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Research papers

Complementary and alternative medicine (CAM) use among South Asian patients with cancer in Britain

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ABSTRACT

Complementary and alternative medicines (CAM) form an increasing part of the cancer management programmes for some patients, despite the continuing marginalised status of such medicines within the Western medical model. Research highlights the use of CAM among South Asian settlers in the UK who also constitute a group prone to rising rates of cancer. This paper argues that it is important to establish the exact parameters and patterns of the use of CAM and its relationships to allopathic medicine among South Asian patients with cancer, in the light of patient-centred re-evaluations of the Western medical model as a way of investigating the impact of the relationship on health outcomes.

Keywords: cancer, complementary and alternative medicine (CAM), ethnicity, South Asian patients

Introduction

Complementary and alternative medicine (CAM) is attracting considerable attention within the context of mainstream healthcare provision in Britain. It has a one-year prevalence of around 20% (Ernst, 2000), with 74% of the British public supporting its availability on the NHS (Vincent and Furnham, 1996). The House of Lords Select Committee on Science and Technology estimated there to be 15 million users of CAM nationwide (House of Lords Select Committee on Science and Technology, 2000). The term CAM is used to refer to a broad range of healthcare practices that have, until recently, remained outside the conventional Western medical model and thus continue to be marginalised by the dominant healthcare system but are, nevertheless, used by patients to supplement their healthcare (Vincent and Furnham, 1998). This paper begins by explaining some of the terminology used in relation to CAM. The marginalised status of CAM in Western medicine is then discussed with particular reference to the implications for South Asian people who have cancer. Such patients may combine the use of CAM with Western medicine. This raises a number of possibilities, including the risk of adverse interaction between medicines and unwanted side-effects, which have so far been under-researched. The paper concludes by setting an agenda for research in this field.

Complementary and alternative medicine

CAM can be divided into traditional medicine, complementary therapies and alternative medicine. *Traditional medicine* refers to approaches and practices to healthcare that incorporate spiritual therapies, manual techniques as well as animal and mineral based medicines to treat, diagnose and prevent illnesses. In

many parts of the world traditional medicine provides the main or only access to healthcare and, consequently, the World Health Organization (WHO) recommends that, in such circumstances and wherever possible, those who provide traditional forms of healing be incorporated into modern medical services (WHO, 2000). In a sense *traditional medicine* refers to all systems of healthcare not directly influenced by the Western scientific revolution in medicine.

Complementary therapies are based on combining allopathic medical techniques with those derived from alternative medical systems (Cassileth, 1999). Examples include homeopathy, acupuncture and chiropractic medicine. *Alternative medicine* is based on the exclusion of allopathic medicine, replacing it with other interventions (usually unproven formulas) such as essiac tea, shark cartilage, mistletoe and ancient Indian herbal remedies (Cassileth, 2000). CAM can thus be summarised as the set of therapeutic practices that are not currently taught within, or considered to be a part of, conventional allopathic medical education or practice.

CAM practices are seen as forming part of traditional medical practices that have historical roots in the developing world. They have remained marginalised in the West because they have been looked down upon as *traditional medicine* and regarded, despite the increased interest in recent years, as alternatives to the Western model of medicine (Zhang, 2002). Take, for example, the practice of acupuncture. This is a traditional Chinese medicine therapy, but in many European countries it is defined as CAM because it does not form part of local healthcare traditions and is thus viewed with suspicion. Hammer (1995) has argued that this marginalisation continues because Western science is unable to move away from the limited biomedical model of care. Drug companies reinforce the biomedical perceptions of disease by continuing to promote drug treatments and racism where Western science is unable to validate non-Western medical principles.

