MEDECINE INTEGRATIVE

Éric PARRAT
Unité de Pneumologie
Centre Hospitalier de la Polynésie Française

Liens d’intérêts

- MSD (participation à un congrès)


TOKYO
11h
7h30
LOS ANGELES
PARIS
20h
SANTIAGO
10h
AUCKLAND
5h

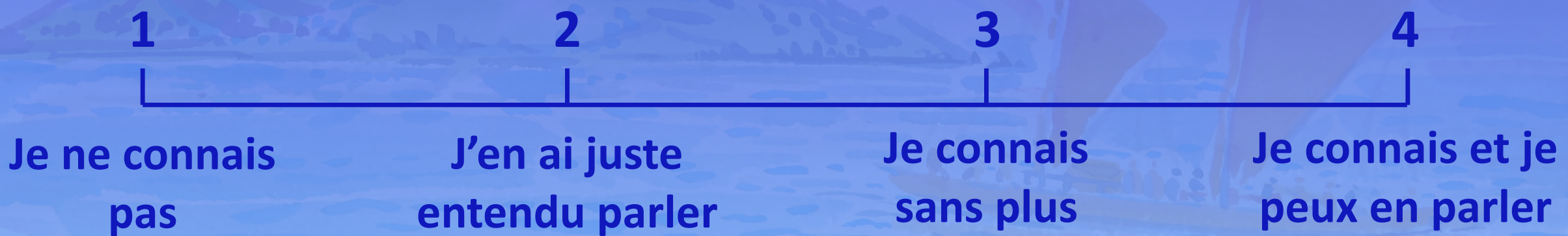
HAURURU

Réseau Polynésien
Maladies Respiratoires

IORANA

La communication interculturelle dans les soins ?

Connaissance de la médecine intégrative ?



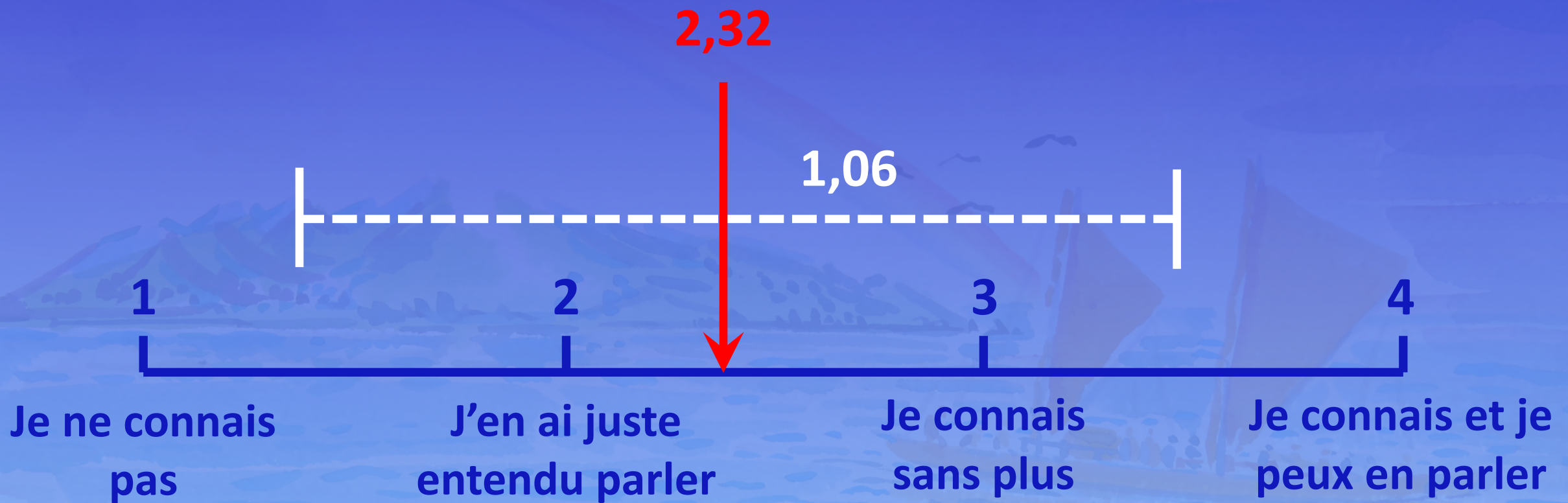
Intérêt pour la médecine intégrative ?

Evaluation des Professionnels de Santé Tahiti

N = 28

- 11 Médecins
- 8 Infirmières
- 1 Aide Soignante
- 5 Sages femmes
- 1 Psychologue
- 1 Kinésithérapeute
- 1 Diététicienne

Connaissance de la médecine intégrative



28 professionnels de santé Tahiti

Un projet de médecine intégrative en oncologie thoracique

Société	Mauvaise représentation
Maladie	Fréquence
	Morbidité
	Mortalité
Soins	Complexité, lourdeur
	Toxicités
	Incertitudes
	Déshumanisation
	Impact sur les équipes

Review Article

How Many Cancer Patients Use Complementary and Alternative Medicine: A Systematic Review and Metaanalysis

Integrative Cancer Therapies
11(3) 187–203

DOI: 10.1177/1534735411423920
http://ict.sagepub.com
SAGE

Markus Horneber, MD[1], Gerd Bueschel, MD[2], Gabriele Dennert, MD, MPH[1], Danuta Less, MD[3], Erik Ritter, MD[1], and Marcel Zwahlen, PhD, MSc[4]

Abstract

Background. No comprehensive systematic review has been published since 1998 about the frequency with which cancer patients use complementary and alternative medicine (CAM). *Methods.* MEDLINE, AMED, and Embase databases were searched for surveys published until January 2009. Surveys conducted in Australia, Canada, Europe, New Zealand, and the United States with at least 100 adult cancer patients were included. Detailed information on methods and results was independently extracted by 2 reviewers. Methodological quality was assessed using a criteria list developed according to the STROBE guideline. Exploratory random effects metaanalysis and metaregression were applied. *Results.* Studies from 18 countries (152; >65 000 cancer patients) were included. Heterogeneity of CAM use was high and to some extent explained by differences in survey methods. The combined prevalence for "current use" of CAM across all studies was 40%. The highest was in the United States and the lowest in Italy and the Netherlands. Metaanalysis suggested an increase in CAM use from an estimated 25% in the 1970s and 1980s to more than 32% in the 1990s and to 49% after 2000. *Conclusions.* The overall prevalence of CAM use found was lower than often claimed. However, there was some evidence that the use has increased considerably over the past years. Therefore, the health care systems ought to implement clear strategies of how to deal with this. To improve the validity and reporting of future surveys, the authors suggest criteria for methodological quality that should be fulfilled and reporting standards that should be required.

Keywords

complementary therapies, complementary and alternative medicine, systematic review, prevalence, alternative medicine, CAM use, cancer

Introduction and Objectives

Consistent and topical information about the frequency and patterns of use of complementary and alternative medicine (CAM) in cancer patients is essential to assess its implications for oncological care as well as to develop evidence-based concepts for research that have the potential to inform continuing education and regulation in the CAM field.[1-4]

However, the only review that attempted to systematically summarize data on the prevalence of CAM use in cancer patients was published in 1998 and included 26 surveys of cancer patients, either adults or children, from 13 countries and found an average prevalence of CAM use of 31%, with rates ranging from 14% up to 64%. The wide range of prevalence of CAM use was not explained by variation among countries or change over time; in fact, the authors concluded that methodological factors like lack of specificity and inconsistent definitions of CAM, possible selection and recall bias, and the lack of a standardized series of questions were the reasons for the heterogeneity in the prevalence estimates.[5] Since the publication of this systematic review, a large number of surveys on the use of CAM in cancer patients have been published. Although many reports and

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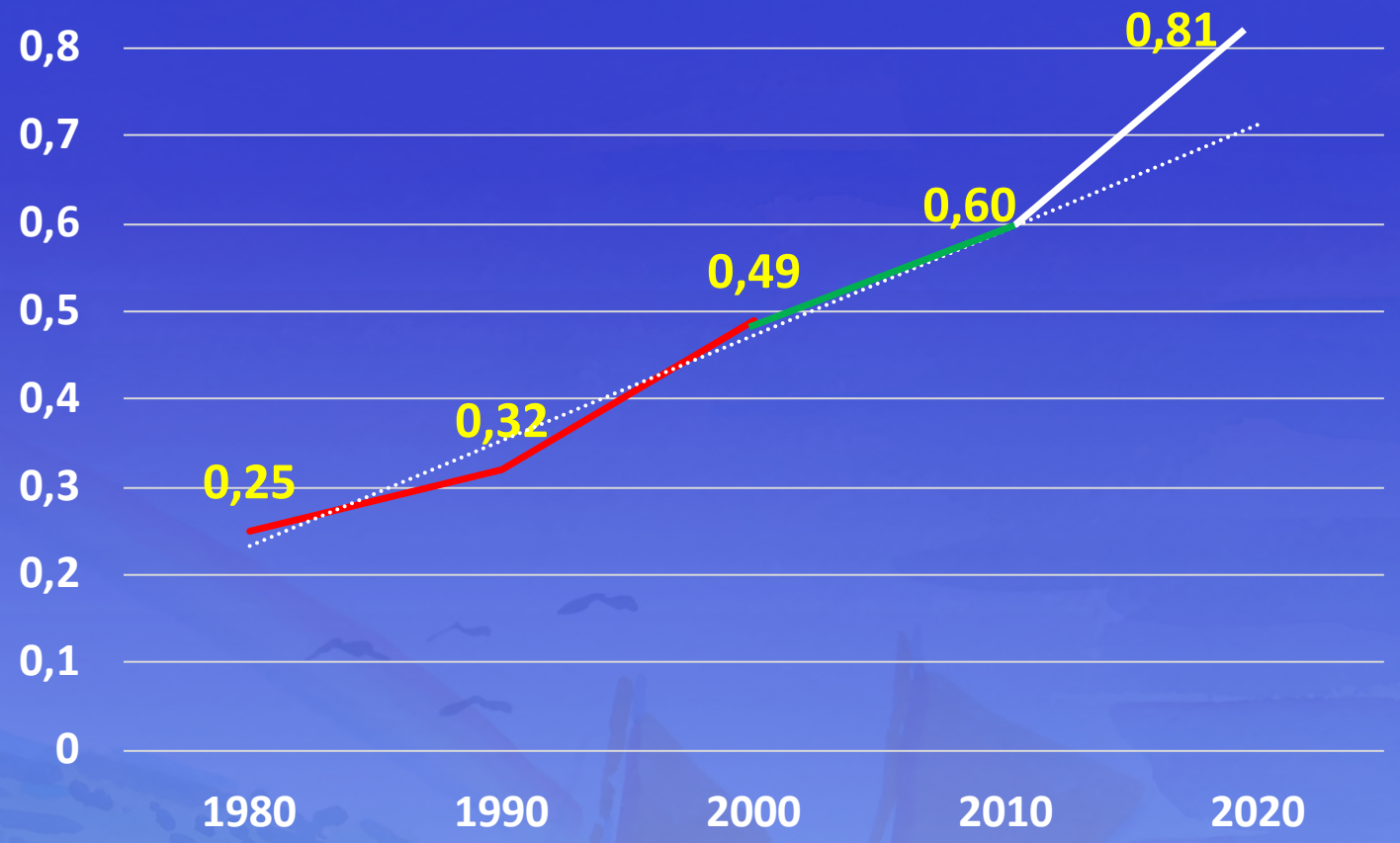

Rodrigues DM. Etude MAC-AERIO 2010.
60%

Utilises-tu des Ra'au Tahiti ?		
Oui	25	**80,6**
Non	6	19,3

JNCI J Natl Cancer Inst (2018) 110(1): djx145

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First published online August 10, 2017
Brief Communication

BRIEF COMMUNICATION

Use of Alternative Medicine for Cancer and Its Impact on Survival

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Affiliations of authors: Department of Therapeutic Radiology, Yale School of Medicine, New Haven, CT (SBJ, HSP, JBY); Cancer Outcomes, Public Policy, and Effectiveness Research (COPPER) Center, Yale School of Medicine, New Haven, CT (CPG, JBY).

Correspondence to: Skyler B. Johnson, MD, Department of Therapeutic Radiology, Yale School of Medicine, HRT 138, 333 Cedar St, New Haven, CT 06520 (e-mail: skyler.johnson@yale.edu).

Abstract

There is limited available information on patterns of utilization and efficacy of alternative medicine (AM) for patients with cancer. We identified 281 patients with nonmetastatic breast, prostate, lung, or colorectal cancer who chose AM, administered as sole anticancer treatment among patients who did not receive conventional cancer treatment (CCT), defined as chemotherapy, radiotherapy, surgery, and/or hormone therapy. Independent covariates on multivariable logistic regression associated with increased likelihood of AM use included breast or lung cancer, higher socioeconomic status, Intermountain West or Pacific location, stage II or III disease, and low comorbidity score. Following 2:1 matching (CCT = 560 patients and AM = 280 patients) on Cox proportional hazards regression, AM use was independently associated with greater risk of death compared with CCT overall (hazard ratio [HR] = 2.50, 95% confidence interval [CI] = 1.88 to 3.27) and in subgroups with breast (HR = 5.68, 95% CI = 3.22 to 10.04), lung (HR = 2.17, 95% CI = 1.42 to 3.32), and colorectal cancer (HR = 4.57, 95% CI = 1.66 to 12.61). Although rare, AM utilization for curable cancer without any CCT is associated with greater risk of death.

Delay or refusal of conventional cancer treatment (CCT), when done in favor of alternative medicine (AM), may have serious survival implications for cancer patients (1–7). However, there is limited research evaluating the use and effectiveness of AM, partly due to data scarcity or patient hesitance to disclose nonmedical therapy to their providers (8,9). To address this knowledge gap, we used the four most prevalent cancers (breast, prostate, lung, and colorectal) in the United States (10) from the National Cancer Database between 2004 and 2013 to identify the factors associated with AM selection and compared survival outcomes between AM and CCT.

Patients who underwent AM were identified as those coded as "other-unproven: cancer treatments administered by nonmedical personnel" and who also did not receive CCT, defined as chemotherapy, radiotherapy, surgery, and/or hormone therapy. Patients with metastatic disease at diagnosis, stage IV disease based on the American Joint Commission on Cancer (AJCC) staging system (11), receipt of upfront treatment with palliative intent, and unknown treatment status or clinical or demographic characteristics were excluded.

Demographic and clinical factors were evaluated using the chi-square test and the t test for categorical and continuous variables, respectively. Independent associations with AM use (vs CCT alone) were identified using multivariable logistic regression. Two-to-one nearest-neighbor propensity score matching without replacement was performed to compare overall survival (OS). Univariate survival analyses were completed using the Kaplan-Meier estimator, log-rank test, and Cox proportional hazards regression. Variables with P value of .10 or less on univariate analyses were entered into a multivariable Cox proportional hazards survival model using forced entry for the 2:1 matched sample. The assumption of proportionality was verified graphically using log-log survival plots. All statistical tests were two-sided, and a P value of less than .05 was considered statistically significant.

