

10. Therapies

This section looks at the use of 7 therapies in supportive and palliative care, namely, massage, aromatherapy, reflexology, homeopathy, acupuncture, hypnotherapy/hypnosis and healing. The following information is provided for each therapy:

- Brief description
- Evidence base
- Use of the therapy in supportive and palliative care (S&PC)
- Practitioner training and qualifications

▪ Evidence base

Search for evidence on the use of the different therapies in palliative care was via the following databases: AMED, BNI, RCN Journals, CINAHL, CISCOP, Medline, PubMed and the databases at the King's Fund. The terms used in the search were: (acupuncture or aromatherapy or massage or reflexology or homeopathy or homoeopathy or acupressure or hypnotherapy or shiatsu or healing or therapeutic touch or reiki) and (pain or anxiety or depression or well-being or well being or constipation or nausea or vomiting or sleep or symptom control or quality of life or self-esteem or self esteem or confidence or mood* or breathlessness or dyspnoea or dyspnea or fatigue or spiritual distress or support or pleasure) and (end of life or palliative care or terminal or hospice or supportive or oncology or cancer or neoplasm or chemotherapy or radiotherapy) and (clinical or trial* or controlled or randomised or non-randomised or systematic review* or qualitative or study or research or project or audit or evaluation or pilot or patient* survey* or consumer choice).

The purpose of the above was to search for evidence on how the therapies may be useful in cancer and palliative care. It was not the intention of the project, nor within its scope, to conduct a systematic review of evidence, and this was not performed.

Evidence was also identified through collaboration with colleagues in the different fields, and the sharing of information.

The available literature was sorted and reviewed according to the following categories, wherever possible, and a summary is provided of symptoms / conditions where the therapy may be useful in supportive and palliative care.

- Systematic reviews
- Randomised and non-randomised trials, with and without control, including pilot studies
- Qualitative / observational / evaluative / outcome-based studies
- Evaluations of service and/or surveys of patient satisfaction

- **Practitioner Training and Qualifications**

The issue of what constitutes adequate training and recognised qualifications is contentious, especially in view of the non-differentiation for most therapies between regulation of the profession, and accreditation of training courses/establishments. The information provided is as accurate as possible within a constantly changing picture. As indicated within each therapy sub-section, up-to-date information is available from The Prince of Wales's Foundation for Integrated Health (www.fimed.org).

10.1 MASSAGE

10.1.1 Brief Description

Massage is the manipulation of the soft tissues of the body for therapeutic purposes (Calvert 1992; Jackson 1993). There are a number of 'schools' of massage (Russell 1994), for example Swedish, remedial, and sports massage. These guidelines include the concept of therapeutic massage, where the language of touch is itself an independent channel of communication (Weiss 1979, Westland 1993, McNamara 1999). The essence of the therapeutic process is embodied in the concept of 'skillful touch' (Juhan 1987), and 'essential touch' (Smith 1990).

In cancer care, Simonton (1991, cited McNamara 1999:21) indicates that "good therapeutic massage is massage done by a well-trained massage therapist who is sensitive to the problems of massaging people with cancer, and is comfortable dealing with people who are seriously ill." Therapeutic massage consists of gentle rhythmical touch, with movements varied to suit individual needs, and a clear start and finish to the session (McNamara 1999).

The recognition that touch and massage can have therapeutic value dates back to the Yellow Emperor's Classic of Internal Medicine (about 2500 BC), Sanskrit texts, Homer's Odyssey, Hippocrates and Asclepiades, Galen in the Middle Ages, and Paracelsus in the 15-16th centuries. There is a vast amount of anecdotal as well as research evidence which suggest that massage therapy has the potential to produce physiological and psychological benefits for palliative care patients (cited Wilkie et al 2000). There are many theories on how massage works (eg Juhan 1987, McNamara 1999).

10.1.2 Evidence base

In cancer care, the scientific evidence relies on a number of studies, mainly based on small numbers. Corner et al (1995)'s quasi-experimental study with 52 cancer patients over 8 weeks found that massage had a significant effect on anxiety, assisted relaxation and reduced physical and emotional symptoms. Wilkie et al (2000) carried out a randomised controlled pilot study with 29 patients to evaluate the effects of massage on

pain intensity, analgesics and quality of life of cancer patients. The study confirmed the findings of other studies, that the use of massage to modify anxiety and the perception of cancer pain is effective in the short-term (Ferrell-Torry & Glick 1992; Meek 1993, Weinrich & Weinrich 1990). However, Wilkie et al's power analysis indicated that a study with a larger number is likely to detect statistically significant (positive) effects of usual hospice care combined with twice-weekly massage on pain intensity, analgesic doses and quality of life.

The results from Wilkinson et al's (1999) study with 103 cancer patients, randomised to receive massage or aromatherapy, suggest that massage, either with or without an essential oil, is beneficial for reducing anxiety levels in patients with advanced cancer. Grealish et al (2000) measured the (short term) effects of foot massage on pain, nausea and relaxation in 87 hospitalised cancer patients, using a quasi-experimental research design. Foot massage was found to have a significant immediate effect on reducing pain and nausea, and encouraging relaxation.

Pan et al's (2000) systematic review of complementary and alternative medicine in the management of pain, dyspnoea and nausea and vomiting near the end of life concludes that, amongst other therapies, massage may provide pain relief.

A Cochrane Systematic Review to answer the question "Does massage or aromatherapy massage decrease psychological morbidity, lessen symptom distress and/or improve quality of life in patients with a diagnosis of cancer in the short and/or longer term?" is underway (Lockhart-Wood, Gambles, Wilkinson 2001). ***(Trends to come)***

Billhult and Dahlberg's (2001) phenomenological research, on eight female cancer patients' experience of massage on 10 consecutive days, describes the experience of 'meaningful relief'. The relief was meaningful for a number of reasons: it offered relief from suffering, an experience of being able to 'feel good' in spite of the cancer and its treatment, feeling "special", empowerment and autonomy, and the massage contributed to the development of a positive relationship with the therapist.

Breden (1999) conducted a qualitative study of three women's experience of therapeutic massage following mastectomy and body image problems. She concluded that therapeutic massage, combined with listening to the women's experiences, could help with certain aspects of adjustment to having had a mastectomy.

Audits and evaluations of service, and interviews show that patients feel they benefit from massage (eg Bell 1999; Billhult & Dahlberg 2001; Byass 1999, Wilkinson 1995). Patients seek therapies to enhance hope (Downer et al 1994), as well as to reduce anxiety, stress and pain. The evidence of use clearly shows that massage is one of most widely-used therapies in supportive and palliative care (eg Wilkes 1992; Ernst 1997; Coss 1998; Bell 1999; Lewith et al 2001; FIM 2001, MacMillan 2002).

It may be concluded that massage is an acceptable intervention with cancer patients. The best available evidence suggests that massage may be useful in:

- **Reducing stress and tension** (eg Garnett 1994; Wilkinson 1995)
- **Alleviating anxiety** (eg Ferrell-Torry & Glick 1992; Corner et al 1995; Wilkinson et al 1999; Byass 1999)
- **Reducing pain intensity** (eg Ferrell-Torry & Glick 1992; Smith et al 1994; Byass 1999; Wilkinson 1995; Field 1998; Wilkie et al 2000; Grealish et al 2000)
- **Reducing nausea** (Grealish et al 2002)
- **Reducing depression** (Wilkinson 1995; Field 1998, Jorm et al 2002)
- **Promoting relaxation** (eg Ferrell-Torry & Glick 1992; van der Riet 1999; Byass 1999; Wilkie et al 2000, Grealish 2002)
- **Improving well-being and quality of life** (eg Wilkinson 1995; Wilkie et al 2000, Billhult & Dahlberg 2001)
- **Altered body image** (Breden 1999, van der Riet 1999)

10.1.3 Massage in S & PC

There is still uncertainty about how and when cancer metastasises. There is a myth/fear that increasing circulation through massage could encourage the spread of cancer. Exercise or taking a warm bath is said to increase circulation equally, if not more than (gentle) therapeutic massage. Some oncologists and radiotherapists have stated that there is no evidence that massage increases the spread of lymphoma or indeed leukaemia cells, and that cancer is not a contraindication to receiving massage (Sikora 1991, cited McNamarra 1999; MacDonald 1999). Nevertheless, equally, there is no evidence that massage does not spread cancer. In the absence of clear evidence on whether or not massage can spread cancer, it is important to work within the boundaries of contraindications and precautions for supportive and palliative care.

10.1.3.1 General contraindications

Massage therapists are trained to assess / screen for conditions in which treatment is contraindicated for any individual.

10.1.3.2 Precautions

Massage therapists with limited experience in supportive and palliative care will need further training and supervision (see Section 6 on Supervision) from an experienced massage therapist. Clinical issues to be considered for people with Motor Neurone Disease, Parkinson's Disease and Multiple Sclerosis are addressed in Section 9.3. The following guidelines on the use of massage in cancer care form a general consensus within cancer and palliative care organisations (McNamarra 1999, FIM 2001):

- **Avoid** using any pressure directly on the area of the cancer.
- **Avoid** pressure work with patients who have a low platelet count. What is considered a low platelet count varies; some haematology consultants advise that patients with a platelet count of 50,000 or less are not treated with massage/aromatherapy or reflexology
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- **Be aware** of the risks of massaging patients with areas of petechiae (ie presence of 'pinprick' bruising – indicators of very low platelet count): use light / 'holding' touch only unless working in a specialist area and with medical team
- **Avoid** massaging areas of bony metastases, and use light / 'holding' touch only
- Unless specially training or qualified in the management of lymphoedema, **avoid** a limb affected by lymphoedema, and use only very light touch on any (other) limb affected by the removal / reduced function of lymph nodes
- **Avoid** massaging over ascites (fluid retention in the abdomen), and use light / 'holding' touch only
- **Avoid** stoma sites, dressings, catheters, TENS machines, etc.
- **Be aware** that patients with advanced cancer/severely impaired mobility are more susceptible to low grade, undiagnosed and asymptomatic, deep vein thrombosis (Johnson et al 1999); use very gentle massage only
- **Be aware** that patients have a lowered immune function, ie more susceptible to infection
- **Be aware** that the skin can be sensitive, and/or 'papery-thin' due to medication and treatment – use very light touch only.
- **Be aware** of other clinical issues (refer to Section 9.2)
- **Radiotherapy**
 - **Be aware** of possible side effects, eg fatigue, soreness of skin, digestive disturbance
 - **Avoid** the radiotherapy entry and exit sites during and for 3-6 weeks following radiotherapy (check and assess whether the skin is still sensitive/tender/sore)
 - **Encourage** the patient to seek advice from the radiotherapy department regarding the use of gels and creams
- **Chemotherapy**
 - **Be aware** of possible side effects of chemotherapy on the whole

person, eg nausea, extreme fatigue, lowered immune function and increased risk of infection, increased risk of bruising, dryness/peeling of skin, digestive disturbance, altered sensation in extremities, hair loss

- **Consider** using gentle massage only, as the patient's system may not be able to cope with a deep treatment

- **MRSA infection**

- (Check whether the patient has Methicillin Resistant Staphylococcus Infection (MRSA) – see referral form or ask the patient/carer)
- Thorough hand-washing with soap and water, as when treating any other patient.
- Gloves and aprons should be worn when treating a patient who has MRSA isolated in body fluids, such as sputum, urine, leaking wounds. In a clinical environment, the aromatherapist should check with medical / nursing staff.
- Organisations in which aromatherapy is provided in a non-clinical environment should check with the patient's doctor, and seek advice on necessary precautions.

