

Abridged report of
a study produced for
Macmillan Cancer Relief

Complementary therapies in cancer care

Dr Michelle Kohn
June 1999

Macmillan 
cancer relief

.....a voice for life.....

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Executive summary

Complementary therapies in cancer care

Macmillan Cancer Relief has commissioned this study in recognition of the value which patients place on complementary therapies, of the need of Macmillan postholders (healthcare professionals) for guidance on how to inform their patients, and of the high profile public and media attention given to complementary approaches in recent years.

The remit of Macmillan is to care for and support patients in a variety of ways from the time of first diagnosis. The stated aims of Macmillan are: to help to improve the quality and availability of care for patients and their families; to address the needs of patients, their families and their carers; to plan and develop new services. Addressing psychosocial needs in cancer patients – as detailed in the Calman-Hine report (1995) – is a great priority for Macmillan. However, the impulse to satisfy these needs must be balanced by evidence in support of complementary therapies and the actions of their practitioners.

This report confirms that a significant minority of people in the UK use complementary therapies, including up to one third of cancer patients. Already, many oncology units and hospices offer at least one to patients. There is evidence from focus groups that complementary therapy provision is enthusiastically received by patients, especially for emotional and psychological support. Moreover, interest in these therapies is expressed by GPs, oncologists, palliative care physicians and Macmillan nurse and medical postholders. Responding to the demand for guidance about these therapies, the orthodox medical bodies are formulating a response. The position statements have been addressed in this report.

The therapies shown by surveys to be the most widely used by cancer patients are the touch

therapies (aromatherapy, reflexology and massage) and psychological interventions (visualisation, meditation and relaxation). Recent studies highlighted in this report suggest that at present cancer patients see these therapies – collectively termed though diverse – mainly as an adjunct to conventional therapy.

Although the evidence base for complementary therapies is still small, that does not imply that they are ineffective. Rather, it reflects the fact that only limited resources have been put into their research in the past and that many clinical trials have been of poor methodological quality. The two therapies for which the ‘best’ scientific evidence exists – as far as cancer care is concerned – are acupuncture for nausea and visualisation/meditation for improved quality of life. For aromatherapy, massage, reflexology and homoeopathy, few formal clinical trials have been conducted. Other therapies, presently considered to be outside the mainstream but discussed in this report, include healing and naturopathy. However, no therapy has in its favour the kind of evidence that would satisfy a proponent of evidence-based medicine. This report describes some government-funded and locally-funded initiatives that aim to improve this situation. It should be pointed out that formal ‘evidence’ is important if complementary therapies are to be considered as ‘treatments’. Research can give some indication of their supportive effects through such means as quality of life assessments, but the more intangible benefits may prove more difficult to assess.

The issues surrounding the provision of these therapies are complex. Regulation and organisation into professional bodies with an agreed corpus of knowledge and skills is still fairly rudimentary, especially for the therapies most used in cancer care. The recent initiatives taken by the British Medical Association, the Department of Health and the Foundation for

Integrated Medicine to focus attention on regulation and training is certainly necessary and should prove fruitful. The quality of therapist training is the most immediate concern, especially for those working within an NHS or clinical setting. It is important to ensure that therapists, whether volunteers or not, are adequately trained and have some biomedical knowledge. In addition, they should be encouraged to work more closely with their orthodox colleagues, both in research and practice.

There is a wide range of methods of delivering complementary therapies in cancer care. These are outlined in this report. Provision in the near future is likely to be determined by prioritisation in a budget-conscious system. Despite the increase in therapies funded by the NHS, the introduction of the government's new NHS reforms in April 1999 has presented two major challenges to complementary medicine. First, there is a new emphasis, principally through the National Institute for Clinical Excellence (NICE), on creating NHS-wide quality standards and achieving value for money. Second, fundholding has been abolished and replaced by Primary Care Groups which, in conjunction with health authorities, will be able to decide how their resources would be best used. This twin emphasis on finance and efficiency may lead to a reduction in purchase of complementary therapy provision based on the current evidence.

Importantly, patients' views on the matter are increasingly being taken into account. However, if patient satisfaction is to count as 'evidence', patients' views must be informed and the right questions must be asked initially. In addition, opinions should be sought among a wide range of patients across the whole spectrum of cancer care.

Patients' interests in complementary therapies are exemplified by the many sources from which they may access information. This report includes spot surveys on media coverage, bookshops, charity information telephone lines, brochures and the numerous complementary therapy umbrella and professional bodies. As the

results show, there is an urgent need for improved information provision. Notably, this study has revealed that one of the most popular, though overlooked, sources of information is the orthodox healthcare provider.

The need to have a framework of quality for complementary therapy information and provision is addressed in a survey conducted of 20 Macmillan-linked centres, which possess cancer information and support facilities. 15 of these centres offer therapies to patients while five offer only information. The extent of complementary therapy provision varies greatly both between centres and in the different regions, with a southern bias particularly in the London, Anglia & South East Region. Variation in provision probably also reflects the enthusiasm of medical staff and trust personnel; top-down support is a key factor in motivating delivery of therapies.

In the surveys of Macmillan nursing and medical practice of complementary therapies, it was clear that postholders are a major resource for patients: for example, 97% of the 145 nurses surveyed and 96% of the 25 doctors surveyed were asked about complementary therapies by their patients and most volunteered information to patients some time. The surveys have shown that 15% of Macmillan nurses and 20% of Macmillan doctors interviewed described themselves as practising complementary therapies. One half of doctors and nurses questioned said that they would like to practise some form of complementary therapy; nurses had a preference for aromatherapy, reflexology and massage. However, most appreciated that practising complementary therapies might not be the most appropriate use of their time and skills. A large majority of both groups would welcome more information and education.

For the future, patients should be provided with good-quality, reliable information about the safety and effectiveness of complementary therapies and the availability of services. The comprehensive training of healthcare professionals, especially nurses and doctors, is integral to the provision of this information.

Preface

The interest of Macmillan Cancer Relief in complementary therapies

Macmillan Cancer Relief has commissioned this study in recognition of the value which patients place on complementary therapies, of the need of Macmillan postholders (healthcare professionals) for guidance on how to inform their patients, and of the high profile public and media attention given to complementary approaches in recent years.

The remit of Macmillan is to care for and support patients in a variety of ways from the time of first diagnosis. The stated aims of Macmillan are: to help to improve the quality and availability of care for patients and their families; to address the needs of patients, their families and their carers; to plan and develop new services. The importance of addressing psychosocial needs in cancer patients – as detailed in the Calman–Hine report (1995) – is a great priority to Macmillan. However, the impulse to satisfy these needs must be balanced by evidence in support of complementary therapies and the actions of their practitioners.

As the Minister of Health has said,

'People want treatment which is dependable, whoever is providing it. They want to be sure that treatment is evidence based, that it works and that it is safe. They also want to be able to have confidence in the professional skills and integrity of the practitioners of any therapy, orthodox or complementary.'

(Dobson 1998)

With the establishment of the National Institute for Clinical Excellence (NICE), evidence-based practice is likely to increase, and pressure will grow for the use of particular treatments to be justified. This is a timely moment for Macmillan to assess the complementary approach by assessing the current use of complementary therapies in cancer care and the current involvement of Macmillan in the provision of these therapies.

Limitations of the report

This report is a condensed version of a larger work which was prepared as an internal education document for Macmillan. It is aimed in particular at medical and nursing practitioners, complementary therapists and policy makers. Like the original, it represents an exploratory study conducted over a short period of time in 1999. It is therefore intended to provide only a 'snapshot' of complementary medicine in cancer care today.

As much of the information was obtained either from existing literature sources or verbally from interviews, accuracy cannot always be guaranteed. Some of the findings are impressionistic; they have resulted from meetings and conversations with both patients and professionals. To protect anonymity and to avoid the possibility of misrepresentation, the names of specific individuals have been omitted.

Part 1 | **The current state of
complementary therapies
in cancer care**

1.1 Knowledge base for complementary therapies in cancer care

1.1.1 Definition of terms

There are several ways of describing complementary therapies.

They can be called 'unconventional therapies', defined by the British Medical Association (BMA) as *'Those forms of treatment that are not widely used by the orthodox health-care professions, and the skills of which are not taught as part of the undergraduate curriculum of orthodox medical and paramedical health-care courses'*. (BMA 1993). Under this definition various therapies are grouped together because they stand outside the parameters of NHS care and training, and not because of commonality of principle or practice.

They can also be described as 'complementary therapies' – which can work alongside and in conjunction with orthodox medical treatment- or 'alternative therapies' – which are given in place of orthodox medical treatment (BMA 1993).

In this study the focus is predominantly on therapies used alongside conventional practice. Therefore, 'complementary therapies' will be the term used throughout. However, where a therapy is used as a substitute for orthodox treatment, it will be described as 'alternative'. In the USA, the Office of Alternative Medicine of the National Institutes of Health has coined the term 'complementary and alternative medicine' (CAM) to encompass both complementary and alternative medical approaches.

The term 'integrated healthcare' is used to describe the provision of orthodox and complementary treatments side by side in a package of care: this is the approach taken by the Foundation for Integrated Medicine (FIM 1997). However, in cancer care it may be thought of as an approach to patient treatment which comprises four key elements:

complementary therapies, counselling, support groups and information provision. The report does not assess the use and effectiveness of the whole integrated approach. Only the complementary therapies themselves are addressed; counselling and support groups are not considered in depth since they are not usually classified as complementary interventions.

1.1.2 Growth in interest

Increased interest by the public

Revealing figures show that a high proportion of the population seeks complementary medicine and that greater numbers are using it (Aldridge 1989, Thomas *et al.* 1991).

The need to accept the fact that these therapies have attracted many patients is particularly pertinent in cancer care. Certain published studies suggest that many cancer patients seek complementary therapists or self-administer complementary remedies, sometimes without the knowledge of their doctor (e.g. Downer *et al.* 1994).

The interest evoked by complementary therapies can be very strong, as illustrated by events surrounding the Bristol Cancer Help Centre. This centre was founded in 1980 to provide an alternative approach to cancer treatment, using a method of combining diet, natural therapies, healing and psychological interventions. In a study (Bagenal *et al.* 1990) subsequently criticised, the approach was questioned and the controversy resulted in a reappraisal of the methods used at the centre. However, the controversy also highlighted the popularity of these therapies among patients. Indeed, the potential benefits of offering help with emotional, mental and spiritual needs, based on

the Bristol approach, were recognised over a decade ago, and a supportive care model was instituted at the Hammersmith Hospital (Bell and Sikora 1996, Burke and Sikora 1993).

'As we proceed through the decade, it is likely that more units will adopt the strategies – to help patients come to terms with cancer and its treatment.'

(Burke and Sikora 1993)

The use of complementary therapies in cancer care is not without its dangers, however. Some medical practitioners are particularly concerned that patients may use alternative remedies, believing them to be magical cures. The fear that patients will abandon orthodox medicine on the basis of exaggerated, unsubstantiated claims, is a concern.

'To encourage the terminally ill to spend the last few precious months of life chasing the false promise of a cure is as cruel as it is intellectually dishonest.'

Cancer surgeon

Shift in attitudes among healthcare professionals

Though the BMA initially described these therapies as a passing fad (BMA 1986), it was apparent by the early 1990s that more and more people were in fact seeking them, and so the BMA responded by reviewing its attitudes, focusing on assessing and guiding safe practice. Treatments were now termed 'complementary' rather than 'alternative' (BMA 1993).

In recent years there has been an increase in the provision by some GPs of complementary therapies, to supplement rather than replace orthodox care (Wharton and Lewith 1986). In one recent survey of GP practices in the Birmingham area, approximately 40% of practices provided access to some form of complementary treatment, and 21% offered a service by a member of the primary healthcare team (Wearn and Greenfield 1998).

In hospital medicine a similar trend is emerging. When hospital consultants were questioned about homoeopathy, one quarter of the sample

had themselves taken homoeopathic remedies; a significant number would consider using homoeopathic remedies as a treatment option for themselves or their family; and one half would like this therapy to be available within NHS care. Most did not know that homoeopathy is available to patients through hospitals (Reilly and Bawden 1999). Also, some nurses and paramedical staff have taken a proactive stance and attended courses in complementary therapies and incorporated them into their practice (Rankin-Box 1997).

In palliative care this change in attitude is seen in the results of the Trent Palliative Care Study, which reported in 1992 that 41.1% of doctors were enthusiastic about complementary medicine, and only 5.5% were hostile (Wilkes 1992).

Increased availability of literature

A visit to any bookshop or a perusal of the popular press will show the amount of information about these therapies that has become available in the past ten years. This undoubtedly reflects public interest in the area of complementary care, and a spot survey of this literature is presented later in this report (please refer to Section 1.2).

As regards information directed at healthcare professionals, the *Journal of the Royal Society of Medicine* has recently published a review article on complementary medicine to assess the state of evidence and to inform decision making (Vincent and Furnham 1999), and there is an increasing specialist scientific literature, with results of controlled trials available for the interested physician and medical scientist. One example of this was the publication in November 1998 of special issues of the *Journal of the American Medical Association* (JAMA), and its sister *Archives* journals, dedicated to clinical trials of complementary medicine. For nurses, an article in *Complementary Therapies in Nursing and Midwifery* (Trevelyan 1998) recently reviewed the practice of therapies, and another article in *Practice Nursing* (Peters and Peacock 1998) focused on integrating the therapies into mainstream medical practice.

1.1.3 Use by the public

Use in general

In 1989 the BMJ reported that 12% of the population had used or were using complementary therapies. The most commonly used were herbals, manipulation, homoeopathy, acupuncture, hypnotherapy and spiritual healing (Aldridge 1989). In the USA a 1997 survey revealed that over 40% of respondents had used a complementary therapy in the preceding 12 months, compared with 34% in 1991 (Eisenberg *et al.* 1998). In Europe, surveys suggest that one third of people have used complementary medicine in the previous year and that the number is growing: for example, the use of homoeopathy – the most popular of complementary therapies in France – rose from 16% of the population in 1982 to 36% in 1992 (Fisher and Ward 1994).

