

CENTER FOR MIND-BODY MEDICINE
COMPREHENSIVE CANCER CARE 2000

CONCURRENT: The Role of the Nurse Healer in Integrated Cancer Care: Innovations Across the Country

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MODERATOR: Janice Post-White, RN, PhD

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P R O C E E D I N G S

DR. GORDON: I would like to begin by introducing our moderator and the first speaker, who is Dr. Janice Post-White. And Janice is an associate professor in the School of Nursing at the University of Minnesota, and she also works at the Center for Spirituality and Healing at the University of Minnesota.

She is an American Cancer Society professor of oncology nursing and a fellow in the American Academy of Nursing. Janice's research centers on clinical intervention research and psycho-immune outcomes and complementary therapies in adults and in children with cancer.

Janice and I have been friends for quite a long time. We connected in the Oncology Nursing Society and the PNI -- what is now called the PNI and Complementary Therapies ———. And it's really been a pleasure to work with Janice and to be mentored by her. So it's my pleasure to introduce Janice.

DR. POST-WHITE: Thank you. It's very much of an honor to be here at this conference at the Center for Mind-Body Medicine. This is the first year that nursing has been sponsored at this conference. They have had sessions appropriate and relevant to nurses, but it's the first time we have had any nursing-specific sessions, so we're very excited about that.

We also want your feedback on the session, so please fill out the evaluation forms and hand them in at the end.

I'm going to talk today first on roles and then Hob Osterlund, who is from Queen's Medical Center in Honolulu, will talk on the how-to's. And I'll talk about the nursing roles and ethical considerations, and Hob will talk about the how-to of administering a program in nurse as healer, and Susan will then talk about end of life as exemplar and rising to the challenge. And we hope to have 20 to 30 minutes at the end for discussion and questions and answers.

The way it was: How did I get involved in CAM and oncology? When I was pursuing my doctorate, I had immunology as my minor, and as I was talking to the immunologist to be on my committee, he asked me what I was planning to study. And I told him imagery in patients with cancer and looking at immunologic and cancer outcomes.

He looked me quizzically and he said, that's witchcraft. I said, welcome to nursing. That's just what I said.

I've taught him a lot over the last 13 years and he's now one of my most ardent supporters, not because I really bought him into CAM or mental imagery but because we've looked at a new way of measuring outcomes in patients with CAM, or we've looked at outcomes. One of the problems with CAM and accepting it is it being a so-called pseudo-science, its not being randomized, controlled clinical studies to measure outcomes in a scientific way that he and other researchers would qualify as being legitimate research.

There have been anecdotal reports of miraculous healing, or no documentation. I started doing complementary alternative medicine in 1981 at Dana Farber Cancer Institute without realizing what I was doing. Now in just this last year, as Mary Jane Ott presented yesterday, we have a formalized program -- they have a formalized program -- I feel like I own everybody right now -- at Dana Farber Cancer Institute, and that has just started.

There are many, many places across the country. One of the things we had hoped to do today was to highlight what people are doing, particularly what nurses are doing across the country. As I started to do slides on who's doing what where, I realized that that would be a whole-day talk. So we're only going to touch on a few of the examples. But many of you are probably integrating CAM into your practice and have formal or semiformal programs. We hope that you will share that at the end.

There has been a window of opportunity in the last 10 years and people are more open to new ways of knowing and healing. What's also changed is technology. We know that technology is very important in our health care today and in our nursing care today. But patients are seeking more than just caring for the patient through technology. There's an interest in complementary alternative medicine, and part of that, I think, recently stems from the use of and interest in Internet resources. I'm on a parent listserv for parents of children with AOL. It's been a wonderful support system. Patients have access to PubMed and literature that we have read for years in scientific journals they now have access to and can look at outcomes and also CAM therapies. There is marketing being done on products and services and there's also availability of these services in their own communities. Because there's a strong economy, there's resources, and patients currently have resources to pay for these services and products.

But there are still consumers wanting more is a primary reason for CAM introduction into cancer care today. A physician in the Minneapolis area, Dr. Glasser, wrote in Harper's magazine in 1998: We are born, we live, and then we die, but these days we do so with less and less help from a medical professional who is paid to discount our suffering and ignore our pain. I know many physicians, and many who I work very closely with who would say that what we really need to do is integrate our care and we've lost touch with compassion and touch with our patients. They are just as adamant as we, as nurses, are in making sure that's a component of our care.

However, I think one of the things that we really need to offer and can offer is hope for our patients through CAM. As Dr. Glasser titled it, the managed failure of managed care. Our vision for the future is that there's more than drugs, diagnostics, treatments, and cure.

Don't get me wrong, these are essential components of our cancer care. The patients want more. They want the caring; they want you to spend time with them; they want you to communicate hope. They also want the touch, the compassion, and the presence from the beginning of life to the end of life.

I think that's nursing. Nursing is touch, compassion, presence, caring, hope, and trust. There was a Gallup poll done last November, in 1999, that patients said, 73 percent of the patients said that nurses were the ones who they had the most and were the most honest profession of all of the ———. Nurses were number one for these patients.

The medical doctors ranked at 58 percent, nurses at 73 percent of establishing the greatest trust.

George Will, a noted editorialist, said, the ideal of the American doctor, that kindly, caring, reassuring Dr. Welby, well, he was essentially a nurse. He also said nurses control the environment of healing.

So what is complementary alternative medicine and integrative cancer nursing care? It's integrating the mind, body, and spirit in cancer care.

Some of the nursing roles are as practitioners, administrators, researchers, and educators. I think, as Hob will also talk about, these are all important components to implementing a program of complementary alternative medicine into your cancer setting.

I'm just going to summarize these very briefly, and then Hob will talk a little more about the practitioner and the healer, and Susan will talk more about the educator, and use some examples.

So what is important for practitioners? I think the bottom line, the most important one, is to energize your passion.

Why is it that we're here today; what does CAM mean to us in our lives; what does searching for hope and spirituality mean for us as well as for our patients? Using CAM yourself is one of the best ways to know what CAM can do to help your patients.

One of the other things we need to do is nursing process -- assess, identify, integrate interventions, and then evaluate and document the outcomes. So we need to assess from our patients what they're interested in, what do they use, what do they have an interest in that we might be able to offer services for; and then, do they have access to these services? Also to identify what barriers there are to change, whether it be in your environment, in your cancer institution; or whether it be within your individual patients or within yourselves or amongst your colleagues.

Then, how to integrate interventions: How do we start by offering some of these interventions to our patients and which interventions should we start with? As well as evaluating the response: Was it successful; did patients like it; how many patients used it; what were the comments or more formal documented outcomes such as through research or QI-to-QI kind of project? We have to make sure that we document the outcomes. If we don't document the outcomes in this millennium, we'll back where we were 13 years ago, with no evidence for any outcomes.

So what are some strategies for integration? This is from Aspen's Advisor for Nurse Executives, in 1997. She basically said the same thing that I have just iterated in terms of how to get started -- begin with yourself and find interested colleagues. You're not going to be able to generate support from everyone in your institution. Find key people who are interested in working with you on this.

Then select particular patient populations who already use CAM. Find out those who are using CAM and find out what they are using and what they might be interested in offering. Choose one particular unit or program to start your project on.

Don't start with the entire system. Incorporate CAM into existing programs or units, although some institutions are doing this. We have Woodwinds in the Twin Cities area and there's Beth Israel Hospital in New York that are actually starting hospitals with an integrated approach, where they're offering CAM services in an entirely new hospital.