10.1.3.3 Modification of approach in S&PC

Massage therapists with limited experience in supportive and palliative care will need guidance and supervision (see Section 6 on Supervision) on modifying treatment. The following guidelines on the use of massage in cancer care form a general consensus amongst massage therapists and other professionals in cancer and palliative care (eg McNamarra 1999, FIM 2001):

- Modify pressure according to the patient's preference – be guided by body language and clinical issues (see Section 9)
- Adapt approach and duration of session to take account of the physical, emotional and energetic condition of the patient (eg use very light touch if the patient is very tired, unwell, emotionally labile). Consider massaging part of the body only, and shorter sessions

10.1.3.4 Teaching carers / patients

It is recommended that, where appropriate, carers and patients are taught basic massage skills, using a base oil, or a pre-blended oil.

10.1.3.5 Possible effects

Massage therapists are trained to inform the patient of possible effects of a treatment, which should not be a cause for concern.

10.1.4 Practitioner Training and Qualifications

10.1.4.1 Training

Massage therapists should be able to practice at the level of the National Occupational Standards for Massage Therapy. The NOS are the minimum standard of practice proposed for massage therapists, and are currently being developed.

In tandem with developing the NOS, the General Council for Massage Therapy are developing the (minimum) core curriculum which would enable a practitioner to practice at the level of the proposed NOS. The proposed core curriculum includes 120 class hours divided into:

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| - | Anatomy, Physiology & Pathology | 55 hours |
| - | Massage (whole body) | 60 hours |
| - | Business, Professional and Ethical studies | 5 hours |

and a minimum of 30 treatments, with a minimum of 12 clients receiving two treatments each.

10.1.4.2 Regulatory Bodies

The General Council for Massage Therapy (GCMT) is working towards a single regulatory body for massage therapy. Massage therapists should be registered

with one of the following seven professional regulating bodies that are currently members of the GCMT:

- Fellowship of Sports Masseurs and Therapists (FSMT)
- Guild of Complementary Practitioners
- ITEC International
- LCSP Register for Remedial Masseurs (LCSP)
- Massage Therapy Institute of Great Britain (MTIGB)
- Massage Training Institute (MTI)
- Scottish Massage Therapists Organisation (SMTO)

The issue of qualifications and regulation is an evolving process. Up-to-date information can be obtained from the Prince of Wales's Foundation for Integrated Health.

10.1.4.3 Insurance

Massage therapists should hold professional indemnity and public liability insurance for a minimum of £1 million.

10.1.4.4 Continuing Professional Development (CPD)

The annual renewal of registration with the above regulatory bodies requires a minimum number of CPD hours.

Massage therapists working in supportive and palliative care should receive additional training or be able to demonstrate competence in adapting treatment.

10.2 AROMATHERAPY

10.2.1 Brief Description

Aromatherapy is the systematic use of essential oils in treatments to improve physical and emotional well being (NOS 2002). Essential oils are non-oily, highly fragrant essences extracted from plants (Tisserand 1988). These natural plant oils are flammable, evaporate easily, are absorbed through the skin, and are applied in a variety of ways, which include massage, vapourisers, baths, creams and lotions, and compresses. Aromatherapists in the U.K. are trained to use essential oils topically and through inhalation (Buckle 1997); elsewhere in the European Union essential oils can be taken orally when prescribed by medical doctors and medical herbalists trained in their use.

10.2.2 Evidence base

As massage is the most widely used medium for applying essential oils in palliative care, the evidence for massage therapy (see section on massage) should be considered alongside this section .

Cooke & Ernst (2000) undertook a systematic review of the use of essential oils and aromatherapy massage in reducing anxiety for patients in a health care setting. Six trials met the inclusion criteria. Three studies were conducted in cancer and palliative care, evaluating the use of aromatherapy and essential oils with massage for reduction of anxiety and symptom scores, and increase in well-being / quality of life (Corner et al 1995; Wilkinson 1995; Wilkinson et al 1999). The results of the studies suggest that aromatherapy massage can be helpful for anxiety reduction in the short term.

However Cooke & Ernst (2000) concluded that the trials were comprised of small samples and lacked methodological rigour. There was no differentiation between the effects of any transdermal absorption, the effects of smell and the influence of psychological factors. The methodologies were considered “sufficiently flawed to

prevent firm conclusions from being drawn". However, it was acknowledged that a double-blind design to compare aromatherapy treatments is probably impossible to achieve. In view of the above, and the increasing popularity of aromatherapy, it was recommended that national guidelines on the use of aromatherapy (and other complementary therapies) within the health service should be developed.

Corner et al (1995)'s quasi-experimental study with 52 cancer patients, compared the effect of an 8-week course of massage, with or without a blend of essential oils, on patients undergoing cancer treatment. Patients were randomised into one of two treatment groups, with a control group of patients who were unable to attend for massage. Patients were interviewed before the study began and at 8 weeks following completion, and outcome measures included the Hospital Anxiety and Depression scale (Zigmond and Snaith 1983) and a quality of life and symptom distress scale (Holmes and Dickerson 1987). The results suggest that massage has a significant effect on anxiety, and this was found to be greater where essential oils were used. Massage also assisted relaxation and significantly improved emotional symptoms, in particular concentration, mood, feelings about appearance and the future. Massage with essential oils showed significant overall improvement in pain, mobility, tiredness, function and ability to return to paid employment.

Wilkinson et al (1999) researched the effectiveness of massage and aromatherapy massage in improving the quality of life of patients with advanced cancer, and patients' perception of the value of aromatherapy massage in improving their quality of life. Patients were randomly allocated to one of the two treatment groups, and received a course of 3 full body massages, with or without the essential oil Roman Camomile. Outcome measurements included the Rotterdam Symptom Checklist (De Haes et al 1990), the State-Trait Anxiety Inventory (Spielberger et al 1983), and a semi-structured questionnaire completed 2 weeks after the last treatment to explore patients' perceptions of the treatment. Both the preliminary study with 51 patients (Wilkinson 1995) and the final results with 103 patients (Wilkinson et al 1999) showed an improvement in quality of life in both groups, with statistical significance in the

aromatherapy group. The results also showed a significant reduction in anxiety in both groups, although the effect was transient. Comparison of results between the two groups suggest that massage with essential oil enhances the effect of the massage, and improves the physical and psychological symptoms, as well as overall quality of life. From the patients' perception, massage or aromatherapy is beneficial in reducing anxiety, tension, pain and depression.

A study not included in the Cooke & Ernst (2000) review was the randomised controlled pilot study (Manderson, Weller, Wilcock, Ernst et al 2001) which assessed the effect of aromatherapy massage in palliative day care. Forty-six patients were randomised to receive day care alone or day care plus weekly aromatherapy massage for four weeks, using a standardised blend of oils. Outcome measures included the centre's own questionnaires which rated quality of life, physical symptoms and patient satisfaction. The scale Profile of Mood States (POMS) was also used. All patients were satisfied with aromatherapy massage and wanted to continue with treatment. There was improvement in all measures in both groups but there was no statistically significant difference between the groups. Due to the high attrition rate, it was recommended that multi-centre trials were necessary for studies of sufficient power.

A multi-centre randomised controlled trial (Wilkinson, Ramirez, Maher, Sun, et al 1999) to evaluate the use of aromatherapy massage in improving psychological distress and other components of quality of life in patients with cancer has been designed in line with Cooke & Ernst's (2000) recommendations. The inclusion criterion was patients with cancer who were psychologically distressed, as assessed by a structured psychiatric interview to be experiencing depression and/or generalised anxiety disorder. Results of this study will be reported in early 2003.

A Cochrane Review to take forward the work of Cooke & Ernst (2000) is in process. This review is on the use of massage and aromatherapy for symptom relief in patients with cancer (Barnes, Wilkinson, Lockhart-Woods 2001).

There are a number of service evaluations / audits on the use of aromatherapy massage in cancer care (eg Evans 1995; Kite, Maher et al 1998; De Valois & Clarke 2001, Hills & Taylor 2001; Hadfield 2001). The findings are similar to those of the abovementioned trials, showing improvement in psychological symptoms such as anxiety, depression, tension / stress, emotions such as fear, anger, guilt, as well as physical symptoms including pain. From the patients' perception, relaxation and reduced tension are most commonly identified benefits.

Despite the lack of scientific evidence on the effects of aromatherapy, aromatherapy remains one of the most widely used therapies in supportive and palliative care (Manasse 2001, Lewith et al 2002, FIM 2001, Macmillan 2002). From the patients' perspective, the service evaluations and audits also support perceived effectiveness and satisfaction. In summary, the best available evidence indicates that aromatherapy (and massage) may be useful in the following ways:

- **Inducing relaxation** (eg Corner et al 1995, Manasse 2001, Hadfield 2001)
- **Reducing anxiety** (eg Corner et al 1995; Wilkinson 1999; Hills & Taylor 2001)
- **Reducing depression** (eg Wilkinson 1995; Hills & Taylor 2001)
- **Reducing pain intensity** (eg Ferrell-Torry & Glick 1992; Smith et al 1994; Wilkinson 1995; Field 1998; Byass 1999; Wilkie et al 2000)
- **Reducing nausea** (eg Grealish et al 2002)
- **Improving sleep pattern** (eg Hills & Taylor 2001)
- **Reducing psychological distress** (eg Kite, Maher et al 1998)
- **Improving well-being and quality of life** (eg Wilkinson 1995; Wilkie et al 2000; Billhult & Dahlberg 2001)
- **Altered body image** (Breden 1999; Van der Riet 1999)

10.2.3 Aromatherapy in S&PC

10.2.3.1 General contraindications

Aromatherapists are trained to assess / screen for conditions in which treatment is contraindicated for any individual.