Use by cancer patients

In a study at the Hammersmith Hospital in London in 1993 (Burke and Sikora 1993), two thirds of cancer patients questioned said they would accept some form of complementary therapy if it was offered in the hospital: users tended to be younger, of higher social class and female.

A recent systematic review of the published literature on complementary therapy use by oncology patients to 1998 (Ernst and Cassileth 1998) found that rates in the UK varied from 16% (Downer *et al.* 1994) to 32% (Burke and Sikora 1993). In the USA, rates varied between 7% (Eidinger and Schapira 1994) and 54% (Cassileth *et al.* 1984, 1996). In 1992 a larger survey in the USA suggested that 9% of patients had used these approaches (Lerner and Kennedy 1992). Comparing UK patterns of use to those of the USA reveals an interesting contrast. Metabolic treatments, diets and megavitamins are more likely to be taken in the USA (Cassileth *et al.* 1984).

In 1998 the NHS executive for the South Thames region commissioned a survey of the use of

these therapies by women with breast cancer. Early findings suggest that, of the 1023 women surveyed, one third of women diagnosed with breast cancer had visited complementary therapists since diagnosis, and over one fifth had used such therapies in the previous 12 months. Costs of treatment were quite modest since much was provided free, and treatment itself was more for side-effects of cancer treatment or for symptoms of cancer than in any hope of a cure (Rees *et al.* 1999). Similarly in the USA a recent study of 480 breast cancer patients has revealed that 28% of newly diagnosed breast cancer patients began to use complementary medicine as an adjunct to conventional therapy (Burstein *et al.* 1999).

1.1.4 Provision to the public

Provision in general

The NHS provides treatment techniques, such as aromatherapy and psychological interventions which complement orthodox practice. For historical reasons the NHS also provides homoeopathic treatment.

NHS provision is governed by costs, trust issues, medical support and available resources, such as the number of therapists. Therapies offered within the NHS reflect these constraints. The true use of therapies cannot, of course, be inferred by existing provision within the NHS as this does not take into account therapies which the patient may be privately pursuing. These may include diet regimes or herbal preparations, or the 'complete health systems' such as traditional Chinese medicine, which has its own theory and diagnostic system.

Provision in cancer care

The Trent Palliative Care Study (Wilkes 1992) surveyed 108 hospices on their provision of therapies, including complementary therapies, and found that the most popular and widely available were massage (70%), aromatherapy (68%) and relaxation (66%). In another survey of oncology departments in England and Wales

conducted in 1995, 38 out of 55 (69%) were offering at least one complementary therapy to patients (White 1998).

Downer *et al.* (1994) found that relaxation, visualisation and diets were most commonly used in the UK. Acupuncture and homoeopathy were also used but to a lesser degree. Some therapies, such as healing and nutritional medicine, were very infrequently provided, owing to the difficulty of establishing the competence of practitioners, and of accommodating their belief systems.

Despite reports that patients, given the chance, would recommend public provision of complementary therapies, many professionals dismiss the basis of these views as the 'feel-good factor'. As one cancer surgeon said,

'What's the evidence that being rubbed down with lavender oil is better than a day trip to France, a shampoo and set, or giving patients gift vouchers?'

In the evidence-based culture of the present NHS, the emphasis is on 'proving that it works'. It seems likely that increased provision will follow research evidence when it becomes available. Until then, the central issue for provision of complementary therapies is the question of the optimum use of scarce resources, though pressure from patients may come to be increasingly important.

1.1.5 Classification

Therapies can be classified in a variety of ways, depending on the focus that is required. Three main classifications are given below, but other frameworks also exist. Physical and psychological treatments are more likely to be incorporated into NHS care, as they represent the 'medically acceptable' face of complementary medicine. All these therapies can be regarded as complementary, since none is a true alternative to orthodox care such as chemotherapy, radiotherapy or surgery for cancer.

Classification by mode of action

In this scheme, therapies are grouped by whether they have a direct physical application, have a primarily psychological effect or whether they purport to have a pharmacological basis. A table of these (modified from Bell and Sikora 1996) is given below.

Physical	Psychological	Pharmacological
Massage	Healing	Diets/vitamins
Aromatherapy	Visualisation	Homoeopathy
Reflexology	Yoga	Chinese herbs
Acupuncture	Art therapy	Essiac
Shiatsu	Hypnosis	Iscador
Osteopathy		Shark's cartilage
Chiropractic		

Classification by application

Therapies can also be thought of as a complete system of care, as useful techniques or as approaches to self-help. These are listed in the table (modified from Peters and Peacock 1998) below.

Complete system	Complementary therapy as a technique	Self-care approach
Homoeopathy	Massage	Meditation
Traditional Chinese medicine	Healing	Diet

Classification by provision

Complementary therapies can also be classified by how they are provided to the patient (Howells 1997), and this classification is perhaps most useful when addressing these therapies in cancer care. In this classification, complementary therapies can be offered by hospital-based practitioners; within a multi-disciplinary approach, for example in hospital pain management clinics; as part of supportive or

therapeutic group therapy within healthcare; as external approaches used by the Health Service; or provided by independent organisations not used by the Health Service. Therapies can also be provided as alternatives to orthodox care. Examples of these types of provision in cancer care are given in Section 1.3.

1.1.6 Role in cancer care

The role of complementary therapies in cancer care is presently undefined: though many opinions exist, there is currently a variety of provision models coupled with a lack of evidence of effectiveness or efficacy. To clarify some aspects of what the role might be, it is necessary to consider why patients seek complementary therapies, how these therapies might be used, and what the influence of patient demand might be.

Reasons why cancer patients seek complementary therapies

Knowing the reasons why patients seek therapies is fundamental in evaluating their use – that is, distinguishing where possible the factors ‘pushing’ patients away from orthodox medicine and those factors ‘pulling’ patients towards complementary therapies.

Orthodox medicine – ‘push’ factors

- failure to produce curative treatments
- adverse effects of orthodox medicine, e.g. chemotherapy side-effects
- lack of time with practitioner, loss of bedside skills
- dissatisfaction with the technical approach
- fragmentation of care due to specialisation

Complementary therapies – ‘pull’ factors

- media reports of dramatic improvements produced by complementary therapies
- belief that these therapies are natural

- empowerment of patient through lifestyle and psychological equilibrium
- focus on spiritual and emotional well-being
- provision by therapist of ‘touch, talk and time’

Models of use in cancer care

Three basic models of how complementary therapies might be used in cancer care have been proposed (Weir *et al.* 1995). For each, the distinction must be made between what the therapy purports to offer and what the patient seeks. A desperate patient seeking a cure is more likely to pursue alternative methods than the supportive or empowering techniques described.

In the *humanistic model*, which aims to provide a supportive role, patients seek symptom relief, decreased side-effects of treatment, and improved quality of life. In the *holistic model*, which aims to empower the user, patients want to gain control of their own health and improve quality of life. In the *radical holistic model*, which encourages self-healing, patients who take this approach seek increased survival and, possibly, cure.

Considerable overlap may exist between the models: for example patients may be given a treatment as a support and find it empowering. The possibilities for self-healing (radical holistic approach) are usually advocated outside the NHS setting.

Importance of the patients’ views

In order to provide optimum patient care, patients’ views are increasingly being taken into consideration. The Calman–Hine report recognised the importance of considering patients’ and their families’ views on therapeutic provision in order to address psychosocial needs (Calman and Hine 1995). Patients increasingly have a voice through patient and health professional alliances, such as CancerBACUP, Cancerlink and the National Cancer Alliance. Focus groups and qualitative research studies are

being used to examine in greater detail patients' experiences, motivations and needs.

The National Cancer Alliance (NCA), which works to improve cancer services, treatment and care, has gathered the views of cancer patients (NCA 1996). Its report, *What Patients Say*, included discussion of the use of complementary therapies.

A combined report from the Bristol Oncology Centre, the Department of Sociology, the University of Warwick and the Bristol Cancer Help Centre has recently been produced, titled *Meeting the needs of people with cancer for support and self management* (Bristol-Warwick 1999). This collaborative project addresses the importance of providing accurate, up-to-date information on complementary therapies, routinely at diagnosis and at subsequent points of vulnerability. It emphasises the importance of equity of provision if integration into the NHS is to be achieved.

Focus groups at the Lynda Jackson Macmillan Centre, Middlesex, have examined from the patient's point of view the process of receiving two therapies, relaxation and aromatherapy, and have assessed referrals, barriers, expectations, services and therapies (Lynda Jackson Macmillan Centre 1998). They found that complementary therapies were high on the list of priorities, particularly as a source of emotional and psychological help. They also noted that some patients mentioned improvements in their physical condition after using these therapies.

Although the message conveyed by such focus groups and qualitative research is that patients value these therapies, care must be taken in drawing conclusions because, first, asking patients if they want a pleasurable treatment is likely to get a positive response especially if the treatment is free and, second, prioritisation among complementary therapies has not been fully explored; for example, the benefits of aromatherapy have not been compared with those of reflexology. As one patient said regarding the evaluation of aromatherapy in comparison with relaxation,

'In a way I don't really see how you can compare the two. They have the same effect on you – but one is being done to you and one you are doing yourself.'

It is also the case that patients involved in such qualitative studies may be a self-selected group, and may not be representative of all patients. In a cost-conscious system with rationing and prioritisation, it is necessary to have a rationale and an evidence base, whether quantitative or qualitative, on which to base provision.

1.1.7 Current initiatives

Research initiatives can be government-funded, charity-funded, and locally-funded, which includes university-based institutions.

Government-funded initiatives

In 1998 the Minister for Public Health announced NHS R&D funding for several complementary medicine research projects. These included a study to evaluate complementary therapies used by women with breast cancer (NHS Executive South Thames, Rees *et al.* 1999).

Charity-funded initiatives

One large-scale trial, funded by the Cancer Research Campaign (CRC), is currently in the recruitment phase: a randomised controlled trial to evaluate the use of aromatherapy massage and relaxation therapy for improving quality of life in patients with advanced cancer. This is a multi-centre trial, consisting of three groups: patients receiving aromatherapy (four weekly sessions); patients receiving relaxation therapy; and patients in a delayed treatment group (eight weeks' wait). The aim is to test clinical effectiveness in a real healthcare setting, and 504 patients will be recruited over two years (CRC funded study 1999).

Locally-funded initiatives

An example of a locally-funded venture is a study involving the Cavendish Centre, Sheffield, on the effects of complementary therapies on the quality of life of patients with cancer. This planned study, with a patient-preference design, aims to measure the quality of life in colorectal oncology patients attending the centre (Cavendish Centre 1999).

University-based research units

As well as the specific projects (detailed above) which are funded from different sources and occur at a variety of sites, there are several research units based in universities. All are trying to investigate aspects of complementary medicine, but progress for all is heavily dependent on funding. They are mentioned in this report as potential sites for future research studies on complementary therapies and cancer. They include

a University of Southampton

The research unit in complementary medicine, staffed by experienced complementary therapy researchers, is within University Medicine at Southampton General Hospital. The unit is involved in policy matters, education and teaching. It also conducts research studies in collaboration with clinicians in University Medicine. Its aim is to evaluate clinical effects of therapies and their scientific basis.

b University of Exeter

There are two units at this institution. The Department of Complementary Medicine is based in the School of Postgraduate Medicine and performs systematic reviews of studies on complementary therapies and some clinical trials. The other unit is the Centre for Complementary Health Studies, which concentrates on teaching but also collaborates with researchers and conducts some trials. It prepared the 1997 report on the professional organisation of complementary therapies for the Department of Health (Mills and Peacock 1997).

c University of Westminster

This has a Centre for Community Care and Primary Health, offering numerous courses in complementary medicine, and a Polyclinic providing patients with therapies. The centre is also involved in policy matters relating to complementary medicine.

1.1.8 Responses of orthodox medical bodies

Responding to the public demand for guidance about complementary medicine, the orthodox medical bodies are formulating a response.

Royal College of General Practitioners (RCGP)

A representative stressed that the College does not have a position statement on these therapies as such, though it acknowledges that they are used by an increasing number of GPs. The College emphasised the need for research to validate their use, especially for vulnerable cancer patients.

Royal College of Nursing (RCN)

The RCN has set up its Complementary Therapies in Nursing Forum, established in response to demand from nurses interested in complementary medicine. It now has some 10 000 members. However, as an adviser for cancer care stated,

'Nurses must not be pressurised into practising complementary therapies as part of the package of care – they must do it only if they are interested, and they must undertake appropriate training.'

The Forum provides educational guidelines and advises on setting up facilities. It has formulated a business strategy, and has a position statement/statement of beliefs, organises seminars and meetings and produces a newsletter, *In Touch*, which promotes networking and information about complementary therapies. As regards the

introduction of these therapies, a spokesperson said,

'We need to be evolutionary, not revolutionary.'

Royal College of Physicians (RCP)

Stimulated by the discussion document produced by the Foundation for Integrated Medicine (FIM 1997), the RCP has set up a committee and has circulated a questionnaire to its fellows to ascertain their attitudes to complementary medicine.

The RCP has recently published *Science-Based Complementary Medicine* (Meade 1998), which provides reviews on how to obtain evidence, discussions of any evidence already available, and ways in which evidence is being sought. As the lead spokesperson said,

'Disbelief amongst conventional practitioners has at least been replaced by a healthy scepticism and a clear wish to examine the evidence sensibly and logically.'

One member of the committee, focusing on the education and training of medical students, said,

'Doctors need training to have the knowledge and confidence to discuss complementary therapies with their patients.'

Royal College of Surgeons (RCS)

A spokesperson agreed that anything that would reduce stress would be advantageous, but that the RCS would be very much opposed to certain alternative therapies, such as fad diets, which can harm patients. For complementary therapies, the importance of evidence of effectiveness from clinical trials was emphasised,

'At the present time, we are so stretched that without evidence we could not justify spending money on unproven treatments.'