We identified 281 cancer patients who chose AM in lieu of CCT. Patient characteristics between AM and CCT are shown in Supplementary Table 1 (available online). Notably, patients in the AM group were more likely to be younger, to be female, to have a lower Charlson-Deyo Comorbidity Score (CDCS), and to

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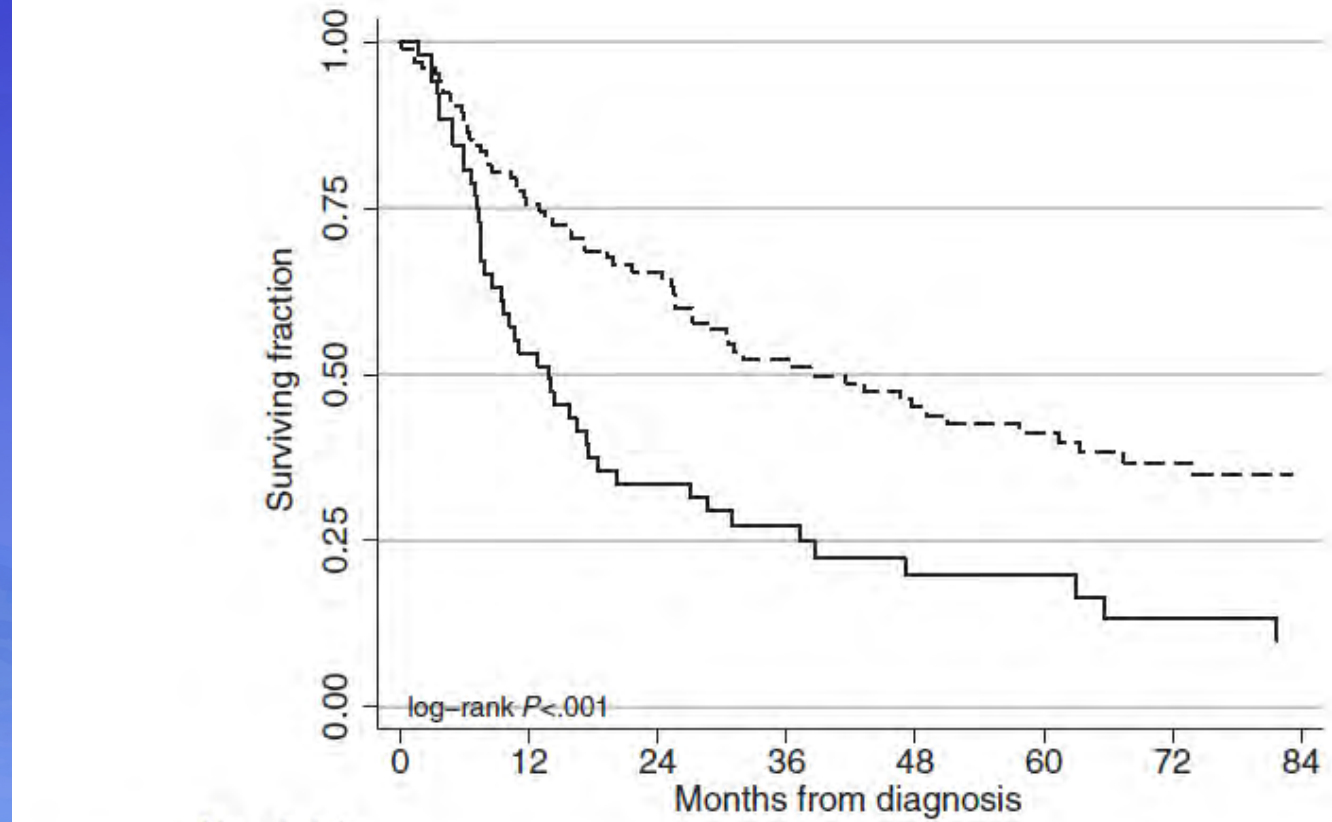

Alsanad et al. BMC Complementary and Alternative Medicine (2016) 16:393
DOI 10.1186/s12906-016-1372-x

BMC Complementary and Alternative Medicine

RESEARCH ARTICLE Open Access

An assessment of the impact of herb-drug combinations used by cancer patients

Saud M. Alsanad[1*], Rachel L. Howard[2] and Elizabeth M. Williamson[2]

Abstract

Background: Herb/Dietary Supplements (HDS) are the most popular Complementary and Alternative Medicine (CAM) modality used by cancer patients and the only type which involves the ingestion of substances which may interfere with the efficacy and safety of conventional medicines. This study aimed to assess the level of use of HDS in cancer patients undergoing treatment in the UK, and their perceptions of their effects, using 127 case histories of patients who were taking HDS. Previous studies have evaluated the risks of interactions between HDS and conventional drugs on the basis on numbers of patient using HDSs, so our study aimed to further this exploration by examining the actual drug combinations taken by individual patients and their potential safety.

Method: Three hundred seventy-five cancer patients attending oncology departments and centres of palliative care at the Oxford University Hospitals Trust (OUH), Duchess of Kent House, Sobell House, and Nettlebed Hospice participated in a self-administered questionnaire survey about their HDS use with their prescribed medicines. The classification system of Stockley's Herbal Medicine's Interactions was adopted to assess the potential risk of herb-drug interactions for these patients.

Results: 127/375 (34 %; 95 % CI 29, 39) consumed HDS, amounting to 101 different products. Most combinations were assessed as 'no interaction', 22 combinations were categorised as 'doubt about outcomes of use', 6 combinations as 'Potentially hazardous outcome', one combination as an interaction with 'Significant hazard', and one combination as an interaction of "Life-threatening outcome". Most patients did not report any adverse events.

Conclusion: Most of the patients sampled were not exposed to any significant risk of harm from interactions with conventional medicines, but it is not possible as yet to conclude that risks in general are over-estimated. The incidence of HDS use was also less than anticipated, and significantly less than reported in other areas, illustrating the problems when extrapolating results from one region (the UK), in one setting (NHS oncology) in where patterns of supplement use may be very different to those elsewhere.

Keywords: Complementary medicines, Alternative medicines, Cancer, Herb-drug interactions, Herbal medicines, Dietary supplements, Conventional medicines

Background

Many studies have recorded a high use of Herbal/Dietary Supplements (HDS) by cancer patients. The MD Anderson Cancer Centre, in USA, reported that 52 % of their cancer patients had used at least one form of Complementary and Alternative Medicine (CAM), and 77 % of those were using herbs and vitamins [37]. Between 25 and 47 % of ethnic Chinese cancer patients living in North America relied on herbal preparations as part of their cancer treatment [6]. In the US, a survey showed that about 63 % of outpatient cancer patients used HDS [35]. In the UK, a systematic review of 11 papers investigating the use of herbal medicines by cancer patients found the prevalence of herbal medicines use varied from 3.1 to 21.8 % among adults and from 4.1 to 20 % in paediatric patients [11].

In the absence of good efficacy data for most HDS, and given their popularity with patients, the most urgent current concern is assuring their safety (WHO [32]). Some herbal medicines have been extensively studied and there is clinical evidence for both potential benefits

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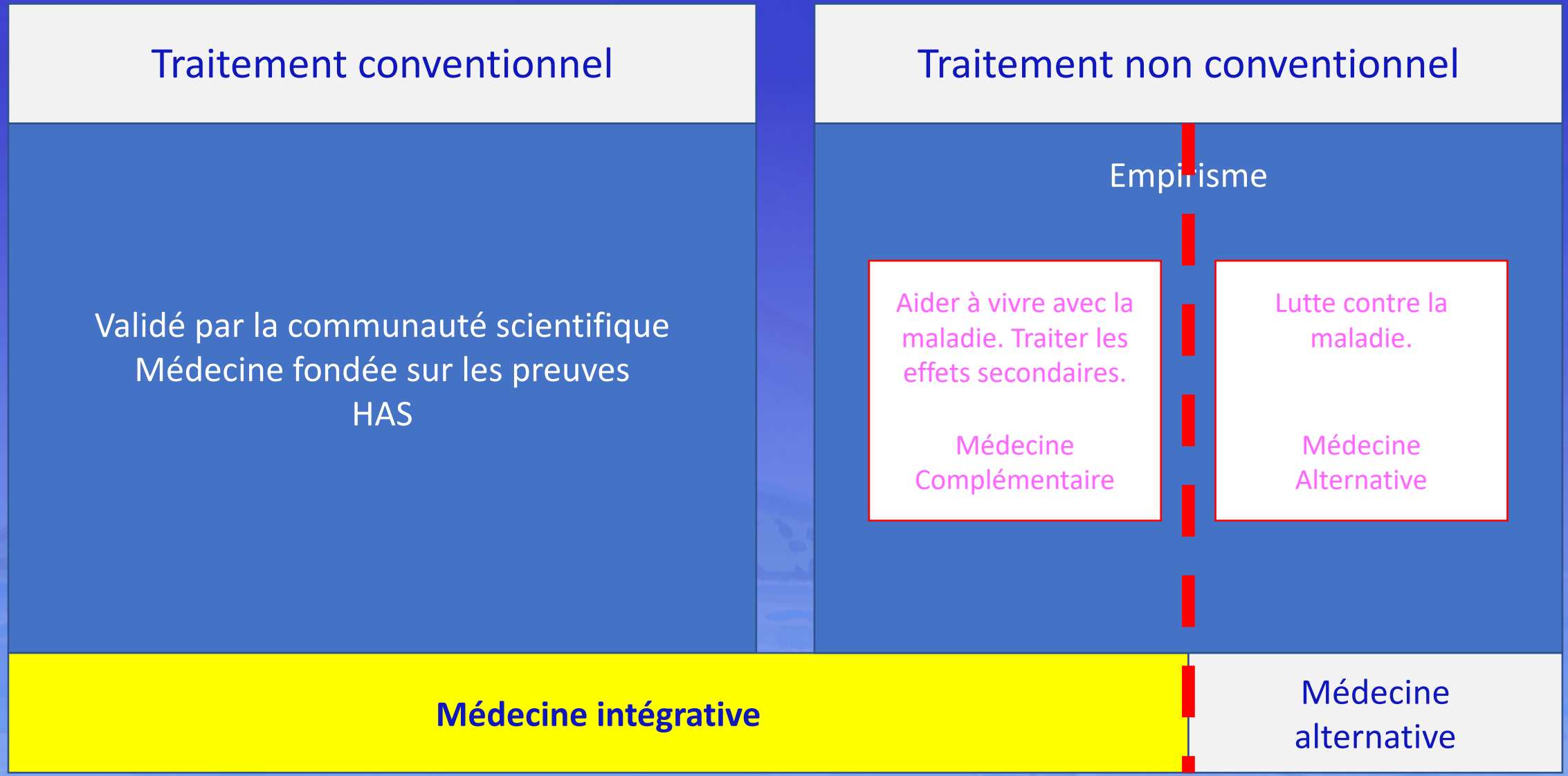
Full list of author information is available at the end of the article

Table 6 Assessment of Herb/Dietary Supplements (HDS) -Conventional Medicine (CM) Interactions

HDS	CM [no of patients[a]]	Possible interactions based on previous reports or theoretical grounds and their assessment[b]
HDI Category: "doubt about outcomes of use"		
Cod liver oil	Aspirin [4]	Both have antiplatelet properties, but the combination did not cause any problems in any of the 4 patients and no previous clinical reports are available.
	Clopidogrel [1]	Both have antiplatelet properties, but the combination did not cause any problems and no previous clinical reports are available.
	Warfarin [1]	Cod liver oil and warfarin both increase INR. This combination has not caused any problems in the patient, no clinical reports are available, and was assessed as unlikely to be harmful.
	Simvastatin [3]	Both have cholesterol-lowering properties. The combination did not cause problems in the patients.
	Atorvastatin [2]	As for simvastatin.
	Rosuvastatin [1]	As for simvastatin.
	Heparin [1]	Cod liver oil has antiplatelet effects and increase INR, and heparin is an anticoagulant, but the but the patient did not experience problems, possibly due to being monitored for heparin effects.
Glucosamine	Insulin [1]	Endogenous glucosamine is involved in glucose metabolism but studies suggest that it is unlikely to affect diabetic control in patients taking insulin.
	Doxorubicin [1]	Glucosamine has produced a modest resistance to doxorubicin in colon and ovary cancer cells in vitro but the effect has not been confirmed in vivo, and was assessed as unlikely to be harmful.
	Epirubicin [1]	As for doxorubicin, and therefore assessed as unlikely to be harmful.
	Paracetamol [4]	Glucosamine sulphate may reduce the efficacy of paracetamol (2 previous reports), by increasing paracetamol sulfate conjugation, but the combination did not cause any problems in our 4 patients.
Omega 3	Dipyridamole [1]	Omega-3 oils and dipyridamole all have antiplatelet properties. However, this combination did not cause ADEs in the patient, and was assessed as unlikely to be harmful.
	Aspirin [4]	Omega-3 oils and aspirin both have antiplatelet properties. However, it did not cause ADEs in the patient, no other clinical reports are available so it was assessed as unlikely to be harmful.
	Simvastatin [1]	Omega-3 oils and simvastatin have cholesterol-lowering properties. However, the combination did not cause ADEs in the patient.
	Pravastatin [1]	As above (for simvastatin) as omega-3 oils and pravastatin have cholesterol-lowering properties.
Fish oil	Simvastatin [2]	Fish oil and simvastatin both have cholesterol-lowering properties. This combination did not cause any problems in the two patients taking it.
	Warfarin [1]	Fish oil and warfarin both increase INR, but the patient did not experience problems, possibly due to being carefully monitored for warfarin effects.
Garlic	Atorvastatin [1]	Garlic and statins lower plasma cholesterol but the but the patient did not experience problems.
	Heparin [1]	Garlic has antiplatelet effects and increases INR, and heparin is an anticoagulant, but the patient did not experience problems, possibly due to being carefully monitored for heparin effects.
Senna	Paracetamol [3]	It has been suggested that senna may reduce the absorption of paracetamol based on weak experimental evidence but our 3 patients did not experience problems.
St John's wort	Omeprazole [1]	St John's wort may lower plasma concentrations of omeprazole but there are no clinical reports.
Eicosapentaenoic acid (EPA)	Dalteparin [1]	EPA has antiplatelet properties and may add to the effects of anticoagulants such as dalteparin. However, the patient has not experienced any adverse effects.
HDI Category: "Potentially hazardous outcome"		
St John's wort	Amitriptyline [1]	St John's wort may lower plasma concentrations of amitriptyline but no harmful clinical reports have been recorded and the patient did not experience any problems.
Green tea	Clopidogrel [1]	It has been suggested that green tea may have additive effects with antiplatelet drugs such as clopidogrel but no clinical reports are available and the combination was assessed as not harmful.
Garlic	Lisinopril [1]	A single report of garlic with lisinopril in 1996 suggested the combination lowered blood pressure more than expected, but the patient did not experience any problems and garlic is taken widely.
Ginkgo	Omeprazole [1]	A clinical study found that ginkgo modestly induced the metabolism of omeprazole but a later study concluded that it was not clinically relevant. The patient reported no harmful effects.
	Risperidone [1]	Priapism was previously reported in a patient taking risperidone and ginkgo. Risperidone alone causes priapism (rarely) and our patient did not experience this.
HDI Category: "Significant hazard"		
St-John's Wort	Amlodipine [1]	St-John's Wort is an inducer of CYP3A4 so the combination may lower plasma concentrations of amlodipine, decreasing hypotensive effects. However, the patient was being checked regularly and reported no ADEs, so the combination was assessed in retrospect as not harmful.
HDI Category: "Life-threatening outcome"		
St-John's Wort	Sertraline [1]	The combination of St John's wort and sertraline may lead to serotonin syndrome (reported in 4 previous studies). This combination is contra-indicated but the patient was no longer taking it.