10.2.3.2 Precautions

Aromatherapists with limited experience in supportive and palliative care will need further training and supervision (see Section 6 on Supervision) from an experienced aromatherapist. Clinical issues to be considered for people with Motor Neurone Disease, Parkinson's Disease and Multiple Sclerosis are addressed in Section 9.3. The following guidelines on the use of aromatherapy in cancer care form a general consensus within cancer and palliative care organisations (eg McNamarra 1999; FIM 2001), and could be included in the induction / training, as needed.

10.2.3.2.1 Aromatherapy massage

- **Avoid** using any pressure directly on the area of the cancer
- **Avoid** pressure work with patients who have a low platelet count. What is considered a low platelet count varies; some haematology consultants advise that patients with a platelet count of 50,000 or less are not treated with massage/aromatherapy or reflexology
- **Be aware** of the risks of massaging patients with areas of petechiae (ie presence of 'pinprick' bruising – indicators of very low platelet count) : use light / 'holding' touch only unless working in a specialist area and with medical team
- **Avoid** areas of bony metastases, and use light / 'holding' touch only
- Unless specially trained or qualified in the management of lymphoedema, **avoid** a limb affected by lymphoedema, and use only very light touch on any (other) limb affected by the removal / reduced function of lymph nodes
- **Avoid** massaging over ascites (fluid retention in the abdomen), and use light / 'holding' touch only
- **Avoid** stoma sites, dressings, catheters, TENS machines, etc.
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- **Be aware** that patients with advanced cancer/severely impaired mobility are more susceptible to low grade, undiagnosed and asymptomatic deep vein thrombosis (Johnson et al 1999); use very gentle massage only
- **Be aware** that patients have a lowered immune function, ie more susceptible to infection
- **Be aware** that the skin can be sensitive, and /or 'papery-thin' due to medication and treatment – use very light touch only.
- **Be aware** of other clinical issues (refer to Section 9.2)
- **Radiotherapy**
 - **Be aware** of possible side effects, eg fatigue, soreness of skin, digestive disturbance
 - **Avoid** the entry and exit sites during and for 3-6 weeks following radiotherapy (check and assess whether the skin is still sensitive/tender/sore)
 - **Encourage** the patient to seek advice from the radiotherapy department regarding the use of gels and creams
- **Chemotherapy**
 - **Be aware** of possible side effects of chemotherapy on the whole person, eg nausea, extreme fatigue, lowered immune function and increased risk of infection, increased risk of bruising, dryness/peeling of skin, digestive disturbance, altered sensation in extremities, hair loss
 - **Be aware** that patients could have extremely altered smell preferences
 - **Consider** using gentle massage only, as the patient's system may not be able to cope with a 'detoxifying' treatment, and skin is often sensitive to touch
- **MRSA infection**
 - (Check whether the patient has Methicillin Resistant Staphylococcus Infection (MRSA) – see referral form or ask the patient/carer)
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- Thorough hand-washing with soap and water, as when treating any other patient.
- Gloves and aprons should be worn when treating a patient who has MRSA isolated in body fluids, such as sputum, urine, leaking wounds. In a clinical environment, the aromatherapist should check with medical / nursing staff.
- Organisations in which aromatherapy is provided in a non-clinical environment should check with the patient's doctor, and seek advice on necessary precautions.

10.2.3.2.2 Aromatherapy via vapourisers

- **Be aware** of respiratory conditions (eg asthma)
- **Be aware** when used in a room where there are other patients or individuals with respiratory conditions, or different smell preferences/allergies
- **Use electric vapourisers in the presence of oxygen**
- **Burners** - follow the health and safety policy of the organisation with regards to fire risks if using aromatherapy burners, eg patients should not be left on their own at any time when a burner is used and burners should not be left unattended.

10.2.3.3 Modification of approach in S&PC

Aromatherapists with limited experience in supportive and palliative care will need guidance and supervision (see Section 6 on Supervision) on modifying treatment. The following guidelines on the use of massage in cancer care form a general consensus amongst massage therapists and other professionals in cancer and palliative care (eg McNamarra 1999, FIM 2001):

- Modify pressure according to the patient's preference – be guided by body language and clinical issues (see Section 9)
- Adapt approach and duration of session to take account of the physical, emotional and energetic condition of the patient (eg use very light touch if the patient is very

- tired, unwell, emotionally labile). Consider massaging part of the body only, and shorter sessions (eg 20-30 minutes).

10.2.3.4 Teaching carers / patients

It is recommended that, where appropriate, carers and patients are taught basic massage skills, using pre-blended oils.

10.2.3.5 Possible side and/or adverse effects

- Aromatherapists are trained to inform the patient of possible effects of a treatment, which should not be a cause for concern
- Possible skin reactions (Buckle 1997)
 - irritation – this would occur immediately, producing contact dermatitis
 - sensitivity – an allergic reaction which occurs over time, after habitual use, in the form of inflammation or as a rash. Patients who have allergic reactions to substances (eg hayfever) or who are taking other medication are likely to be more sensitive to essential oils (Buckle 1997).
 - Phototoxicity – some chemicals in citrus oils (eg lemon, bergamot, grapefruit, lime) are known to cause phototoxicity (eg Buckle 1997)
- Reactions with orthodox drugs – essential oils are used in such small amounts (eg 1% dilution in S&PC) that, unless taken orally, they are unlikely to affect the therapeutic action of most orthodox medication (Tisserand and Balacs 1995)

10.2.3.6 Essential oils

In the absence of scientific data, the following guidelines form a general consensus amongst aromatherapists working in palliative care (eg Buckle 1997; Price & Price 1995; FIM 2001).

There is a difference in opinion regarding the need to recommend oils which are considered 'safe', and those to be avoided / used with precaution in certain

conditions, such as with oestrogen sensitive cancers, patients with reduced kidney function, and hypertension. There is no definitive evidence to support the range of opinions, and it is recommended that professionals refer to the work of Tisserand and Balacs (1995) “Essential Oil Safety”, and experienced aromatherapists working in supportive and palliative care.

10.2.3.6.1 Decision to use essential oils

- The decision to use (and mix) essential oils should only be made by aromatherapists who meet the standard indicated later in this section.
- Essential oils should only be used (and mixed by aromatherapists) following assessment of the patient or screening for contraindications
- Develop a protocol for the safe use of a range of essential oils by other members of the clinical team in situations, such as, for use with vapourisers
- Massage therapists, practitioners of simple massage or carers should use blends made by aromatherapists

10.2.3.6.2 Blending and strength of oils

- It is the general consensus within aromatherapy education and training that a 1% dilution (or less) is used with children and adults with vulnerable health. Supportive and palliative care patients fall within this category.
- It is suggested that bath blends are first diluted in a medium, and that essential oils are not mixed ‘neat’ in bath water as the patient’s skin may be hypersensitive.

10.2.3.6.3 Buying oils

- Essential oils should be purchased from a supplier who is a member of the Aromatherapy Trade Council (ATC))
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- Suppliers should supply a safety data sheet for each oil purchased (CHIP 1994; COSHH 1994; Buckle 1997), including a GLC readout of constituents of the oil.

10.2.3.6.4 Storage and packaging

Undiluted essential oils should be stored and packaged as follows (Buckle 1997; Price & Price 1995; Tisserand & Balacs 1995):

- In a locked container at all times, away from naked flames, food or drink
- Oxidation changes the chemical composition of essential oils, and the process is speeded up by heat and light. Undiluted essential oils should be:
 - packaged in blue or amber glass bottles, away from direct sunlight
 - packaged in glass bottles containing integral droppers of UK standard (20 drops per ml).
- Stored in a cool environment (ideally in a refrigerator)

10.2.3.6.5 Accidents with essential oils (Buckle 1997:102)

- Skin reaction to undiluted essential oil
 - Dilute with carrier oil (to dilute), then wash the area with unperfumed soap and water and dry. Keep the bottle to show content, and seek medical assistance
- Undiluted essential oil splashed in the eye
 - Irrigate the eye with milk or carrier oil (to dilute), and then with water. Keep the bottle to show content, and seek medical assistance
- Ingestion of more than 5 mls of essential oil (to be treated as poisons)
 - Give milk to drink, keep the bottle to show content and seek medical assistance.
- Essential oil bottle broken and oil spilt on floor

- Soak up the liquid with paper towel and collect the glass. Dispose of glass in “sharp’s container” in a clinical environment, or wrap in layers of paper and dispose in secured polythene bag in other settings

10.2.3.6.6 Disposal

Empty bottles should be disposed of in “sharp’s container” in a clinical environment, or wrap in layers of paper and dispose in secured polythene bag in other settings

10.2.4 Practitioner Training and Qualifications

10.2.4.1 Training

Aromatherapists should be able to practice at the level outlined in the National Occupational Standards for Aromatherapy (NOS Aromatherapy 2002). The NOS are the minimum standard of practice proposed for aromatherapists.

The (minimum) core curriculum which would enable practitioners to practice at the level of the NOS has yet to be agreed by the Aromatherapy Regulation Working Group. The curriculum which the member organisations of the Aromatherapy Organisations Council (AOC) has agreed to currently consists of 200 class hours divided into:

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| - | Anatomy & Physiology | 40 hours |
| - | Massage (whole body) | 60 hours |
| - | Aromatherapy | 80 hours |
| - | Business, professional and ethical studies | 20 hours |

and 15 case studies 50 treatment hours

over a minimum training period of nine months.

10.2.4.2 Regulatory Bodies

The Aromatherapy Regulation Working Group (ARWG) is working with aromatherapy organisations towards a single regulatory body for the profession.

The ARWG currently consists of the following professional bodies:

- Aromatherapy Organisations Council (AOC)
- International Federation of Professional Aromatherapists (IFPA)
- International Federation of Aromatherapists (IFA)
- Institute of Complementary Medicine (ICM) / British Register of Complementary Practitioners (BRCP)
- British Complementary Medicine Association (BCMA)
- The Aromatherapists Society (AS)

Aromatherapists should be registered with a regulatory body which requires practitioners to be trained, at a minimum, to the National Occupational Standards for Aromatherapy (2002). At present these include the following organisations:

- a. Aromatherapy Organisations Council (AOC) Associations
 - Aromatherapy & Allied Practitioner's Association (AAPA)
 - Association of Holistic Therapies International (AHPI)
 - Association of Medical Aromatherapists (AMA)
 - Association of Natural Medicine (ANM)
 - Association of Physical & Natural Therapists (APNT)
 - English Societe de L'Institute Pierre Franchome (ESIPF)
 - Guild of Complementary Practitioners (GCP)
 - International Holistic Aromatherapy Foundations (IHA)
 - International Federation of Aromatherapists (IFA)
 - ITEC Professionals
 - Renbardou Institute (RI)
- b. International Federation of Professional Aromatherapists (IFPA)
- c. Federation of Holistic Therapists / International Institute of Health and Beauty Therapists (FHT / IHHHT)
- d. Institute of Complementary Medicine (ICM)

The issue of qualifications and regulation is an evolving process. Up-to-date information can be obtained from The Prince of Wales's Foundation for Integrated Health.