The recognition of the Western medical model as being the product of a particular cultural formation, that is to say the West, rather than the application of techniques based on universal features found in all human communities, arises from the *decentring of the West*. This term reflects the recognition that the peculiarities of Western cultural practices are distinct from any notion of a universal cultural formation. Modern Western medicine is based on a model of healthcare that began around 1850 by deploying discoveries in the natural sciences to the specific treatment of illness. Improvements in public health, the discovery of germs, the use of x-rays and the development of other medical technologies such as pharmaceuticals, especially penicillin, created new approaches to the treatment of illness and disease that differed radically from previous ways of conceptualising and treating human pathologies (Porter, 1997). What we now call CAM is very similar to the dominant mode of healthcare treatment in Europe prior to 1850 and the medical and scientific breakthroughs that established modern technological medical practices. Western medicine is predicated on the assumption that it is a neutral model of modern healthcare thus not only setting itself apart from other systems of treating the sick but also establishing itself as superior (Foucault, 1975; Porter, 1997). This notion of superiority is consistent with the history of colonialism. The study of how members of minority groups use CAM often retraces some of the themes and topics associated with the literature that developed within the context of colonial relationships (Said, 1985; Inden, 1990). The very distinction between complementary and alternative medicines on the one hand and mainstream medical science on the other illustrates the divisions between the colonisers and the colonised. Furthermore Western medicine has suffered from what Husserl (1970) called the crisis of European science, the realisation that science and technology could not resolve and cope with all human ailments. The superiority of the Western medical model is no longer assured. The apparent inability of conventional medicine to cure chronic diseases and the consequences of failed treatments contribute to the increased use of CAM (Trevelyan and Booth, 1994; Vincent and Furnham, 1998; White, 2000). In addition, the move towards CAM shows increased preferences for patients' personal informed judgements about healthcare (Andrews *et al*, 2003), perceived negative side-effects of drugs and a desire for more natural treatments (Verhoef *et al*, 1998; Richardson *et al*, 2000). CAM is frequently regarded as non-toxic (Begbie *et al*, 1996; Richardson *et al*, 2000). Given the extensive use of CAM and the relative paucity of data concerning the safety of CAM therapies, patients may be putting themselves at risk by their use of these treatments (Ernst and Fugh-Berman, 1999).

South Asians and CAM

CAM existed in the UK prior to the technological advances in medical care and still continues to this day. However, it has come to be associated with the cultures and healthcare practices of settlers from South Asian (Pakistanis, Bangladeshis and Indians) and other non-Western cultures (Ahmad, 1992). Linked with this association is the perception that the use of CAM is rooted in superstition and ignorance. Little effort is made to understand approaches to the management of health or the treatment of disease that are rooted in non-Western paradigms. Such approaches are regarded as at best quaint and at worst dangerous. The

dominant Western view is that CAM practitioners, such as Vaids and Hakims, pose a threat to their patients because their approaches and treatments do not conform to Western medical thought. Discourse on the subject is dominated by Western views, creating polarised arguments centred on the West and the Rest. Thus the qualities and values of the West as modern, urban and scientific find their opposites in the non-West as traditional, rural and superstitious (Sayyid, 1997). In this discourse, CAM is regarded as distinct from the scientific and technological enterprise of the West and is thus part of the non-West.

The polarity of this discourse prevents acknowledgement that members of both Western and non-Western cultures use CAM although specific practices and uptake may vary between different groups. A recent study in the United States found that some ethnic groups, for example African Americans and Hispanics, were less likely to avail themselves of CAM than the majority white population group, while Asian Americans (American citizens of East Asian heritage) were more or less as likely as the white population to use CAM (Keith *et al*, 2005).

In the UK the discourse of the West and the non-West contributes to the ways in which South Asian immigrants and their cultures, including healthcare treatment, are represented. Polarised arguments about, and perceptions of, CAM are further fuelled by racism and the legacy of colonialism. This is not to deny that CAM is to be found among South Asians, but to understand that the distinction between CAM and the Western model is not purely medical outside the influence of wider cultural, social and historical contexts.