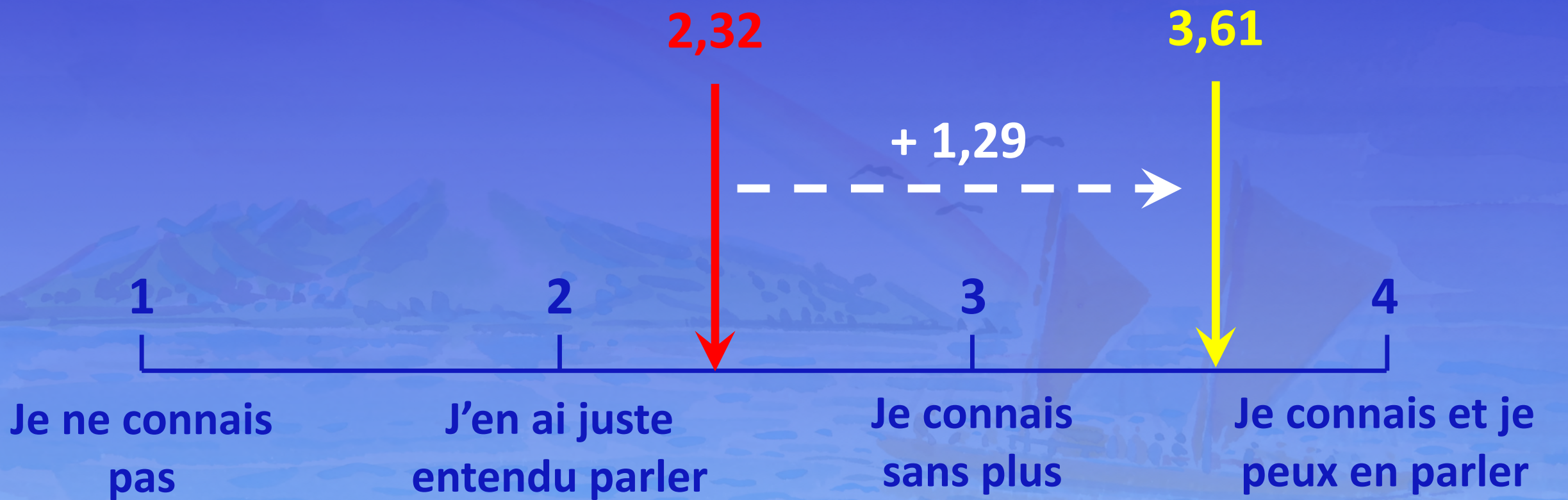
[a]This is the number of patients exposed to the particular combination. In some cases, patients were also taking other recorded combinations
[b]The potential interactions and previous reports are taken from Stockley's Herbal Medicine Interactions, except where not included in that reference, in which case other sources are given



Massiani MA. Les thérapies non conventionnelles dans la pratique de la cancérologie : quelles réponses apporter aux patients ? Rev Mal Resp 2018; 10: 269-274.

La médecine intégrative

Connaissance de la médecine intégrative

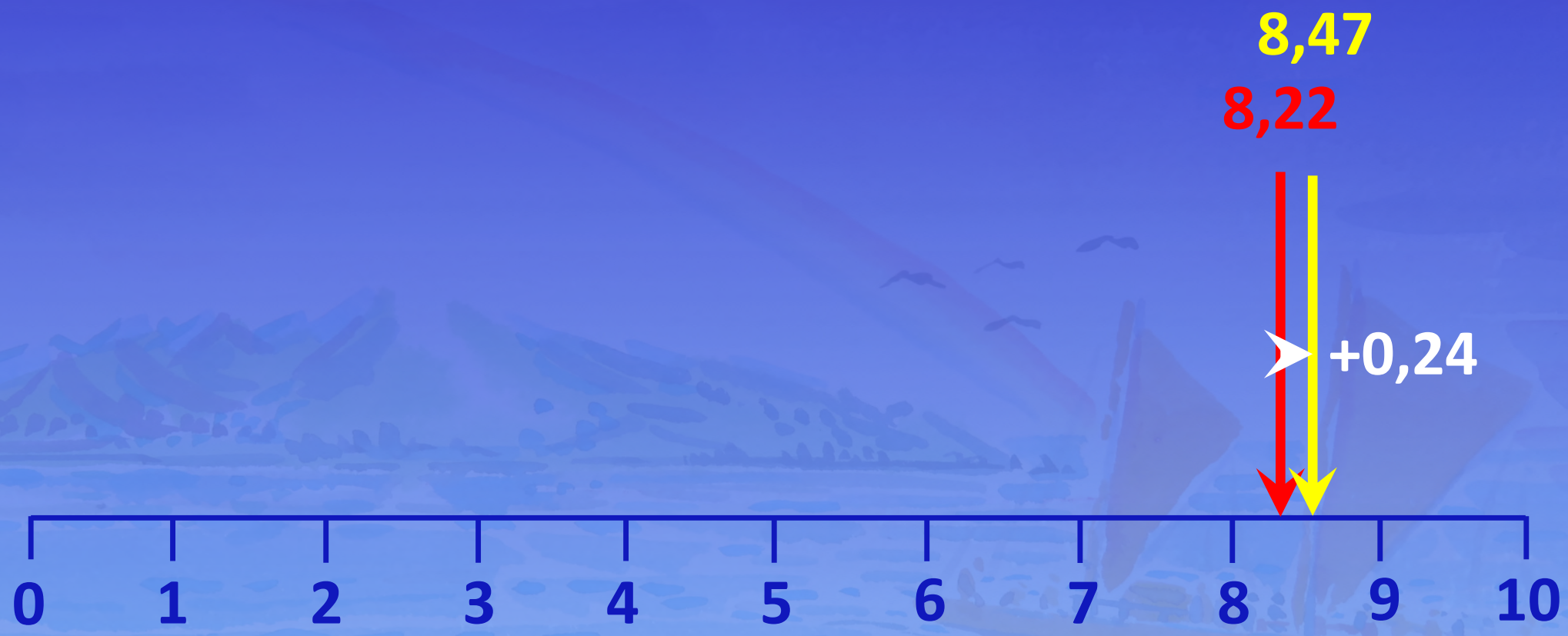


Avant Après

28 professionnels de santé Tahiti

$p = 4,4.10^{-5}$

Intérêt pour la médecine intégrative *(7 items)*



Avant Après

28 professionnels de santé Tahiti

p = 0,41 NS

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JACM

SPECIAL FEATURE

The Berlin Agreement: Self-Responsibility and Social Action in Practicing and Fostering Integrative Medicine and Health Globally

Organizing Committee, World Congress on Integrative Medicine and Health*

Editor's Note: At the end of this document is a list of individuals who led the creation of the agreement and of the initiative organizations to have subsequently endorsed it. If an organization with which you are involved may be interested in being listed among those endorsing, please engage your organization's appropriate process and, on gaining approval, send a brief note that briefly describes your organization, then state your support to Margit Cree at (margit.cree@charite.de). Thank you for your interest. — John Weeks, Editor-in-Chief, *JACM*

Introduction

FACED BY MULTIPLE CHALLENGES, including the rise of chronic, lifestyle-related diseases, and grossly inequitable access to healthcare, we are committed to achieving the Sustainable Development Goals 2030 to foster healthy lives and promote well-being for all ages. We are part of a global movement to orient care, and the education, research, and policy that support it, toward a model that draws on biomedical, complementary, and traditional medicine practices and respects multiple philosophies. This approach to medicine and healthcare:

> "… reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic and lifestyle approaches, healthcare professionals and disciplines to achieve optimal health and healing."[1]

Our work stands on that advanced in 1978 at the Alma-Ata Conference that mobilized a movement for primary healthcare for all and officially declared the importance of integration of effective traditional practices to promote global health. Today, the World Health Organization (WHO) advocates universal health coverage and integration of safe and effective traditional providers and complementary services into health service delivery, as well as self-care practices. These are key objectives of the WHO's traditional medicine strategy 2014–2023. We also affirm our alignment with the declarations from Beijing in 2008 and Stuttgart in 2016 and fully support calls on governments and nongovernmental agencies to adopt, support, fund, research, and promote activities that advance evidence-informed integrative care models.

With this Berlin Agreement, we call on ourselves as individuals to engage, to the best of our abilities, in the following.

Model health

Recognizing that our ability to impart and enhance health and well-being is not only performed by a social and professional health practice but is also informed by our own self-care and resilience, we strive to model personal engagement in health-creating practices.

Engage patients

Knowing that the most important strategy for fostering health is to engage patients in better lifestyle choices, we seek to develop our skills to activate patients to be self-responsible, to strengthen their resilience, and become captains of their own healing processes.

In respect of the importance of natural processes as guides for enhancing well-being, we educate and stimulate patient understanding of, and participation in, efforts to protect and sustain the natural environment.

Promote interprofessionalism and team care

Knowing that no single type of practitioner has all the answers that can be useful to a given patient, we individually seek to develop quality relationships with members of other

[1]Definition of Integrative Medicine and Health. Academic Consortium for Integrative Medicine and Health (www.imconsortium.org).

World Congress on Integrative Medicine and Health, Berlin, Germany.

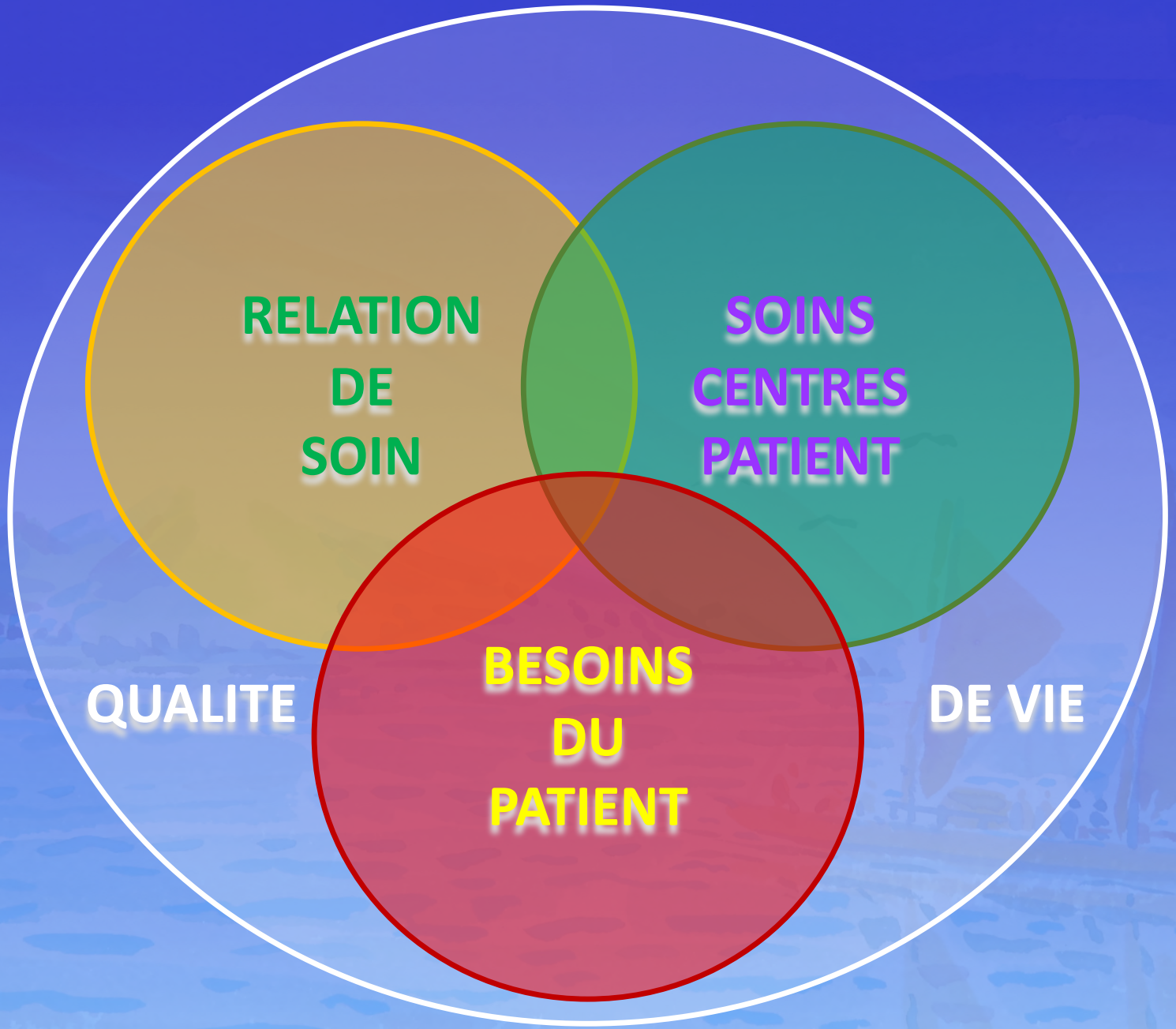
*Members of the Organizing Committee, World Congress on Integrative Medicine and Health, are listed under Acknowledgments at the end of the article.

Engagement de Berlin pour une médecine intégrative

	Principes
1 Être acteur de la santé	Responsabilité individuelle
2 Impliquer activement les patients	Autonomisation des patients
3 Promouvoir l'inter-professionnalisme et le travail interdisciplinaire	Ouverture
4 Reconnaître l'importance des médecines traditionnelles	Diversité des recours
5 Construire une démarche et une pratique reposant sur des preuves scientifiques	Données probantes
6 Encourager la recherche interdisciplinaire en médecine intégrative	Recherches croisées
7 Stimuler la collaboration entre toutes les parties prenantes	Co-construction
8 Rapprocher la prévention et les soins	Complémentarité entre prévention et soin
9 Être acteur de changement	Engagement individuel

« Cette approche de la santé et des soins, tendant vers une médecine intégrative, réaffirme l'importance de la relation entre le praticien et le patient, s'appuie sur la globalité de la personne et entend répondre à ses besoins personnels. Elle est fondée sur des preuves scientifiques, elle utilise toutes les approches thérapeutiques et modes de vie appropriés, et elle engage tous les professionnels du soin et de la prévention vers une santé et une qualité de vie optimales »

« Cette approche de la santé et des soins, tendant vers une médecine intégrative, réaffirme l'importance de la relation entre le praticien et le patient, s'appuie sur la globalité de la personne et entend répondre à ses besoins personnels. Elle est fondée sur des preuves scientifiques, elle utilise toutes les approches thérapeutiques et modes de vie appropriés, et elle engage tous les professionnels du soin et de la prévention vers une santé et une qualité de vie optimales »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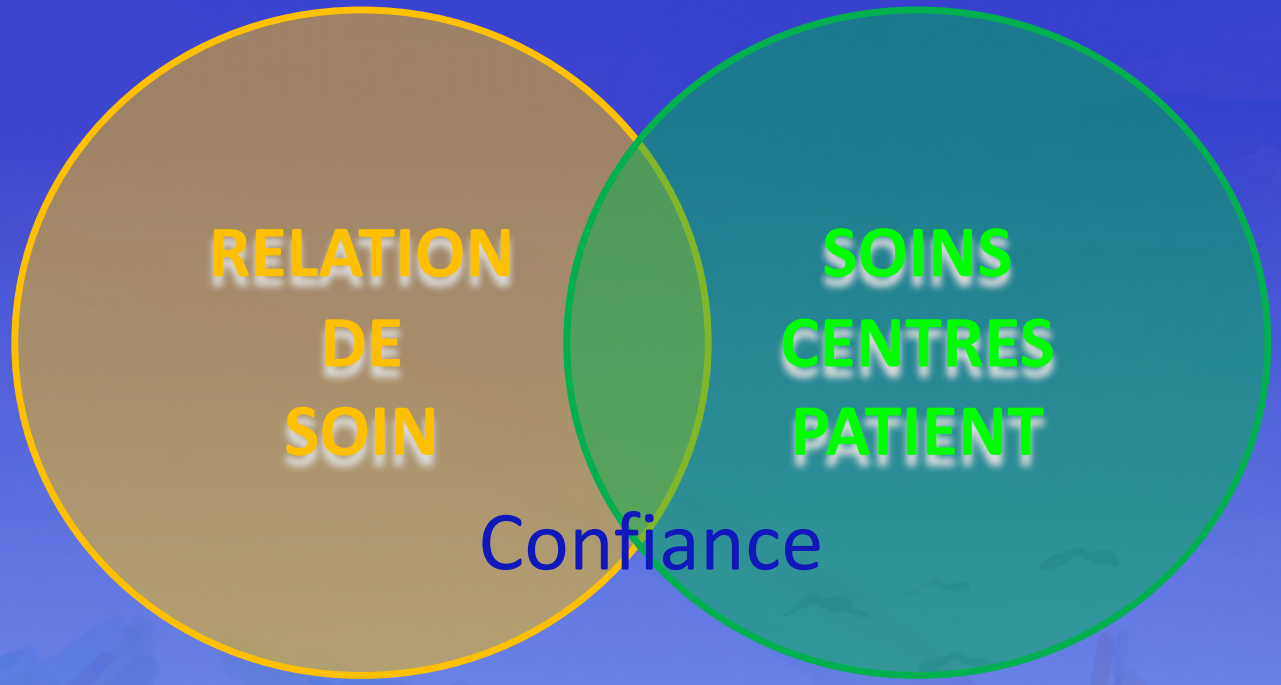