10.2.4.3 Insurance

Aromatherapists should hold professional indemnity and public liability insurance for a minimum of £1 million.

10.2.4.4 Continuing Professional Development (CPD)

The annual renewal of registration with the above regulatory bodies requires a minimum number of CPD hours.

Aromatherapists working in supportive and palliative care should receive additional training or be able to demonstrate competence in adapting treatment.

10.3 REFLEXOLOGY

10.3.1 Brief Description

Reflexology is an art and science that deals with the principle that there are reflex areas in the feet and hands which correspond to all of the glands, organs and parts of the body (NOS 2002). The purpose of the systematic application of pressure, using the thumb and fingers, to specific reflex points on the feet (or hands) is to release congestion, promote the flow of energy and promote homeostasis. Reflexology, reflex zone therapy or reflexotherapy are all terms that refer to the current use of the treatment (Tiran 2002).

The language of reflexology is not easily understood by people with conventional western medical training. Reflexology may be more easily understood, in conventional health care settings, as a sophisticated system of touch. Techniques include the application of pressure to all areas of the feet (or hands) that relate to a reflexology map; reflexologists identify areas which have an 'altered texture' (according to the therapist) and then massage these and other related areas (Tiran 2002, Mackereth 2002).

Reflexologists do not diagnose specific medical problems, but aim to treat the imbalances of each individual in order to alleviate symptoms, both physical and emotional (Lynn 1996, NOS 2002).

10.3.2 Evidence base

A randomised controlled study of reflexology treatments with 35 women with premenstrual syndrome during an eight-week period showed a decrease in premenstrual signs and symptoms (including anxiety), significantly more in the intervention group than in the placebo group (Oleson & Flocco 1993).

Stephenson et al (1999) completed a quasi-experimental cross-over study on the effects of foot reflexology on anxiety and pain in 23 patients with breast or lung cancer. A Visual Analogue Scale (Cline, Herman, Shaw & Morton 1992) was used to measure

anxiety, and the Short-Form McGill Pain Questionnaire (Melzack 1987) to measure pain. The study reported a significant decrease in anxiety; the effects on pain reduction were less clear.

Foot massage was used as a nursing intervention in a quasi-experimental study with 87 patients hospitalised with cancer (Grealish et al 2000). Patients were randomly assigned to one of three factor control groups. Heart rate was monitored. Visual analogue scales were used to measure self reports of pain, nausea and vomiting, and relaxation. Findings support the view that foot massage has a significant (immediate) effect on pain, nausea and relaxation.

Hodgson's (2000) study compared the effects of a course of three real or placebo reflexology treatments on the quality of life of 11 patients with cancer. The outcome measures included the Holmes and Dickerson (1987) quality of life scale, modified to incorporate an open-ended question for patients' comments. There was statistical significance in the difference in improvement in quality of life between the two groups: all the patients in the reflexology group reported an improvement. However, improvement in breathing was the only individual symptom with a statistically significant result. The patients' perception, from both groups, was that it was relaxing, calming and comforting.

A Cochrane Collaboration systematic review on the use of reflexology to decrease psychological morbidity and symptom distress, and improve quality of life of cancer patients is underway. ***Trends to come*** (Fellowes, Gambles, Lockhart-Wood and Wilkinson 2001).

Audit and evaluations of service similarly identify relaxation, relief from tension and anxiety, and improved well-being as the primary benefits of reflexology in palliative care (Hills & Taylor 2001; Gambles, Crooke and Wilkinson 2002).

There is much anecdotal literature which similarly support the use of reflexology in cancer care for relaxation, well-being and stress relief (eg Gillard 1995; Stephenson 1996; Botting 1997; Joyce & Richardson 1997; Tanner 2000; Hodgkinson 2000).

Despite the lack of scientific evidence, surveys of patient-use reveal that reflexology is one of the most widely used therapies in cancer care (eg Oneschuk et al 2000; Lewith et al 2001; FIM 2001; Manasse 2000; Macmillan 2002; Gambles, Crooke & Wilkinson 2002).

In summary, the best available evidence indicates that reflexology may be useful in the following ways:

- **Enhancing relaxation** (eg Dossey et al 1995; Hodgson 2000, Gambles, Crooke & Wilkinson 2002)
- **Relieving stress and tension** (eg Dossey et al 1995; Micozzi 1996)
- **Reducing anxiety** (eg Stephenson et al 1999, Hills & Taylor 2001; Gambles, Crooke & Wilkinson 2002)
- **Improving quality of life** (eg Hodgson 2000; Hills & Taylor 2001)
- **Alleviating symptoms**, such as constipation, diarrhoea, pain, nausea, fatigue, poor appetite (eg Hodgson 2000, Hills & Taylor 2001)
- **Alleviating the side effects of chemotherapy** (Hills & Taylor 2001)
- **Providing emotional support** (eg Trousdall 1996; Hodgson 2000; Hills & Taylor 2001)

10.3.3 Reflexology in S&PC

10.3.3.1 General contraindications

Reflexologists are trained to assess / screen for conditions in which treatment is contraindicated for any individual.

10.3.3.2 Precautions (Hodkinson & Williams 2002)

Reflexologists with limited experience in supportive and palliative care will need further training and supervision (see Section 6 on Supervision) from an experienced reflexologist on the following issues:

- **Avoiding** a limb or foot with suspected deep vein thrombosis or obvious varicose veins

- **Avoiding** areas on the foot/hand that relate to new surgical wounds
- **Adjusting** pressure according to patients' needs when working on lymphoedematous feet or hands
- **Avoid** colonic stimulation if there are any symptoms or risk of intestinal obstruction
- **Adjusting** pressure for patients with a low platelet count, taking note of any existing bruising and skin viability. A platelet count of 50 or less is considered low by some haematology consultants.
- **Awareness** that the person's health may fluctuate enormously from day to day
- **Awareness** that peripheral sensation may be affected by the person's psychological state, or medication, such as steroids, narcotics or chemotherapy
- **Awareness** that peripheral neuropathy may be a symptom of diseases such as multiple sclerosis, and certain tumours

10.3.3.3 **Modification of approach in S&PC** (Hodkinson & Williams 2002)

Reflexologists with limited experience in supportive and palliative care will need guidance and supervision (see Section 6 on Supervision) on modifying treatment. In general, a gentle relaxing treatment/pressure should be given, and stimulating treatments avoided. The following are some suggestions for modifying treatments:

- Gentle and sensitive palpation over the zones relating to tumour site(s)
- Assess the condition of the reflexes and adapting treatment accordingly so that the feet are not overstimulated in any way, especially in patients with altered peripheral sensation or peripheral neuropathy

- Establish a working pressure that is comfortable for the patient at all times, and tailoring treatment to avoid strong reactions
- Use an appropriate neutral (natural) medium of base/vegetable oil or cream if the skin is very dry
- Treatments should be individualised in frequency, and length of treatment according to individual health/energy levels.

10.3.3.4 Teaching carers / patients

It is recommended that, where appropriate, basic reflexology skills are taught to carers, and self-help techniques to patients.

10.3.3.5 Possible effects

Reflexologists are trained to inform the patient of possible effects of a treatment, which should not be a cause for concern.

10.3.4 Practitioner Training and Qualifications

10.3.4.1 Training

Qualified reflexologists should be able to practise at the level outlined in the National Occupational Standards for Reflexology (NOS Reflexology 2002).

The Reflexology Forum is currently working on a (minimum) core curriculum, which would enable a practitioner to practise at the level of the NOS. The proposed curriculum consists of 200 teacher contact hours and 600 home study hours over a period of 2 years. A total of 100 recorded treatments would be completed: 6 detailed analytical case studies (involving a minimum of 6 treatments each) and another 64 treatments.

Course content includes:

- Origin, theory and development of reflexology
- Reflexology Technique

- Treatment and Practice Procedure
- Anatomy & Physiology
- Relating Illness and Disease to Reflexology
- Hands and Foot Reflexology

10.3.4.2 Regulatory Bodies

The Reflexology Forum (RF) is working towards a single regulatory body for reflexology. Qualified reflexologists should be registered with an organisation that is currently a member of the RF or one of the other professional bodies for reflexologists:

- Association of Reflexologists (AOR)
- British Reflexology Association (BRA)
- Centre for Clinical Reflexology (CCR)
- Guild of Complementary Practitioners (GCP)
- International Federation of Reflexologists (IFR)
- International Institute of Reflexology (IIR)
- ITEC Professionals
- Reflexologists Society (RS)
- Reflexology Practitioners Association (RPA)
- Scottish Institute of Reflexology (SIR)

Other professional bodies include the British School of Reflex Zone Therapy, Federation of Precision Reflexologists, Reflexology Organisations Council.

The issue of qualifications and regulation is an evolving process. Up-to-date information can be obtained from The Prince of Wales's Foundation for Integrated Health.

10.3.4.3 Insurance

Qualified reflexologists should hold professional indemnity and public liability insurance for a minimum of £1 million.

10.3.4.4 Continuing Professional Development (CPD)

The annual renewal registration with the above regulatory bodies requires a minimum of number of CPD hours.

Reflexologists working in supportive and palliative care should receive additional training or be able to demonstrate competence in adapting the treatment.

10.4 HOMEOPATHY

10.4.1 Brief Description

Homeopathy (Gk: similar – suffering) is the treatment of illness by using medication (known as remedies) prescribed according to the principle that ‘like cures like’. That is to say, the patient is prescribed a remedy which, from experiment and experience, is known to produce very similar symptoms when proved (tested) in healthy people to the symptoms from which the patient is suffering.

The remedies used are derived from plant, animal and mineral sources which, through a process of serial dilution and agitation (succussion), are rendered both dilute and free from side effects (Lewith & Kenyon 2001; Thompson & Reilly 2002a). It is not possible to ‘overdose’ on homeopathic medicines, in the usual understanding of the word, but taking more than one needs over a prolonged period can result in a ‘proving’ of the remedy, which means that one starts to feel and exhibit the symptoms the remedy is meant to cure/relieve. These symptoms resolve when the remedy is stopped or changed to a more appropriate one.