British Medical Association (BMA)

In recent years the BMA has accepted that patients seem to want complementary therapies, and recognised that it must therefore contribute

to ensuring safe practice by evaluating issues of regulation, competence and safety (BMA 1993). The BMA has since also addressed education and training by surveying UK universities, medical schools and institutions of nurse education (Morgan *et al.* 1998). It appreciates that quality control is necessary for standards and course content. The results of the survey showed that over 100 courses or modules in complementary medicine were being provided. Education was more common in nurse education than in that of doctors.

One spokesperson stressed that competence is an issue that needs to be addressed, since most of the therapies remain unregulated:

'With all the new degree courses, there will be an increase in clinical practice – but do the therapists have the clinical skills?'

Other medical societies

Other societies, such as the Royal Society of Medicine, do not have an official view on complementary medicine, but will provide a forum for debate.

1.1.9 Issues surrounding use and provision

Rationing and prioritisation of services

In the absence of formal proof of efficacy, many members of the medical profession are conscious that complementary therapies have a low priority in the list of healthcare interventions that should be provided in cancer care.

'We can't pump money into massaging patients when we haven't got the money to cut their tumours out.'

Cancer surgeon

'How much of our resources are we prepared to put into complementary medicine compared to cancer treatment, such as chemotherapy?'

Consultant oncologist

Some specialists would, however, be prepared to give higher priority to complementary therapies.

'Maybe oncologists would reconsider giving last-ditch chemotherapy to desperately sick patients if they had something else to offer. It may save money from the drug budget.'

Palliative care physician

Many physicians take a more supportive view of complementary therapies when rationing is not considered.

'The complementary therapy scheme is an essential part of the comprehensive care that should be available to all cancer patients.'

Consultant radiotherapist

If formal integration were to be achieved, complementary therapies would need designation of funds – how much, and to which patients or centres, are open questions. Though formal integration would give treatments status, it is unlikely to be achieved before the problems of clinical effectiveness are resolved. However, many believe that prioritisation is a matter that also should involve patients and take account of their wishes. It is certainly true that decisions about prioritisation should be taken in the open, where questions about the role of these therapies, and how much is to be spent on them for cancer care, can be heard by all.

With a government committed to the redress of inequality, a problem may arise for complementary therapies. It appears that the proponents and users of these therapies come disproportionately from the middle classes. If, indeed, uptake by the poor is negligible, it may be that provision of these therapies by the NHS is of low priority.

'Educated middle-class women mainly use complementary therapies. Such people can often afford private care. Often they are the worried well.'

Consultant oncologist

An important issue in provision for cancer care is when these therapies should be provided. Current provision tends to occur both in the

treatment phase, i.e. during chemotherapy or radiotherapy, and in palliative care. There is a need to reach consensus with oncologists, palliative care physicians, surgeons, GPs and nursing practitioners about which therapies should be provided at each stage of disease – and this, of course, depends on the existing evidence base as well as the views of the patients.

Research difficulties

It is generally agreed that research is needed to evaluate the worth of this approach. However, this is expensive and time-consuming, and requires resources and skills. For research into the role of complementary therapies in cancer to be carried out, there has to be a merging of skills. Trained researchers from orthodox medicine have to be encouraged into the field to conduct trials and assist with statistical analysis, while complementary therapists must be willing to collaborate and advise on possible changes to the design of trials. In reality, such research needs the active support of research bodies that have the manpower and skills to guide and advise.

There are also methodological problems involved in subjecting these treatments to clinical trials. These are more fully discussed in Vincent and Furnham (1999); they concern mainly the constraints put on the provision of the therapy to conform to the design of the trials, and the nature of the control group.

Section 1.4 of this report details what is known about research into these therapies for cancer. Overall, the results are inconclusive for all therapies, but this is more a reflection of the quality of studies done than of the therapies themselves. Most are uncontrolled, have small sample sizes, are poorly reported or have some other flaw. Clearly, there is a need for good-quality studies exercising imagination and commitment, but these require a higher level of funding and expertise than seems to be available.

Education and training

The NHS is familiar with recognised professions – physicians, technicians and nurses – and there is a move towards greater numbers of members of these professions undertaking training in complementary therapies (for instance, medical acupuncturists and nurse members of aromatherapy organisations). In these cases, training is overlaid on good clinical practice. However, many complementary therapists who work outside public or charitable organisations have no biomedical training beyond their therapies (though some therapies offer physiology as part of their training courses). There are some notable exceptions, such as osteopaths and chiropractors, who are now regulated by statute. Thus there is a need for formal educational and training standards, to protect the public. The European Commission's report, *Unconventional Medicine*, has recommended defined minimum European Standards of medical knowledge to be established for therapists (European Commission 1998). In general, the moves towards self-regulation of therapies include aspects of education and training.

The advent of Healthwork UK (the Health Care National Training Organisation), a charity licensed by the government to provide training for the whole healthcare sector, may become important in assuring standards of education and training in complementary medicine.

Regulation of therapies and therapists

In 1997 the Department of Health commissioned the Centre for Complementary Health Studies at the University of Exeter to survey all complementary therapy organisations to determine the state of self-regulation among these bodies (Mills and Peacock 1997). This survey found that while the degree of self-regulation of organisations varied greatly, there was a clear motivation to self-regulate. A follow-up survey is under way to gauge and facilitate development of professional standards.

In general, therapists recognise the need for self-regulation both to enhance their professional

credibility and to protect the public. The most organised of complementary therapists – osteopaths and chiropractors – have successfully obtained statutory regulation which lays down duties incumbent on the profession to regulate and develop practice while protecting the title 'osteopath' or 'chiropractor'.

The therapies used mostly by cancer patients, aromatherapy, reflexology and massage, are not statutorily regulated and are fragmented. Other therapies are divided within themselves – homoeopathy and acupuncture both have medically trained members and others without training – and this reduces their ability to self-regulate.

Regulation brings certain benefits to patients. They can be more assured of the competence and integrity of a therapist, and confidentiality is less of an issue. As one patient said,

'My aromatherapist thinks it will inspire confidence if she tells me of her famous patients who come for treatment.'

At the Foundation for Integrated Medicine (FIM) conference, 'Professional Competence, Public Confidence' in May 1999, the Minister for Public Health said that although statutory regulation is the hallmark of a mature system it is not really suitable for many complementary therapies at the moment. However, she stressed the importance of self-regulation and of having robust registration systems for every therapy. This is especially important in the context of the healthcare reforms and the advent of Primary Care Groups, which will begin to closely monitor complementary therapies in their areas.

Language and communication

On the fringe of complementary medicine, there is a tendency to use language and concepts alien to the mainstream model. Such concepts include 'rebalancing energy levels', and 'the need for the patient to want to get well'. While these concepts may or may not have a basis in fact, complementary therapists – especially in cancer care – should be encouraged to improve explanations, both to avoid accusations of

blaming patients for their illness and to be more easily accepted amongst orthodox colleagues. Certainly, the more bizarre alternative diagnoses (e.g. psychic diagnoses) should be avoided.

Integration of complementary therapies into orthodox care

There is a demand from complementary therapists for integration into mainstream medicine. However, many treatments are already 'integrated' in the sense that some NHS professionals have also received training in complementary therapies. Also, surveys of GPs have shown that 21% offer a service by a member of the existing primary care team (Wearn and Greenfield 1998). Thus integration, when it occurs, tends to happen in an existing primary care set-up or a specialist centre. The position of an independent therapist may appear insecure in the longer term.

Therefore, for successful integration (and delivery to the patient), complementary therapists should acquire biomedical training at least at a basic level. They also need other qualities, such as a willingness to compromise and to learn from experience. On the organisational side, accommodation within a centre or unit must be made available and explicit contracts or service agreements offered. At the moment provision is based on top-down support from physicians or a supportive trust, and guidelines for hiring therapists are locally implemented. In an ideal world, provision would not be 'personality driven' as at present, and secure financial agreements would be offered.

The practical issues involved in integrating complementary therapies into the NHS have been addressed in several recent reports. Overall,

the reports reveal key issues and suggest guidelines, but they do not provide policies, and so local initiatives have to be taken. These reports have included

- *Complementary Medicine in the NHS – Managing the issues* (NHS Confederation 1997). A survey of use of complementary therapies by NHS services in Leicestershire
- *Professional Organisation Of Complementary And Alternative Medicine In The United Kingdom 1997* (Mills and Peacock 1997). A survey of complementary medicine organisations commissioned by the Department of Health
- *National Survey of Access to Complementary Health Care via General Practice* (MCRU 1995). A survey conducted with the University of Sheffield
- *Complementary Medicine – New Approaches to Good Practice* (BMA 1993). A report recommending more research and the development of postgraduate education to inform doctors about these techniques
- *Integrated Healthcare – A Way Forward for the Next Five Years?* (FIM 1997). A discussion document summarising conclusions of four working parties on the current position and what might be done to help the different interest groups to work more closely together. The four working parties address the issues of 'Research and Development', 'Education and Training' of health professionals and therapists, 'Regulation' of practice, and 'Delivery Mechanisms' through which therapies could be provided to the user. At the recent FIM conference in May 1999, emphasis was placed on regulation, to gain public confidence.

1.2 Accessing information about complementary therapies

Introduction

This section investigates how the public, including cancer patients, accesses information about complementary therapies. Information is available in various forms: through word of mouth, through literature and via healthcare professionals. In each case the central questions are

- a How easy is it to obtain information?
- b How valid and accurate is the information obtained?
- c How useful is the information likely to be to cancer patients?

Much of the material available to patients is of dubious quality. To serve the best interests of the public and healthcare professionals, and to enable them to make informed choices on treatment options, guidance is urgently needed. This is especially important for the vulnerable cancer patient. There has been a shift towards information provision through support centres within the NHS, using the services of healthcare professionals with some knowledge of these therapies.

In its recent publication, *Information for Health: an Information Strategy for the Modern NHS 1998–2005* (NHS Executive 1998), the NHS Executive set out several goals. Among these aims were (a) to provide access for NHS patients to accredited, independent, multimedia background information and advice about their condition and (b) to provide every NHS professional with on-line access to the latest local guidance and national evidence on treatment, and the information they need to evaluate the effectiveness of their work.

Currently, these objectives are not being met. There is an urgent need for charities and the NHS to provide this service. To this end

Macmillan is involved in the development of a national information resource.

Sources of information

The sources consulted for this section are not intended to be fully comprehensive. Instead they are presented to give a flavour of the main ways in which the public and healthcare professional receives information about complementary therapies. These sources include

- word of mouth
- media: newspapers, magazines, radio and television
- literature: books and journals
- databases
- websites
- umbrella organisations
- professional bodies
- charities, via telephone lines
- charities, by brochures
- independent charity resources
- complementary therapy centres
- healthcare professionals

1.2.1 Popular media

Several national newspapers now have regular 'alternative medicine' columns, showing how popular these articles are becoming. The quality of the material varies greatly. As part of the preparation of this report, a 'spot survey' of all the Sunday newspapers was undertaken on Sunday 30 May 1999 to assess their content of information on complementary therapies in general. Ten titles were reviewed in all, and two of these had a complementary therapy feature,

including the *Sunday Times* which carries a regular column, 'What's the Alternative?' The author of this column stated,

'There is an explosion of interest in complementary health. There has never been a wider choice of spas, retreats and healing centres.'

Media influence on the public is illustrated by a feature in the *Mail on Sunday* on 13 June 1999, which followed the story of a breast cancer patient who had abandoned orthodox treatment one year before, to seek alternative treatments in Mexico.

'Today she offers a glowing picture of hope for other sufferers and is on a mission ... determined to spread the word about alternative cancer treatments.'

The article alerted readers to a new information service which the patient had established to promote her views.

1.2.2 Literature: books and journals

The major bookshops now have a large selection of books on complementary and alternative medicine. Few of these are specifically aimed at the cancer patient. As part of the preparation of this report, a 'spot survey' of three major bookshops in Cambridge was undertaken: only one book dealing specifically with cancer was found, though some of the 100+ general complementary medicine titles listed had a chapter devoted to cancer.

The best of these include

- *Choices in Healing*. Michael Lerner (1998), MIT Press. US publication, available in the UK
- *Complementary/Alternative Medicine: An Evidence-Based Approach*. John W. Spencer and Joseph J. Jacobs (1999), Mosby Publishing. US publication, available in the UK. This publication contains a chapter on cancer and complementary therapies

- *Life after Cancer*. Ann Kent (1996), Cassell Publishing
- *What you really need to know about Cancer*. Robert Buckman (1997), Macmillan Press
- *Cancer Information At Your Fingertips*. Val Speechley and Maxine Rosenfield (1996), Class Publishing

Other useful titles include

- *A Guide to Unconventional Cancer Therapies*. Ross Gray (1997). Ontario Breast Cancer Information Exchange Project, available by subscription from Canada
- *Canadian Breast Cancer Research Initiative* (CBCRI – December 1996). An Information Package (including Essiac, Iscador), available by subscription from Canada

In addition to books, there are some journals devoted to complementary medicine. While some are aimed at the popular market, others are more scientifically orientated. Those in the latter category include

- *Complementary Therapies in Medicine*. Editor, Andrew Vickers
- *Alternative Therapies in Health and Medicine*. Executive Editor, Larry Dossey
- *The Journal of Alternative and Complementary Medicine: Research on Paradigm, Practice and Policy*. Editor-in-Chief, Kim Jobst
- *Journal of Integrated Medicine*. Editor, Andrew Weil
- *Focus on Alternative and Complementary Therapies (FACT)*. Editor, Edzard Ernst (University of Exeter)

1.2.3 Databases

There are a number of databases that provide information on complementary therapies as part of a more general, comprehensive service.

These databases comprise

- MEDLINE
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- Bath Information and Data Services (BIDS), specifically BIDS-EMBASE.
- PSYCLIT

Other databases specialise in information on complementary therapies and surrounding issues

- CISCOM (compiled by the Research Council for Complementary Medicine, London)
- EXTRACT (Centre for Complementary Health Studies, University of Exeter)

To conduct systematic reviews on complementary medicine, CISCOM provides comprehensive coverage, including information gathered from more general sources (MEDLINE, CINAHL etc.) in addition to the more specific material from complementary medicine journals. However, it is always wise to search more than one database.