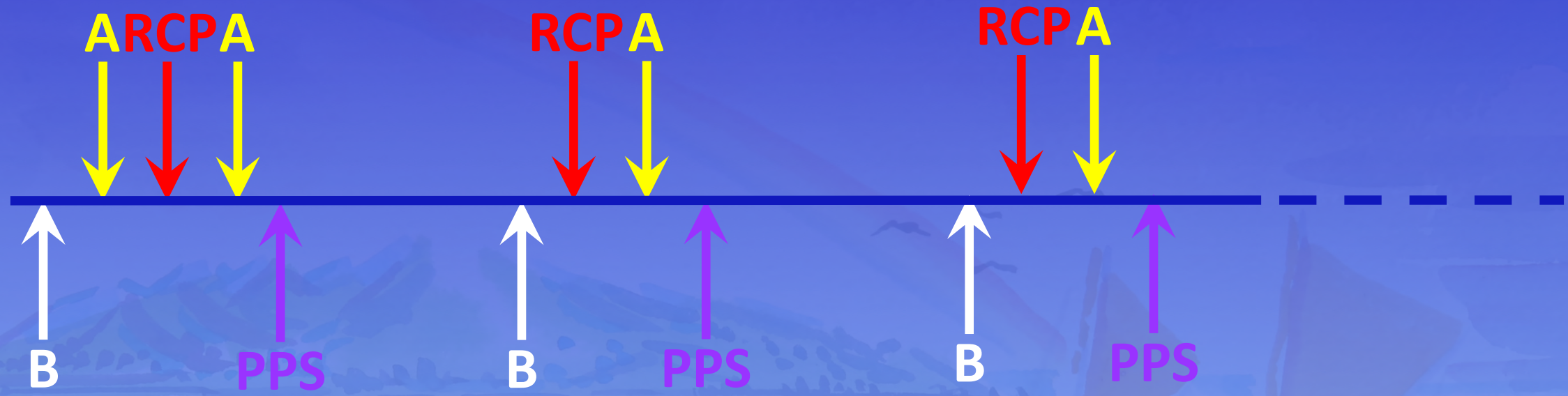
1 Praticien

1 Equipe oncologie thoracique

1 réseau d'équipes pluridisciplinaires

Application en oncologie thoracique

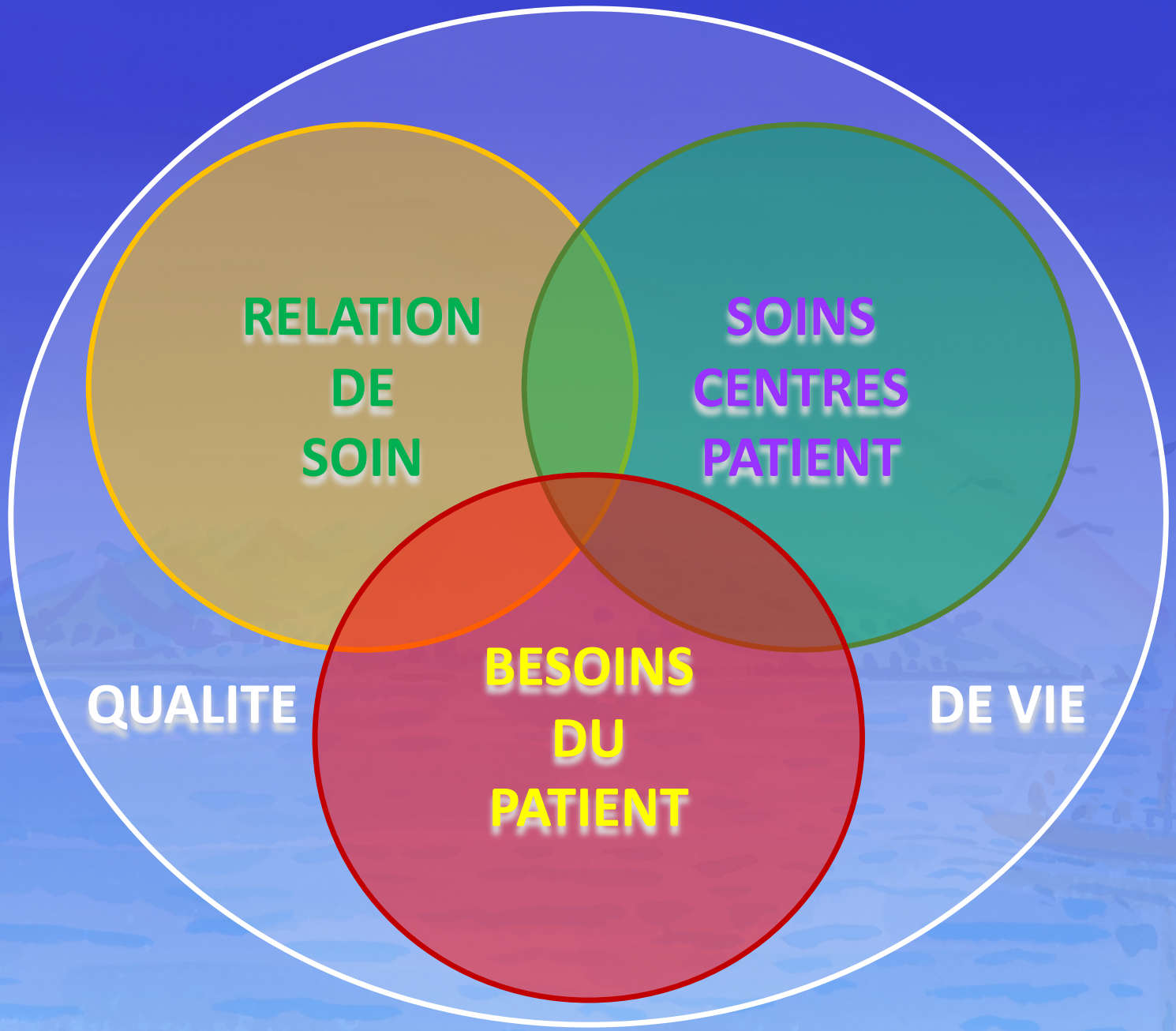
Le parcours du patient



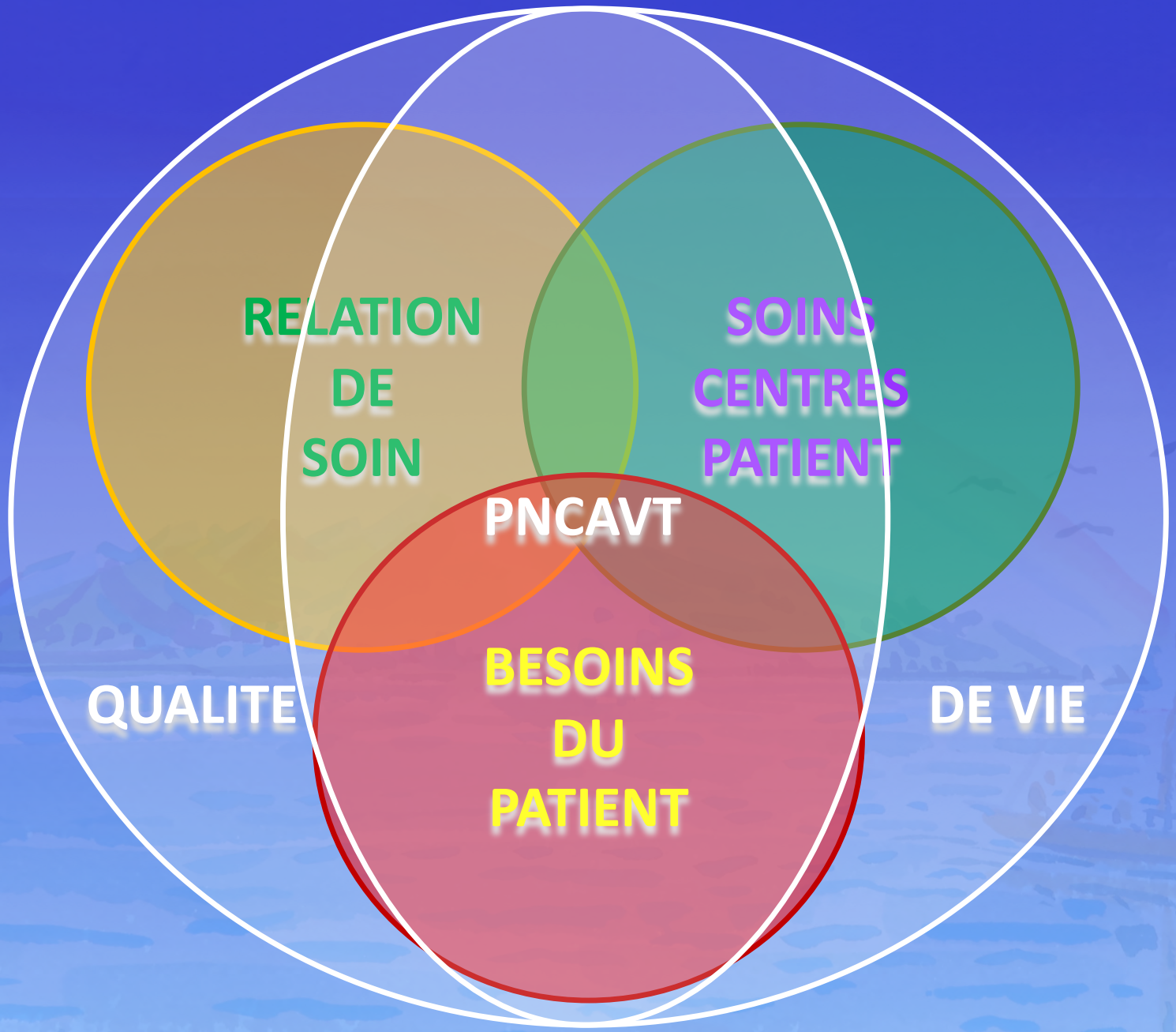
ETP

Soins de Support

A = Annonce B = Bilan



PRATIQUES
NON
CONVENTIONNELLES
A VISEES
THERAPEUTIQUES
(PNCAVT)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PNCAVT

Règles générales

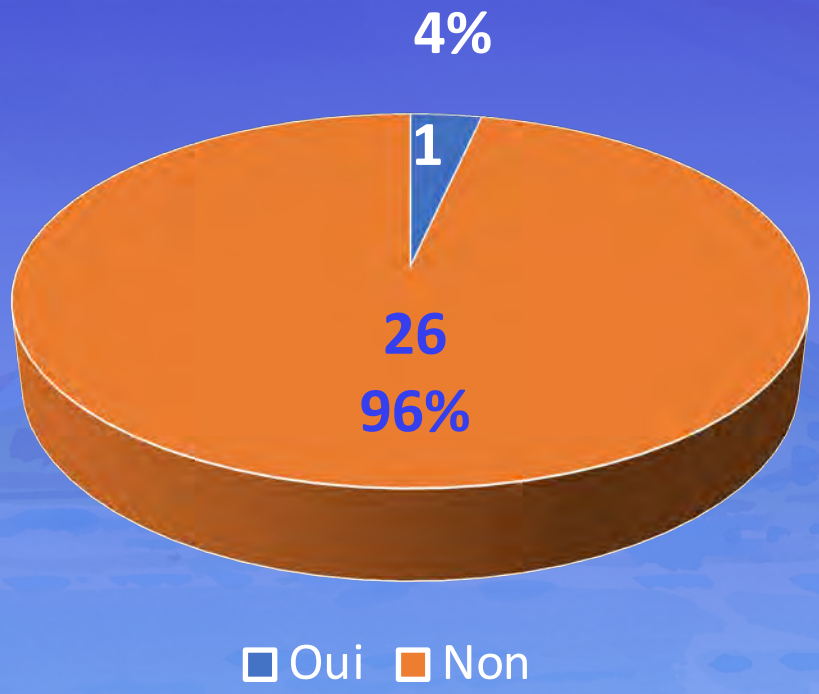
Recommandations de mise en œuvre ?

Oui

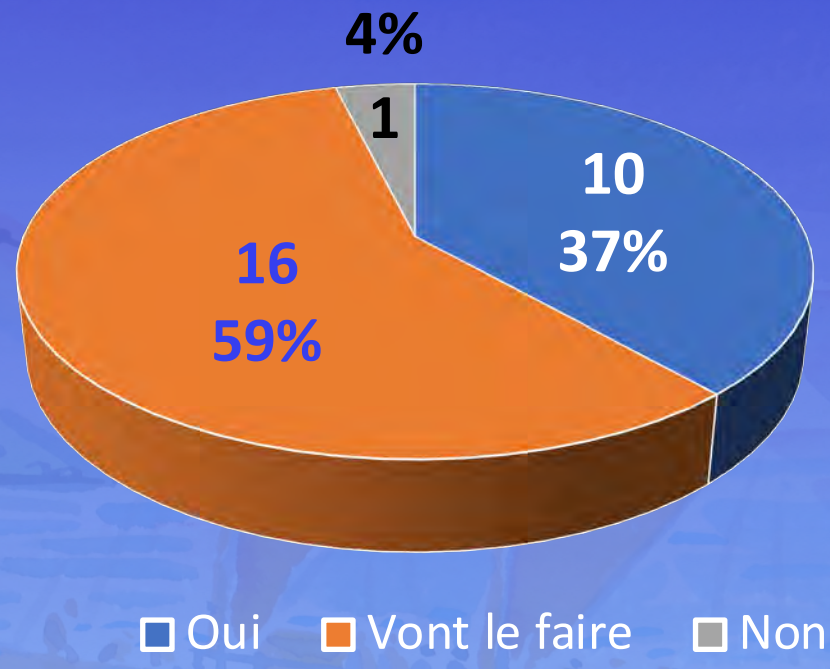
Non

Introduction raisonnée et sécurisée de la médecine traditionnelle dans les systèmes de santé