These are very innovative progressions, but you need a lot of money to do that. If you're trying to integrate CAM into your current environment, try to incorporate it into your existing programs, is probably a more feasible way to start.

Then once you get these programs up and running, designing a particular proposal, whether it be an intervention proposal or a research proposal, and developing specific educational and curriculum to intervene with your staff as well as with your patients, and educate your staff and patients. Look at research outcomes that will then change practice.

As I mentioned, many people across the United States and across the world are using some forms of CAM. In a survey in 1996, in the U.K., of 393 nurses, 68 percent of them were already using massage with their patients; 59 percent were using aroma therapy; 18 percent, reflexology; and 13 percent, therapeutic touch.

The Healing Touch International is one of the largest training organizations and it says that 30,000 nurses are now using some form of hands-on touch in their current practice.

Dr. Susan Bauer did a survey with Judith Coska at the David Eisenberg conference on CAM in March and of the 20 nurses that attended those sessions, they wanted to know what their background in CAM was and what their current use of CAM therapies in practice were.

Nine of these 20 were certified or working on certification in CAM in various areas in terms of imagery, biotherapy, healing touch, massage therapy, and nutrition. Forty-four percent of them had graduate degrees, and nine of them were nurse practitioners.

The mean time in nursing was 24 years, and the mean age was 50.5. And they were able to identify at least 10 training programs across the United States that they had had exposure to or were familiar with or had attended to receive training in CAM.

These were some of the things that they were using in their current practice with patients -- and it isn't all cancer, but some of them were. Meditation was the top one. Fifty percent of these nurses were using meditation with their patients. The other top ones were herbals, humor, massage therapy, therapeutic touch, progressive muscle relaxation, and prayer. Some of the other ones are: 10 percent to 20 percent, music, journaling, Reiki, homeopathic therapies, magnet therapy, and reflexology. A wide variety of CAM therapies being integrated in practice in different settings across the nation.

How well-prepared were they to offer these services? Those of you who have gone to school earlier than the last decade probably didn't have any formal training in complementary alternative medicine.

Some of us have gotten our own individual through workshops or our own investigation on our own or coming to conferences like this. Most of these nurses, however, felt quite a bit or very prepared to offer their services or have the services offered within their institution. There were five people who said only a little or somewhat prepared.

I'm going to talk a little bit about our complementary integrative medicine program at Children's Hospital and Clinics in the Twin Cities area; partly as an exemplar for developing a program.

But very briefly, we developed the program a year and a half ago, and our focus within this program is to integrate research. I didn't make this slide, but I notice that pediatric CAM research is number one on the list. Research is my role within the program.

I think one thing that has sold the program, across the Twin Cities area at least, is the fact that we are measuring outcomes. We are measuring if we know we make a difference through any of these CAM interventions. It's helped to buy in the institution and the medical doctors who are in the institution.

We also offer clinical services. In addition to those we are studying, we offer clinical services above that. We have education and information services. We have an information specialist who is full-time with us, who does our Web design and who also helps field questions from the community.

We are offering culturally competent care, and this is something we are working very strongly on integrating in terms of redesigning our instruments to cover different nationalities. We're not quite there yet. We have a healing help-line and we have a healing place for parents to go.

We did a survey a year ago and found that 59 percent of our children with cancer were using some form of CAM. Part of that was related to the parents who were using CAM were more likely to use CAM in their children. That compared to our general population of pulmonary and general pediatrics of 39 and 36 percent use. So the use was higher in the oncology population.

The therapy most often used was prayer and this isn't prayer that the patients used, it was prayer that the children used. The other top three interventions were nutritional supplements, mega-vitamins, and massage therapy and you'll notice here that 16 percent used massage therapy, but 31 percent were interested in massage.

So that told us from a program standpoint that perhaps we should think about offering massage. So we now have a full-time massage therapist on staff and starting another research study where we'll hire another full-time in September.

We were also somewhat surprised by the great interest in herbal therapies and homeopathics and aroma therapy and music therapy. So we are now starting an aroma therapy study next week and we are investigating with a pharmacologist of the institution on herbal therapies and having them offered at the institution, and setting up policies for how patients can bring in their own herbals and homeopathics and be protected in terms of legalities.

Why do these children use CAM? Why do their parents seek CAM for their children? The top three reasons were to manage side effects, to cope with emotional aspects, and to feel more hopeful. In your packet is an abstract from the American Cancer Society, and I think they surveyed over 400 or 500 women with breast cancer.

These reasons for using CAM were the very same reasons that they gave -- to feel more hopeful, to participate in their care, and coping with the emotional aspects of cancer. It's also consistent with what's in the literature.

Some of the things that we're doing we're not studying at the time. We have two acupuncturists on staff. We're doing healing touch therapy. We're doing aroma therapy. We are doing an intervention study, a crossover design, looking at ginger, spearmint, and peppermint aroma therapy for the control of nausea and vomiting in kids receiving chemotherapy.

So when they get their serotonin inhibitors, they will also choose one of the aroma therapies and it will be the exact times when they're doing the same -- repeat protocol. If they're leukemia patients when they're in one delayed intensification phase, they'll get the intervention; when they're in the other delayed intensification phase, then they will get the control. It's a crossover design.

We're also doing massage therapy, and this is our massage therapist Lisa. We're offering it as services to children. And we finished one research study on mostly inpatients with leukemia and lymphoma.

We did it as a feasibility study to find out do these patients accept massage, do children accept massage? There's a number of literature out there on massage therapy and outcomes on pain, nausea, and vomiting, but very little literature -- none, actually -- on children with cancer getting massage, and we wanted to know if it would work.

What we found is these children had very little pain and nausea and not a lot of anxiety, which kind of surprised us, so we didn't influence those outcomes.

But what we did find, very significantly on the graph on the right, is we gave massage to the parents, and the parents' anxiety decreased. We did a 15-minute chair massage to mom or dad while the child, ages infant to 17 years old, observed, and then we did the 30- to 45-minute massage on the children, or whatever they tolerated and the parents' anxiety decreased.

We just received a grant from the American Massage Therapy Association to start a study in August that will now look at randomized control studies similar to aroma therapy, where we do the parents and we do the children and have a control period to control for.

One of the most important things is in our survey we found that only 57 percent of them had told the health care team they were using some form of CAM and 18 percent did not tell why because we didn't ask.

We need to ask if we want patients to tell us what they're using. If you walk away with anything today, and you don't already know, is to make sure you ask your patients what they are using. We're finding that many of our patients are already using something; we just need to find out what that is and why.

One of the risks of using some form of complementary alternative therapy are interactions with chemotherapy, particularly if it's herbals or homeopathics.

Kara Kelly is a physician who's going to talk in the pediatrics session this afternoon and Sunday morning. She did a survey and found that 85 percent of their children on their cancer clinical trial

group, CCG, were using some form of CAM. Twenty-five percent of these children were using herbs, and 34 percent using nutritional.

How are we going to know if we don't ask to find out what they're using and what difference that will make in our clinical trial outcomes? ——— that was published in The Oncology Nursing Forum did a survey of patients in NIH clinical trials and found 63 percent of them were using some form of CAM; 17 percent herbals and 22 percent vitamins and antioxidants. So it's important to find out what they are using.

What are some of the other risks? Impurity of herbal preparations, high calcium and phosphorous and contamination. It's improving, but there's a lot of variety there out on the market. Unknown effects of high-dose therapy, especially in pediatrics. What are the normal doses that we should prescribe for our patients; how do we know what those are? Finding reputable resources and sources and the issue of foregoing standard medical care in replacement for CAM therapies is a risk. It's also costly. Most of these costs are paid out of pocket at this time.