1.2.4 Websites

The Internet has a large number of sites purporting to provide information on complementary therapies. These include

- <http://www.gn.apc.org/rccm> (Research Council for Complementary Medicine, UK)
- <http://altmed.od.nih.gov/nccam> (Office of Alternative Medicine, National Institutes of Health, USA)

1.2.5 Umbrella organisations

There are several organisations that encompass different divisions of complementary medicine, some acting as regulatory bodies and others as sources of information on the wide range of treatments available. Several of these umbrella organisations are mentioned in the brochures of cancer charities as sources of further

information. The following were contacted in the preparation of this report to assess the service provided and the ease of access to information.

Research Council for Complementary Medicine (RCCM)

Founded in 1983, the RCCM is an independent research charity and functions as an information resource on complementary therapies. It also undertakes, evaluates and promotes research in complementary medicine to 'encourage safe, effective practice and improved patient care'.

It has the CISCOM database with over 40 000 references, used by practitioners and health organisations, who may request searches on specific topics. A spokesperson pointed out that 'one in four reviews are missed by the other databases'. A subset of CISCOM is the register of randomised trials for the Cochrane Collaboration in complementary medicine. It is important to note that since good data from randomised clinical trials is still lacking for much of complementary medicine, the database is a source of selected materials of varying levels of evidence.

The RCCM is equipped to do literature searches (for a fee) and has MEDLINE access, but would not be the resource of choice for anyone wanting to make general enquiries about therapies or practitioners. It is not mentioned by any of the charity brochures reviewed in this report.

The RCCM does man telephone lines but deals mainly with research-based topics and addresses precise questions.

Institute for Complementary Medicine (ICM)

The ICM believes that the public has 'the right of access to complementary medicine', and runs the British Register of Complementary Practitioners to make it easier for the public to identify professional practitioners. The register contains the names of practitioners 'who have achieved a high level of competence, are able to practise their particular branch of complementary medicine in safety, are covered

for public liability and professional indemnity, and abide by a strict code of ethics'. The ICM set up the British Council of Complementary Medicine (BCCM), which is a Registered Educational Charity and an Incorporated Company.

The ICM is mentioned by most charity brochures (and by all five examined for this report, i.e. *The Cancer Guide* (Macmillan Cancer Relief), *Help is There* (Macmillan Cancer Relief), *Cancer Care and Information Handbook* (Cancer Support Centre, Wandsworth), *Cancer and Complementary Therapies* (CancerBACUP), *Complementary Care and Cancer* (Cancerlink).

The organisation can be contacted by telephone, fax or e-mail or through its website. Telephone lines are manned on weekday mornings. The information requested during the preparation of this report was provided quite promptly.

The Council for Complementary and Alternative Medicine (CCAM)

This was formed in 1984 to provide a forum for 'communication and co-operation between professional bodies representing acupuncture, herbal medicine, homoeopathy, naturopathy and osteopathy'. It endeavours to 'establish standards of education, training, qualification, ethics and discipline for practitioners of complementary and alternative medicine, for the protection and benefit of the public'. CCAM also seeks statutory registration for all or any of the member bodies who want such registration; and also, when appropriate, to preserve freedom of choice for members of the public to select their means of healthcare. The members of the council are the British Acupuncture Council, the College of Osteopaths, the Society of Homoeopaths and the National Institute of Medical Herbalists. The Council is mentioned only in the CancerBACUP brochure (of the five reviewed).

The CCAM does not man telephone lines, but does record messages. A fee is required from those writing for information. The information requested during the preparation of this report was provided after three weeks.

British Complementary Medicine Association (BCMA)

The Association registered practitioners until two years ago, and produced a code of conduct. The BCMA National Practitioner Register is a list of practitioners who belong to member organisations of the BCMA. The BCMA is mentioned only in the CancerBACUP brochure (of the five reviewed).

The BCMA answers telephone calls. Enquiries made were referred to CCAM and the Guild of Complementary Practitioners.

British Holistic Medical Association (BHMA)

This has its own members but is not a practitioner-regulating body. The BHMA is mentioned only in the CancerBACUP brochure (of the five reviewed).

During the preparation of this report, four attempts to contact this organisation by telephone were unsuccessful.

Guild of Complementary Practitioners (GCP)

This is the largest national multi-disciplinary body, with some 4500 members. It has its own regulations for full membership, including a minimum qualification in anatomy and physiology, recognised qualification in the core subject, and full insurance cover. The GCP is not mentioned by any of the charity brochures reviewed in this report, though it is the largest multi-disciplinary body.

The Guild answers telephone calls and responded to enquiries.

Foundation for Integrated Medicine (FIM)

This is a small, influential body which acts as a 'steering group' to facilitate integrated healthcare (*Please refer to Section 1.1.9*).

It was not mentioned by name in any of the charity brochures reviewed in this report.

FIM answers telephone calls but does not carry specific information on cancer-related issues.

1.2.6 Professional bodies

There is a confusing array of these professional bodies, representing two dozen or so of the best known modalities in complementary and alternative medicine. To date, only two such disciplines are state regulated; osteopathy and chiropractic. Self-regulation (to varying degrees of independent review and co-ordination) is the situation with some of the other disciplines. Whilst certain other complementary therapy organisations, most notably for acupuncture, struggle for statutory registration (a process which took thirty-five years in the case of osteopathy), there is clearly a need for a comprehensive review of the present situation with regard to the public interest.

A thorough survey of UK professional associations in complementary medicine has been undertaken by the Centre for Complementary Health Studies at the University

of Exeter. This work was first published in 1997 and is currently being updated (Mills and Peacock 1997).

The professional bodies are quite often signposted by cancer charities as sources of further information for patients interested in complementary therapies. Macmillan Cancer Relief's *The Cancer Guide* cites the National Federation of Spiritual Healers, the British Acupuncture Council and the British Homoeopathic Association. CancerBACUP and Cancerlink between them mention another twenty or so of these organisations in their brochures.

It was considered of interest to telephone several of these professional bodies to ascertain the response to enquiries about cancer care. The responses of the three main organisations representing homoeopaths are detailed below as an example of the kind of information available to patients.

Spot telephone survey of information provided to enquiries about cancer care by the three main organisations representing homoeopaths

Society of Homoeopaths	It was emphasised that homoeopaths would not focus on treating cancer <i>per se</i> , the whole emphasis being on holistic treatment. People manning the telephone lines would not give advice over the telephone as they are not medically qualified, but would refer the patient to a homoeopath in the area.
British Homoeopathic Association	Patients would be recommended to see a medically trained homoeopath for cancer-related treatment. The operator would be happy to send out information relevant to cancer and homoeopathy, but could not give advice over the telephone.
Faculty of Homoeopathy	A number of calls are apparently received concerning homoeopathic care in cancer. Again, information or advice is not given out over the telephone, as telephone-line staff are not qualified so to do. The Head of Corporate Development, made it clear that cancer patients would be told that homoeopathy could help in a 'complementary' way rather than by replacing conventional medicine. The caller would be provided with a list of medical homoeopaths in their area. In contrast to the Society of Homoeopaths, a few doctors (based at the major homoeopathic hospitals) were named.

1.2.7 Cancer charities: telephone survey

A telephone 'spot survey' was conducted to discover the type and quality of information that the larger cancer charities provide to members of the public who telephone for advice on

complementary therapies. It must be stressed that this survey was not intended to be a comprehensive evaluation of the service provided, but rather a simulation of what might be experienced by a concerned member of the public who requested information. The results are shown in the table below.

Charity contacted	Result of call	Literature mentioned/sent
Macmillan Cancer Relief	<ul style="list-style-type: none"> ● Transferred to information team ● Cautious about claims for therapies 	<i>The Cancer Guide</i> <i>Help is There</i>
Tenovus	<ul style="list-style-type: none"> ● Operator knowledgeable ● Information is given to cancer patients, especially about reflexology and relaxation with emphasis on support rather than cure 	none
Ulster Cancer Foundation	<ul style="list-style-type: none"> ● Operator explained that it was not policy to advise on or recommend complementary therapies ● Patients referred to CancerBACUP 	none
Action Cancer N. Ireland (ACNI)	<ul style="list-style-type: none"> ● Transferred to information officer ● Recommended use of reflexology, aromatherapy and visualisation 	ACNI brochure
Marie Curie Cancer Care	<ul style="list-style-type: none"> ● Transferred to information officer who recommended contact with a professional at Marie Curie 	Brochures for 11 hospices which offer therapies
Cancer Research Campaign	<ul style="list-style-type: none"> ● Referred to information unit ● No recommendation about specific therapies ● Suggested contacting Royal London Homoeopathic Hospital, Bristol Cancer Help Centre, Richmond House 	none
Imperial Cancer Research Fund	<ul style="list-style-type: none"> ● Referred to communications department ● No recommendations about therapies ● Suggested speaking to Hammersmith Cancer Centre 	none
Cancerlink	<ul style="list-style-type: none"> ● Call returned by press office ● Distinguished between complementary and alternative medicine 	<i>Complementary Care and Cancer</i>
CancerBACUP (London)	<ul style="list-style-type: none"> ● Operator explained that complementary therapies were not an area of CancerBACUP's expertise ● No advice about specific therapies 	none
CancerBACUP (Glasgow)	<ul style="list-style-type: none"> ● Referred to knowledgeable informant ● Described CancerBACUP's involvement with use of therapies for cancer patients 	<i>Cancer and Complementary Therapies</i>
Breakthrough	<ul style="list-style-type: none"> ● Transferred to press office ● Interested in therapies but no specific information 	no brochures but a section of <i>Breakthrough</i> magazine sent
Breast Cancer Care	<ul style="list-style-type: none"> ● Informed that requests for information had to be in writing 	none

Of the 11 charities contacted, only three (Imperial Cancer Research Fund, the Ulster Cancer Foundation and Breast Cancer Care) offered no information. Six charities (Tenovus, Action Cancer Northern Ireland, Marie Curie Cancer Care, Cancerlink, CancerBACUP, Breakthrough) gave helpful advice.

The case of CancerBACUP, from which two very different responses were given by two different centres, illustrates that the provision of information might be dependent on the views of the person manning the information line. However, it is important to note that no charity questioned had a formal policy toward the use of complementary therapies by cancer patients. The therapies most often mentioned by the charities questioned were relaxation, visualisation, aromatherapy, massage and reflexology. Counselling is also considered by most as a type of complementary therapy, though it is not considered to be one by most complementary therapists.

Conclusions

- Eleven cancer charities could be contacted.
- Three were rather negative towards providing information about complementary therapies.
- Six charities had a positive open attitude to complementary therapies.
- Six charities had some information to send out.
- No charity could provide a caller with proper evidence of efficacy.
- No charity had a formal policy towards enquiries about complementary therapies.

1.2.8 Cancer charities: brochures

As illustrated by the telephone 'spot survey' above, some cancer charities have prepared brochures which they can send out to interested parties. Five of these are reviewed in this section.

a CancerBACUP:

Cancer and Complementary Therapies

The brochure begins by comparing and contrasting conventional, complementary and alternative therapies. It then discusses the psychological state of the patient in relation to cancer, and lists many self-help methods used in cancer treatment. Relaxation and meditation exercises are described. There follows synopses of numerous complementary (and alternative) therapies under the subheadings of 'Psychological methods', 'Physical treatments', 'Unconventional medication' and 'Diet therapies'. Wherever possible, results of trials and research are mentioned (whether positive or negative) and the general medical opinion of the method's efficacy is given.

The brochure ends with details of relevant organisations: umbrella organisations such as the British Complementary Medical Association (BCMA), the British Holistic Medical Association (BHMA), the Council for Complementary and Alternative Medicine (CCAM), the Institute for Complementary Medicine (ICM) and a host of other organisations from the Bristol Cancer Help Centre to the National Federation of Spiritual Healers. Charities (including Macmillan) are mentioned at the end.

Overall, this brochure gives an objective and informative overview of the field of complementary medicine and its application to cancer.

b Cancerlink:

Complementary Care and Cancer

This does not attempt to explain all the various therapies, but rather to answer the questions asked by many, such as: Does complementary care work? What will my doctor say? How do I choose between different types of complementary care? The brochure goes some way towards answering these questions, addressing difficult issues such as whether to choose complementary care over conventional medicine. After mentioning the costs involved, there is a 'Do's and don'ts' guide to choosing a complementary therapist, a useful checklist with

some sound advice. No other charities are mentioned in the final section.

The umbrella organisations mentioned are the ICM and BHMA, and finally there is a glossary of complementary medical practices interspersed with the names and details of affiliated societies and associations. The Bristol Cancer Help Centre is mentioned in a few paragraphs.

The information in the Cancerlink brochure is less detailed than that in CancerBACUP's brochure, possibly because a conscious effort has been made not to overlap information. However, some difficult questions of relevance to many cancer patients have been addressed. The importance of being well informed and trusting one's instincts are the important messages.

**c Macmillan Cancer Relief:
*The Cancer Guide***

Two pages, out of a 34-page broad guide to many aspects of living with cancer, are given over to complementary therapies. They are discussed in a fairly positive way, explaining that the paucity of scientific evidence is the reason why some doctors might not endorse their use. Various therapies are listed but not explained and there is a brief 'Do's and Don'ts' checklist with a selection of the points that are mentioned in *Complementary Care and Cancer*. The organisations mentioned are the ICM, the National Federation of Spiritual Healers, the British Acupuncture Council, the British Homoeopathic Association, the Bristol Cancer Help Centre. (FIM is to be included in the updated guide – June 1999.)

Concise and to the point but without reproducing all the information available in other guides, *The Cancer Guide* summarises the current position.

**d Macmillan Cancer Relief:
*Help is There – National Contacts for People with Cancer***

This leaflet is an at-a-glance guide to national organisations for information and advice. The

Bristol Cancer Help Centre is listed, with a brief outline of its services.