Connaissance de la stratégie OMS



Connaissent leur existence



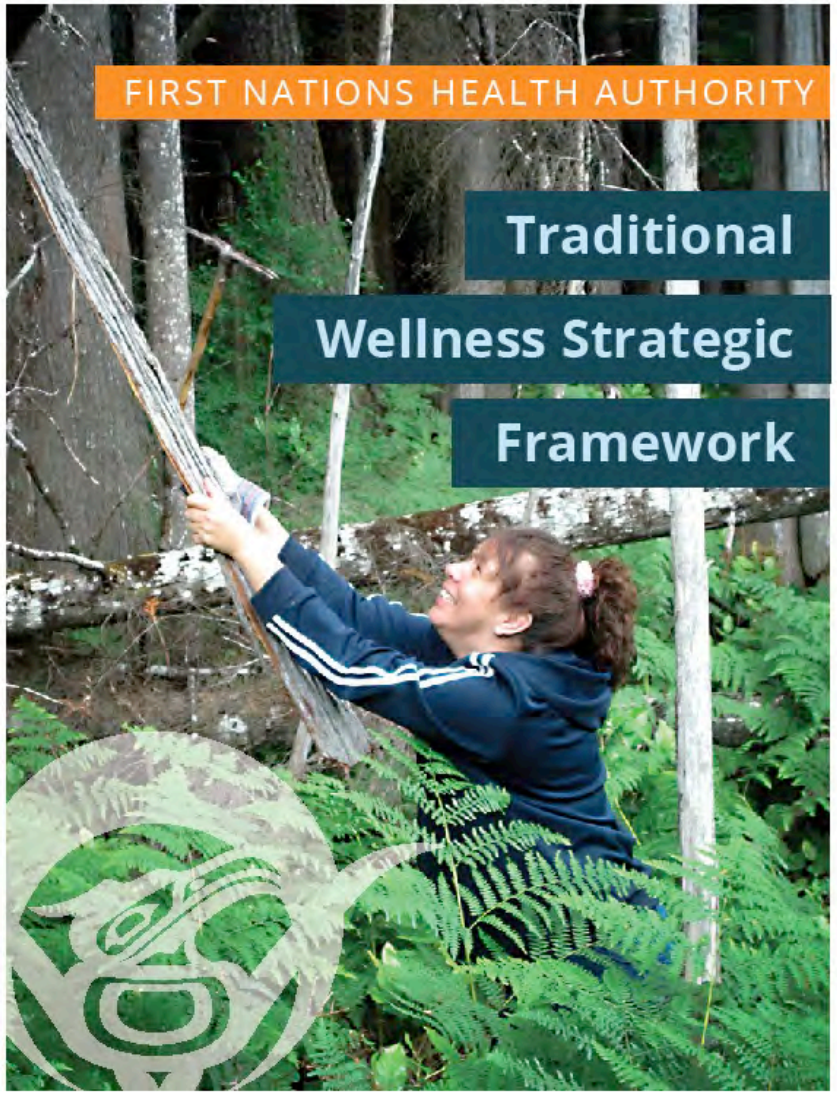
Les ont consulté

Avant Après

28 professionnels de santé Tahiti

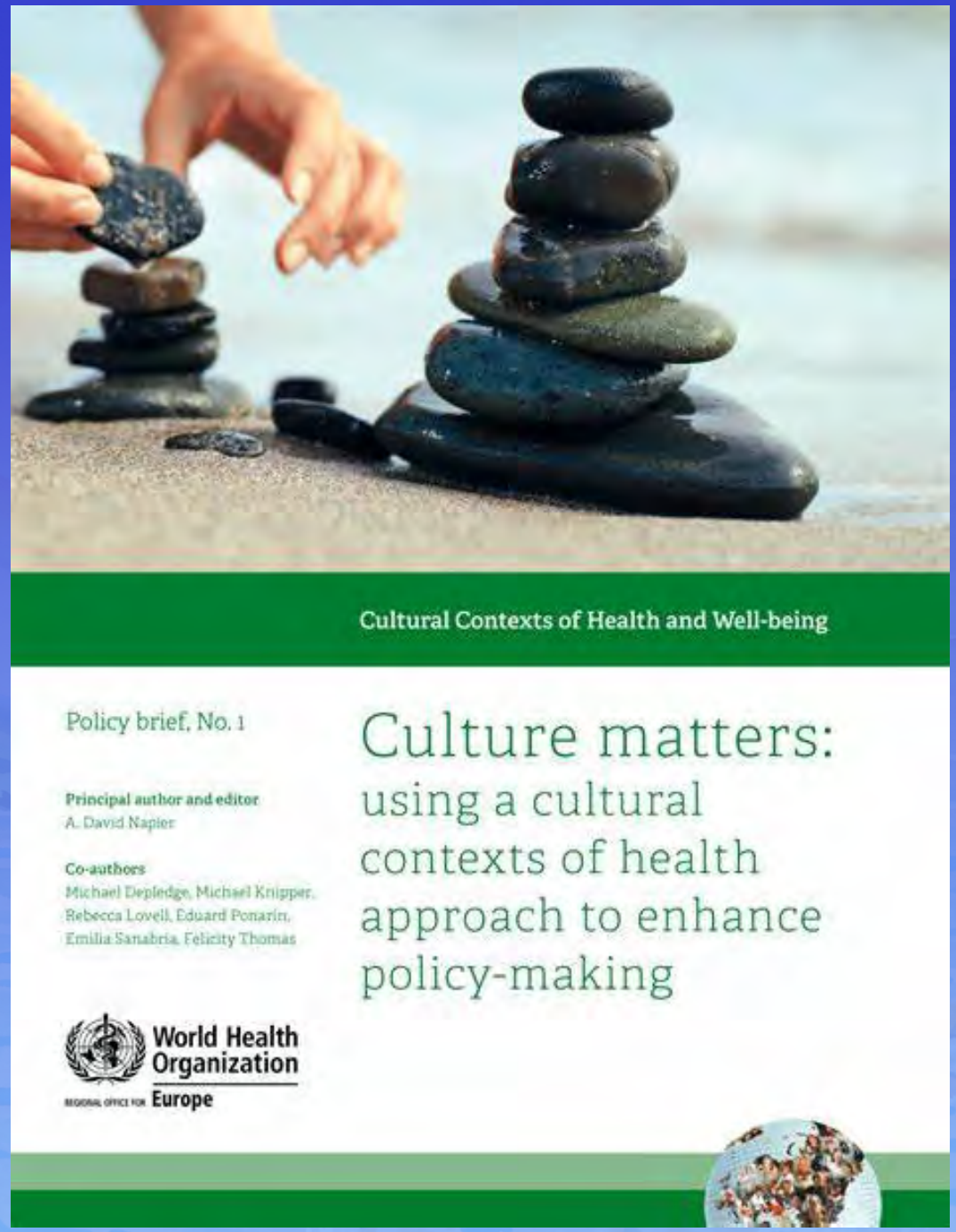
Médecine Intégrative

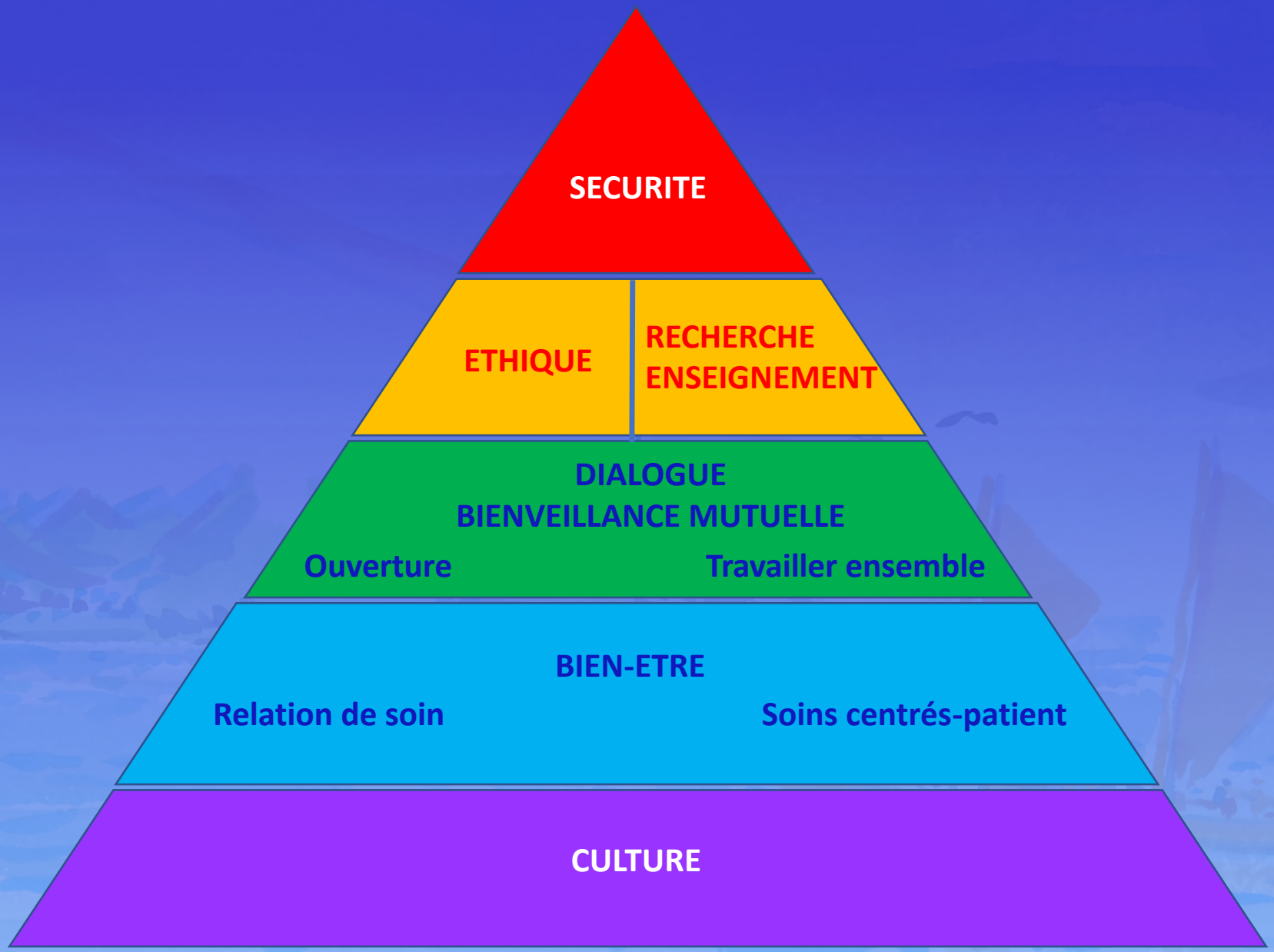
Bien-être



Humanisme

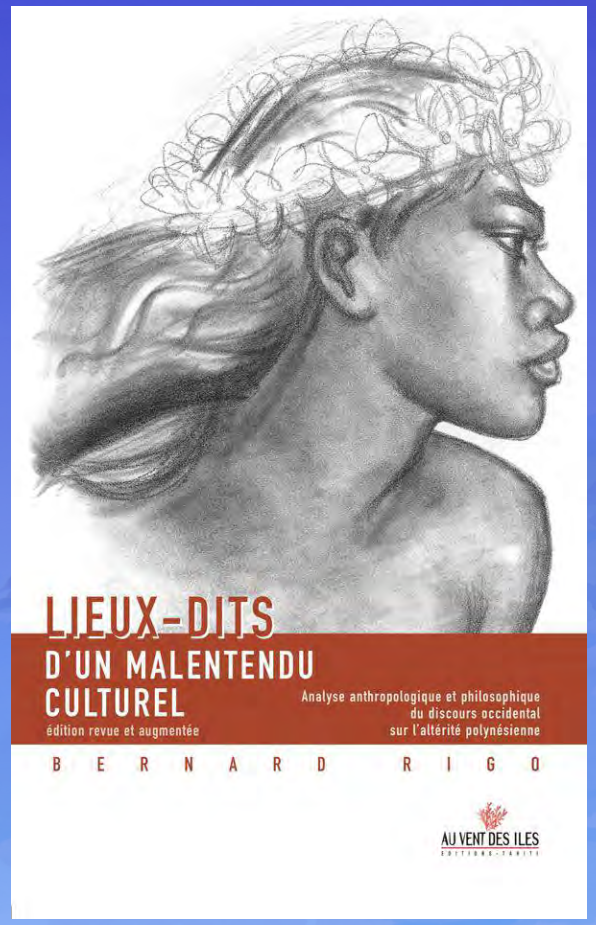
Conditions culturelles et de communication interculturelle




SECURITE
ETHIQUE
RECHERCHE
ENSEIGNEMENT
DIALOGUE
BIENVEILLANCE MUTUELLE
Ouverture
Travailler ensemble
BIEN-ETRE
Relation de soin
Soins centrés-patient
CULTURE

Le projet Polynésien

Constat de communication interculturelle



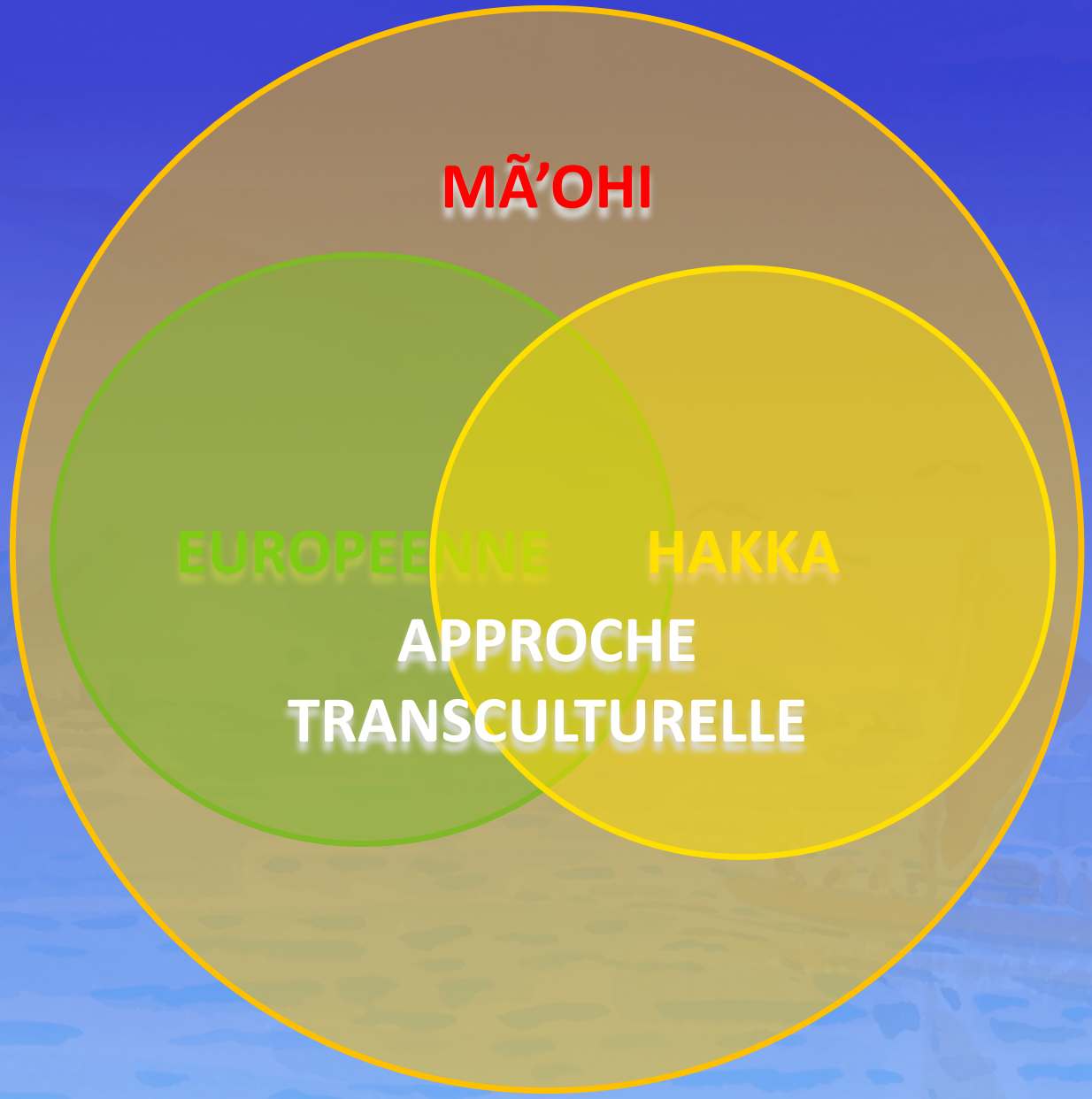
"Nous pouvons nous haïr - l'histoire l'atteste peut-être - nous pouvons nous aimer - l'histoire