The Dinkler and Nichol (?), if you haven't read this article and you're thinking about starting CAM or integrating CAM into your practice, it's an excellent article. It was published in The Journal of Health and Hospital Law in 1997. It talks about the legal and ethical issues and gives some very concrete suggestions for offering these -- for monitoring these services in your setting.

They ask very much the same things that I've been saying: Inquire. Ask direct, nonjudgmental questions about CAM use. One of the things they emphasize, if we know that there is a risk or it's been published that there is a risk of some form of herbal or CAM therapy, we have the responsibility to know that there is a risk and to counsel our patients in that way or we can be held legally liable for not informing them.

We are responsible for educating them if they ask questions. It doesn't mean we need to know everything about all CAM therapies or everybody in the institution needs to know. They have to have a resource of an individual to ask. You need to have resources to go to.

Then we need to determine why they're seeking CAM. Maybe there's some other reason, some other therapies that will offer adjunctive therapies that will meet their needs just as well or in addition to their CAM therapy.

The Oncology Nursing Society has a standard for respecting autonomy. The client and family participate in care and ongoing decision-making consistent with physical, psychological, and spiritual capabilities and their value system. So we need to let our judgment aside and adjust the patient's, where they're coming from and then evaluate. Evaluate the risks, benefits, safety, contraindications, the effects, as well as the credentials of providers.

It's our responsibility to know the risks, the anticipated results, and other treatments available.

Very briefly, I'm going to breeze through -- Susan Bauer's going to talk a little bit more on a curriculum and education of nurses in CAM. I think today, any of you who are in academics or educating nurses, the issue today isn't whether to include curriculum on CAM, it's what to include, at what level to teach it, the best balance between skill and content, and whether they should be elective or required courses.

We're currently addressing some of these issues in our Center for Spirituality and Healing, which started two years ago through an Academic Health Center initiative, and is supported through the medical school. Much of the focus is on educating medical students, but also nursing and other disciplines, such as pharmacology.

The purpose of the center is to promote healing and well-being of individuals and communities, serving a spirit of trust, respect, and partnership. Our goal is to promote interdisciplinary education, research, and patient care that integrates biomedical, complementary cross-cultural, and spiritual aspects of care.

We have a graduate minor in complementary alternative medicine at this time. We have 17 faculty representing nine disciplines, and we have eight core CAM courses and 25 other courses. We have submitted several applications for pre-doc and post-doc training, and it is being integrated into medical school curriculum and students are taking the courses.

I'm going to skip through this, but one of our Ph.D. RNs who participates in the program, who is also a licensed acupuncturist, said the goal of students is to have deep compassion to ——— and suffering and support wellness as they incorporate alternative care into their professions while still honoring their scientific training. One of the issues in Academic Health Center is how to offer and teach about CAM, but also to maintain that scientific training background.

So to summarize, what are some of the issues in the year 2000? It's how to integrate care. It's how to get access for all of our patients, not just those patients who have enough money and resources for them. What is the cost, and how do we get reimbursement so there is access across the board?

What is the quality, accreditation standards and licensing, for practitioners to come to our institutions to practice? Then, what are some of the outcomes?

Some of the ethical issues include getting informed consent, respect for autonomy, assumption of risk, to define the scope of therapies, to coordinate care with the CAM provider, not just refer to the CAM provider, but then to follow up, address issues of credentialing and standards of care.

There are more and more articles published in journals on outcomes of complementary alternative medicine. The Oncology Nursing Forum in January and February had two articles on acupressure for nausea and the effects of foot reflexology on anxiety and pain in patients with breast and lung cancer. The Journal of Alternative and Complementary Therapies also has many research studies on the outcomes, as well as some of the medical journals.

The reality is, is CAM is here to stay. I think the importance of CAM is how to integrate it into our patients' lives so that we can empower them on their journey that they're sailing.

Thank you.

I'm going to pull up Hob's session quickly and introduce her. We're going to go a little bit back and forth from the screen.

Hob Osterlund is a nurse who's been in Honolulu, in Queen's, for approximately 20 years, I think she said. She's going to talk on healing touch at the Queen's Medical Center. Hob is the creator

and coordinator of Hawaii's first acute pain management program at the Queen's Medical Center in Honolulu.

Since 1991, this program has included the practice of healing touch, and more than 3,000 healing touch treatments each year are provided to inpatients, many of whom have a cancer diagnosis. Queen's is the first medical center in the country to have offered such an energy-based practice to so many patients in an allopathic setting.

Hob's background is varied. She received her associate of arts in nursing from Lynn Betton Community College in Oregon, and bachelor of science in wildlife biology at the University of California at Berkeley, and then her master of science in nursing at the University of Hawaii at Manoa.

She's received many awards and honors, and she has a videotape and she also on the side does a performance of Ivy Nurse, but she that promises is a whole other suitcase and she's not going to be able to integrate it today. But I've heard very rave reviews on her performance.

So we look forward to her talking today about how she integrates the healing touch at their setting and what difference it makes. Welcome, Hob.

MS. OSTERLUND: Thank you very much. I want to tell you if what you expect to hear about is the role of the healer and the how-to, I can really answer that in a very brief moment and then we'll go on to a little bit more of a description.

I think that the integration of healing touch and the success at Queen's really has to do with kind of a combination of personality elements that I would suggest that you all consider. It's kind of a combination of Annie Oakley, Florence Nightingale, and Lili Tomlin.

It is, for me, the Annie Oakley aspect has been that I feel like what happened is I let a few cattle out into a pasture, and then what happened was this tremendous stampede occurred, and ever since then, for the last several years, I've only tried to keep up with it and occasionally push a wandering calf back into the stampede.

But by and large, this is all happening because it's time and because it's right, and not because I in particular have any skills.

In fact, I'm uncomfortable even calling myself a healer; that it actually is more the cowgirl element and the comedy element that I identify with because it's also all very funny and very fun to participate in.

So if you could cap that for me for a minute, I'm just going to run through a couple of slides here and then go back to the LCD. If we can dim the lights -- Susan, right behind you.

Just a bird's eye view of where I live, and I hope you get to visit sometime. The Hawaiian Islands, as you know, for those of you who have had a chance to visit or live there, are very nurturing all by themselves. That's why it's such an international source of joy. So it can't help but have an element, too, of that manifestation in health care.

Not far from the hospitals that we all work in are places of great renewal. The Queen's Medical Center is right in the middle of downtown Honolulu, right in a district that includes the capitol and the governor's mansion and all the main business district of the state. And is itself a very

beautiful kind of setting, founded 150 years ago and includes lots of open-air settings and lots of greenery, which is a source, of course, of great healing all by itself.

So just the opportunity -- it must seem funny to people from Minnesota to think of open-air settings year-round, but that's what we get to have.

The internal setting, also organized more and more around the opportunity for people to feel at home and feel comforted by a natural sense of element.

It's the only hospital in our country that's been founded by royalty. Of course the people of Hawaii and the creator of the hospital, of the Queen's Medical Center, is herself the monarch of a people that believes in the role of healing and the role of mana, the power of the internal sense and our connection to the divine. So she's still very much present.

In fact, the person who up until recently was the chairman of the whole Queen's Health Systems doesn't -- he doesn't use the term "channel," but he talks to the queen, who is, of course, long since passed on, and tells us what she would want. So he's been quite an inspiration to us all in understanding what her spirit intended on all kinds of levels.