There are different approaches to the practise of homeopathy. In the classical approach, one remedy is prescribed at a time, based on a match of one of the known remedy pictures to the patient’s whole symptom picture, including the symptoms of their presenting/diagnosed complaint. Pluralist homeopathy involves the prescription of several single remedies at a time or close together, often in alternation, according to the practitioner’s perception of different facets of the patient’s condition that need to be treated. Complex homeopathy involves the use of fixed combinations of several remedies in single dose forms prescribed according to the conventional diagnosis of the patient’s presenting condition. Some practitioners will use just one of these approaches while others may use a combination of them.

Homeopathy is practised by homeopaths who are voluntarily self-regulated health care practitioners, and by statutorily registered health care professionals who have done

post-graduate studies in homeopathy after their primary education in a conventional health care discipline. For many of the former group, homeopathy is a second career, and they will often have other professional skills and expertise. The latter group includes doctors, dentists, nurses and pharmacists who use their clinical judgement, within the clinical context in which they work, to determine the extent to which homeopathy is relevant to their patients. Their training to use homeopathy builds on their primary professional training and expertise, and affiliation is to their primary profession (NOS 2000).

10.4.2 Evidence

There have been several large meta-analyses and systematic reviews of the use of homeopathy for different conditions, which show a positive trend, ie that homeopathy appears to be more effective than placebo (Kleijnen et al 1991; Boissel, Cucherat et al 1996; Linde, Melchart et al 1997; Linde & Melchart 1998, Cucherat, Boissel et al 2000). However, the conclusion is that the evidence is not sufficiently convincing because of methodological shortcomings and inconsistencies, as well as some publication bias. The conclusion is that there is a need for more trials of greater methodological quality. It is also not known whether homeopathy is better than other treatments (as opposed to placebo), and for what conditions homeopathy is most effective (RLHH 1999; Lewith & Kenyon 2001).

It was also recommended that homeopaths should critically evaluate their performance and personal experiences in well-planned case series and observational studies as clinical trials seemed to rarely reflect what happens in everyday practice. Homeopathic consultations, the review of cases and prescribing of remedies involves consideration of the person as a whole and is individualised; this approach does not lend itself easily to clinical research.

Ernst's (1999) systematic review of trials of classical homeopathy versus conventional medications for adults and children with rheumatoid arthritis, proctocolitis, irritable bowel disease, malaria, otitis media or tonsillitis, found that the few comparative clinical trials

of homeopathy contain serious methodological flaws. He concludes that the value of homeopathy compared to allopathic medication is unknown. However, Ernst's (2001) overview of exemplary studies and available systematic reviews of complementary therapies in palliative care concluded that, although the evidence is not compelling for any of the therapies, promising results exist for some treatments, including homeopathy.

Since the above reviews were published, there have been other randomised controlled trials. A double blind randomised controlled trial on the efficacy of homeopathic treatment for skin reactions during radiotherapy following surgery for breast cancer involved 65 women (Balzarini, Felish & De Canno 2000). The results suggested that the homeopathic mixture was superior to the placebo in minimising the dermatological adverse effects of radiotherapy.

Oberbaum (1998) described the use of a homeopathic complex preparation in chemotherapy-induced stomatitis in an uncontrolled study with 27 patients, and found a reduction in the duration of symptoms in the treated group. This study was followed by a randomised, double blind controlled trial of the homeopathic medication TRAUMEEL S in the treatment of chemotherapy-induced stomatitis in 32 children undergoing stem cell transplant (Oberbaum et al 2001). Stomatitis scores were evaluated according to the World Health Organisation grading system for mucositis. Results indicated that TRAUMEEL S may reduce significantly the severity and duration of chemotherapy-induced stomatitis in children undergoing bone marrow transplantation. The results of this study are being taken forward in a multi-centre trial on the use of TRAUMEEL S in adults undergoing bone marrow transplant (Thompson 2002).

There are a number of outcome-based observational studies which support the use of homeopathy in cancer care for psychological distress, including anxiety and depression (Clover, Fisher et al 1995), pain (Vozianov & Simeonova 1997, cited Thompson 1999), symptom control and its impact on mood disturbance and quality of life (Thompson & Reilly 2002a; Thompson & Reilly 2000b). A double blind randomised placebo-controlled trial of homeopathy in the management of menopausal symptoms in breast

cancer survivors followed the above pilot study (Thompson & Reilly 2002b), and a paper on the study awaits publication (Thompson 2002).

Case studies describe the effectiveness of homeopathy for various symptoms. These include the value of intrathecal baclofen and homeopathy for the treatment of painful muscle spasms associated with malignant spinal cord compression (Thompson & Hicks 1998), and the use of homeopathic remedies for a patient with advanced cancer of the liver, spleen and gall bladder (Every 1999).

Surveys of patient satisfaction and effectiveness from the patient's perspective of homeopathy used within a package of care showed a high levels of satisfaction (Reilly 1995; Sharples & Van Haselen 1998; GHH 1998; Spene 1999 – cited Boyd 2002). The surveys also showed a reduction in the use of conventional medication, an improvement in the presenting complaint, overall ability to cope and well being, fewer appointments with the general practitioner, outpatients and admissions to other hospitals.

In summary, the evidence for the clinical effectiveness of homeopathy is confusing (Lewith & Kenyon 2001), and scientific research into homeopathy in the cancer setting is in its infancy (Thompson & Reilly 2002). Nevertheless, homeopathy is one of the eight most popular complementary therapies used by cancer patients (Downer et al 1994), and there is evidence that patients find the approach helpful. Although more detailed clinical research is required, the best available evidence suggests that there is some basis for prescribing homeopathic remedies in the following circumstances:

- **Fatigue** (Thompson & Reilly 2002a and b)
- **Hot flushes** (Thompson & Reilly 2002a and b)
- **Pain, including joint pain and muscle spasm** (Clover, Fisher et al 1995; Voizianov & Simeonova 1997; Thompson & Hicks 1998; Thompson & Reilly 2002a)

- **Anxiety and stress** (Clover, Fisher et al 1995; Thompson & Reilly 2002a and b)
- **Depression** (Thompson & Reilly 2002a and b)
- **Quality of life, including mood disturbance** (Clover, Fisher, et al 1995; Thompson & Reilly 2002 and b)
- **Radiotherapy and skin reactions** (Balzarini, Felish & De Canno 2000)
- **Respiratory conditions (eg hayfever, sinusitis, allergic asthma, bronchitis)** (Kleijnen et al 1991; Linde, Melchart et al 1997; Cucherat, Boissel et al 2000)
- **Headaches (incl migraine)** (Kleijnen et al 1991; Linde & Melchart 1997; Linde & Melchart 1998)
- **Post-surgery ileus** (Cucherat, Boissel et al 2000)
- **Rheumatoid arthritis** (Linde & Melchart 1998; Cucherat, Boissel et al 2000)
- **Influenza** (Cucherat, Boissel et al 2000)

10.4.3 Precautions and Possible Side/Adverse Reactions (Scrine 2002; Thompson & Reilly 2002a)

- Aggravation of symptoms at start of treatment – this is unusual in palliative care, is usually short-term and falls away gradually.
- Aggravation of symptoms following repeated doses of a remedy – important to stop the remedy or decrease the frequency of administration, which should be accompanied by an overall improvement in well-being within a couple of weeks.
- Return of old symptoms – this is thought to be a response of the body's self-healing mechanism, where in the process of positive change, previous trauma is revisited briefly before an overall improvement is experienced
- New symptoms – this may mean that the remedy does not match the patient's symptoms and needs to be changed. This can also occur if the correct remedy is chosen but is given too frequently, or if the patient has a history of sensitivity to other medication. When the remedy is stopped, symptoms should cease.

- Effects on symptom control and conventional medication – if homeopathic remedies reduce pain or improve other symptoms, the dose of allopathic medication may need to be reviewed. Otherwise, the clinical experience of homeopaths is that homeopathic remedies are unlikely to interact with allopathic medication in the usual chemical understanding of the term.

10.4.4 Practitioner Training and Qualifications

10.4.4.1 Training

Statutorily regulated health care professionals mostly undertake their post-graduate homeopathy studies with the Faculty of Homeopathy (the Faculty). There are a number of private and university educating homeopaths who are voluntarily self-regulated. The Council of Organisations Registering Homeopaths (CORH) consists of organisations that register homeopaths. The Faculty and CORH agree that education and training should enable all homeopaths, who practise independently, to practice at the level of the National Occupational Standards for Homeopathy (NOS 2000). Until now there has been no formal accreditation mechanism for mapping courses and qualifications against the National Occupational Standards, but the Accreditation Working Group of CORH is currently considering the issue of the standards and accreditation. The Society of Homeopaths has established a formal procedure for course recognition, which mirrors an independent accreditation process. The Society of Homeopaths currently recognises 20 courses that meet its recognition criteria and procedures. Recognition is awarded for a five-year period, after which the course provider is invited to apply for re-recognition.

At the Faculty, there is a structured three level training pathway for medical homeopaths, to Licentiate (one year introductory, LFHom), Diploma (4 years, DFHom – Dent or Pharm), and Membership and Specialist Register (6-8 years, MFHom) level. This training pathway has been submitted to the Specialist Training Authority who accredits all specialist training pathways. The different levels of training qualify practitioners for different levels of practice.

The completion of the Membership level training (MFHom) certifies a doctor's competence to use homeopathy in a wide range of clinical situations in primary care or on referral, with the support of specialist colleagues. The completion of a further two years specialist training, following MFHom, qualifies a doctor for independent specialist practice in the community or within a medical speciality.

For (voluntarily regulated) homeopaths their education and training is delivered either through three year full-time or four year part-time courses in private educational institutions or through university based degree courses. The University of Westminster and University of Central Lancashire currently offer three year full-time BSc (Hons) degree courses of education and training in homeopathy.

10.4.4.2 Licence to Practice

Statutorily regulated health care practitioners who practise homeopathy carry a statutory licence to practice by virtue of their registration with their relevant regulatory body.

(Voluntarily regulated) homeopaths are granted Diploma or University Degree together with a Licence to Practice by their educational establishment once they have successfully completed the course. Although the Licence to Practice is not a legal requirement and does not have any legal status, the courses accepted by the professional bodies define the terms on which a Licence to Practice can be awarded to students. They further stipulate the terms on which candidates can proceed to a register.

10.4.4.3 Regulatory Bodies

Statutorily regulated health care professionals who practise homeopathy can become members of the Faculty of Homeopathy, but the Faculty is not a regulatory body. Statutorily regulated health care professionals who practise homeopathy are regulated by their appropriate regulatory body.