Recent research suggests that the use of CAM is fairly widespread among South Asians in Britain (Hussain-Gambles *et al*, 2004). South Asian settlers form the UK's largest ethnic minority group, consisting of 4% of the total population (Office for National Statistics, 2001). For South Asian people, the use of CAM includes complementary therapies, traditional practices and alternative medicines such as herbs and spiritual healing. Homeopathy is an example of complementary therapies used by South Asians in Britain. Alternative practices include many therapeutic regimes derived from the Greek and Ayurvedic systems of medicine such as herbs, enemas and other purgatives. Most alternative medicines used by South Asians distinguish between treatments that are described as 'hot' (*garam*) and those considered 'cold' (*thanda*) (Malik and Quereshi, 1997). The degree to which CAM is used by South Asians is a function of both the cultural, social background of the South Asian patients and the nature of their ailments. Patients with medical conditions that cannot be treated with confidence by allopathic medicines are perhaps more likely to resort to non-allopathic treatments, for example patients with terminal cancer.

Cancer and cancer-related mortality is a common and increasing cause of death amongst South Asians in the UK (Bahl, 1996; Winter *et al*, 1999). A recent study suggests that, in the UK, South Asian women with breast cancer have more advanced disease at diagnosis and possibly present later to their general practitioners (GPs) with breast symptoms (Velikova *et al*, 2004). This finding is contradicted in a study by Dos Santos Silva *et al* (2003), which suggests a higher survival rate from breast cancer in the first 10 years after diagnosis among South Asian women. It is argued that such differences in findings are not due to the classic socio-economic deprivation or disease stage at presentation, but possibly due to other factors such as compliance with treatment regimens and even low alcohol consumption. There is still considerable paucity of data to show why South Asian women present later to GPs with breast symptoms and have higher survival rates than women who are members of the dominant white majority. An investigation into CAM use amongst South Asian patients with cancer may contribute to understanding these patterns.

It is important to note that CAM may not be used exclusively, and that South Asian patients may be mixing and matching allopathic treatment with complementary medicines and thus putting themselves at risk (DeAngelis, 2003). A common myth about CAM medicines and preparations is that they are inherently safe, but CAM products containing powerful pharmacologically active substances can be toxic either alone or in combination with other medication (Begbie *et al*, 1996). The major danger comes from herbal medications, some of which can cause severe life-threatening toxicity; for example, garlic can prolong bleeding time (DeAngelis, 2003). Many common herbal substances can interact with Western pharmaceutical products. For instance, St John's Wort is a weak monoamine oxidase (MAO) inhibitor (Morris *et al*, 2000) that has been shown to reduce the clinical effectiveness of half of all marketed drugs (DeAngelis, 2003). There is a paucity of data concerning the safety of CAM therapies (Ernst and Fugh-Berman, 1999) and it is therefore important to discover the prevalence of CAM use and the extent to which it is used along with allopathic remedies.

An agenda for research

The dearth of information about CAM use amongst South Asians in Britain warrants carefully designed studies. We recommend that these studies focus on the following specific issues. First, research is needed at the interface between CAM use and modern, Western medicine, with a focus on the attitudes of Western health professionals towards CAM and its use amongst

ethnic minority communities. Such data will be important in helping clinicians understand why patients use CAM, and facilitate the negotiation of safe, effective medical treatment plans. Second, it is important to know whether the use of CAM, either on its own or in conjunction with allopathic medicine, has a negative or positive effect on healthcare outcomes both quantitatively and qualitatively. Third, the provision of CAM, either as a substitute for or in conjunction with allopathic medicines, may effect a shift from a doctor-centred to a patient-centred approach. In this context, CAM could make useful contributions towards positive healthcare outcomes. Finally, it is necessary to 'decolonialise' the distinction between CAM and Western medicine. This requires an understanding of the racist and colonial assumptions that underlie some of the perceptions of CAM, and removal of their influence.

Conclusion

This paper examined the use of CAM by South Asian patients with cancer. The possibility of incorporating CAM into the mainstream healthcare system would seem to offer some of the benefits discussed above. The marriage of CAM and the Western medical system may help provide a holistic healthcare system that is based on an approach which emphasises patient needs, both physiological and psychological.

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CONFLICTS OF INTEREST

None.

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