So healing touch many of you are familiar with. We call it an energy modality, meaning that those of us who practice these kind of arts have a philosophy that includes some integration of what we think of as an energy field.

There might be other words for it. You might call it an aura, you might call it vibes, you might call it something altogether different. But that there is such a thing as subtle energy that surrounds the body and can be influenced and that in fact we don't even have to touch physically the person.

We can use a very light touch and still have great influence over what happens with the physical body. Because the energetic body is always integrating with the physical body. Of course we all know that it's a mystery how we even appear solid to begin with, because we're all made up of lots and lots of what seems to be empty space.

The core of healing touch is therapeutic touch. Therapeutic touch began this work in nursing many years ago, and therapeutic touch provided the core for then what became healing touch.

Healing touch includes now many other modalities and techniques, but also includes the essentials of therapeutic touch.

Healing touch assumptions are that there is this subtle universal energy in and around each and every one of us. It differs from some belief systems that think that only certain priests or certain people with healing capacities are able to do this.

We believe that everyone has this capacity and has this access. So we can teach parents of children or teach loved ones, in a very simply demonstration that takes only a couple of minutes, teach them techniques that they can use that can be very helpful to their loved one.

That of course is energy can be influenced, as I mentioned and that this is key, that this energy is benevolent. This is where many very fiery discussions happen, when people ask us if this is not from Christianity or is it from, in fact, some opposing religious belief. Which of course it isn't, but there are many people that believe that the energy that surrounds us is not at all benevolent

but in fact can be malevolent and can be something very frightening and unhealthy. We'll talk a little bit more about that in a second.

How it is administered at Queen's: We have a pain management program, and it's primarily an acute pain management program where four nurses actually do consultations around a 500-bed medical center.

Two of us are clinical nurse specialists. I'm the coordinator of that program and then two people are instructors who follow all the epidural patients. It's a nursing-run pain management program. There is not still much physician presence in Hawaii in pain management, and so, since 1989 when I began the program, it has been primarily nursing presence.

We began healing touch -- this is when I sort of let a few cattle out into the pasture in 1991, when the first class happened in Hawaii and we invited the faculty over, Janet Minken (?), who is the originator of the healing touch program to teach the level I class. It was full just by word of mouth.

Ever since then, there have been literally hundreds of classes in Hawaii around healing touch. Hundreds of the staff at Queen's are trained in healing touch. But as you know, staff nurses are way too busy these days to even keep up with what they have to do. It's an impossible job, as you know, staff nursing these days, and so healing touch is often not something they feel like they can integrate.

But they're very happy to have our volunteers come. The volunteers are really the backbone of the program. Many are retired nurses. We actually had the opportunity a few years ago to decide whether or not the volunteers should -- it be mandated that they be nurses.

We did that because we had a person who wanted to be a volunteer who actually would have, had she stayed, stirred up a lot of trouble. So we thought, well, maybe we should make this just nurses and decided against that, decided that it was too restrictive to do that.

I thank my lucky stars ever since then that that's what we decided because as soon as we decided that, we actually had someone who wanted to be a volunteer who was a nurse, who would have stirred up even more trouble, and she was a nurse.

So we realized that the distinction of nurses or not nurses is a distinction of people who really believe in holistic, meaning that they don't come in with an agenda to convince people to throw down their chemotherapy and come with them, but instead really look at it from a holistic viewpoint, which is what serves each individual.

What is really the thing that works for you? For you it might be something strictly complementary, and for you it might be something strictly allopathic, and for you it might be something -- a mixture of that.

But my role, and the reason I say Florence Nightingale, is to not only know what my destiny is and to know what it is that is my divine calling, but also to be able to recognize and support yours. So that means I have to come in with a relative lack of ego that I know what the answer is for you.

So what we do, then, is screen volunteers. We have now 60 of them who provide these 3,000 hours of treatments every year and who are really miraculous people. I mean, they come in with a genuine desire to be of service.

We have now some designated ones who we call partners, which means that when new people come in, they actually follow these partners for awhile before they become volunteers so they have a chance to be oriented by, sort of, senior volunteers in the program.

I don't have anywhere near the time to physically follow 60 volunteers around the hospital, so it actually is a model in economic good sense, because it doesn't cost anything to have volunteers except to have them be of high caliber and to be sure that we meet some JACO criteria. By the way, I heard somebody recently call JACO "the Joint." So, I like that.

The Joint is coming to town for us in the fall with our new pain standards. We're delighted to have an opportunity to display to them how we do this.

I already covered some of this. We had the first class in 1991. In 1994, I was starting to pull my hair out a little bit thinking that we'd created a benevolent monster, in that we were getting so many requests for healing touch and had no idea how we were going to fill these requests.

We were already a busy pain management program before this began and now, because of the cultures in Hawaii, really, it began to happen that word of mouth informed people. We never still, to this day, have had any active marketing -- that patients heard about it and wanted it.

A retired nurse called me and said how about if some of us retired nurses take the healing touch class and become volunteers and I still kiss her feet when I see her because the idea was so wonderful.

She was responsible for inspiring a number of the retired nurses in our community, many of whom were already well-known to the physicians and to the other professionals in our medical center, and at whom you could not look and see a new-age flake no matter how biased you might be about this kind of training.

They're mostly Japanese. One thing you can count on with nurses is that they are so steadfast in that nurses have seen and done everything. You can't spook a nurse. I mean, we have seen it all and so they brought a real backbone, a real core that has been really responsible for the success of the program.

Well, let me back up for a minute to that Allied Health Professional status. All the volunteers now meet Allied Health Professional status, which means -- you may know that status in your settings. An Allied Health Professional means that the individuals are people like speech pathologists, physical therapists, profusionists, folks like that who are not employees of your setting but who have privileges to come touch and see patients.

So all of the healing touch and now guided imagery is also under us. All the guided imagery and all the healing touch volunteers fall under Allied Health Professional status.

We have in Human Resources, their files, copies of their training references. Our hospital has a form on all of their charts covering all of their liability, so that any potential lawsuit means that our medical center will cover them. All of those kind of things are all in the professional kind of

setup so that they are alongside all those other health professionals. It's really a nice capacity to have them in.

Healing touch policy at the Queen's Medical Center is that anybody who has taken Level I may do healing touch on the patients at Queen's. That includes not only nurses, but we have pharmacists, dieticians, all kinds of folks who have taken healing touch, including a number of our vice presidents; all of whom have the freedom to do healing touch on patients, by our policy.

We require verbal consent on the part of the patient because some of our detractors say that we are doing this against people's religious beliefs, that we are taking innocent people and pinning them down and forcing them to have healing touch against their religious belief.

So of course, we don't do that and we're clear that we ask for people's consent without ever trying to talk anyone into it. People always tell us that they're willing before we bring in the practitioners. The people who get the consent, by the way, are not the practitioners, so that the tactful patient doesn't feel like they're hurting your feelings if they should say no. So that's something that we are very clear about.

This "M.D. order not required" is, sort of, four really simple words on your screen and, as I'm sure you know, required many more conversations than it appears. But the thing that I learned that is quite remarkable to me, and I'm saying this on tape, so I want to share. If you take this tape, I want you to share this tactfully in places that you think are -- in a discriminating sort of way.

We started doing healing touch at Queen's in 1991, as I said, and we did it until -- in 1994, after the volunteer program began, it started getting lots of publicity. It got really popular. All of a sudden, this thing that we had been doing right in front of everybody, we hadn't been hiding it, became threatening and I thought to myself, now, why is it that nobody ever said anything about it until it got popular?