(Voluntarily regulated) homeopaths should be registered with one of the professional organisations which are members of the Council of Organisations Registering Homeopaths (CORH). CORH has been established over the past two years with the primary objective of establishing a single national professional regulatory body of homeopaths for the U.K. The current members of CORH are the existing associations that currently register homeopaths. They are as follows:

- Alliance of Registered Homeopaths (ARH)
- Association of Natural Medicine (ANM)
- British Register of Complementary Practitioners (ICM/BRCP)
- Complementary Medical Association (CMA)
- Fellowship of Homeopaths (FoH)
- Guild of Complementary Practitioners (GCP)
- Homeopathic Medical Association (HMA)
- International Register of Consultant Herbalists (IRCH)
- Society of Homeopaths (SoH)

The issue of qualifications and regulation is an evolving process. Up-to-date information can be obtained from The Prince of Wales's Foundation for Integrated Health, The Faculty (for statutorily regulated health care professionals who practise homeopathy) and CORH (for voluntarily regulated homeopaths).

10.4.4.4 Insurance

Statutorily regulated health care professionals who practise homeopathy are insured to practise homeopathy within their standard insurance to practice as statutorily regulated health care professionals. Insurance of (voluntarily regulated) homeopaths is normally included within their registration with the various existing regulatory/professional bodies; however, some may hold separate insurance.

10.4.4.5 Continuing Professional Development (CPD)

Some of the existing professional bodies for (voluntarily regulated) homeopaths expect members to engage in regular CPD activity, CORH's Registration Working Group is currently considering the issue of CPD with a view to making it essential for all members of an eventual single national register. CPD is obligatory for all

statutorily regulated health care professionals who practise homeopathy and is overseen by a team of trained supervisors within the Faculty of Homeopathy.

10.5 ACUPUNCTURE (Filshie 2002)

10.5.1 Brief Description

Acupuncture is a word derived from the Latin *acus*, 'needle' and *pungere* 'to pierce'. It is a therapeutic technique that involves the insertion of fine needles into the skin and underlying tissues at specific points, for therapeutic or preventative purposes (Ernst 2001). The origins of acupuncture go back at least 2,000 years in China (Ma 1992). Anthropologists and Medical Historians have described many ways in which sensory modulation has been used for therapeutic purposes over the years and in different cultures (Melzack 1994). Indeed, Ötzi, the European Ice Man, discovered in the Alps in 1991 and dated 5,200 years old, had numerous tattoos on his body over areas which corresponded to areas of arthritis on imaging (Dorfer 1999). The locations and asymmetry of the tattoos on the body suggests that they were not ornamental, and many were at many sites commonly used for acupuncture treatment, so it was concluded that they represented a therapeutic technique.

Traditional Chinese Acupuncture (TCA) is used to treat a wide variety of disorders and is a part of Traditional Chinese Medicine (TCM). In TCM, the fundamental concept is *qi* (pronounced 'chee'), which is usually translated as 'energy' (Vickers and Zollmann 1999; Ernst 2001). The roots of the concept '*qi*' and many of the most important traditional acupuncture concepts are at the very heart of Chinese culture – *qi* is associated with the image of a warm hearth, a full stomach, and the sense of well-being (Birch and Felt 1999). It is believed that *qi* is present at birth, circulates throughout the body and controls its workings; when *qi* is fully dissipated death occurs. The major pathways for its circulation are the 'meridians' or channels that form a continuous network throughout the body. The basic concept of health is a balance of two opposites, yin and yang, and illness is seen in terms of disturbances in the flow of the energy.

Practitioners who use this traditional, energetic concept of acupuncture hold the theory that the body can be stimulated to correct its own energy flow and restore balance by needling or pressing on the acupuncture points which lie along the meridians and

elsewhere in the body. TCA practitioners often perform an elaborate pulse and tongue diagnosis and utilise numerous other 'laws' (Lu and Needham 1980; Kaptchuk). Acupressure uses similar principles but without needles; it can be administered with local finger pressure or pressure bands.

Though many western medical acupuncturists undertook initial extensive training in traditional eastern diagnostic techniques, neurophysiological advances in the study of acupuncture caused them to challenge the credibility of the traditional energetic diagnostic approach. Recent neuropharmacological and neurophysiological advances have given acupuncture a sound scientific basis and far more clinical acceptability for the sceptical opponents of the subject. For example, acupuncture's actions are blocked by pre-treatment with injection of local anaesthetic (Chiang, et al, 1973; Research Group of Acupuncture Anaesthesia, 1973; Dundee and Ghaly, 1991). It releases β -endorphin (Sjolund et al, 1977; Clement-Jones et al, 1980), met-enkephalin and dynorphins, which work on MOR, DOR and KOR (μ , δ , and κ) opioid receptors (Han and Terenius 1982; Han et al, 1991). Oxytocin is released which is anxiolytic and analgesic (Uvnas-Moberg et al, 1993). It releases serotonin with both analgesic and mood enhancing properties (Han and Terenius, 1982). It has widespread autonomic effects (Ernst and Lee, 1985; Lundeberg 1999) and releases endogenous steroids (Roth et al, 1997). Acupuncture is thought to up-regulate endogenous opioid gene production (Guo et al, 1996) which explains why 'top-ups' are required in part to maintain the gene expression in a 'switched on' mode (Zieglgänsberger 2002, personal communication).

Indeed, to date there has been little evidence to substantiate the meridian theory (White, 1999), though the meridian pathways frequently coincide with the referral pattern of trigger points (Filshie and Cummings, 1999).

Many neurophysiological mechanisms are described in further detail by Bowsher (1998), Pomeranz (2001), White (1999), Lundeberg (1999), and Filshie and Thompson

(in press). There is approximately a 71% overlap between acupuncture and trigger points (Melzack, Stillwell and Fox, 1977) and trigger point acupuncture is particularly effective for myofascial musculoskeletal pain (Baldry, 2001). The diagnostic value of the pulse diagnosis has also been challenged (Vincent, 1992; King et al, 2002; King et al, 2002).

As a result of the diverse, often challenging, ways in which traditional acupuncture is taught, for example, Chinese, Korean, Vietnamese and Japanese acupuncture, plus Chinese and French auriculoacupuncture or ear acupuncture, western medical acupuncturists often take a more pragmatic approach to treatment. Some have simplified the treatment approach, leaving the complex energetic approach to its historical context only (Mann, 2000; Campbell, 2001; Baldry, 2001). In the UK Traditional Chinese Acupuncture and Western Medical Acupuncture are most often used plus an eclectic mix of treatments such as microsystem acupuncture, for example auriculoacupuncture.

Western Medical Acupuncture treatment is not restricted to pain treatment alone and is used for treatment of multiple problems including respiratory problems, GI symptoms, cardiac, neurological and gynaecological conditions (Filshie and White, 1998) using the following principles. They use a mixture of segmental points appropriate to the disordered segment, for example T1 and T2 when the intercostobrachial nerve is damaged, trigger points, tender points, plus selected traditional 'strong' points which have stood the test of time. Acupuncture is currently performed in over 84% of Pain Clinics (Woollam and Jackson, 1998; CSAG, 2000). Twenty-one per cent of GP practices offer access to acupuncture (Thomas 2001).

Western Medical Acupuncture is used following an orthodox diagnosis based on conventional history taking, examination and special investigations (Filshie and Thompson, in press). This is important as an energetic diagnosis alone is potentially dangerous in certain circumstances (Filshie, 2001). As a result of this, specific training courses have been developed in the UK for palliative care physicians and other medical

practitioners who wish to treat palliative care patients and also acupuncture courses to familiarise other doctors and acupuncture practitioners who work with cancer patients (see 10.5.3).

In palliative care acupuncture is used alongside conventional medical treatment and has an increasing supportive role for pain, symptom management (Filshie; 2001; Wong et al; 2001). Some practitioners advocate its use to enhance psycho-spiritual well-being (Aung, 1994; Wong et al, 2001, though Filshie and Thompson (2000) are more circumspect and acknowledge that psychoneuroimmunomodulation can go part way to explain how acupuncture works on the body and the mind, but suggest that any metaphysical components to acupuncture should be debated in philosophical circles.

10.5.2 Evidence Base

Significant positive evidence is now available based on systematic reviews and meta-analyses for the use of acupuncture for the control of nausea and vomiting (Vickers, 1996), postoperative nausea and vomiting (Lee and Done, 1999), experimental pain (White, 1999), dental pain (Ernst and Pitler, 1998), headache (Melchart, 1999) and fibromyalgia (Berman, 1999). Acupuncture treatment for back pain is somewhat more controversial with a positive review (Ernst and White, 1998), a negative review (Smith, 2000) and a rather neutral review (Van Tulder, 2000). Cummings (2000) has critically appraised these anomalies. Inconclusive evidence exists for stroke, asthma and neck pain and negative evidence for weight loss and smoking cessation (Ernst, 1999), though the results for this are comparable to the success of nicotine patches.

Based partly on Vickers (1996) data on acupuncture for nausea and vomiting, the National Institute of Health Consensus Statement on Acupuncture (NIH, 1997) recommended acceptance of acupuncture as a useful clinical modality of treatment.

Acupuncture has been used to treat acute postoperative pain in cancer patients and also chronic or intractable pain associated with the cancer or its various treatments, for

example surgery and radiotherapy. It is also used for non-pain symptoms such as nausea and vomiting, dyspnoea, xerostomia and many other troublesome problems in palliative care.

The results of clinical trials of acupuncture for pain unrelated to cancer have often been conflicting, with inconclusive results based on heterogeneous data and greatly flawed methodology (Patel, 1989; Ter Riet, 1990). This is hardly surprising, as trial methodology for acupuncture studies is particularly complex (White, 2002). Though randomisation is possible, suitable 'blinding' of patients is problematic, as is the provision of a credible needleless placebo (White, 2001). Though, depending on the research questions asked, it is possible to use an alternative non-acupuncture group for comparison. A more recent pain review of Ezzo et al 2000 was similarly inconclusive but showed some superiority of acupuncture treatment compared with untreated patients.

10.5.2.1 Acute Postoperative Pain and Symptom Control

Acupuncture reduced pre and postoperative analgesic requirements in a randomised controlled trial of 250 patients undergoing major abdominal surgery for cancer (Poulain, 1997). Intradermal needles sited pre-operatively and remaining postoperatively reduced postoperative analgesic requirements in a study involving 191 patients having upper and lower gastrointestinal surgery (Kotani et al, 2001). It also caused less pain and increased mobility in the postoperative period for patients undergoing axillary dissection for breast cancer (He et al, 1999). Acupuncture as an alternative to anaesthesia is risky, but as an adjunct can be very efficacious in reducing pre and postoperative analgesic requirements.