**e The Cancer Support Centre (Wandsworth):
Cancer Care (publication funded by Macmillan Cancer Relief)**

In its section 'Coping with Cancer', this booklet devotes six pages to information about complementary therapies under the sub-headings of 'Holistic approaches', 'Physical therapies', 'Psychological approaches', 'Nutritional therapies' and 'Useful organisations'. The therapies are briefly described, and further reading is suggested, including Cancerlink's *Complementary Care and Cancer*. The organisations mentioned are the Bristol Cancer Help Centre and the ICM.

Brochure summary

Each of these publications has some useful information to impart about the use of complementary therapies by cancer patients. All stress the need for the patient to feel comfortable with a therapy, and to ensure that their practitioner is adequately qualified. It is emphasised that not all therapies are suitable for all patients, and that medical advice should always be sought before embarking on a course of therapy. There is not too much repetition of material (except in explaining therapies) and the less in-depth pieces (such as the chapters in *The Cancer Guide* and *Cancer Care*) refer the reader to other resources of information.

In general, all brochures present an unbiased view of complementary therapies, and there is a good overview of the different therapies available in *Cancer Care* and *Cancer and Complementary Therapies*. Evidence of scientific trials to date (or lack of evidence) is mentioned by CancerBACUP and Macmillan Cancer Relief's *The Cancer Guide*, and all publications mention the ICM and the Bristol Cancer Help Centre

1.2.9 Independent charity resources

During the preparation of this report, the existence was noticed of several independent centres from which information on complementary therapies is also available to the public. Increasingly, patients are informed of these facilities by their orthodox NHS carers. These resources include

a The Cancer Resource Centre, Wandsworth

Formerly known as the Cancer Support Centre, Wandsworth, this was established in 1983 to give support and information, and to provide a range of complementary therapies to help patients take some control over their treatment. Emphasis is placed on patient education and supporting the primary medical treatment which most attenders undergo. Much of the centre's funding comes from official grants, donations and local fundraising events. The centre offers a wide range of therapies, counselling and support groups, which are taken by both professional staff and supervised, qualified volunteers.

A study entitled *Massage for People with Cancer* has been completed on behalf of the Cancer Resource Centre, in an attempt to answer some of the questions that arise about safety for cancer patients and to offer guidelines for safe practice.

b The Haven

The first of the Haven centres is due to open early in 2000 in Fulham, West London. The objective of these centres is to 'fill the need for a physical place where breast cancer sufferers and their families have access to information and advice about all the options available to them'. Medical opinion was sought at the outset, primarily from the Hammersmith Hospital and the Breast Cancer Unit at Charing Cross Hospital. The Haven centres plan to work with other cancer charities to share resources. The London Haven will, it is hoped, be the blueprint for a number of regional day centres across the country, providing care and information at easily accessible locations.

c Cancer Black Care

In response to different cultural and ethnic needs of patients, this organisation is targeted specifically at ethnic minorities. It has existed for three years, and has recently obtained funding for an information officer, and to develop a resource room and a counselling service.

Other ways in which the public can access information and advice about complementary therapies, such as through information support centres and healthcare professionals, have been addressed in Part 2 of this report.

1.3 Models of provision

Several models exist which show how complementary therapies can be provided in cancer care. In this section they are presented as five discrete models (modified from Howells 1997), but in reality there is a considerable scope for overlap between 'methods' and the final one chosen at a particular site will reflect the range and purpose of therapies and therapists available. The examples selected all have some degree of Macmillan involvement.

1.3.1 Model 1: hospital-based individuals

This model covers people such as doctors, nurses, physiotherapists or radiographers, who themselves practise complementary therapies within a hospital setting.

Example of this model in practice:
Falkirk Royal Infirmary

A Macmillan nurse specialist incorporates aromatherapy and massage into her practice at Falkirk Royal Infirmary. She is one of many nurses interested enough in complementary therapies to have undertaken further training. Since the incorporation of complementary therapies into practice can be problematic, she is one of the few to have had the opportunity to use these as part of her routine duties. The reaction of other colleagues to her involvement with complementary therapies ranges from indifference to scepticism, and she has had to earn their confidence.

She provides therapy on an *ad hoc* basis, and offers only aromatherapy and massage, having taken a 12-month diploma in aromatherapy. Thus there is no 'menu' of therapies for a patient to choose from, and the approach is unstructured. There is no cost to the patient, as

the service is offered as part of her role as a nurse, though her ability to practise complementary therapies within this role remains at the discretion of her employers: they have emphasised that her employment is as a clinical nurse specialist, not a complementary therapist. She has to retain medical support and cannot afford to be seen as a 'loose cannon'. Neither clinical audit nor research into effectiveness are undertaken, and anecdotal evidence is used to claim benefits. As she says,

'Body massage is better than just listening to me, or having to think of what to say next.'

1.3.2 Model 2: provision within a multi-disciplinary setting

This model describes the provision of complementary therapies within a multi-disciplinary setting.

Examples of this model in practice

a Hospital-based example: *The Lynda Jackson Macmillan Centre, Mount Vernon Centre for Cancer Treatment, Middlesex*

The centre is in clinical proximity to, but physically independent from, the Mount Vernon Centre for Cancer Treatment, and has a distinctively non-clinical atmosphere. The centre has a very large catchment area, spanning 13 district general hospitals. Patients attending the hospital, and those referred from the catchment area, may use the Lynda Jackson Macmillan Centre, which receives 50% of its funds from the local NHS Trust and the remainder from donations, fundraising or grants. To limit costs, the centre tends to use volunteer therapists and volunteers in the drop-in centre, which offers a

fixed number of therapy sessions and provides group relaxation sessions. Free information brochures on other charities are available.

Therapies offered include touch therapies (aromatherapy, massage, reflexology), Shiatsu, Alexander technique, psychological interventions and 'Look good, feel better' cosmetic makeover sessions. They represent the 'medically acceptable' face of complementary medicine and are provided as part of the 'integrated approach'. The Director of Services has rigorously implemented policies for therapies and therapists to enable their safe use, and in-house training and continuous evaluation provide quality control for therapists. Patient satisfaction surveys are used to assess outcome. This process allows clearer identification of the patients' views of the service. The centre has a 'research co-ordinator', and several key projects have been undertaken, including the ongoing CRC trial. Other key projects have included,

- *Developing Clinical Trial Protocols: The Use of Patient Focus Groups* (Bradburn *et al.* 1995)
- *Development of an Aromatherapy Service at a Cancer Centre* (Kite *et al.* 1998)
- *A Qualitative Investigation of Users' Experience of Aromatherapy and Relaxation Classes in a Cancer Support and Information Centre* (Lynda Jackson Macmillan Centre, 1998)
- *Bridging the Gap in Cancer Patient Care*, part of an MSc thesis (Howells 1997), addressing key issues in the use of complementary therapies
- *Complementary Therapists and Cancer Patient Care: Developing a Regional Network to Promote Co-operation, Collaboration, Education and Patient Choice* (Howells and Maher 1998)

The Centre's Medical Director provides key medical support and leadership, and the information officer meticulously guides the information provided.

b Hospice-based example:

North Devon Hospice, Barnstaple

The hospice has been established for 17 years and has had a complementary therapy programme since 1996. Its catchment area covers a large rural area (100 square miles), and GPs may refer patients specifically for treatments. It enjoys the close support of palliative care physicians and local GPs. Complementary therapies are provided within the hospice to enhance the patient's quality of life. As one patient said,

'Please emphasise that we come to day care to get better, not to die.'

A multi-disciplinary approach is offered, in contrast to many hospices where *ad hoc* services are provided by nurses or volunteers. Complementary therapies are available for patients and for the main carer. The most frequently provided therapies are the touch therapies – massage, aromatherapy and reflexology – and hypnotherapy and acupuncture. In addition, art therapy and manual lymphatic drainage are offered, as are therapeutic touch and nutritional medicine. Patients receive therapies free of charge. National Lottery Grants have largely contributed to running the service. The hospice has recently been awarded its third grant in reflection of its practice, and aims to use the money to consolidate its work and extend complementary therapies.

The hospice closely vets therapists, and guidelines are in place to protect patients and ensure safe practice. Patients' notes are centralised on the computer system, so their treatments are recorded as part of their total care. The service was evaluated by an independent assessor, for which focus groups were held to assess patients' responses and perception of the benefits/disadvantages of the service. One comment was,

'Much of the emphasis was on the therapist rather than the therapy.'

The Education Officer is much involved in teaching and writing on palliative care and complementary therapies (Penson 1995, 1998).

1.3.3 Model 3: patient groups within a healthcare setting

This model involves patient groups using supportive or therapeutic techniques in a healthcare setting. Therapies offered in this model are psychological treatments designed to change negative perceptions of cancer and embrace positive attitudes. They aim to decrease stress and possibly to influence survival (Greer and Moorey 1979, Spiegel *et al.* 1989, Fawzy and Fawzy 1993).

Example of this model in practice:

Behavioural Oncology Unit, Aberdeen Royal Infirmary

This is a clinical and research unit within the hospital, associated with the University of Aberdeen Medical School. It researches into the effects of psychological therapies, such as meditation, hypnotherapy, relaxation and visualisation, in conjunction with orthodox methods of cancer care. Patients are referred from the oncology department, and see one of the same three staff members at each visit, to establish rapport and so that changes in a patient's mood might be better detected. It is now routine policy to offer a combination of relaxation therapy and guided imagery to all women with breast cancer undergoing primary medical therapy for sizeable and locally advanced breast cancer. All staff practising the therapies are either medically trained or trained by those responsible for the unit and its research.

Multi-disciplinary psychological evaluation and psychometric testing occur on a regular basis. A clinical trial involving 170 breast cancer patients is underway: each patient receives chemotherapy and various psychological treatments. The unit has already shown that some chemotherapy patients undergoing relaxation and visualisation have lower stress levels (Walker *et al.* 1999). Although the group's

research has shown that successful use of guided imagery and relaxation techniques can boost the immune response and therefore have implications for survival and longevity, the emphasis is placed on a better quality of life and reduction of stress, since biological factors outweigh psychological factors in the progress of the disease (Walker *et al.* 1992, 1999).

1.3.4 Model 4: independent approaches within the NHS

These approaches to care are 'external' – that is, independently organised but still within the NHS. The five NHS homoeopathic hospitals in London, Glasgow, Liverpool, Bristol and Tunbridge Wells are examples, and can be used for complementary cancer care.

Example of this model in practice:

Royal London Homoeopathic Hospital

The long-established Royal London Homoeopathic Hospital (RLHH) sees patients who have been referred by a physician. Patients are increasingly referred by oncologists and by their GPs 'when their doctors are at a loss for symptom control' or at their own request. Patients are seen by a doctor who specialises in cancer care. The aims are to enhance quality of life; to enhance symptom control; to support the cancer patient; to encourage self-help.

'We give the best middle-of-the-road advice.'

A 'package of care' is provided. Homoeopathy is prescribed for symptom control and for general well-being, and Iscador, a mistletoe derivative, is often prescribed for chemotherapy-induced nausea. A wide range of complementary therapies are offered – touch therapies, psychological interventions, manual lymphatic drainage, Shiatsu and acupuncture. Dietary regimes are not set, but healthy eating is recommended. Policies are in place for selection of therapists.

The hospital is committed to evidence and evaluating effectiveness of treatments. Its portfolio, *The Evidence Base of Complementary Medicine* (RLHH 1997), states,

'A number of alternative therapies and diagnostic methods have been shown to be worthless. The RLHH does not use these therapies and methods.'

The practice is very much compatible with mainstream evidence-based medicine. However, the emphasis is not on waiting for definitive proof but on acting on the best possible evidence. Studies have been conducted to ascertain the effectiveness of treatments and to elucidate patients' perspectives (Clover 1995; Sharples and Van Haselen 1998).

1.3.5 Model 5: independent organisations

There is an increasing number of such organisations, and aspects of their work have been adapted for use within the NHS – that is, in a multi-disciplinary setting.

Examples of this model in practice

a *Bristol Cancer Help Centre (BCHC)*

The BCHC was founded 18 years ago and was the pioneer of holistic cancer care in the UK. Having largely recovered from the study (Bagenal *et al.* 1990) which suggested that Bristol patients fared worse than controls, it is now often referred to as a resource for complementary therapies in cancer care (*please refer to section 1.2*).

The aim of the centre is to empower cancer patients by emphasising that many of the most important factors that affect their health are within their control. The mission statement says,

'We will help you learn that you can strengthen your immune system and enhance your potential for recovery.'

The approach is more radically holistic suggesting that recovery and survival may be enhanced by the therapies. As one representative said,

'It is crucial to be active.'

The centre is keen to emphasise that the approach complements orthodox treatment to promote health, and to forge links with practitioners and oncologists to cultivate working partnerships. A recent study conducted in collaboration with a leading oncologist at the Bristol Royal Infirmary is evidence of this increasing acceptance (Bristol-Warwick 1999).

A residential two-day introductory course is offered, and a five-day follow-up course allows time to consolidate the approach. Mind/body approaches are taught, and healing, counselling and medical support are provided. Nutritional guidance is given, and the diet is notably more moderate than in former years.

As regards costs, the approach is so intensive that extensive resources are used and few patients are treated at any one time. The role of the Bristol model as a template guide for future initiatives is being re-evaluated by new management, taking into account costs to the patient and the availability of other complementary therapy resources.

b *Cavendish Centre, Sheffield*

The Cavendish Centre was established in the early 1990s to provide psychosocial support and help with symptoms and information.

'The aim was to offer a security blanket for vulnerable cancer patients.'

Patients are frequently referred from the community or hospitals. The centre has extensive medical support from many GPs and oncologists.

The importance of an assessor, who suggests an appropriate 'package of care' for a particular patient, is stressed. Fourteen therapists offer a range of therapies. These are the touch therapies, such as massage, aromatherapy and reflexology, and also acupuncture and homoeopathy. The psychological interventions

are represented by hypnotherapy, relaxation and art therapy. Notably, healing is available. Therapists are evaluated for training, qualifications and beliefs. A strict code of conduct is enforced,

'Therapists must not explicitly or implicitly suggest prolongation of life or cure.'