I realize that many physicians, male physicians in particular, don't seem to notice what you're doing unless they think it's either, A, competitive with them, or B, sexually attractive to them. So if you're not either of those things in their vision -- I often pass physicians in the hallway, clearly doing this kind of work, and I would say hi, and they wouldn't say anything to me.

These are people that I've known for many years. I used to think they were rude. I realized it's not rudeness, it's that they truly do not see me some days because I don't fit into either of those ways of thinking for them.

I realized what a great boon that is for us -- all the things that we can do without being secretive or sneaky in any way but because it literally does not register on the Richter scale for people who see things through those eyes. And I don't want to categorize all physicians in that way, but it is literally -- what happened there is that we had this grow in its own popularity without there being any secret about it.

Then, of course, the issue of M.D. order came up. But we have managed to negotiate over and over again in many different settings that it not be an M.D. order situation. We have had support all along from the Queen's Medical Center administration, the Health System board of trustees. The current chair of the board of trustees I have treated with healing touch myself.

Nursing has always been supportive of healing touch at Queen's. The culture and community of Hawaii probably has been the most significant factor because we are -- caucasians are a minority in Hawaii, and those of us who are caucasian have long since forgotten our healing roots.

But not so true for Pacific Islanders and for Asians. For Japanese, for Chinese, for Southeast Asians, for Tongans, Samoans, Hawaiians, and Filipinos, the people who make up the majority of our population, it's not so long ago that they remember healing.

As a matter of fact, in Hawaii, the majority of people seek some kind of complementary therapy before it was even recognized as that.

The physicians have now added themselves to our support. We have 60 physicians now who have simply given blanket consent. We go with physician, what we call permission rather than orders.

So it has them be part of the loop, where they -- and they belong in part of the loop, but it doesn't mean that we have to phone them every single time and say is this okay.

So we have 60 physicians, and they are our major admitting physicians at Queen's, who say please, any time, any place, with my patients, do healing touch or guided imagery; don't call me about it, just do it. So that's what we do. If there are exceptions or if we know the physician is especially opposed, then we do call them out of courtesy and respect, actually, more than out of a policy need to do that.

There is national support for healing touch, as you already know about. The www.healingtouch.net is available for you to look up and see the hundreds of classes that go on across the country every year, and Healing Touch International is responsible for international certification, where you can become internationally certified as both a practitioner and an instructor and therefore you have that credential after your name.

The American Holistic Nursing Association was also under the auspices in which healing touch originally was certified, and since has switched to Healing Touch International, but the American Holistic Nursing Association, www.ahna.org, is also an organization that you can check on if you want to understand more about how this support happens.

The challenges for healing touch are around whether it's based, does it work, is it from a religion, is it Christian, is there a fee? Those kinds of questions tend to come up. But over the years since it's become so well-known in Hawaii and so popular, these questions have dissipated and we hear them much less.

There is a spiritual base, however, which many people confuse. In a spiritual base is that assumption that there is this benevolent energy that we can all tap into.

To me, it's clear it's God. To you, you might call it universal energy. Someone else might call it Allah or Buddha or Akhman. Whatever you call it, it's clear that there is a divine source that we have access to.

Does it work? It certainly does work in many situations. It's free, by the way, to all the patients. There is no fee at all. We have done patient satisfaction surveys, which I'll show you here in a second.

We've got many calls to Patient Relations over the years, many letters, many immediate responses -- hundreds and hundreds of immediate responses to our practitioners.

We've received two complaints to Patient Relations about healing touch in those nine years, now, and those two complaints were "I asked for it and didn't get it."

In the patient satisfaction survey, we interviewed almost 200 patients. Ninety-five percent of them were either very satisfied or satisfied. There was, and this is interesting to those of us who do pain work, an average pain decrease of 2.8 on a 0 - 10 scale after a 20-minute treatment with no side effects, and it's free.

If you had a drug that did that, imagine the kind of publicity we'd get. Bob St. Marie and I would be out talking full-time about this product. Only no one would pay us to do it because nobody's making any profit off of it, right. You understand the politics of that is a whole other discussion. An average relaxation increase of 1.8 on a 1 - 4 scale.

So people were twice as relaxed and had almost 3 points in pain relief as a result of healing touch treatment, maybe from someone who'd only taken a 20-hour course.

Healing touch research for those of you -- we're not going to spend a lot of time on that today except to tell you that we have two projects going on at Queen's. But again, that Healing Touch International number, that www.healingtouch.net, you can have access to their healing touch research individual, who is responsible for keeping track of all of the healing touch research going on nationally.

There are about 60 projects going on right now. Two of them are happening at Queen's. One is a post-op pain study which looks at the difference in pain after mastectomies with ladies immediately after surgery who have received healing touch. The other one is called the Hutoba (?) Study, which is looking at healing touch in its effectiveness on employees with back injuries. Both of those are ongoing with no conclusive results yet because we're still building our numbers.

There are several off-shoot kind of programs happening as a result of this program at Queen's. One of them, that I'm the most involved in and the most excited about, is something called Bosom Buddies of Hawaii. Bosom Buddies of Hawaii, and I have several pamphlets for those of you who want to come by and pick one up.

Bosom Buddies is a statewide program to match healing touch practitioners with ladies with breast cancer, and match them for an entire year so that that person is their bosom buddy to do healing touch with them for free for a whole year.

We have 13 major organizations in Hawaii involved, including the American Cancer Society and many other organizations; the Executive Office on Elderly Affairs and the Queen's Medical Center and a number of other hospitals.

So all are participating. The money from that is all contributed money. The medical centers involved provide in-kind contributions, but it's all contributed money. So our goal is to match with 100 people this year. We just got started this year after a year's worth of planning and training. So we now want to match with 100 people and provide that service, look at what kind of results they believe they've received as a result.

O Ka Mana Ka Ho'ola is a week- long retreat -- Life Is In Your Spiritual Power -- that includes healing touch. I also have a flyer about that for anybody who's interested. A seven-day residential retreat that is a fabulous program for people with life-threatening illnesses.

The Hawaii Nature Fast is an opportunity for you to be in a pristine wilderness area and experience something quite amazing in silence without any food for several days in the wilderness. It is an opportunity to come face-to-face with you and the Divine.

There is also an International Symposium on the Healing Arts. For those of you who want to come experience our wonderful state, that's in May of 2001. I have a flyer about that. So healing touch is very much involved with that.

I also want to recommend an article for those of you who want to look at this more in depth. A wonderful person by the name of Alexa Umbeit wrote an article called "Healing Touch Applications in Acute Care Settings." I have one copy of that available with me today, so you can write down the issue. But it's AACN Clinical Issues, Volume 11-1, available for you.

Let's put that clip back on, if I could. So, just so you know the image here of what we're seeing or what we think we see and what you think of as a solid physical body that slams shut at your flesh, that it doesn't indeed slam shut at your flesh, that we are always integrating the energy of those around us from quite a distance away. This is kind of a vision of a particular artist of how that might look.

I wanted you to see a few of the healing touch volunteers here so you can get an image yourself. This is about a third of our volunteers, who recently received a big group award at the Queen's Medical Center. They have, by the way, received many awards, including a JC Penney Award and a National Volunteers Award. This was just last month when they received a group award at the Queen's Medical Center for 20,000 hours of volunteer time since 1994.