Communication	88
Moyens	24
Psychologue	20
Douleur	14
Dispositif annonce	11
Soins palliatifs	7
USP	6
Coordination	5
EMSP	5
Diététique	4
Service d'oncologie	4
Traitement	4
Référent médical	3
PAC	3
Priorité	2
Personne confiance	2
Formation oncologie	2
Prise décision	2
Délais	2
Centres référents	1
Éducation tt	1

Audit qualité oncologie CHPf 2012

PARRAT / VANSON

Réunion des 3 cultures


MÃ'OHI
EUROPEENNE
HAKKA
APPROCHE
TRANSCULTURELLE

Conception et évaluation d'un outil de soin

UNIVERSITE TOULOUSE III - PAUL SABATIER
FACULTE DE MEDECINE
ANNEE 2017
2017 TOU3 1034

CONCEPTION ET EVALUATION
D'UN CARNET CULTUREL
D'EXPRESSION ET DE SUIVI EN SOINS DE SUPPORT
DANS LE CANCER BRONCHIQUE
EN POLYNESIE FRANCAISE

THESE
POUR LE DIPLOME D' ETAT DE DOCTEUR EN MEDECINE
SPECIALITE MEDECINE GENERALE

Présentée Et Soutenue Publiquement
Le 25 avril 2017
par :
BARTHE-VONSY Poerava
née le 02 février 1989 a Papeete (987)

Directeur de Thèse : Monsieur le Docteur Eric PARRAT
JURY :
Monsieur le Professeur Julien MAZIERES Président
Madame le Docteur Brigitte ESCOURROU Assesseur
Madame le Docteur Marie Eve ROUGE-BUGAT Assesseur
Monsieur le Docteur Eric PARRAT Assesseur
Madame le Docteur Sandrine POUSTIS Assesseur

28 fenua

La Dépêche
Lundi 8 mai 2017

SANTÉ - Cancer du poumon : une innovation pour accompagner les malades en soins palliatifs

A Haere I Mua : un *"carnet culturel"* qui donne la parole aux malades

En 3 points

- En Polynésie française, la prise en charge du cancer broncho-pulmonaire (CBP) a longtemps été problématique, notamment du fait du silence des malades polynésiens confrontés à la maladie.
- Afin de pallier les problèmes de communication entre patients et professionnels de santé, un carnet complémentaire au programme personnalisé de soins (PPS) est actuellement proposé au sein de l'équipe de soins palliatifs du CHPF.
- L'utilisation d'un support visuel basé sur une histoire traditionnelle a été envisagée et évaluée par une équipe pluridisciplinaire. Elle a donné lieu récemment à la soutenance d'une thèse de médecine par une jeune Polynésienne.

Une partie des personnes qui constituent le noyau de base du programme (de gauche à droite) : Aurélia Malogne, psychologue ; Mathilde Giroud de l'équipe mobile de soins palliatifs ; Delphine Lutringer, médecin de la santé publique ; Poerava Barthe-Vonsy, auteure de la thèse ; le docteur Éric Parrat, pneumologue ; Yves Doudoute et Johan Hiront Bouit, de l'association Haururu.

Mieux établir le contact entre soignants et malades

Dossier correspondant : C.J.

Un carnet tenu par le malade, *"capitaine"* de son équipage

Le carnet culturel intitulé A Haere I Mua (En avant !) a été évalué au sein du CHPF auprès de 171 professionnels de santé et 35 patients atteints d'un cancer bronchique incurable, en prolongement du Plan polynésien du cancer. Il est une réponse originale qui vise à intégrer la dimension culturelle dans le processus thérapeutique, au niveau des soins palliatifs. Organisé autour du concept d'équipage de va'a, il est conçu pour que le patient – considéré comme son capitaine et non réduit à sa position de malade passif – puisse s'y exprimer librement (écrire, dessiner, coller) et le montrer à qui il veut, notamment à sa famille. *"La communication est indispensable dans le cas du cancer du poumon. La question était de créer un outil sous un format polynésien, c'est-à-dire quelque chose de très visuel, très coloré, qui raconte une histoire"*, explique le Dr Parrat. Elle rappelle l'aventure maritime parfois héroïque qui s'est répétée de multiples fois dans l'épopée des Polynésiens à travers le Pacifique, *"une histoire qui porte l'espoir"*. Ce carnet a été conçu en partenariat avec l'association Haururu dans le cadre d'un projet d'école de médecine intégrative, qui associe médecine conventionnelle occidentale et médecine traditionnelle polynésienne. Et à l'évidence, si la prévention et les thérapies innovantes peuvent porter l'espoir d'une survie prolongée, il semble désormais acquis qu'il y a nécessité d'un ancrage culturel de la relation médicale, en particulier dans l'accompagnement des soins palliatifs alors que les malades n'ont plus guère que quelques mois, voire semaines, à vivre. C'est en tout cas ce que patients et professionnels de santé demandent si l'on en croit l'enquête menée par des équipes interdisciplinaires et que relate la thèse de Poerava.

A Haere I Mua
En Avant

Réaction

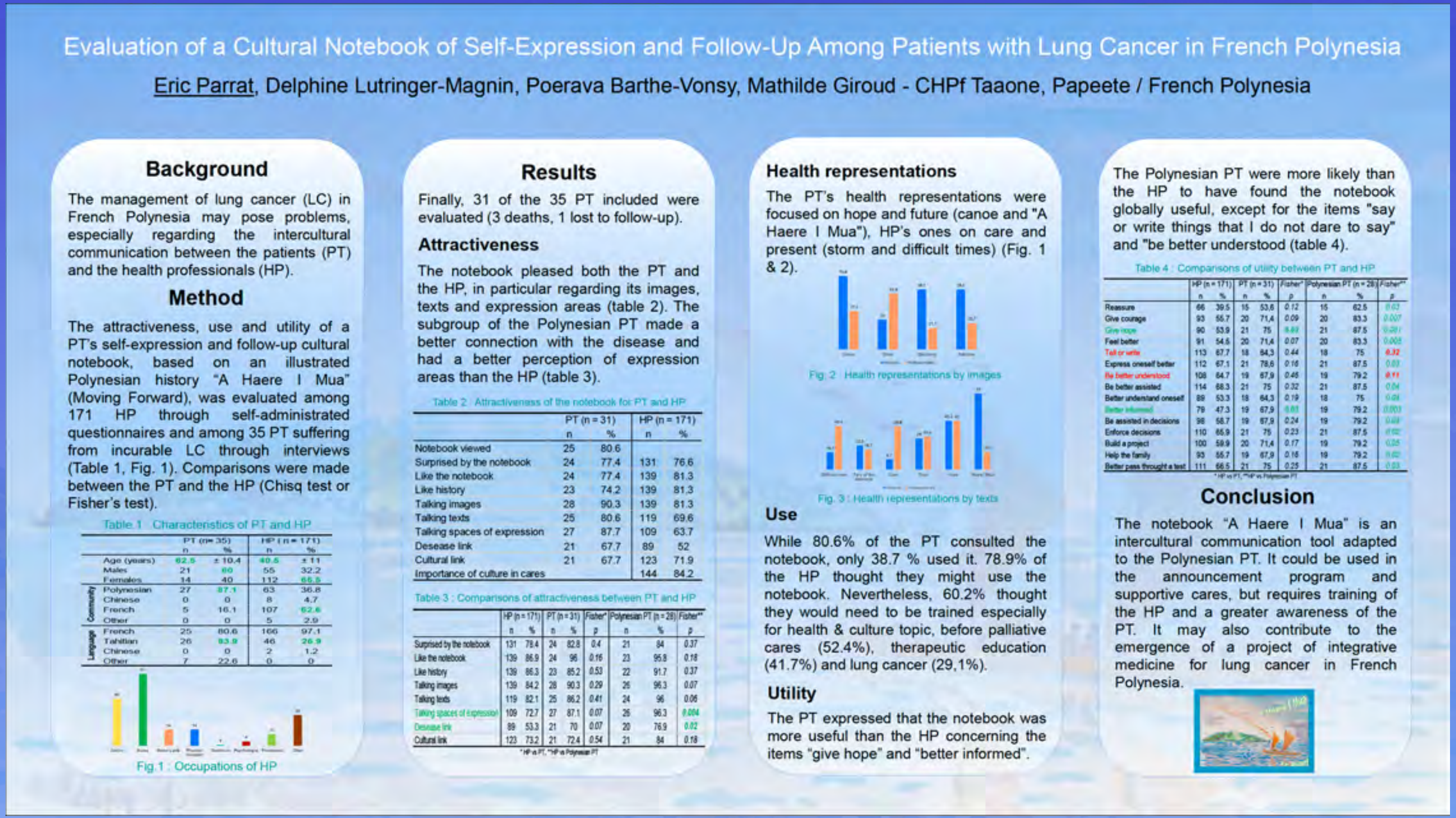
Poerava Barthe-Vonsy
Auteure de la thèse de doctorat

"Associer les approches occidentale et polynésienne"

"Mon but était de revenir en Polynésie après mes études en métropole (voir son portrait dans La Dépêche de dimanche du 2 avril, p.9) et de soigner mes ta'ata Tahiti en leur apportant quelque chose. Au départ, la médecine traditionnelle m'intéressait. Mais je pense qu'il me fallait mieux la connaître pour mieux connaître mes patients et leur apporter un plus. J'ai donc eu l'idée de concrétiser ma thèse de doctorat autour d'une thématique qui associe les deux approches : la scientifique occidentale et la traditionnelle polynésienne."

Le cancer bronchique, l'une des principales causes de mortalité en Polynésie

La problématique de santé que représente le cancer bronchique est loin d'être anodine. En Polynésie française, le cancer est la deuxième cause de mortalité et, chez les hommes, le cancer le plus mortel est celui des bronches et des poumons, tandis qu'il occupe la deuxième place chez les femmes. En forte relation avec un tabagisme aggravé par la consommation d'un tabac de très mauvaise qualité avec de forts taux de nicotine et de goudron, il pose d'ailleurs la double question de la prévention et des soins – notamment dans le cadre de l'accompagnement en soins palliatifs.
Rencontre autour du carnet culturel, le samedi 13 mai, à Moorea.



Evaluation of a Cultural Notebook of Self-Expression and Follow-Up Among Patients with Lung Cancer in French Polynesia

Eric Parrat, Delphine Lutringer-Magnin, Poerava Barthe-Vonsy, Mathilde Giroud - CHPf Taaone, Papeete / French Polynesia

Background

The management of lung cancer (LC) in French Polynesia may pose problems, especially regarding the intercultural communication between the patients (PT) and the health professionals (HP).

Method

The attractiveness, use and utility of a PT's self-expression and follow-up cultural notebook, based on an illustrated Polynesian history "A Haere I Mua" (Moving Forward), was evaluated among 171 HP through self-administrated questionnaires and among 35 PT suffering from incurable LC through interviews (Table 1, Fig. 1). Comparisons were made between the PT and the HP (Chisq test or Fisher's test).

Table 1 Characteristics of PT and HP

		PT (n= 35)		HP (n = 171)	
		n	%	n	%
	Age (years)	62.5	± 10.4	40.5	± 11
	Males	21	60	55	32.2
	Females	14	40	112	65.5
Community	Polynesian	27	87.1	63	36.8
	Chinese	0	0	8	4.7
	French	5	16.1	107	62.6
	Other	0	0	5	2.9
Language	French	25	80.6	166	97.1
	Tahitian	26	83.9	46	26.9
	Chinese	0	0	2	1.2
	Other	7	22.6	0	0

Fig.1 : Occupations of HP

Results

Finally, 31 of the 35 PT included were evaluated (3 deaths, 1 lost to follow-up).

Attractiveness

The notebook pleased both the PT and the HP, in particular regarding its images, texts and expression areas (table 2). The subgroup of the Polynesian PT made a better connection with the disease and had a better perception of expression areas than the HP (table 3).

Table 2 Attractiveness of the notebook for PT and HP

	PT (n = 31)		HP (n = 171)	
	n	%	n	%
Notebook viewed	25	80.6		
Surprised by the notebook	24	77.4	131	76.6
Like the notebook	24	77.4	139	81.3
Like history	23	74.2	139	81.3
Talking images	28	90.3	139	81.3
Talking texts	25	80.6	119	69.6
Talking spaces of expression	27	87.7	109	63.7
Desease link	21	67.7	89	52
Cultural link	21	67.7	123	71.9
Importance of culture in cares			144	84.2

Table 3 : Comparisons of attractiveness between PT and HP

	HP (n = 171)		PT (n = 31)		Fisher*	Polynesian PT (n = 28)		Fisher**
	n	%	n	%	p	n	%	p
Surprised by the notebook	131	78.4	24	82.8	0.4	21	84	0.37
Like the notebook	139	86.9	24	96	0.16	23	95.8	0.18
Like history	139	86.3	23	85.2	0.53	22	91.7	0.37
Talking images	139	84.2	28	90.3	0.29	26	96.3	0.07
Talking texts	119	82.1	25	86.2	0.41	24	96	0.06
Talking spaces of expression	109	72.7	27	87.1	0.07	26	96.3	0.004
Desease link	89	53.3	21	70	0.07	20	76.9	0.02
Cultural link	123	73.2	21	72.4	0.54	21	84	0.18

*HP vs PT, **HP vs Polynesian PT

Health representations

The PT's health representations were focused on hope and future (canoe and "A Haere I Mua"), HP's ones on care and present (storm and difficult times) (Fig. 1 & 2).

Fig. 2 Health representations by images

Fig. 3 : Health representations by texts

Use

While 80.6% of the PT consulted the notebook, only 38.7 % used it. 78.9% of the HP thought they might use the notebook. Nevertheless, 60.2% thought they would need to be trained especially for health & culture topic, before palliative cares (52.4%), therapeutic education (41.7%) and lung cancer (29.1%).

Utility

The PT expressed that the notebook was more useful than the HP concerning the items "give hope" and "better informed".

The Polynesian PT were more likely than the HP to have found the notebook globally useful, except for the items "say or write things that I do not dare to say" and "be better understood (table 4).