The therapies are free of charge to patients. As an independent charity the centre fundraises to support its activities. Audit procedures are in place. The emphasis on delivering the 'package

of care' means that therapies are not judged against each other: the focus of interest is rather the patient's response to whichever therapy is assessed.

The research focus is still in its infancy but is being developed. A collaborative research project with Weston Park is planned. This will assess the effects of therapies on the quality of life of patients with colorectal cancer who will be invited to attend the centre (Cavendish Centre 1999).

1.4 The complementary therapies – evidence, safety and applications

The therapies

This report concentrates on those complementary therapies that cancer patients predominantly use, and which are most frequently made available to them at specialist centres. They comprise mainly the touch therapies – aromatherapy, reflexology and massage – and psychological interventions – relaxation, guided imagery and meditation – and therapies such as acupuncture, homoeopathy, spiritual healing and naturopathy. The list is not exhaustive, however, and excludes the more peripheral therapies, such as psionic medicine, that may be used by some patients. For each of the chosen therapies, a brief description is given, including possible mode of action, and some indication of the principal conditions for which each is used. A comment from an expert in that therapy is also included. It must be stressed however that the descriptions of, and comments about, each therapy are not intended to be definitive.

Types of evidence

This section deals with evidence and the reader should be aware that there are various kinds of evidence, some better than others. The lowest grade is that of *personal anecdote* and *single-case study*, which monitor the response of an individual to a treatment. As there are many reasons why people's health can change, these alone do not tell us much about the effect of the therapy. Better evidence can be gleaned from reviews of case records from a large number of patients, or from *cohort studies* in which a group of people is given the same treatment and their progress monitored. But even this does not provide evidence of efficacy of a treatment, since many other factors, such as placebo effect or patient-therapist interaction, might be involved. For this *controlled trials* are needed in which a treatment group is compared with a control group which, ideally, has an indistinguishable placebo but which may also be a waiting list control or an existing treatment

control. The key elements in any trial are that the participants should have been randomly allocated to the treatment or the control, and that both they and the organisers of the trial should be unaware of their group allocation (a 'double blind' trial).

1.4.1 Acupuncture

Acupuncture has its roots in traditional Chinese medicine (TCM) and is therefore part of a system involving multiple therapeutic interventions such as diet, manipulation, meditation and herbal medicine. In this system the body is believed to be traversed by a life-force or energy (called *chi*), and disease is caused by an imbalance in these forces. The aim of acupuncture – in conjunction with other treatments – is to restore the energy balance and health.

Since its introduction to the West, after Richard Nixon's visit to China in the 1970s, various mechanisms of action have been put forward to explain acupuncture in western scientific terms, but no explanation is wholly satisfactory, and the therapeutic value is still a matter of debate.

Traditionally, acupuncture has been used as part of a combination of therapies specifically put together according to the needs of the individual patient. In the West it has come to be used, usually as a single therapy, for a wide range of conditions but especially for pain, the addictions, high blood pressure and nausea. Acupuncture is used in some oncology clinics and in palliative care to control pain and for chemotherapy-induced nausea.

Evidence for effectiveness

There have been many hundreds of scientific studies of acupuncture, from experimental studies to full-scale clinical trials. It may seem strange, then, that the clinical effectiveness of the therapy is still undetermined.

Methodological problems have bedevilled scientific investigation: most published studies do not have a placebo acceptable to the most rigorous sceptic, and clinical trials have often

been of poor methodological quality. Chronic pain is one clinical condition for which trials using acupuncture have been conducted. One review of the literature on chronic pain (Ter Reit *et al.* 1990) found 51 reports which had some form of control group. Of the best quality trials, they found equal numbers of trials in favour of the effectiveness of acupuncture as against irrespective of category of pain. Similar inconclusive results have been found after literature reviews of acupuncture for smoking cessation (15 trials; Ter Reit *et al.* 1990), and for low back pain (11 trials; Tulder *et al.* 1999).

Acupuncture may be particularly promising as a therapy for chemo- and radiotherapy-induced nausea. A placebo-controlled trial showed that such nausea could be significantly reduced by treatment (Dundee and Yang 1991) and a review by Vickers (1996) of all trials on the effect of needling the P6 point on the palm (the 'inner gate') found a significant reduction in nausea, over a wide range of conditions, with acupuncture treatment. As regards cancer pain, two uncontrolled retrospective studies, of 339 patients given acupuncture for intractable cancer pain, have been conducted. Taking both studies into account, 50% of patients reported improvements in pain over seven days (Filshie 1985, 1990).

Safety and costs

Complications associated with needle entry are known, and these range from infection due to inadequate sterilisation to major consequences such as pneumothorax. Fainting is also a well reported side-effect (Rampes 1995). A session, which can involve detailed lifestyle and personality assessment, can cost from £20 to £50 for the acupuncture alone, though subsequent sessions may be cheaper and/or may be required only at progressively longer intervals.

Training, qualifications and professional bodies

In the UK, anyone can use the title 'acupuncturist', but qualified acupuncturists fall into two main categories

- a** Medically qualified acupuncturists are represented by the British Medical Acupuncture Society, which has 1300 doctors on its register. It offers training to two levels: basic competence in the technique acquired on weekend courses plus evidence from 30 case histories, and a Certificate of Accreditation which requires 100 hours training and a log book of 100 case histories. Some members of this organisation would like to restrict acupuncture practice to medically qualified practitioners only, to ensure safety and therapeutic standards.
- b** Non-medical acupuncturists are represented by the British Acupuncture Council and, unlike medical acupuncturists, most of these are not statutorily registered. To register with this body, applicants must have undergone two years' full-time training to standards set by the British Acupuncture Accreditation Board and comply with the code of ethics. Many members practise TCM and view the training of medical acupuncturists as too science-based and rigid.

Expert comment

One medically qualified expert with much experience in the field of acupuncture in cancer care emphasised that acupuncture should not be regarded as a complementary therapy since it is practised by mainstream doctors and has 'scientific basis' in the form of recent neuropharmacological and neurophysiological advances. In relation to cancer care, it was emphasised that its main use is for pain relief and chemotherapy-induced nausea (Thompson and Filshie 1993). For cancer pain, both TENS (transelectrical nerve stimulation) and acupuncture are used to 'improve pain control' sufficiently to allow reduced dosage of analgesics and, therefore, reduce side-effects. The expert uses acupuncture for both pain and nausea in patients and feels that there is much scope for its use in cancer care. However, since acupuncture is not without complications, its use should be medically led in cancer patients, and performed by anaesthetists, palliative care physicians and general practitioners.

1.4.2 Aromatherapy

Many plant species contain essential oils, which give them their distinctive smell. The oils can be condensed from any plant parts by a distillation process to create a very concentrated aromatic solution. These oils have been associated with healing properties.

Practitioners believe that each essential oil can have a particular physiological or psychological effect. The chemical constituents of the oils, in a vegetable carrier, are quickly absorbed through the skin into the bloodstream, and any therapeutic effect probably results from a combination of a physiological effect of the oils, the relaxation of the massage procedure and the specific effect of the massage on the body. As oils also excite the sense of smell and thereby elicit certain emotions, the limbic system of the midbrain, concerned with emotional as well as visceral function, may also be involved in the effect of aromatherapy, including the release of hormones or chemicals in the brain. However, some proponents claim a more ethereal, mystical rationale for the therapy.

Aromatherapy is said to be useful for stress, since it is said to aid relaxation and soothe emotions, for example by the use of lavender and eucalyptus. It is also used for menstrual and digestive problems and bacterial infections, and for skin conditions such as acne, eczema and burns. In cancer care, aromatherapy is used for stress management and relaxation, and is often provided by nurses and paramedical staff.

Evidence for effectiveness

One controlled trial of cardiac surgery patients in intensive care found that the group that received active aromatherapy had significantly less anxiety after five days, but other physiological variables were largely unchanged (Stevensen 1994). Similarly, in one of the few randomised controlled trials of aromatherapy, the effect of lavender oil for perineal discomfort after childbirth was investigated in 635 women but there was no difference between groups in

terms of discomfort at the end of the study (Dale and Cornwall 1994).

As regards cancer care, one uncontrolled study (Kite 1998) investigated the aromatherapy service at Mount Vernon Centre for Cancer Treatment. Six sessions of aromatherapy were given to 58 patients, who at the end of the study showed significant improvements in anxiety and depression. Also, during a trial in 1995, 51 cancer patients had three massages over three weeks with or without the essential oil roman chamomile. Anxiety was reduced and quality of life improved in the group treated with the oil (Wilkinson 1995, 1996). The small-scale nature of studies to date makes it difficult to draw conclusions. A CRC-funded multi-centred randomised controlled trial – 504 patients in four centres – is currently underway to evaluate the use of aromatherapy massage and relaxation therapy in improving quality of life in patients with advanced cancer.

Safety and costs

Undiluted oils can harm skin and should certainly not be taken into the body. There is also a chance of allergic skin reaction in sensitive people. Some oils can induce a reaction when combined with sunlight. Costs can range from £30 to £55 per session.

Training, qualifications and professional bodies

Aromatherapy, like most complementary interventions, is unregulated. However, most practitioners belong to the Aromatherapy Organisations Council, which is an umbrella body for at least 14 aromatherapy organisations and more than 80 colleges involving almost 7000 therapists. It runs a range of short- or long-term courses (180 hours in class is a stipulated minimum) and national standards are being developed.

Expert comment

The expert consulted stated that patients are often satisfied with their treatments, but is aware of the need to formally evaluate the

effects of aromatherapy and massage in cancer care. Short-term benefits, in terms of reduced anxiety have been demonstrated but research has usually been observational, non-controlled or on small samples. It was emphasised that complementary therapies must be regarded as 'packages of care', and this should be borne in mind when designing trials. The importance of the particular qualities of the therapist and the therapeutic relationship was acknowledged: this is not a failing of the treatment but rather complicates its assessment.

1.4.3 Healing

Healing, also known as 'therapeutic touch' in the USA, can be defined as the channelling of 'energy' from a source through a healer to the patient for therapeutic purposes. The source of this energy is unknown – it may be God or a natural reservoir in the universe – but the claim is that it can help to stimulate self-healing mechanisms in the patient, promoting alleviation or cure of disease. Conceptually, healing can be divided into two main forms: faith healing, which is generally carried out in a religious setting and may require faith on the part of the healer or patient; and spiritual healing, which does not necessarily have a religious basis and is the modality practised in the UK. It can occur either during face-to-face sessions between healer and patient, or distantly in the form of 'absent healing'.

The exact mechanism of action is unknown. One suggestion is that the human body is an electromagnet, producing a radiating energy field (which may involve an 'aura') that can be affected by the incoming energy channelled through the healer. Another possibility advocated is that the power of love can encourage the spirit body of the patient to reverse disease progression in the physical plane.

Healers claim that there are no conditions that cannot benefit from healing. It can be used to speed up recovery after illnesses treated by orthodox means, to alleviate symptoms and, at

least in principle, to affect a complete cure. Spiritual healers are allowed to practise in GP surgeries, under the clinical supervision of the GP.

A number of surveys have attempted to determine its use by cancer patients. One of these, by Cassileth *et al.* (1984), found that healing was used though less frequently than diets or vitamins. Downer *et al.* (1994) found that 16% of cancer patients in the UK used some kind of complementary medicine and that healing was one of the most popular. A recent survey from Norway found that 74% of cancer patients who used complementary medicine were using healing either alone or in combination with another therapy (Risberg *et al.* 1996, 1998).

Evidence for effectiveness

There is some evidence that visiting a healer can be beneficial. Dixon *et al.* (1998) showed the clear benefits to chronically ill patients of visiting a healer on the recommendation of a GP. Though this study was not placebo controlled, it indicates that for long-term patients in the community, consulting a healer can have some benefit, for whatever reason. As regards clinical trials, Benor (1992) found a large number of studies on plants, animals and human beings which on balance favoured healing, though many of these were of very poor quality. Of five good-quality studies on human physical problems, three reported a significant effect of healing over placebo and two did not. A pilot study recently reported the use of Reiki healing as an aid to pain management in 24 people, some of them with cancer pain, and stated that there was a highly significant decrease in pain following healing (Olson and Hanson 1997). However, there have been no large-scale trials of healing as an adjunctive cancer treatment to allow assessment of its therapeutic effectiveness.

Safety and costs

There are no reports of adverse effects of healing, beyond disillusion if the treatment fails to have a beneficial effect. Some healers charge nothing at all or merely ask for a contribution, but most ask for £20 (or upwards for a

renowned healer) for an hour-long session which comprises counselling and healing.

Training, qualifications and professional bodies

The Confederation of Healing Organisations (CHO) is an umbrella body created to represent the interests of a large number of healing organisations, the largest of which is the National Federation of Spiritual Healers (NFSH), representing 6500 members. Members of the NFSH conform to very strict ethical guidelines and must complete a two-year probationary period which involves vocational training and case reports of five cases. However, there are no healing qualifications, and anyone can call themselves a healer. All members of CHO and allied organisations have professional indemnity and public health liability insurance.

Expert comment

The expert consulted, also a practising GP, described the 'healing' process as the channelling of energy from the healer to the patient. The healer has the intention that the patient should benefit, not unlike most healthcare professionals. In response to the question of using healing for physical healing, the expert stated that extraordinary things can happen. For cancer patients, outcomes might be feeling better, having more energy, or re-evaluating their purpose in life. The expert stated,

'Spiritual issues are often paramount in answering the questions, Why me? Why cancer?'

It was emphasised that although palliative care teams and hospices are often excellent at providing psychological support, they do not focus on spiritual support and care. Healing is about encouraging self-healing – emotional, mental, spiritual and perhaps physical – through care and compassion. Though a supporter of evidence-based medicine, the expert pointed to difficulties in measuring outcomes when a range of variables is involved. The exaggerated claims made by certain healers were acknowledged.

'Charismatic healers are the worst things about spiritual healing. They give spiritual healing a bad name.'