This is just to let you know that all of this work is a stretch. Whatever you do, just know it's a stretch, but remember Florence and read about her and be inspired by her life, and know what it was that she did. Because she overcame all kinds of odds, all kinds of obstacles, and we're doing the same in this work. But we're doing it because it's right.

So I want to thank you for your time, and we look forward more questions afterwards.

DR. POST-WHITE: Thank you very much, Hob. Actually, Alexa was one of my graduate students working with Hob's data, and so it's exciting to see that she followed through as a Master's student, analyzed some of their data in its preliminary phases and then published a paper on it. Alexa did a very nice job, so if you're interested, I highly recommend it.

The last speaker today before we open for questions is Dr. Susan Bauer. Susan is an assistant professor of nursing and medicine in the Graduate School of Nursing and Department of Medicine Division of Preventive and Behavioral Medicine at the University of Massachusetts Worcester.

She has much research and clinical experience related to psycho-behavioral factors and health outcomes in the oncology population. She is also an adjunct assistant professor of nursing at the University of Massachusetts Amherst School of Nursing. Prior to a faculty appointment at UMass, Dr. Bauer completed an NIH-funded pre-doc fellowship in psycho-neuroimmunology at

Rush University in Chicago, and also an American Cancer Society-funded post-doc fellowship in psycho-oncology at Dartmouth Medical School in New Hampshire.

The focus of Dr. Bauer's research in CAM involves behavioral interventions for cancer patients, with a particular interest in those with premature menopause related to cancer treatment. She recently received a two-year clinical research grant from the Susan Koman Foundation. I believe she was the first nurse to receive such a grant, to investigate an expressive variety in intervention for women with metastatic breast cancer. I believe she's going to tell you a little bit about that today. Susan -- no? You're not? She has too many things going on to talk about them all.

DR. BAUER: Thank you, Janice. It seems like a theme at this conference is

Bridging the gap; bridging the gap between conventional health care and integrative which is complementary alternative health care. I'm hoping in the next 15, 20 minutes or so I can shed some light into my ideas of how nurses and the nursing profession can help to bridge that gap.

My presentation is twofold. There are going to be two parts. The first part is going to be -- I'm going to talk about an end-of-life exemplar and describe a case scenario of a cancer patient at the end of life and how the nurses were really very, very important to her care.

The second part of my presentation will be some pragmatic global discussion on how nurses can rise to the challenge and really be leaders in shaping the future of CAM.

I'm going to talk to you about a patient that I worked with. Her name is Jeanie, and Jeanie was a 74-year-old woman with metastatic breast cancer. I had the privilege of knowing her during my psycho-oncology post-doc. She was really a wonderful person.

Despite her advanced cancer stage, she was so vibrant, so full of life, and just had a very positive energy about her. She had a very interesting past -- traveled extensively, she loved to hike and fly-fish and take photographs.

When I met Jeanie, she was told by her oncologist that basically they had exhausted all convention treatment options and essentially there was nothing left for them to do. Despite that, Jeanie was not ready to give up.

She wanted to still explore -- she still wanted to live, and there were things that she wanted to do that she wanted to get done.

Her oncologist said that he would not leave her, that he would still be there to help manage her symptoms and to keep her out of pain. But despite that, Jeanie still felt quite abandoned. She felt like he didn't care about her, that he was less interested and didn't care and was not as involved in her care.

There was a team of nurses that rallied and came together and helped Jeanie to live as good as she could and to make her life as full as possible. First, there was a nurse practitioner, who worked in a collaborative practice with the physician and Jeanie wanted to try anything and everything.

She sorted through volumes of literature that she picked up on the Internet, through bookstores, and tried to get information on different alternative therapies. She considered extreme diets, various herbs and supplements, acupuncture, energy therapies.

She wanted to try anything and everything, and yet didn't know where to turn. She had a lot of questions. It was the nurse practitioner who helped her sort through the questions, helped her sort through the literature and decide what were the best options for her.

The nurse practitioner did not consider herself a CAM expert. However, she did some reading, too and she called colleagues, she consulted experts who knew the answers, who could help her in helping Jeanie in making the right decisions.

This nurse felt that it was her professional responsibility to guide Jeanie through this process, that she couldn't just stop, that she needed to be there for her.

I also want to mention the hospice nurses. The hospice nurses were very integral to her care. These were nurses who were trained in therapeutic touch. Not all of them, but some of them were trained in therapeutic touch and Reiki; they were knowledgeable about aroma therapy. They used these therapies to help her manage the symptoms.

Her main symptoms were pain and anxiety and difficulty sleeping. Using these therapies really made a difference. The nurses also worked with the family members. The family -- they were tired, they were stressed, they were sad, and using these therapies with the family was also very helpful.

I really think that hospice nurses, that are so skilled and could do this sort of work in Jeanie's home, was really such a gift. I think that all hospice nurses that do this need to be commended on that.

Then, what about me, how did I know her, where do I fit in? Well, I was the psycho-oncology person and I was called, I was consulted as the person to help her cope with dying. During my time with her, I integrated a variety of complementary therapies.

I did mindfulness meditation and guided imagery; we did expressive writing; we did some art; and also prayer. Jeanie asked me to help her figure out how she can heal her relationships with her family. That was really her priority and her goal at this time in her life, was to heal these relationships.

So here's what we came up with. She put together a family scrapbook, which is made up of photographs, mementos from vacations and special times together. She made personal audio tapes for each of her children and her grandchildren. In the audio tapes, she told stories, stories that spoke to them individually, as people.

She wrote letters to each of her siblings and her dearest friends. The greatest thing that she put together that she worked on was something called a crazy quilt.

For any of you that have done any quilting and know anything about crazy quilts, they are -- it's like, in essence, a fabric collage, where there's no formal pattern. Basically, everybody puts together pieces of fabric in any way they want and in the end it turns out to be really beautiful.

Well, Jeanie did this with her family over the last three to four months of her life. What came of it was not only the ultimate gift to leave the family, but what was really the greatest gift was the healing that occurred with all of the family members during that time.

One thing that I didn't mention is that Jeanie had an estranged son, named Rob and one of her things was to really help and heal that relationship. It was nice to see that that indeed did occur. In the last weeks of her life, he was there at her bedside taking care of her. He would rub lotion on her hands and feet; he did gentle range of motion exercises with her; he sat at her bedside and he read Thoreau.

My reason for sharing this story with you is that I believe that Jeanie lived a very good life, that her time was well spent, that her life was meaningful. It was really possible because of the nurses that were involved in her care.

I just want to recap the different CAM-related roles that the nurses played in Jeanie's care.

First, was the direct care that was given to her. The other was the nurse practitioner being there to answer her questions and identifying resources.

Finally, the family involvement and, really, all three nurses actively incorporated the family, brought the family in and took care of the family as well as the patient.

I want to emphasize a couple of points of why palliative care nurses are in a situation where they actually guide and educate patients regarding CAM. For patients at this time in their life, that are dying, oftentimes they do feel abandoned by other health care professionals, and it is the nurse that becomes the main resources. These patients are likely to try different therapies, especially when the conventional therapies are no longer available.

It's my belief that a palliative care nurse who is both well-informed about CAM therapies and can effectively communicate is essential to the care of a dying patient and his or her family.

Why do nurses promote personal relationships? How are we able to do that? We know that nursing education emphasizes the care of the family and in the personal-skill development. We're also very comfortable with family dynamics, and therefore we don't shy away from engaging the family in the care.

However, I really think that we underestimate. I think we take it for granted that we include the family. I mean, we know how to do that. It really is a knack that not all professionals have been trained at and know how to do. It's inherent to who you are and what we do, and I really don't want us to underestimate that.