10.5.2.2 Chronic Cancer and Cancer Treatment Related Pain

Acupuncture has been used quite extensively for control of chronic and treatment-related cancer pain. However, the majority of work relies on observational reports, audits and case series to date. It is notoriously difficult to recruit patients to clinical trials in palliative care (Faithful, 1996) and acupuncture is no exception. There is a high attrition rate for conventional studies (Kirkham, 1997), let alone studies in CAM.

In summaries of two extensive audits (Filshie and Redman, 1985; Filshie, 1990), acupuncture was found to improve pain control and reduce analgesic requirements in patients who had failed to respond to conventional treatment, though 'top ups' were likely to be more frequent than with non-cancer patients. An increase in mobility often accompanied pain reduction.

Cancer treatment related pains such as post-surgical syndromes or post-irradiation-like pain respond better than patients with extensive disease. The more advanced the disease, the shorter the response to treatment. Any tolerance to treatment was often an indication for tumour recurrence and hence a warning to check on the cancer status of the patients. Leng (1999) showed similar results in a hospice-based audit. Pain control from abdominal cancer was also achieved for at least one month in a case series of patients with mild or moderate pain and 72% with severe pain (Xu, Liu and Li, 1995) Wen (1977) gave several electroacupuncture treatments per day and then steadily reduced the number of treatments per day on patients who responded with uncontrolled pain. Percutaneous Electrical Nerve Stimulation (PENS) is reported as a 'novel treatment' but appears to be electroacupuncture with a new name. It has been found in one extremely small study to help two out of three patients with periosteal needling (Ahmed, 1998).

Aung (1994) combined acupuncture with Qi Gong and breathing exercises and meditation in his case series. A recent audit by Johnstone et al (2002) showed success for a range of symptoms including pain: 86% of patients considered it 'very important' to continue to provide an acupuncture service. An audit in patients with breast cancer-related pain showed an improvement of depression scores in addition to pain and distress and interference with lifestyle (Filshie et al, 1997). Maintenance of relief is often problematic in cancer patients and two studies showed the short-term improvement in pain control using semipermanent indwelling needles in the ear, auriculoacupuncture, the former included five patients with motor neurone disease (Dillon and Lucas, 1999; Alimi, 2000).

10.5.2.3 Nausea and Vomiting

Numerous randomised controlled trials (RCTs) have been performed using mostly the traditional point PC6 with a variety of stimuli to reduce chemotherapy induced nausea and vomiting. The impact of uncontrolled nausea and vomiting may be significant and may even lead to patients abandoning chemotherapy due to the negative impact on quality of life. Prevention is more successful than treatment once it develops.

Acupuncture, electroacupuncture, acupressure or transcutaneous electrical nerve stimulation (TENS) were all compared with a control treatment. Seven out of eight studies were positive (Dundee et al, 1987; Stannard, 1989; McMillan et al, 1991; Price et al, 1991; Dibble et al, 2000; Shen et al, 2000; Roscoe et al, 2002). Roscoe et al (2002), the negative study, used electrical stimulation at PC6 but did not stipulate the exact electrical parameters used and may have been different from those found to give optimal effect by the late John Dundee and Christine McMillan (1991).

Andrew Vickers (1996) performed the first systematic review on acupuncture for nausea and vomiting and reviewed acupuncture for nausea and vomiting associated with surgery, cancer chemotherapy and morning sickness. The review concluded that, although the studies were not methodologically perfect, PC6 acupuncture seems to be an effective antiemetic technique, though somewhat less effective in some of the trials reviewed when administered under anaesthesia.

Numerous other subsequent reviews have come to similar conclusions (Mayer, 2000; Jacobson, Workman and Kronenberg, 2000; Pan, 2000; Wong, Sagar and Sagar, 2001). However, a preliminary analysis of the Cochrane review (Richardson et al, 2001) examining the effectiveness of acupuncture for chemotherapy-induced nausea and vomiting found that the stimulation of PC6 acupoint reduced vomiting during chemotherapy, but the effect appears to be short-term only. The challenge remains to compare adequately powered RCTs with newer antiemetics such as the 5HT-3 antagonist ondansetron.

Nausea and vomiting in advanced terminal care is considerably more complex and may be due to one or many of the following causes: gastrointestinal problems including intestinal obstruction; drugs, for example strong opioids like morphine; metabolic causes including hypercalcaemia and renal failure; brain metastases; dehydration etc. The cause of the nausea and vomiting needs identifying by orthodox medical diagnosis and clinical tests as appropriate and acupuncture may or may not be indicated. If acupuncture is found to be of potential value, having excluded serious causes, points with known physiological effects e.g. ST36 (Tougas et al, 1992) or CV12 or ST25 may need to be added if reversible gastrointestinal dysfunction is contributing to the nausea and vomiting.

10.5.2.4 Shortness of Breath

In a single-blind RCT on 24 patients with chronic obstructive pulmonary disease (COPD), and disabling shortness of breath, patients had significant benefit in subjective breathlessness with the use of traditional acupuncture compared with sham, and had an increased 6-minute walking distance, though objective measures were unchanged (Jobst et al, 1986). In a further single-blind, randomised crossover study, 31 patients with severe COAD were taught to practice acupressure daily for 6 weeks, then sham acupressure for a further 6 weeks. Dyspnoea, as measured by a visual analogue scale, was significantly less with real acupressure (Maa et al 1997). Ernst's (2001) review concluded that, despite the paucity of trials, there is data to support the use of acupuncture/acupressure to relieve dyspnoea towards the end of life for patients with severe chronic obstructive pulmonary disease.

A prospective study of 20 patients (Filshie et al, 1996) with cancer-related breathlessness at rest, who were treated with acupuncture at points on the upper two inches of the sternum and L14 for 10 minutes, found that 70% of patients reported a marked symptomatic improvement; there were significant improvement in visual analogue scores of breathlessness, relaxation and anxiety that peaked at 90 minutes, and lasted up to 6 hours. Respiratory rate also significantly decreased. Semipermanent indwelling needles were used to prolong the effect, which can remain in place covered by a clear plastic dressing for up to four weeks at a time to give patients

immediate 'control' to massage in the event of a panic attack or prior to any, even trivial exercise (Filshie and Thompson, in press).

10.5.2.5 Xerostomia

Acupuncture has been shown to improve the unpleasant symptoms of xerostomia due to a variety of causes. Blom and Dawidson's team have performed many studies, including an RCT on 38 patients with xerostomia following radiotherapy that showed both classical and superficial acupuncture to increase salivary flow (Blom et al, 1996). In another study, 50% of patients with xerostomia, who were refractory to pilocarpine were also helped (Johnstone et al, 2001). Lundeberg has described many of the physiological principles by which it is known to work (Lundeberg, 1999). Acupuncture has also helped patients in late stage palliative care for xerostomia dysphagia and articulation problems (Rydholm and Strang, 1999).

10.5.2.6 Cancer-Related Hot Flushes

Acupuncture has been found to be helpful for hot flushes due to the natural climacteric. (Wyon et al, 1994). Acupuncture can reduce the hot flushes associated with hormone manipulation in breast cancer care following tamoxifen (Cumins et al, 2000). Semipermanent needles inserted in SP6 can help to maintain the effect in patients who fail to respond to a short course of weekly treatments (Towlerton et al, 1999). Do it yourself (DIY) needling can be taught to patients, but taking great note of any cautions or contraindications prior to treatment with clear instructions for the return to hospital of used needles for safe dispersal (Filshie and Thompson, in press). It has also helped patients with prostate cancer undergoing hormone treatment (Hammar, 1999).

10.5.2.7 Acupuncture for AIDS Patients

The majority of patients with AIDS seek Complementary Medicine to help in addition to conventional treatment. Forty-eight per cent of 1016 patients with AIDS used acupuncture to treat their symptoms (Green et al, 1999). Though acupuncture has been found helpful for sleep disturbance (Philips and Skelton 2001), a large RCT

comparing acupuncture with amitriptyline and placebo failed to show any benefit of acupuncture over the other treatments for pain of peripheral neuropathy (Shlay et al, 1998).

10.5.2.8 Anxiety and Depression

The use of indwelling ASAD (Anxiety, Sickness and Dyspnoea) points on the upper two inches of the sternum have been found to be useful for anxiety as well as dyspnoea and in some cases nausea, though not formally tested (Filshie and Thompson, in press). Patients can stimulate the semipermanent needles covered by a clear plastic dressing by gently massaging over the needles when they are particularly anxious, and this can have a rapid calming effect in responders. Though acupuncture has been found to be equally helpful as tricyclic drugs (Ernst et al, 1998), there are much more reliable drugs available for treatment of depression in this group of patients. Mood frequently often coincidentally 'lifts' during a course of acupuncture treatment.

10.5.2.9 Miscellaneous

Patients with cancer often present with non-cancer related symptoms. A prospective and descriptive study with 291 acupuncture patients showed a reduction in symptoms, such as musculoskeletal, respiratory, psychological, and neurological, in the majority of patients (Chapman, Norton and Paterson 2001). The outcome measure used was the 'Measure Yourself Medical Outcome Profile' questionnaire.

Acupuncture has been found to be helpful for a variety of vascular problems including angina and ischaemic skin flaps (Lundeberg, 1999) and even radionecrotic ulcers have been healed, which classically never heal (Filshie, 1988). Acupuncture has also helped intractable hiccup (Yan 1988), dysphagia due to oesophageal obstruction (Feng, 1984), radiation proctitis (Zhang, 1987) and uraemic pruritis (Duo, 1987).

10.5.2.10 Safety

In the hands of appropriately qualified health professionals, acupuncture seems safe (Vincent, 2001).

The four professional bodies that register practitioners of acupuncture (see 10.5.4.3) issue clinical standards and guidelines for safe practice, for the use of acupuncture with any client.

A whole issue of the journal *Acupuncture in Medicine* has been devoted to safety in acupuncture including an article on safety of acupuncture in palliative care (Filshie, 2001). This entire issue of the journal will be available to download from January 2003 via the British Medical Acupuncture Society's website, www.medical-acupuncture.co.uk. It is recommended that any practitioner practising acupuncture in palliative care should read it, though it will naturally need updating from time to time.