1.4.4 Homoeopathy

The German physician Samuel Hahnemann claimed to rediscover the ancient principle that 'like can treat like', a concept known to the ancient Greeks. In his law of minimal dose he codified the belief that 'ultradilution' of a substance can increase its potential to cure disease.

Accordingly, homoeopathic remedies are prepared from a 'mother tincture' – the original solution of the substance – which is diluted down in successive steps. At each step, the solution is given a vigorous shake ('succussed'), and homoeopaths believe that the power of the diluted solution to heal is conferred ('potentisation' occurs) during these successive shakes. There is great debate about how this might occur, or indeed whether it is occurring at all. The most prevalent view is that the 'power' generated during 'potentisation' is stored in chemical form, perhaps through a lasting alteration to the structure of the water (the 'memory of water' theory) presently undetectable by science. The therapeutic effect might be transferred to the patient via an unknown mechanism.

Homoeopathy claims to treat the 'whole person' – not just the local symptoms of the disease – by boosting a dysfunctional 'self-healing mechanism'. Homoeopaths therefore prescribe a remedy that is specific to a particular patient at a particular time. According to homoeopathic theory, there is no disease that cannot in principle be treated. Like other complementary therapies, homoeopathic remedies tend to be most used by patients for the chronic conditions for which orthodoxy has no cure, such as asthma, chronic pain and emotional problems. In a survey of cancer patients in the UK, 16% reported using some form of complementary

medicine: homoeopathy was one of the most frequently used therapies (Downer *et al.* 1994).

Evidence for effectiveness

The most rigorous overview of clinical trials was conducted by Kleinjen *et al.* (1991) after a review of all the scientific literature. This group found a total of 107 controlled trials over a large number of different conditions, from respiratory diseases to psychological problems. Though the quality of trials was very variable, overall 81 reported positive results for homoeopathy and 24 found no benefit of homoeopathy over placebo. Of the 22 best-quality trials, 15 showed a benefit of homoeopathy and 7 showed no benefit. An extension and re-analysis of this review in the *Lancet* (Linde *et al.* 1997) arrived at essentially the same conclusions. One trial, comparing the effects of a homoeopathy preparation of grass seed pollen and placebo in 144 hay-fever sufferers (Reilly 1986) found a significant reduction in symptoms in the treatment group.

As regards cancer care, a pilot study from the Glasgow Homoeopathic Hospital in 1995 found a significant reduction in stress in 21 out of 50 patients with breast cancer who survived to six-month follow-up. There have also been some claims, published in *Health Which?* in 1997, that homoeopathy can reduce the hot flushes sometimes caused by chemotherapy. The conventional view, however, is that homoeopathy is not appropriate as a single cure for life-threatening conditions. To 1999, there have been no good quality trials of homoeopathic remedies for cancer.

Safety and costs

As most true homoeopathic remedies have either no molecules of the original solution left, or so few as to be negligible, there is usually little chance of direct harm. However, there have been some reports of contaminated products. Homoeopaths report that 'aggravations' of symptoms can occur shortly after start of treatment, but claim these are minor and transient.

First consultation can cost between £30 and £100, with cheaper follow-up appointments. In addition, GPs can prescribe remedies and can refer patients to one of the homoeopathic hospitals.

Training, qualifications and professional bodies

Homoeopathy is the only complementary therapy to have a Faculty of Homoeopathy to train medical doctors, and five NHS-funded hospitals. Anyone can use the title 'homoeopath', but there are two categories of professional training available

- a** Medical homoeopaths, who take a six-month examined postgraduate course at the Faculty of Homoeopathy, become registered and abide by the code of conduct: there are presently over 400 of these
- b** Non-medical homoeopaths, who take a three-year full-time course organised by the Society of Homoeopaths, after which they become members, abide by the code of conduct and use the letters RSHom. Currently, there are over 1100 members

Expert comment

The expert consulted, who has had many years' experience in treating cancer patients and who works in an acute NHS Trust Hospital, stressed the importance of auditing practice to demonstrate patient satisfaction and effectiveness. The expert's philosophy is that since cancer is a multifactorial and enigmatic disease, a multifactorial approach should be adopted in its treatment. Usually, the advice given extends beyond prescribing a homoeopathic remedy. Since diet, stress, genetics, environmental and other factors may be implicated in the origin of the disease, these areas are addressed as part of the holistic approach. The suggestion that patients may influence their disease, rather than expect cure, is key to the contribution from this expert. It was emphasised that medically trained homoeopaths are to be preferred, since they understand the

disease process and know when the patients require other interventions.

Another medical homoeopath reinforced the importance of being guided by the patient,

'The approach is narrative-based. It is observational.'

1.4.5 Massage therapy

Massage is a generic term for a variety of techniques which involve touching, pressing or kneading the surfaces of the body to promote mental and physical relaxation. Types range from traditional Thai massage to the Ayurvedic *marma*. The precise tissues and points that are stimulated, and how the massage therapist connects with them, depend on the culture from which the technique has originated and the philosophy on which it is based. Western massage, such as the kind used by sports therapists, concentrates on the structures and physiology of the body as recognised by orthodox western science. By direct stimulation of skin and underlying tissues, massage can relieve tension and stimulate circulation, indirectly promoting relaxation and the benefits that accrue from it.

Massage is used primarily for musculo-skeletal pain, since part of the pain experienced is often caused by the tension caused in guarding the body against pain. Massage can relieve this additional pain by helping the body to relax. Similarly, it is also used for stress-related problems such as tension headaches, sleeplessness, sciatica and migraine. Some practitioners claim that it can help conditions such as asthma and irritable bowel syndrome.

Evidence for effectiveness

Despite many anecdotal claims for the effectiveness of massage to relieve anxiety and depression, and for the relief of pain, when Vickers (1996) reviewed the literature on the effectiveness of massage the results were disappointing. Good-quality conclusive studies were few, and overall there was no good

evidence that massage relieved pain. This finding, however, is counterintuitive and probably says more about the paucity of good research than the effectiveness of massage. In a research paper in 1994 from the Macmillan Practice Development Unit at the Institute of Cancer Research, London, 52 cancer patients undergoing an eight-week course of massage reported significantly reduced anxiety and decreased physical and emotional symptoms (Corner, 1994). In another study of massage for cancer pain, 60% of patients said their pain was reduced after a 30-minute massage, and this was confirmed by physiological tests (Ferrel-Tory and Glick 1993). In another report, post-mastectomy lymphoedema was reduced by massage (Becker 1990), while a study at the Liverpool Marie Curie Centre followed 87 patients who had been referred for massage and had completed the course; 71 of these completed a postal questionnaire, and most found the experience of massage beneficial (Wilkinson 1995, 1996).

While these results are intriguing, massage urgently requires further evaluation if it is to prove its worth as a specific therapy. It is nevertheless widely used in the NHS cancer care units, and anecdotal benefits are claimed.

Safety and costs

As eastern types of massage can be quite vigorous, there may be some pain and discomfort after a massage session. Patients should be relatively safe in the hands of a trained therapist, though anyone with underlying disease of the bones, varicose veins, blood clots or severe back pain should seek medical advice first. Indeed it is always wise to seek medical advice. A one-hour session can cost upwards of £25.

Training, qualifications and professional bodies

Massage therapists are unregulated, and there are several hundred training colleges in the UK with over 60 kinds of massage qualifications. British Massage Therapy Council is preparing a

list of organisations and drawing up a registration procedure for practitioners and a training programme. There is also the Massage Therapy Institute of Great Britain. The Shiatsu Society has a register of practitioners, and members conform to a code of practice and ethics. Massage is widely available inside the NHS, and is provided by trained therapists, such as nurses/paramedical staff (dual training) and trained volunteers.

Expert comment

The expert consulted was a research practitioner who had published a critique of the methodology of research studies evaluating massage. She concluded that, after analysis, the methods employed varied so greatly between studies that it was difficult to make any firm conclusion about the effectiveness of massage.

'We need to replicate existing studies rather than constantly changing the methodology. We need to draw on the knowledge gained from earlier studies.'

1.4.6 Naturopathy, diets and herbals

This section outlines the use of these therapies and is not intended as a detailed critique.

Naturopathy

The term 'naturopathy' actually covers a range of therapies, and within it patients might find diets and various physical techniques. The philosophy is that 'natural cures' can give the body the maximum opportunity to heal itself without interference. In the UK, the term is used to describe a core of 'therapies' arranged around the principles of dietary advice (including fasting), hydrotherapy and exercise.

Training, qualifications and professional bodies

In the UK, naturopathy has traditionally been associated with osteopathy and some

naturopaths today are also osteopaths. It is represented by the General Council and Register of Naturopaths (with 180 members in 1997) and the Register of Nutritional Therapists Ltd (with 95 members in 1997).

Expert comment

The view of the expert consulted was that the aim of naturopathy is to help the individual restore his/her normal function to as near its healthy level as possible.

'A naturopath is creating health, not treating disease.'

It uses a careful nutritional approach combined with controlled exercise and positive thinking: foods should preferably be organic, though the diet should not be too restrictive. Patients should eat things with high nutritional value. The basic idea is that the therapy 'will initially release energy' within the patient. The mistake made by dieticians, in the view of this expert, is to push food on to patients when they cannot 'use it' optimally. In cancer patients naturopathy might 'stimulate the immune system, prevent blocks in energy, and contain the cancer'.

Diets and dietary supplements

Diet and supplements are extensively used by the general population, but are also proposed for certain conditions. The following are three examples with relevance to cancer care.

a The Gerson diet

Developed in Germany, this diet consists of mainly fresh organic fruit and vegetables with emphasis on those parts with a high potassium content. Sodium is restricted.

There are other additional ingredients, such as vitamin B12 and royal jelly. Gerson himself made great claims for the use of the diet in cancer (Gerson 1978), but further evidence from randomised clinical trials is needed to support its use as a therapy. Some cancer patients have used this diet, but it is rigorous and requires commitment to see it through.

b Vitamin supplements

Vitamin supplements are seen by some as complementary therapies. Much research is being undertaken within orthodox science to assess the effectiveness of vitamin supplementation. In cancer care, there is limited evidence for the recommendation of vitamins A, C and E as supplements for patients, though it is essentially inconclusive and falls short of indubitable scientific proof of efficacy (Canadian Breast Cancer Research Initiative, Vitamin A, C and E supplements, 1996). As vitamins can interact with each other and with other medications, the use of supplementation by cancer patients should be done under the care of a physician.

c Shark's cartilage

Shark's cartilage is thought to contain a factor that inhibits the development of the blood supply to a tumour, preventing angiogenesis. As a result, supporters argue that the tumour can be starved of its necessary nutrients. They claim that it works best on solid tumours, as these need substantial new blood vessels to grow. The scientific basis for the use of shark's cartilage is the finding that sharks infrequently get cancer. No clinical controlled studies of the effectiveness of shark's cartilage have been published, despite the thousands of cancer patients who have bought and used it (Markman 1996). This suggests that, despite extensive commercial publicity, the product offers unsubstantiated benefit to cancer patients.

Herbal remedies

Plant products have been used for centuries and much of western allopathic medicine, including oncology drugs, is derived from plants. Each has a different mode of action. Between 1960 and 1981 approximately 114,000 plant extracts from 35,000 species were screened for anticancer activity. None proved effective in clinical trials during that time, and so interest diminished (Reynolds 1991). However, other countries,

notably Japan, France and China continue to screen new plant materials. The problem with studying plant products is the lack of standardisation of dosage and formulation. Also, the plant contains many potentially effective compounds, and determining which are beneficial and which are harmful is a challenge. Moreover, the constituents may work synergistically to provide the effect.

Hundreds of herbal remedies purported to have anticancer benefits are available over the counter, for example Chinese herbs, ginseng and garlic. Most of them have no such demonstrated benefit. The following are two examples of herbals for which many anecdotal claims are made in the popular literature available to cancer patients.

a Iscador

Iscador is the brand name of an extract of the common species of European mistletoe, *Viscum album*. This plant was studied by Rudolph Steiner, who believed that cancer was caused by an imbalance of forces on the body for growth and organisation. He proposed the use of mistletoe extracts as a therapy for cancer since this plant exhibits a strong antagonism towards regular organisation and might stimulate the body's own organising forces. Despite many anecdotal claims, the case study and clinical trial evidence for Iscador remains insubstantial. None has demonstrated a conclusive benefit for cancer care. (Canadian Breast Cancer Research Initiative, Iscador, 1996.)

b Essiac

The original recipe for Essiac – a mixture of four or more herbs (burdock root, Indian rhubarb, sheep sorrel and slippery elm) – was apparently discovered by an Indian healer in Canada. Its aim is to purify the body and place it in a state of balance with respect to the 'great spirit'. The therapy was taken up in the 1920s by a Canadian nurse, Rene Caisse, who administered it to cancer

patients, and it later became commercially available. Its proponents claim that it stimulates the immune system and improves quality of life. Though there is much anecdotal and laboratory evidence of biological activity of some of the ingredients, no formal clinical trials of evidence apparently exist. (Canadian Breast Cancer Research Initiative, Essiac, 1996.)

1.4.7 Psychological interventions

The aim of these therapies is to alter the quality of an individual's thoughts and thought processes. This could lead to psychological and possibly physiological change. As well as simple relaxation, there is classical meditation, which attempts to still the mind from its everyday thoughts to obtain calmness and inner peace. The range of meditation techniques includes the mantra-based Transcendental Meditation (TM) and traditional Buddhist meditation. Once peace is established, the person has the mental space and clarity to direct the attention at will. Thus, a person with cancer might visualise the regression of a tumour, or a depressed person a positive mental state.

It is obvious that the act of stilling the mind can lead to a reduction in worry and psychological stress. However, the intimate connection between body and mind is becoming increasingly recognised through the science of psychoneuroimmunology (Rossi 1993) and it is very likely that the contents and direction of the mind can affect physical as well as mental ailments. Mental rest induces alpha waves in the brain, and these can promote changes to muscle tone and skin resistance. It may also raise levels of serotonin in the brain, in a manner similar to fluoxetine (Prozac). Lifestyle improvements which can follow reductions in sleep problems or stress can lead to abandonment of bad habits such as smoking or heavy drinking which cause ill-health. Since we all recognise the effect our mind has on our body, it seems intuitively true that these therapies have great potential: it is

the techniques that need to be refined and developed.