From my own personal experience with my mother, who was dying of cancer, I can look back and there were, really, two nurses that made all the difference in the world to her; but not only to her, but to me.

During my experiences with them, I think that they were mentors to me and that was well over 15 years ago.

Creative examples involving the family, as I mentioned, the interactive family projects. Here is an example of a crazy quilt. You can see it's just like pieces of fabric thrown together, but it

turns into something quite beautiful. Other creative examples -- rubbing lotion on the legs and feet, gentle range of motion. We know that the power of touch really transcends all words.

I'm going to change gears a little bit and talk more globally on how nursing can contribute to CAM leadership, science, and innovation.

Well, there are really four ways, and I believe that we need to have a voice. We already have a voice, but we're talking about an individual voice and a collective voice, and to use that voice in changing policy, research, and education locally as well as nationally and internationally.

What do I mean by using our voice? We know that CAM is a natural dovetail to nursing. Those of us that are nurses know what nursing is all about, the holistic philosophy that we embrace. It is part of nursing. However, it seems like nursing has been too quiet in the CAM movement.

It's very disconcerting for me. There's a lot of activity going on, there's a lot of energy with CAM movement around the country. But nursing seems like it's been lost, and I just don't understand it because if you look back the roots of our profession, it naturally dovetails with our profession more than any other profession.

This is illustrative that nursing representation on expert panels, advisory boards, and conferences has been minimal. As Janice mentioned, this is the first nurse-specific session at this conference.

I had the opportunity to present at the David Eisenberg Harvard Medical School Alternative Medicine Conference in March, and I was one of two invited nurses to speak there out of the entire conference. Two invited nurses. And it was the first time in six years that there had been any nurses that were invited to speak there. It really troubles me, and I don't want it to continue.

For policy issues, four major areas for policy: Establishing standards of practice, establishing consistency of training, credentialing, and reimbursement. This is not only for us as nurses who are practitioners and using the different CAM therapies, but also as advocates for our patients.

Because there are, as you see at this conference and knowing your own experiences, there are a lot of discrepancies and a lot of inconsistencies throughout the country and throughout the world because the field is so new.

We need to come together and to set some standards. It's our obligation, and as Janice mentioned in referring to the Dinkler article, it's not only our ethical but it's also our legal responsibility to do that as well.

Research nurses are key players in multidisciplinary CAM research. We're principal investigators. Tactically prepared nurses are very capable of conducting very quality research and obtaining independent research funding. We're collaborators, we're co-investigators, we actually can be research staff on different CAM studies, as well as be part of the intervention.

If the intervention is, say, healing touch intervention, the nurses are the intervention, too.

Last year there was a hearing before the Committee on Government Reform on research issues and improving care at the end of life. Director of international nursing research, Dr. Patricia Grady, presented on this. This NIH initiative is coordinated by NINR. It's multidisciplinary; NINR

is working with NCI, the National Institute for Aging, National Center for Complementary Alternative Medicine.

The emphasis of the initiative is on CAM, and four of the requests for applications in 1999 -- there were 12 that were funded -- the majority of them were by NINR and the majority of them were CAM-related. So nurses are doing research on using CAM, getting funded, and we are playing a lead role on the national level at NIH.

Touch upon education issues. I really believe that education is really the foundation of everything that I've said so far and what the two of us have spoken, that education is the beginning of all this.

We need to start early. We know that many of us have had very little formal training in CAM, and it has not been integrated into formal nursing curricula until very recently. Even now, it's very inconsistently done; it's just kind of touched upon in different courses. Because it's so new and because most of the nurses had been practicing a long time, most nurses don't have training in it.

So we need to not only train the nurses that are practicing now, but we also need to start early and to develop it into the programs when the nurses are first being educated. We need to combine our strength and resources with other schools and with other disciplines. We cannot do this alone. None of us should be working in isolation, but we can be working with one another.

We need to work with schools of nursing, medicine, pharmacy, and others, such as massage schools, and we need to, as I mentioned, combine our talents and resources. We need to bring our students together.

I recommend that we teach in the same classroom, especially for overlapping content. It's absolutely crazy for the same courses to be taught to different students, especially within the same institution or even within the same city.

I think the CAM minor at the University of Minnesota is a fine example of that, where the students are, within the graduate school, they can come from all different majors but take the same classes and come out with a CAM minor.

Also, we need to have interdisciplinary CAM fellowships. I'm really pleased to see that Dr. Andy Weil, with a little bit of nudging and prodding -- you know that he recently said that his CAM residency and fellowship that has been only open to physicians will now be open to nurses as of next year. So I'm really happy about that. He listened a little bit.

So integrative health care really begins with integrative education.

I don't know if there are any people in the audience that are not nurses, but if there are, my plea to you is to recognize the unique contribution of the skills of nurses.

We're practitioners, we're educators, administrators and researchers. I invite you to invite nurses to join in the CAM efforts and to combine strengths and be partners.

My plea to the nurses is please rise to the challenge. Be active participants and leaders in shaping CAM. Be creative in finding solutions. Be partners with others, so we can bridge the gap and provide safe, quality, environmentally conscious integrative health care to all.

Thank you.

DR. POST-WHITE: Thank you very much to Susan and Hob and _____, and thank you for all you for being so patient and bearing with us with the time frame.

When we first talked about what we wanted to talk on, it was "an hour and a half? What can we cover in an hour and a half?" Then they came back after we had it all planned out and they said you have an hour. So we thought, well, we'll do what we can. But we have a lot of information to share, so thank you for bearing with us on this.

We'd like to open it up for discussion, and if there are any questions or comments, please feel free to share them with us.

SPEAKER: My name is Kathy _____ Institute, Newport, Michigan; and I'm also a certified healing touch practitioner _____. I want to commend all of you on being able to present the content you did in the _____ you did.

One comment, Susan, on what you said -- nurse leaders and nurse researchers are doing a lot work, a lot of research, and you showed it up there. It's _____ its way into Oncology Nursing Forum and _____.

I guess what I would encourage in publishing research is that we _____ putting our research into multidisciplinary journals.

No one outside our profession is going to read our journals, and it's a real quandary because a lot of the research is going on in graduate schools and doctoral programs. Our professors encourage us to publish in nursing journals.

Although they're excellent journals and we want to promote our profession, we're not going to get the word out about what we're doing with research unless we start _____ in multidisciplinary journals like Alternative Medicine and things like that.

So my point is to say to encourage _____ to go back to their institutions and encourage us to start going out there and not being so isolated, and saying we are doing this stuff and we don't have to isolate _____ well, it's only _____. And that's not to put down nursing journals; they're quality journals. It's just nobody's going to read our stuff if it's in the nursing journals.

I don't know how other people feel about that, but it's just -- I know in doing my own graduate work, there's excellent stuff in the Journal of Holistic Nursing and Oncology Nursing Forum and all of the stuff, but I don't believe that physicians read it. I mean, I think it's hard enough just keeping up with their own literature -- you know, in support of our colleagues, I think they have enough difficulty keeping with their own stuff.

However, I was so profoundly affected by the fact that every single one of them seemed to notice the JAMA article _____ everyone noticed that one. So I believe that the do notice what needs to be noticed, so we've got to get out there as researchers in putting that stuff out there in order to get that support. I just wanted to share that; it's one of my things.

DR. BAUER: I'd be interested to hear what you think. But I actually think that we should be publishing in both nursing and non-nursing journals, because the nurses don't look at the other journals and I think that we need to be sharing this information with each other as well.

