6 (151)
	Negative effect	0 (0)	5 (5)	5 (14)
	Neither benefit nor harm	0 (0)	5 (18)	5 (39)
Total		0	16 (82)	16 (204)

[a] No of patients sampled, based on attitudes towards HMs and experiences of the temple regime reported by questionnaire [7], out of the total number of patients expressing this attitude.

2. Methods

2.1. Setting

This study was conducted at Arokhayasala, Wat (=temple) Khampramong, Sakon Nakhon Province, Thailand. The temple was set up as a hospice in 2005, following the recovery from nasopharyngeal cancer of the Abbot of the Arokhayasala Foundation who used a combination of conventional and herbal medicine with meditation to aid his recovery.

2.2. Participants

2.2.1. Inclusion criteria

Patients resident at the temple who were 20 years or older, had a cancer diagnosis from their physician, spoke Thai or English, and gave informed consent to participate in this study.

2.3. Sample selection

The patients interviewed in this study were purposively selected according to their experiences of the temple regime and to attitudes towards HM in general (because HM is the main basis of the temple regime), in order to obtain a range of opinions representative of the attitudes expressed by patients who were resident at the hospice. A questionnaire was administered to potential participants as previously reported [7], which investigated these perceptions. No patients reported an overall negative attitude to HM, only positive and neutral attitudes, which was to be expected as all had chosen to attend the HM hospice. However, patients who had experienced the temple regime did report a range of perceived beneficial, neutral, and negative effects. After classification according to these attitudes and experiences, the samples were of unequal proportions, as shown in Table 1, but as they were representative of each type, a meaningful comparison of data among patients with different attitudes and experiences could be attempted.

2.4. Ethics, consent and permissions

Ethical approvals were obtained from the University of Reading Ethics Committee, UK (Project no 12/34), the Thai Traditional Medicine Ethical Committee, and the Ethical Committee of Sirindhorn College of Public Health Yala, Thailand (Project no. 094/2555). Organisational approval to collect data from patients was granted by the Abbot (July 8th 2012). Informed consent was gained from participants prior to data collection.

2.5. Data collection

Information leaflets were provided and explained to participants, and informed consent was obtained for participation in the study. A trained researcher (author BP) conducted face to face semi-structured interviews in the patients' own accommodation at Arokhayasala, for their convenience. Interviews took place between 5th January 2013 and 31st August 2014. All the interviews were audio-recorded and transcribed verbatim in Thai. Patient identifiers were changed to preserve anonymity. The transcripts were imported into N-Vivo v.10, a qualitative analysis software [8].

2.6. Data analysis

Transcripts were coded and analysed thematically in Thai. The five key steps of thematic analysis are: ***familiarisation, generating codes***, ***searching for themes***, ***reviewing themes*** and ***defining and naming themes*** [9]. For the first steps of analysis, interviews were read through at least twice to gain familiarity with the details and an overview of the gathered data. Data were then organised into meaningful groups using the method of Burnard et al. [10], who proposed a validation process of checking the coding of findings by asking an independent qualitative researcher (a trained qualitative researcher who was fluent in Thai and not involved in the study) to read the statements and identify themes according to the same coding system [10]. Three Thai transcripts were randomly selected and a comparison of interview codes developed by both researchers found 85.2% agreement. The next step was the generation of a thematic framework from the data and a rearrangement into themes which could be named and defined. Selected quotes were translated into English by author BP for use in reports and publications. Data saturation was reached after analyzing nine interviews.

3. Results

32 patients were sampled and interviewed as shown in Table 1. Participant characteristics and cancer types are shown in Figs. 1 and 2. 28.1% of participants were between 40 and 49 years old and the two most prevalent types of cancer were breast (22%) and liver (22%).

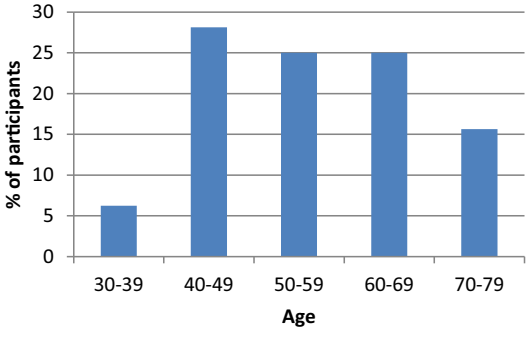

Fig. 1. Age of participants.