Table 4 : Comparisons of utility between PT and HP

	HP (n = 171)		PT (n = 31)		Fisher*	Polynesian PT (n = 28)		Fisher**
	n	%	n	%	p	n	%	p
Reassure	66	39.5	15	53.6	0.12	15	62.5	[illegible]
Give courage	93	55.7	20	71.4	0.09	20	83.3	0.007
Give hope	90	53.9	21	75	[illegible]	21	87.5	[illegible]
Feel better	91	54.5	20	71.4	0.07	20	83.3	0.005
Tell or write	113	67.7	18	64.3	0.44	18	75	0.32
Express oneself better	112	67.1	21	78.6	0.16	21	87.5	[illegible]
Be better understood	108	64.7	19	67.9	0.46	19	79.2	0.11
Be better assisted	114	68.3	21	75	0.32	21	87.5	0.04
Better understand oneself	89	53.3	18	64.3	0.19	18	75	[illegible]
Better informed	79	47.3	19	67.9	[illegible]	19	79.2	0.003
Be assisted in decisions	98	58.7	19	67.9	0.24	19	79.2	[illegible]
Enforce decisions	110	65.9	21	75	0.23	21	87.5	[illegible]
Build a project	100	59.9	20	71.4	0.17	19	79.2	[illegible]
Help the family	93	55.7	19	67.9	0.16	19	79.2	[illegible]
Better pass throught a test	111	66.5	21	75	0.25	21	87.5	[illegible]

*HP vs PT, **HP vs Polynesian PT

Conclusion

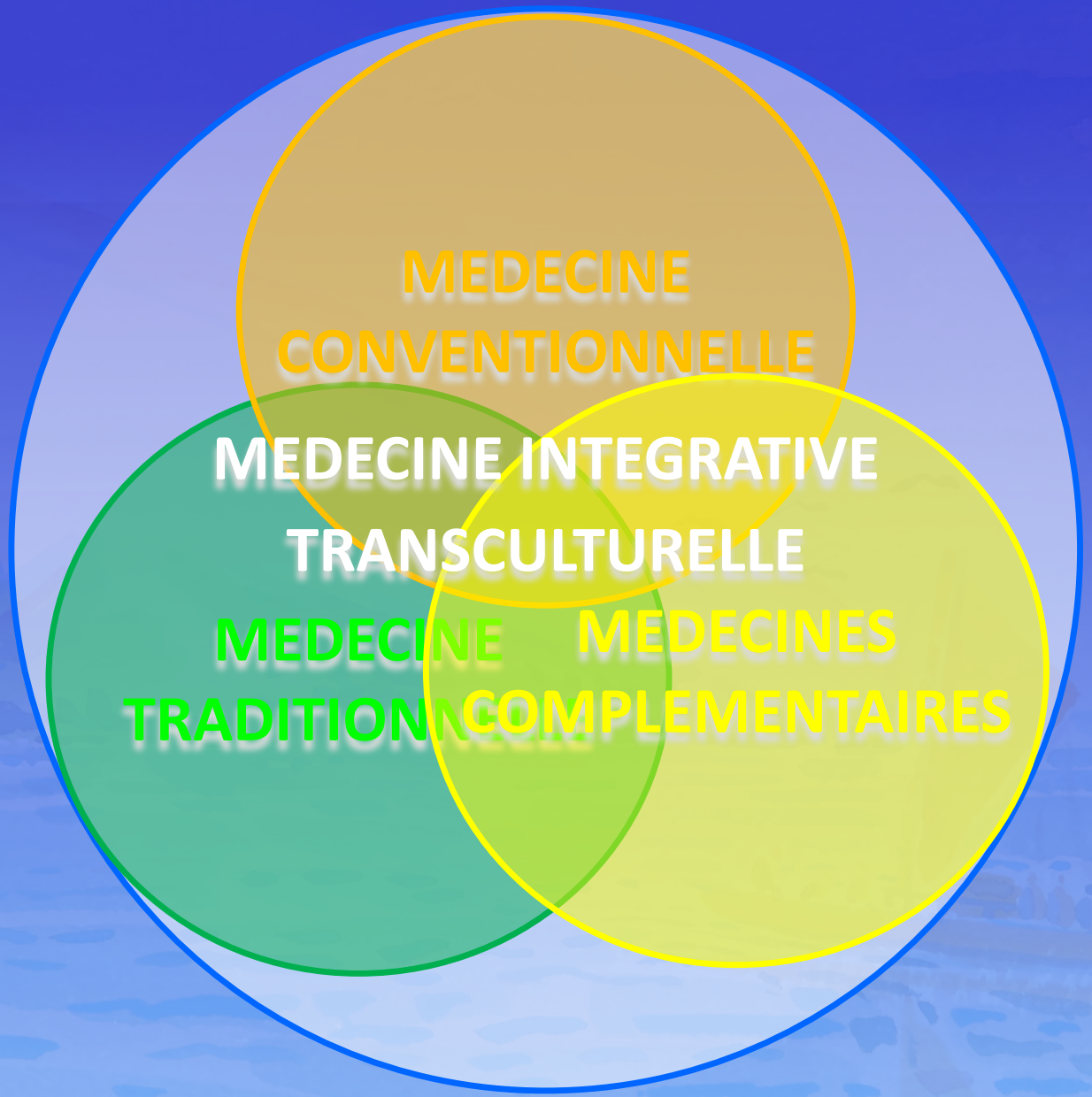
The notebook "A Haere I Mua" is an intercultural communication tool adapted to the Polynesian PT. It could be used from the announcement program and supportive cares, but requires training of the HP and a greater awareness of the PT. It may also contribute to the emergence of a project of integrative medicine for lung cancer in French Polynesia.

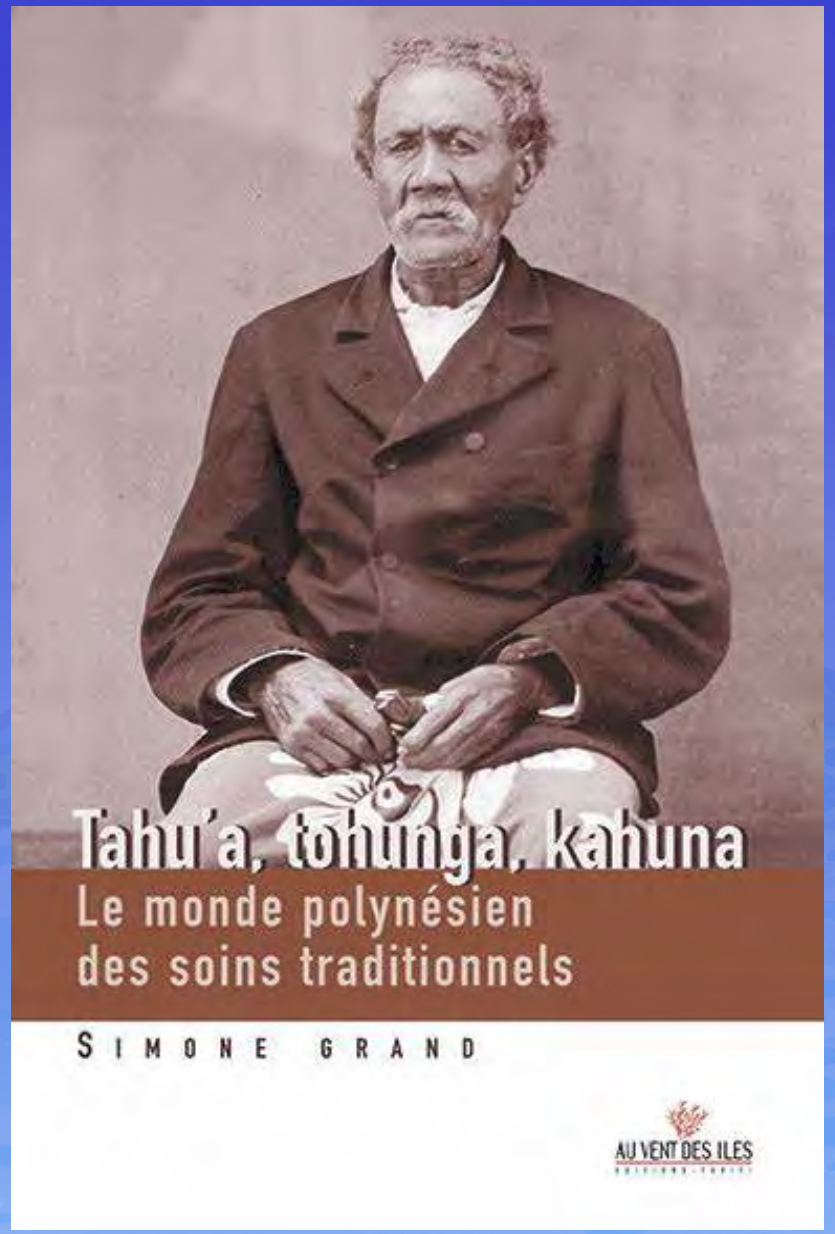
Réunion des 3 médecines

MEDECINE TRADITIONNELLE

MEDECINE CONVENTIONNELLE

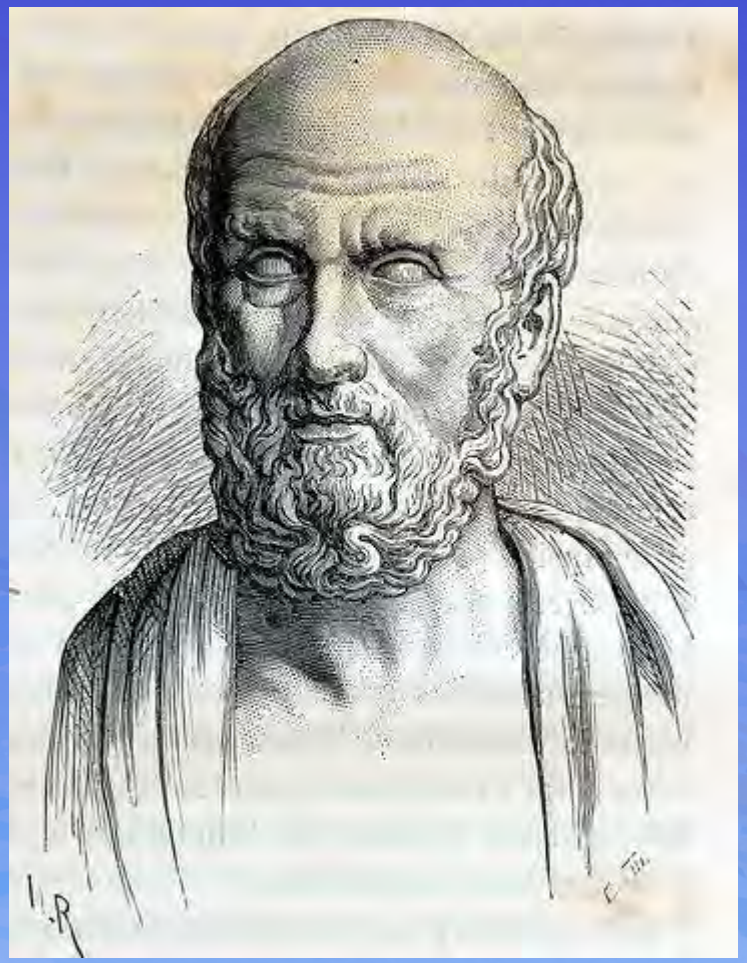
MEDECINES COMPLEMENTAIRES


MEDECINE
CONVENTIONNELLE
MEDECINE INTEGRATIVE
TRANSCULTURELLE
MEDECINE
TRADITIONNELLE
MEDECINES
COMPLEMENTAIRES



MEDECINE INTEGRATIVE TRADITIONNELLE TRANSCULTURELLE

Universalité des soins



La Dépêche
Mardi 13 septembre 2016

PAPENO'O - Séminaire de trois jours au Fare Hape

Haururu peaufine ses projets de développement

L'association écoculturelle Haururu a organisé un important séminaire durant trois jours sur le site du Fare Hape, dans la haute vallée de Papeno'o.

L'occasion de préciser de manière concrète les trois thématiques qui sont à la base de son engagement depuis plus d'une vingtaine d'années: la protection de l'environnement, des échanges culturels avec les "cousins" du triangle polynésien et l'appropriation des valeurs traditionnelles associée à une dynamique pédagogique adaptée à la société contemporaine.

Vendredi dernier, la jeune docteurante en biologie Herehia Helme a ainsi tenu à présenter à l'association les premières constatations des recherches qu'elle mène dans le cadre de sa thèse concernant l'impact des aménagements hydroélectriques sur le peuplement des anguilles, dans la vallée (lire notre édition du 10 septembre).

Dimanche dernier, l'association a reçu la trentaine de Hawaiiens qui participent cette semaine au Festival Polynesia (lire notre édition d'hier).

Mais auparavant, samedi dernier, c'est à une journée de réflexion que se sont livrés ses membres afin de mieux cerner son devenir, en particulier en ce qui concerne des projets d'aménagement du site, sur lequel sont envisagés des travaux de rénovation des structures existantes, mais pas seulement.

Plusieurs *fare* traditionnels doivent en effet être construits dans la perspective d'un déploiement pérenne des activités de Haururu, avec et pour la population.

Création d'une fondation

L'association est en charge de l'animation et de la gestion du site du Fare Hape, un haut lieu de la culture traditionnelle des temps anciens, en pleine nature au centre de l'île de Tahiti, où ont été dégagées et reconstituées des structures archéologiques qui ont aujourd'hui valeur culturelle, mais aussi touristique. Haururu, qui accueille tous les ans près de 3 000 enfants scolarisés pour des activités pédagogiques, veut aller plus loin et faire de ce "village" un véritable centre d'immersion et de formation.

Outre de possibles subventions pour mener à bien les premières étapes de ce développement, l'association envisage sérieusement la création d'une fondation. Ce type de structure juridique, rendu possible en Polynésie française depuis juillet avec l'adoption d'une loi du Pays ad hoc, est en effet à même de lui assurer une indépendance financière pour l'accomplissement de ses missions d'intérêt général.

Le séminaire a donc aussi été l'occasion de formuler les pistes de développement projetées, avec la présence d'intervenants reconnus pour leurs compétences et leur engagement dans de nombreux domaines, notamment la santé (Dr Éric Parrat), les arts (Viri Taimana du centre des métiers d'art, Marguerite Lai du groupe de danse traditionnelle O Tahiti E, Eriki Marchand du lycée Samuel Raapoto), le patrimoine culturel (l'archéologue Paul Niva), mais aussi l'horticulture, la nourriture... et autres activités permettant aux jeunes générations la redécouverte des valeurs naturelles et traditionnelles polynésiennes. K

De notre correspondant C.J.

Photo: Claude Jacquier/LDT

Le séminaire de réflexion a été entrecoupé de nombreux chants, une pratique régulière de l'association.

Photo: Claude Jacquier/LDT

Le village du Fare Hape, au cœur de la caldeira, va être rénové.

La santé est aussi affaire de culture

Photo: Claude Jacquier/LDT

Le docteur Éric Parrat (à gauche), pneumologue, travaille depuis plusieurs années au rapprochement de la médecine conventionnelle avec l'art des tradipraticiens. Président de l'association Réseau polynésien des maladies respiratoires (Repmar), ce médecin hospitalier connaît bien la problématique des enfants asthmatiques. "*S'il n'y a pas de réflexion culturelle dans la pratique de la santé, on ne peut pas s'en sortir*", a-t-il expliqué en indiquant s'associer au projet de création d'un *fare rapa'au*, lieu de partage de connaissances traditionnelles (plantes médicinales, massage...) et de pratiques thérapeutiques classiques. L'occasion de réunir durablement, comme ici à l'occasion du séminaire, tradipraticiens et infirmiers hospitaliers.

Les tradipraticiens à l'hôpital


Ethiques
Réglementaires
Administratives
MEDECINE
INTEGRATIVE
TRADITIONNELLE
TRANSCULTURELLE
Médicales
Scientifiques
Sociétales

Les résultats

Question de recherche

Question principale

- Est-ce que PS et TP veulent travailler ensemble ?
- Est-ce PS et TP peuvent travailler ensemble ?

Questions secondaires

- Quelles sont les conditions pour travailler ensemble ?
- Quelles implications pour le système de santé ?

Engagement par charte éthique des PS

CHARTE DE PARTICIPATION DES PROFESSIONNELS DE SANTE AU SEMINAIRE FARE RAPA'AU

Nous participons à un séminaire expérimental dont l'objet tient à la mise en œuvre d'un projet de médecine intégrative réunissant la médecine traditionnelle polynésienne avec la médecine conventionnelle et les autres médecines complémentaires. Le lien est scellé par une immersion culturelle propre au projet Fare Fenua de Fare Hape, haute vallée de la Papenoo, Polynésie française. L'organisation de la manifestation est régie par un engagement conventionnel entre le CHPf et les associations HAURURU et REPMAR consultable auprès des organisateurs.

Clause générale

L'accès au séminaire est restreint à des tradipraticiens, professionnels de santé agrées, experts des médecines complémentaires et personnes physiques de la société civile engagées dans le projet Fare Rapa'au.