A number of surveys have reported the use of these therapies in cancer. Relaxation and imagery were two of the most popular therapies reported in a survey of cancer patients (Downer *et al.* 1994). Again, imagery to boost the immune system was a predominant therapy reported in a telephone survey of cancer patients (Miller 1998). Many oncology units have now incorporated a psychotherapist or cancer counsellor into their practice teams (Cosh and Sikora 1989). In addition, behavioural interventions are used to control chemotherapy-induced nausea and vomiting (King 1997).

Evidence for effectiveness

Many studies have been done on meditation and the reports are usually positive in conditions such as hypertension and post-natal depression. However, other meditation techniques are also as effective for anxiety reduction, and it has been reported that other activities, such as exercise, can have a very similar effect. Few investigations, however, have tested the specific effectiveness of meditation, imagery or relaxation. As often occurs in complementary medicine, there is a dearth of evidence from randomised controlled trials due, partly, to difficulties in finding a suitable placebo intervention for comparison and also to the lack of funding for such investigations.

Psychological interventions seem to be valued by cancer patients, but there is some scepticism among health professionals regarding their true effectiveness. As regards psychological support, a controlled trial of women with breast cancer, randomised to receive weekly support group or not, showed that the support group had less anxiety, fatigue, confusion after one year and survived 18 months longer at ten-year follow-up (Spiegel 1989). Again, there is evidence that adjuvant psychological therapy, developed specifically for patients with cancer-related psychosocial disorders, may decrease distress and improve quality of life (Greer 1991, 1995); that group therapy can promote significant

psychosocial changes (Evans and Connis 1995); that psychological interventions can improve morbidity and mortality in cancer (Blomhoff and Ekblad 1995); and that relaxation and imagery can decrease cancer pain (Syrjala *et al.* 1995).

However, reviews of the literature have been much less promising. A review of imagery techniques for cancer pain uncovered many poor-quality studies without convincing effects (Wallace 1997), while a review of cognitive interventions as a treatment for depression in cancer patients could not make a recommendation about effectiveness (Lovejoy 1997). In a review of psychological approaches to cancer (Loscalzo 1996) there was some evidence that these can reduce powerlessness and increase hope. In a review of the field, Walker (1992) found that hypnotherapy can be useful for all the above, apart from survival enhancement. A further review by the same author (1999) found evidence that psychological interventions – including hypnosis – could also modulate the immune response in a way possibly relevant to cancer.

Safety and costs

Meditation and other psychological interventions may unlock suppressed worries and fears, and for that reason it is usually wise to undertake it under guidance. Some GPs prescribe psychological interventions under the NHS.

Training, qualifications and professional bodies

Anyone can call themselves a meditation teacher, though specialist courses are offered for training in conducting relaxation or guided imagery sessions. However, these therapies are often acquired as part of general nursing communication skills and are practised by many nurses and paramedical staff after only a limited amount of formal training – often from tapes or books. However, in some units psychological interventions are taught by a clinical psychologist who leads more formal programmes.

Expert comment

The expert consulted has been much involved in the practice and research of psychological interventions in cancer care, and has come to believe that these therapies are undoubtedly here to stay. Relaxation and guided imagery are the therapies that have the most substantial evidence supporting their use in cancer care. However, patients should be carefully assessed and the therapies only given to those found suitable. Nurses who may be trained to practise therapies should select patients accordingly. Specialist backup from psychologists or psychiatrists would be preferred.

1.4.8 Reflexology

Reflexology has its roots in traditional Chinese medicine, and practitioners apply pressure to specific zones on the soles and top of the feet to assess the disease state of the patient and also to improve health. Each zone on the foot is said to correspond to a zone of the body, and to be connected to it in terms of energy flow along an energy pathway. Massaging these points is thought to unblock the energy pathway and restore normal energy flow. As regards diagnosis, some reflexologists claim to feel granular structures at specific points in the foot, indicative of disease in the corresponding organ, and it is hypothesised that these may be uric acid deposits from the diseased organ concerned. Similarly, unusual swellings at points on the foot can also indicate a weakness of the corresponding body part.

Reflexology is used to restore energy levels and promote emotional well-being, and is used for most chronic conditions. It is used as a support during radio- or chemotherapy treatment for cancer in some oncology units.

Evidence for effectiveness

Much has been written about reflexology, but there is a dearth of scientific investigation into this therapy. Some studies have reported positive physiological effects, but they are small and of

poor quality. In one controlled clinical trial in the USA, 35 women with pre-menstrual syndrome were randomised to receive either true or sham reflexology. The real treatment group showed an improvement in range of physical and mental symptoms compared with the control group (Oleson and Flocco 1993). This appears to be the only randomised controlled trial of reflexology. There are no good clinical trials of its effectiveness in cancer.

Safety and costs

No data exist to show ill effects, but some reflexologists will not treat certain conditions. Costs range from £20 upwards for a one-hour session, but up to eight treatment sessions are recommended.

Training, qualifications and professional bodies

Reflexology is represented by six organisations, each of which issues a code of conduct for its members. The two largest are the Association of Reflexologists, which has 70 accredited courses in the UK and over 2600 members, and which entitles graduates to use the letters MAR and has set standards for the profession; and the British Reflexology Association, linked with the Bayley School, which also issues qualifications that entitle the graduate to use the letters MBRA. Accredited therapists of both organisations must have insurance.

Expert comment

A practising reflexologist who treats cancer patients explained that reflexology could help with cancer as part of a 'holistic' regime including diet and visualisation to 'rebalance' the body. Most often, its role would be to enhance quality of life and combat side-effects of orthodox treatment. This expert would not recommend reflexology as a 'cure' in itself, but rather as part of a broader complementary approach. It was stated that no research into reflexology and cancer is known, and that training standards of therapists need to be regulated.

1.5 Policy context

1.5.1 Background

The 1990s have seen an increase in complementary therapies funded by the NHS. Family doctors were given formal approval to employ complementary therapists in 1991 (NAHAT 1995). The *National Survey of Access to Complementary Health Care via General Practice* (MCRU 1995) found that 40% of all GP practices in England provided their patients with access to complementary therapies. Other surveys found that GP fundholders, who were responsible for managing their own budget and had freedom to purchase care for their patients where they liked, were more likely to provide complementary therapies than non-fundholders. At the same time there were wider signs of NHS support for such therapies. A report by the National Association of Health Authorities and Trusts found the vast majority of purchasers have a positive attitude towards complementary therapies and towards provision of some therapies by the NHS (NAHAT 1995).

1.5.2 New challenges

The election of a Labour government in 1997, and the introduction of its new NHS reforms in April 1999, has presented two major challenges to complementary therapies.

First, there is a new emphasis, principally through the National Institute for Clinical Excellence (NICE), on creating NHS-wide quality standards and achieving value for money by ensuring that only those medical interventions that can be shown to be clinically effective or cost effective are provided by the NHS. In Scotland, these roles are to be undertaken by

the Clinical Standards Board for Scotland, the Scottish Health Technology Assessment Centre and the Scottish Programme for Improving Clinical Effectiveness.

This approach has caused concern that, if research fails to demonstrate that complementary therapies are clinically effective, NHS purchasers will be obliged to divert funding into more evidence-based interventions. The optimistic view of NICE is that it could 'legitimise' provision of effective therapies and propel them into the medical mainstream. The pessimistic view is that a purely scientific approach will fail to understand the complexities of complementary therapies; that perfectly 'good' interventions will be outlawed because there is no 'evidence' of effectiveness in the conventional scientific sense.

Second, fundholding – the engine of therapy purchasing – has been abolished and replaced in England by Primary Care Groups (PCGs) and in Wales by Local Health Groups (LHGs). This is an area-based GP model which commissions care on behalf of groups of up to 50 GPs responsible for populations of between 80 000 and 200 000. This has led to fears that collective decisions not to purchase these therapies will prevent individual GPs providing NHS funding for them. As one observer said,

'GP fundholders were small groups who could be imaginative; with PCGs it may be hard for those who want to make use of therapies to do so and stand up and be counted.'

Although Local Health Care Co-operatives (LHCCs) in Scotland and equivalent primary care structural changes in Northern Ireland are, as yet, not so advanced, it is anticipated that similar issues will arise in due course.

1.5.3 Labour's reforms

NICE will issue clinical practice guidelines to the NHS based on relevant evidence of clinical and cost-effectiveness. It will examine both new interventions (drugs, devices, procedures) and current practice, to 'identify unjustified variations in use, or uncertainty about clinical and cost-effectiveness'. It will produce guidance on the appropriate use of particular interventions at each stage of the management of a condition from self-care, through primary and secondary care, to specialist care. The government White Paper, *A First Class Service: Quality in the New NHS* (1998) states,

'National guidance will mean that interventions with good evidence of clinical and cost-effectiveness will be actively promoted so that patients have faster access to treatments known to work. Equally it will help protect patients from new interventions with inadequate evidence of clinical and cost-effectiveness and ensure that interventions which are effective only in limited circumstances are appropriately used.'

National Service Frameworks will be developed to define national models of care for specific services in an attempt to iron out variations in service provision across the NHS. The Calman-Hine framework (Calman and Hine 1995) for cancer services sets out the standard of care that patients can expect in primary, secondary and specialist care settings. Local cancer services will be expected to organise around this blueprint. Quality of service delivery at local level will be governed by clinical governance frameworks to ensure that the clinical standards drawn up by NICE and national service frameworks are implemented, monitored and updated. The performance and effectiveness of service and governance frameworks will be regularly monitored by the Commission for Health Improvement, and through a National Survey of Patient and User Experience.

The latter initiative is promoted as an 'important lever for change'. Patients will be asked about ease of access to services, waiting times, the

quality of information provided about their care and their views on the 'efficiency of the medical and technical aspects of their care'.

1.5.4. Purchasing policy

In England, health authorities (HAs) and PCGs will be responsible for drawing up commissioning strategies for primary and secondary care, informed by local health needs and national guidelines. HAs will draw up a three-year Health Improvement Plan (HIMP) in conjunction with local health professionals. These will identify: health needs; the services needed to meet those needs; and the financial investment required. PCGs will commission health services for their populations within the HIMP framework. According to the White Paper *The New NHS – Modern, Dependable*,

'PCGs will be able to make choices about cost-effective patterns of services and will be free to switch resources over time to support them.'

There is no formal national NHS guidance on the purchasing of complementary therapies. The Health Secretary (Dobson 1998) has made the following statement by way of a general strategic approach,

'What counts is what works – We are trying to raise clinical standards by promoting evidence-based medicine. More and more rigorous standards are being applied both to therapeutic practices and the practitioners themselves – and effective complementary and alternative therapies have nothing to fear from that.'

The Public Health Minister has elaborated on this,

'It is for local purchasers and clinicians to decide how their resources would be best used to meet the health needs of their populations, having taken into account all of the available evidence as to the most appropriate and effective forms of treatment, whether conventional or complementary.'

(Hansard, written answers, 30 March 1999, col. 650)

A Junior Health Minister, asked in Parliament about what plans he had to increase the availability of homoeopathic and herbal medicines for cancer treatments on the NHS, said,

'Like other forms of treatment, the availability of homoeopathic and herbal medicines on the NHS is a matter, firstly for the clinical judgement of the clinician in respect of individual patients and secondly, upon decisions taken at a local level on how resources should best be used to meet the health needs of the local population in the context of local health implementation plans.'

(Hansard, written answers, 13 April 1999, col. 106)

Both GPs and health authorities have in the past elected not to purchase complementary therapies, or specific complementary therapy interventions. One survey published in the *Journal of the Royal Society of Medicine* found that among GPs the most common obstacle to purchasing complementary therapies was lack of finance (Wearn and Greenfield 1998). Other obstacles were lack of time and shortage of practice space. Although the government is determined to introduce evidence-based purchasing, the survey found that,

'GPs seem more concerned about the physical and financial factors that directly affect the practice than about evidence of efficacy.'

Anecdotal evidence from the Royal London Homoeopathic Hospital suggests that HA decisions on whether to refer to the hospital are based on two main factors. These are finance and effectiveness – although the balance between the two is constantly shifting. As a spokesperson said,

'One of the big frustrations is that HAs are eclectic organisations. One of the things we have found quite difficult is deciding who is the key influence – the finance director or the director of public health.'

Enfield and Haringey HA decided in 1998 to cease funding homoeopathy (but not other forms of complementary therapy). A spokesperson stated that it 'had not received any good evidence of the effectiveness of

homoeopathic medicines for any condition' and concluded,

'I do not believe the HA should fund harmless but ineffective treatments; rather, the effective application of effective treatments should be pursued.'

It was explained that the anticipated savings to the HA were relatively small (£92 000 per annum), and should homoeopathic remedies be proven effective, they would be purchased.

A survey and report by the NHS Confederation found,

'A constant theme emerging from the study was a lack of understanding of complementary therapies on which to base decisions both about their clinical effectiveness and their operational management – There would appear to be a need for a government-funded national initiative – to ensure that such issues as effectiveness, training, qualifications, competence and funding are addressed.'

(NHS Confederation 1997)

1.5.5 The future

At a national level there would appear to be a contradiction between the government's wish to ensure NHS-wide equality of access to treatment through the implementation of framework standards, and its general policy that purchasing is a 'local decision'. In the absence of national guidelines on complementary therapy purchasing, the 'lottery by postcode' of NHS complementary therapy provision will continue. Until guidelines (themselves informed by research into effectiveness) are provided, there is evidence to suggest that complementary therapies, while a relatively marginal element of NHS purchasing, will be among the first services to be squeezed whenever lack of finance dictates cuts in provision. The move to an evidence-based approach to purchasing these therapies, possibly through NICE, may prove key to its future in the NHS.