That's part of how the practice and the science is going to grow within our profession, is educating nurses as well. So I see a place for both.

SPEAKER: I agree with you very much. I'm just saying not only there. I just want us to get out there and share ———.

DR. POST-WHITE: I just want to say I agree, and I think we do need to publish in both. I think there are barriers on both sides, and I was going to ask you how much you thought nurses read other medical journals, who are busier and busier today.

Although I think maybe it goes a little easier in that realm that we look more interdisciplinary than physicians do. It's not just physicians. It's all the disciplines.

I have a chaplain I've worked very closely with on our Hope study, and she caught me the other day and she says, you know, Janice, I've got to publish that paper in our spirituality journal because it's all in nursing, and this belongs in our spirituality and our chaplaincy realm also.

So I think there are other disciplines who have somewhat the same problem. Although I think it's changing, one of the barriers I've found as a nurse getting published in CAM in journals has been somewhat of a barrier, and I always try the other journals first invariably.

It's changing, because there are more journals of alternative therapies and -- but by and large, New England Journal of Medicine, Journal of Neuropsychosomatic Medicine, Brain Behavior Immunities, some of the other ones I've tried invariably are much, much harder to get published -- especially from a research perspective -- in those journals.

So I think some things still need to change before we will get there. But I think that should still be a goal. Thank you for sharing that.

MS. RIEGER: My name is Mary Rieger and I'm an acupuncturist. I work part-time for the Center for Mind-Body Medicine doing their school program because I worked on ——— education. So I have a couple of things.

Susan, I reach out to nurses ——— doctors -- constantly going to schools or to hospitals ——— talk, and I talk to ——— and that kind of thing, because this is -- there is a hard connection, this is what I do and this is what you do and it's the same, it's just two different fields. So I just encourage you to, you know, let's keep it going because that's where it's happening.

In terms of journals, I helped the center do a little piece of research with the school program, where we took breathing, meditation, all kinds of stuff into the stuff into the schools in D.C. It has been in existence for six years, and then Dr. Gordon decided we're not doing it anymore. But I would encourage you to publish in educational journals if you're into peds, and family journals.

Because the stuff that you're doing needs to be in the home sector in the community, and that's another bridge that needs to be moved. Because there's so much in terms of education. I mean, the great picture would be more doctors and nurses doing more in the schools -- you know, setting up clinics in the schools, giving talks at PTAs.

I mean, really, you know? We all have kids or nieces and nephews -- so that kind of thing. So I would encourage you to big-picture, because you're the ones that are doing it, have always been doing it, and there's a -- everybody wants to hear it. That's just a whole other spectrum of areas where you can serve and where you'll just be soaked up.

DR. BAUER: Thank you very much. Thanks.

MS. OSTERLUND: I'd like to take just a little tiny bit of a different tack. I appreciate that comment. One of my favorite topics is the invisibility of nursing and how, if you walk into Borders bookstore, you'll find books by physicians and psychologists but none by nurses -- maybe one by nurses.

It's amazing that the public -- 73 percent of the public trusts us, because I don't know how they know us unless they've been sick or have loved ones that are sick. We simply don't speak our voice.

So I really believe that it's a worthiness issue, that the most common introductory statement -- every nurse in this room knows what's the first thing that you say when you call a physician: I'm sorry to bother you.

That's -- I call it the I'm sorry to bother you syndrome. I really -- and everybody knows where that goes. That takes a one down, I'm not as smart as you are, sorry to bother you even though you make \$500,000 at doing this and I don't make quite that much. I'm really, really sorry to bother you. I know you're busy and I'm really not that busy.

Every nurse is -- I mean she has -- the only reason the nurse can even read the policies and procedures is because she went into the bathroom to sit on the toilet and there is a Policies on the wall; otherwise she wouldn't have time to read them on a lunch break.

The day you get a lunch break is a rare day, right? It's a -- that should be named a national holiday.

So, you see, nurses are very, very busy and too busy, often, to tell the story is one of the issues. But the other issue, really, I think, is the core issue of my voice is not as important as yours. So I think we really need to find out -- I love the idea of speaking at PTAs and going out in the public.

I'm, frankly, a little tired of trying to get physicians to recognize us. I think I'd much rather go to the public and say, You guys already trust us. Let's build those relationships and the physicians will follow, because they follow what the public wants.

DR. POST-WHITE: I just wanted to add a touch to ———. I think -- I'm actually working with one of our moms, who's a nurse practitioner who just recently moved to the Twin Cities area, and she -- we don't have a school nurse even.

So I think, Kathleen, I have a wonderful idea for school nursing, it's a whole other career. But I have a child who finished treatment for leukemia, that you'll hear about tomorrow, and one of my emerging passions is if we teach these kids stress reduction and managing stress in their life when they're children, think what they'll grow into as adults.

I think -- the same thing we talk about training our nurses and our physicians at the training level -- we tried to change in Minnesota, we had a demonstration project statewide and tried to change physicians' and pharmacist and nursing behavior relating to pain management in cancer, and found after a year and a half intervention we really didn't change the behaviors. I think the message to us is get them while they're young.

SPEAKER: That's it.

SPEAKER: My name is Robin ———, I'm from Sheridan, Wyoming. I'd like to comment on something you said about nursing education. My Master's degree is in rehabilitation counseling. I've been in private practice for seven years helping people develop individualized integrated treatment plans.

The thing that I find amazing is that there aren't more nurses trained at the graduate level in other disciplines. I go to meetings, and people are very surprised that I'm cross-trained in different modalities. It's very useful to have your graduate training in a different field other than nursing.

So there are other -- and I like what you're doing in terms of overlapping and bringing curriculum in with other disciplines, because I think it really adds to your knowledge base.

SPEAKER: I would just say that I'm combining nursing, music, art, and a doctor of ministry together to form a Butterfly Ministry to help people cope.

SPEAKER: Good for you, Kara. You have a whole career ahead of you.

SPEAKER: Dozens of them.

SPEAKER: Any other comments?

SPEAKER: I just have a question. I'm kind of from a rural area in South Dakota. So in our schools of nursing in that area, there isn't that access to further your education in the CAM-related field. You know, being a family -- being a wife and having a full-time job and what have you, and children, how do people get to programs?

SPEAKER: I have one brochure from the CAM program. We are going distance education, as we are with many of our other nursing. Many of the people -- students in out-state Minnesota, North and South Dakota, and Iowa are taking our courses through the Internet.

I don't recommend it for everyone and I don't recommend you do all of your courses that way. But you can also do it as a professional development- type of student. You don't have to be a degree student to be taking these courses. The beauty of these CAM Courses is the public can take them. You don't have to be pursuing a degree to take them.

So anyone from the public can register for so many graduate-level course credits and be able to take courses on CAM therapy, including traditional and Chinese medicine and acupuncture and learn some of the same skills.

But that would be one way. Otherwise, I recognize the difficulty in the rural settings. I think some of that will change, but I'm interested if anyone else has any comments on how you get the interventions in the settings as well as the education.

SPEAKER: I just want to make a 30-second note of clarification about the relationship with physicians. My suggestion -- I know everybody's eager to go -- my suggestion was that we stop seeking approval and do the radical act of just loving them. Then move on to wherever the approval really comes from, which is internal and from the Divine, and grow the web.

It's really integrating and strengthening the web. It's not turning around and blaming any part of it for not holding you up.

DR. POST-WHITE: Thank you. Go in peace.

(Whereupon, the PROCEEDINGS were adjourned.)

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