Le séminaire est bilingue Français / Tahitien. Les participants s'engagent à tenir des propos simples et compréhensibles afin que des traductions soient assurées, dans les deux langues, entre les participants, et en bonne intelligence. Les propos sont strictement axés sur le projet de médecine intégrative dans toutes ses dimensions et ses possibilités de mise en œuvre opérationnelle à titre expérimental. Tous les participants sont encouragés à s'exprimer largement sur tous les sujets et à faire des propositions.

Clause éthique

Notre éthique est fondée sur quatre principes indivisibles : Respect / humilité / doute / juste milieu.

- Respect, des personnes et des opinions, dans tous nos échanges, sans discrimination ni prosélytisme.
- Humilité, face au concept de la santé et au grand mystère de la vie et de l'univers auquel nul d'entre nous ne saurait prétendre à détenir une vérité.
- Doute, sur toutes les affirmations qui nous assaillent, en nous posant plus de questions que nous ne cherchons à obtenir de réponses, mais en essayant de proposer des solutions innovantes.
- Juste milieu, sans excès ni défaut, en restant en permanence mesurés relativement à nos conceptions, angoisses, et croyances personnelles.

Notre démarche est strictement humaniste et respectueuse de la nature et de l'environnement. Elle exclut tous propos d'ordre politiques, religieux, commerciaux ou polémistes. La convivialité entre les participants doit être strictement respectée à tous instants.

Clause de Confidentialité

Elle porte sur les aspects techniques et pratiques du projet. Il est ainsi interdit de diffuser tous documents portant la mention « confidentiel » qui pourraient être remis aux participants pendant ou au décours de la manifestation. Chacun participant est néanmoins encouragé à se porter en messager du projet ; dans le cadre de sa charte, toujours sans prosélytisme, et de proposer à d'autres personnes relevant de la clause générale à rejoindre notre démarche dans sa dimension éthique.

Le séminaire fait l'objet d'une double évaluation scientifique bénéficiant d'une garantie de confidentialité par l'association REPMAR :

Méthodologie doublement comparative

Biomédicale	Anthropologique
- Pourcentages - Moyennes - Comparaisons avant / après - Test non paramétrique sur données appareillées - Test de Friedman - Seuil Alpha 5%	- Recensement des mots - Récurrence des mots - Regroupement par champs thématiques - Pourcentages - Comparaisons avant / après
Logiciel Biosta TGV	Logiciel NVIVO

RECIPROCAL PEER REVIEW FOR QUALITY IMPROVEMENT: AN ETHNOGRAPHIC CASE STUDY OF THE IMPROVING LUNG CANCER OUTCOMES PROJECT

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Collaboration scientifique ethno-médicale

Box 3. Lessons for optimising RP2PR

Organising RP2PR – making it happen

- A dedicated, core team to organise the process is essential
- Legitimise participation e.g. gain CEO approval
- Minimise the logistical burden for participating teams and allow sufficient time to arrange visits

Creating a safe & productive learning environment

- Recognise team achievements, not just weaknesses
- Pair teams with differing strengths, not 'good' with 'bad'
- Maximise peer influence and peer-to-peer learning through the inclusion of team members from a range of disciplines
- Reciprocity of visits within pairs is important for promoting constructive attitudes and trusting relationships
- Plan the structure of visits carefully to support in-depth discussion and equal 'voice'
- Use an independent facilitator to maintain solution-oriented focus; consider the pros and cons of a clinical vs. non-clinical facilitator

Ensuring credibility

- Include observation of 'live' practice, such as the MDT meeting
- Ensure data is perceived as credible

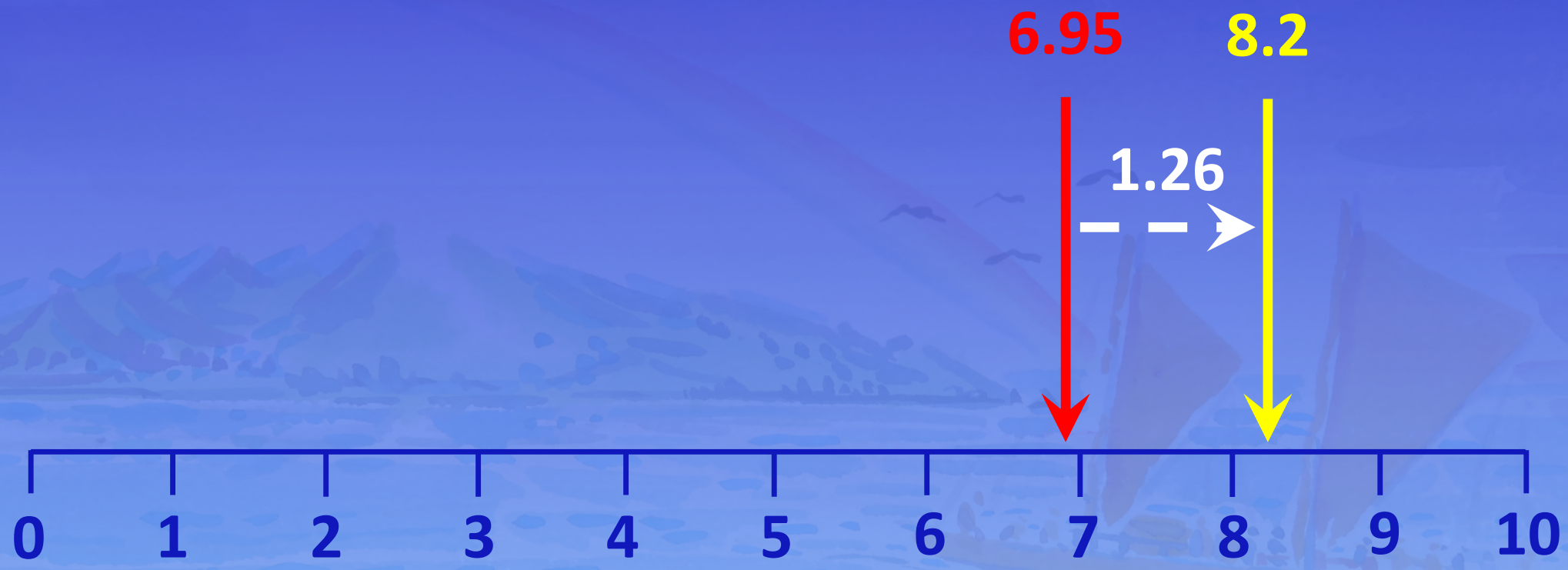
Aveling EL. BMJ Qual Saf 2012

Volonté PS de travailler avec TP

Avant Après

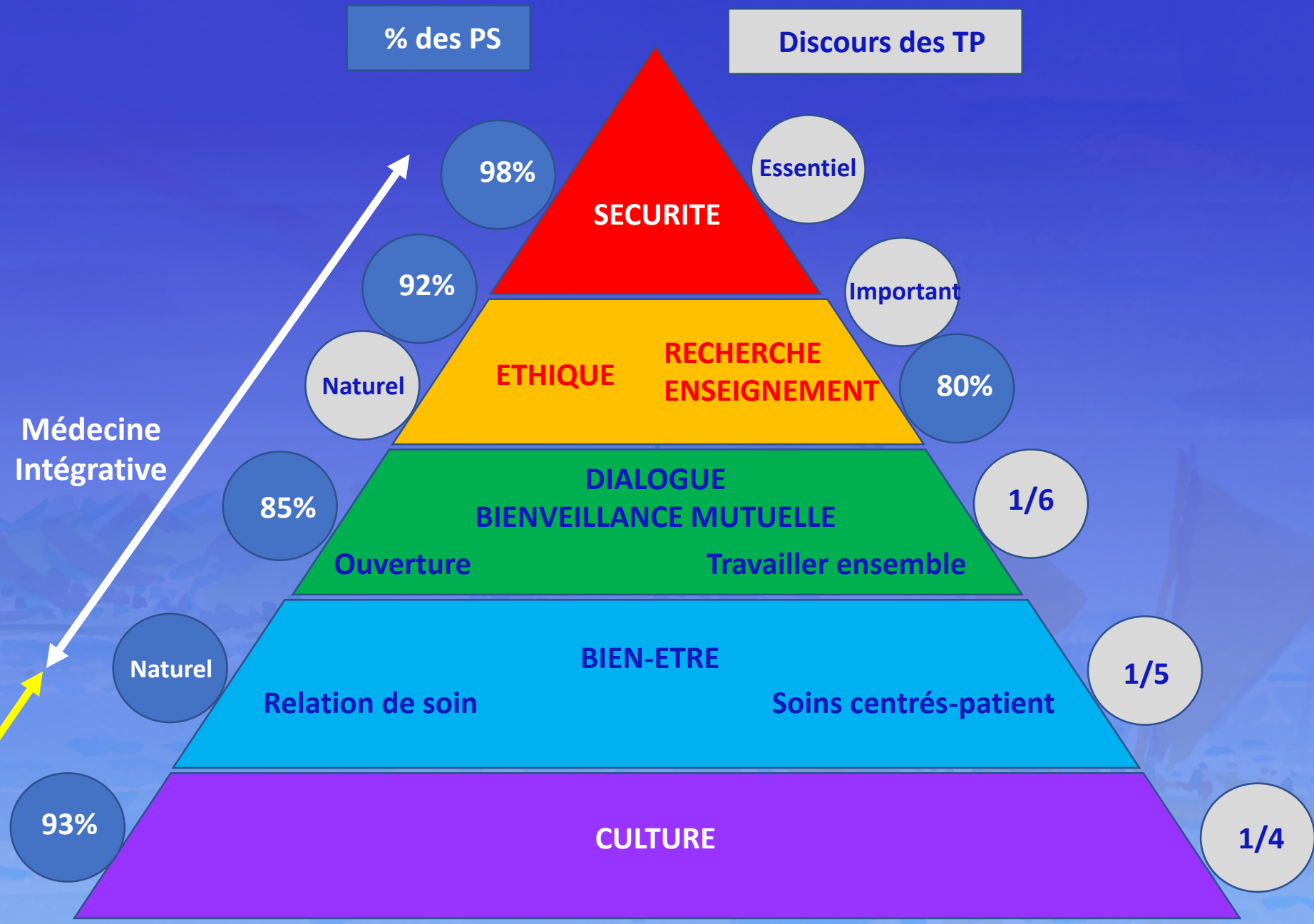
p = 0,08 NS

PS Capacité à travailler ensemble



Avant Après

p = 0,049


% des PS
Discours des TP
98%
Essentiel
SECURITE
92%
Important
Naturel
ETHIQUE
RECHERCHE
ENSEIGNEMENT
80%
Médecine
Intégrative
85%
1/6
DIALOGUE
BIENVEILLANCE MUTUELLE
Ouverture
Travailler ensemble
Naturel
BIEN-ETRE
1/5
Relation de soin
Soins centrés-patient
Culture
et Santé
93%
CULTURE
1/4


Stratégie de l'OMS
pour la médecine
traditionnelle pour
2014-2023
Organisation
mondiale de la Santé


JACM
The Berlin Agreement:
Self-Responsibility and Social Action in Practicing
and Fostering Integrative Medicine and Health Globally


Cultural Contexts of Health and Well-being
Culture matters:
using a cultural
contexts of health
approach to enhance
policy-making
World Health
Organization
Europe

Perspectives

Place de l'outil culturel dans l'annonce

Comment travailler ensemble

RESPECT- HUMILITE

Collaborations multicentriques

Hôpitaux de Toulouse

JEAN MOULIN

CHPF

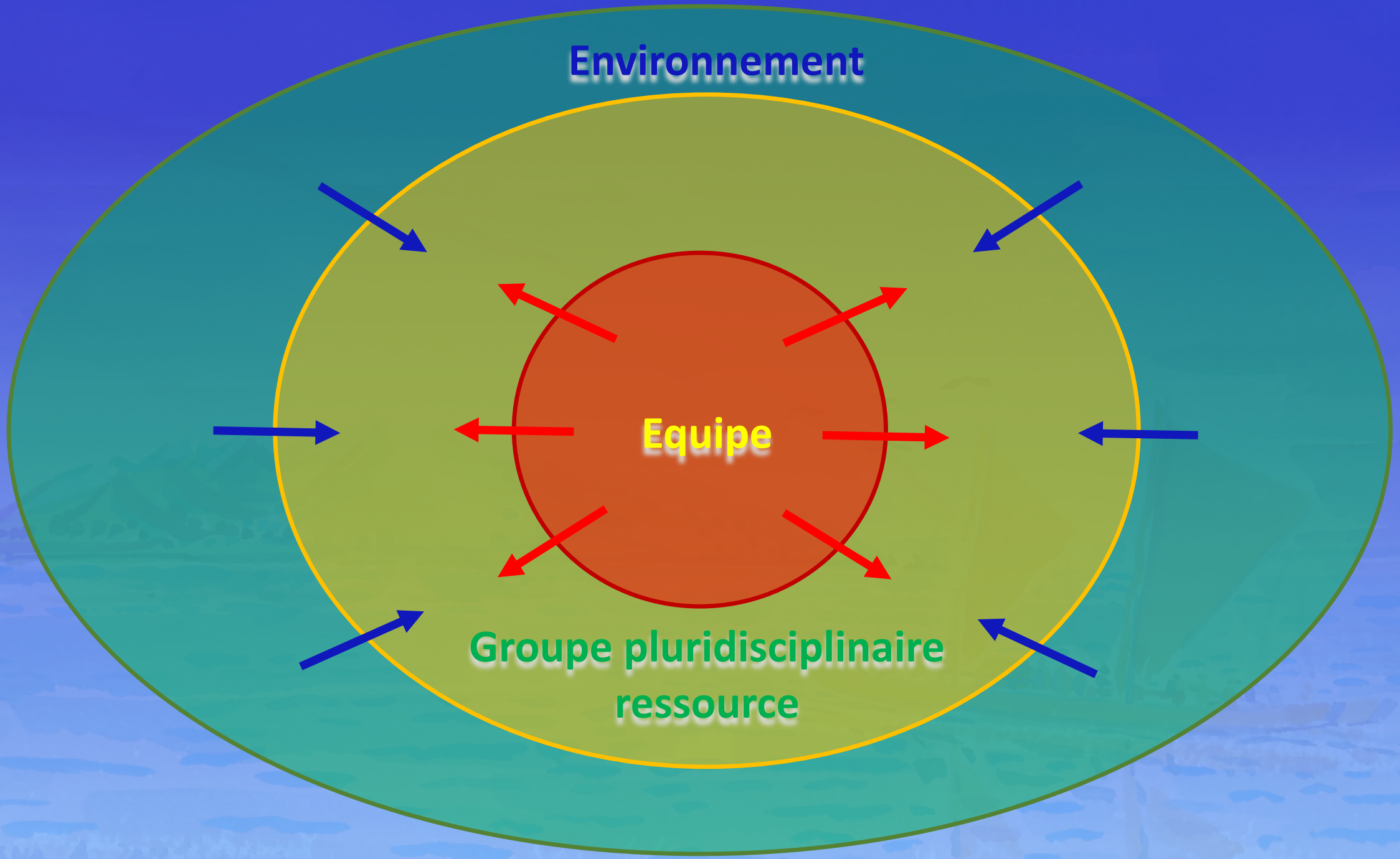
Prendre soin des soignants pour soigner les patients en oncologie thoracique :

Recherche sur les Souffrances Soignés-Soignants autour des Pratiques Intégratives Relationnelles

ReSSSP!R

Projet collaboratif Toulouse - Lyon - Papeete

Conseils au service de la médecine intégrative en oncologie thoracique


Environnement
Equipe
Groupe pluridisciplinaire
ressource

HAURURU

Réseau Polynésien Maladies Respiratoires

MARURU

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