Serious adverse effects are well recognised but rare. Peuker and Gronemeyer (2001) reviewed rare but serious complications of acupuncture including:

- Delayed or missed diagnosis of the condition treated. Acupuncture can mask both cancer and disease progression which is potentially very worrying (Filshie, 2001)
- Bacterial and viral infections (hepatitis B,C and HIV)
- Trauma to tissues and organs

The most common serious adverse event is pneumothorax. This is a particular hazard in patients with thin chest walls, and cachexic patients will therefore be at particular risk. The introduction of systemic infection through bacteraemia (septicaemia in immunocompromised patients, and endocarditis in patients with heart valve lesions) is also a recognised hazard and requires attention to appropriate precautions.

The use of single-use disposable needles has virtually prevented the occurrence of spread of hepatitis B and C infections.

Relatively mild reactions to treatment are common: bleeding (3%) and pain at the site of needling (1%) are common local reactions. In a varying proportion of cases (1% to 3%) symptoms may be aggravated. This seems to make little difference to the eventual recovery of the patient. Generalised reactions after treatment also occur, ranging from a pleasant drowsiness to disabling weakness and lethargy. Symptoms such as headache, nausea and vomiting, and dizziness are also recognised rarely. Patients may also occasionally react severely during the treatment, with events such as fainting. Two recent large prospective studies on side effects on a total of 66,000 patients showed a low incidence of significant minor adverse events 13 per 10,000 or less, though the number of cancer patients treated in the samples were unspecified (White et al, 2001; McPherson et al, 2001)

Cancer patients are often more sensitive to acupuncture than other patients and many become excessively drowsy during treatment so it is advisable to have nursing assistance when treating them. Patients are often cachectic and they should be given superficial needling with the greatest of care especially over the chest wall. It is unsafe to use acupuncture without a reasonably full knowledge of the clinical stage of the disease and the current status of orthodox therapy (Filshie, 2001).

In summary, current evidence supports the use of acupuncture and acupressure in the palliative care for chemotherapy-induced and post-operative nausea and vomiting with high level evidence emerging for acute pain and xerostomia. Despite the limited scientific evidence, there is data to support the use of acupuncture for other symptoms, and may be useful in the supportive and palliative care for the following conditions:

- **Chemotherapy-induced and post-operative nausea and vomiting** (Dundee et al, 1987; Stannard, 1989; McMillan et al, 1991; Price et al, 1991; Dibble et al, 200; Shen et al, 2000; Aglietti, 1990; Roscoe et al, 2002. Reviews: Vickers, 1996, Richardson et al, 2001. Postoperative nausea and vomiting: Lee and Done, 1999)
- **Pain relief** (Acute pain: Poulain, 1997; Kotani, 2001; He et al, 1999. Chronic pain: Wen, 1977; Filshie and Redman, 1985; Filshie, 1990; Aung, 1994; Thompson and Filshie, in press; Xu, Liu and Li, 1995; Dillon and Lucas, 1999; Leng, 1999; Filshie, 2000; Johnstone et al, 2002; Alimi et al, 2000)
- **Non-cancer related pain: musculoskeletal** (Baldry, 2001); **dental pain** (Ernst & Pittler 1998); **headache** (Melchart, Linde & Fisher 1999); **experimental pain** (White, 1999) **fibromyalgia** (Berman, 1999)
- **Breathlessness, including severe COAD and use of indwelling semi-permanent needles** (Jobst et al 1986; Filshie et al 1996; Maa et al 1997; Ernst 2001; Filshie and Thompson, in press)
- **Xerostomia (dry mouth)** (Blom et al 1992; Blom et al 1993; Talal et al 1992; Blom, 1996; Blom & Lundberg 2000; Johnstone et al 2002)
- **Radiation-induced rectitis** (Zhang 1987)
- **Hiccups** (Yan, 1988)
- **Hot flushes, including semi-permanent indwelling needles** (Wyon, 1998; Towlerton, Filshie et al 1999; Hammar, 1999; Cumins, 2000; Johnstone et al 2002)
- **Angina** (Richter et al 1991; Ballegaard et al, 1995)
- **AIDS** (Philips and Skelton, 2001)

10.5.3 Acupuncture in S & PC

10.5.3.1 **Contraindications**

- Avoid any area of actual or potential spinal instability due to cancer – it potentially increases risk of cord compression or transection

- Insertion of needles directly over the tumour itself or nodules or related sites (eg ascites)
- Severely disordered clotting function
- Indwelling needles with patients at risk of bacteremia (e.g. in valvular heart disease, immunocompromised patients)
- Avoid needling a lymphoedematous limb
- Avoid needling directly above a prosthesis
- Avoid needling over any intracranial deficits following neurosurgery

10.5.3.2 Precautions

- Only use sterile, single-use disposable needles
- Take particular care when needling over the ribcage and the domes of the pleura, especially in cachectic patients and the hyperinflated chests of patients with chronic obstructive pulmonary disease
- to reduce the risk of pneumothorax – paravertebral needling or needles to the top of the sternum are useful alternatives
- Avoid the arm on the side of mastectomy and/or axillary lymph gland clearance
- If tolerance occurs it may represent progressive disease and full investigation of tumour status may be required
- Caution with indwelling semipermanent needles in any ‘strong reactor’ to acupuncture
- Be aware that patients may be undergoing chemotherapy, radiotherapy or hormonal treatments (refer to Section 9, Clinical Issues)
- Be aware that patients may be particularly fatigued and are living with a chronic/life-threatening illness (refer to Section 9, Clinical Issues)

Additionally, any advice about offering acupuncture as an alternative to conventional treatment or over optimism about the potential for helping any patient and unsuitable lifestyle advice is clearly inappropriate. These patients need especially sensitive handling as they are often angry about their illness or in denial (Filshie, 2001).

10.5.4 Practitioner Training and Qualifications

10.5.4.1 Training

Doctors, nurses and physiotherapists practice acupuncture as a skill additional to their statutorily regulated profession. The British Medical Acupuncture Society provides training for doctors and other regulated healthcare professionals. There is an accreditation process with two levels - Certificate and Diploma level, and continuing professional development is monitored through re-accreditation. Physiotherapists and nurses are trained on courses recognised by the Acupuncture Association of Chartered Physiotherapists, or the British Academy of Western Acupuncture.

Specific Foundation Courses are available for doctors wanting to practice acupuncture in palliative care patients run by the BMAS. A supplementary one-day course is also available for practitioners, medical and non-medical, who use acupuncture in palliative care patients.

Traditional acupuncturists can be medical or non-medical professionals who have undertaken a 3 year training course (or equivalent) accredited by the British Acupuncture Accreditation Board (BAAB), and are members of the British Acupuncture Council (BAcC). Traditional acupuncturists who have trained in other countries or on other courses can apply to the BAcC Admissions Committee for validation of their qualification and practice in order to be eligible for registration with the BAcC.

10.5.4.2 Regulatory Bodies

The Acupuncture Regulatory Working Group (ARWG) is working to develop recommendations for the statutory regulation of acupuncture in England. The ARWG is supported by the Department of Health and The Prince of Wales's Foundation for Integrated Health. Its report is expected by July 2003.

Practitioners of acupuncture should be registered with one of the following four professional bodies who are members of the ARWG:

- Acupuncture Association of Chartered Physiotherapists (AACP)
- British Academy of Western Acupuncture (BAWA) (also registers nurses)
- British Acupuncture Council (BAcC)
- British Medical Acupuncture Society (BMAS)

10.5.4.3 Insurance

Practitioners should be insured to practice acupuncture.

10.5.4.4 Continuing Professional Development (CPD)

The BAcC has a policy for the continuing professional development of its members. Continuing Professional Development in doctors is monitored through the BMAS.

10.6 HYPNOSIS / HYPNOTHERAPY

10.6.1 Brief Description

There are numerous theories but no universally accepted mechanism to explain all the phenomena of hypnosis. Hypnosis has been described as a psychological state in which certain human capacities are heightened while others fade in the background – during hypnosis the person’s critical faculty or logical mind is suspended or diminished, leading to an increase in the probability of the acceptance of therapeutic interventions (Hawkins 1994, cited in Lioffi and Mystakidou 1996).

(Trance is) “a waking state of awareness in which a person’s attention is detached from his or her immediate environment and is absorbed by inner experiences such as feelings, cognition and imagery”. (M Heap 1996). ‘Suggestion’ is the purposeful use of the phenomenon of trance and is at the heart of hypnosis (Zahourek 2001).

Trance or change in state of mind is akin to intense or focused concentration / attention, a state which may be induced by techniques, such as deep relaxation routines, visualisation, imagery / guided imagery, autogenic training, neuro-linguistic programming and meditation, as well as in other situations such as music festivals, religious ceremonies and sporting events (Finlay and Jones 1996, Owens 2002).

In hypnosis the imagination, rather than the intellect is active (Taylor 2002).

Hypnosis is a valuable tool which involves interaction between body and mind, using the mind to effect therapeutic change, and can be instrumental in engendering coping strategies, helping people to connect with their inner being, activate innate healing forces (Spiegel and Moore 1997, Owens 2002).

In a consultation, the clinician, by the use of rapport building and communication skills, will establish the needs of the patient and remove any doubts, fears and misconceptions they may have about hypnosis. Close empathic rapport is the first stage of the hypnotic process, and is generally followed by *induction*, following which the patient is guided into a state of deep relaxation. Within this state communication is retained, and specific suggestions geared to that person's presenting concerns are made. The benefits, and growth of the patient's autonomy are reinforced by *self hypnosis techniques*, and by *post hypnotic suggestions*.

10.6.2 Evidence

10.6.2.1 As an adjunct to more conventional forms of psychotherapy

There is substantial evidence that hypnosis can be a valuable adjunct to more conventional forms of psychotherapy. The following are some examples:

Kirsch et al (1995) carried out a meta-analysis on 18 studies in which a cognitive-behavioral therapy was compared with the same therapy supplemented by hypnosis. The results indicated that the addition of hypnosis substantially enhanced treatment outcome, so that the average client receiving cognitive-behavioral hypnotherapy showed greater improvement than at least 70% of clients receiving non-hypnotic treatment.

Similarly, Schoenberger (2000) writes of the growing body of research evaluating the use of hypnosis with cognitive-behavioral techniques in the treatment of psychological disorders. Overall, studies demonstrate a substantial benefit from the addition of hypnosis.

Lynn S J et al (2000), summarised the evidence for the effectiveness of hypnosis as an empirically supported clinical intervention. Indications are that as a whole, the clinical research to date generally substantiates the claim that hypnotic procedures can ameliorate some psychological and medical conditions.

Bejenke (2000) writes of the benefits of early intervention with cancer patients in a study based upon fifteen years of clinical practice. The use of hypnosis, including imagery and psychoneuroimmunological modalities, as a preparation for surgery, chemotherapy, radiation, bone marrow transplantation etc. can reduce physical suffering and treatment side effects, and facilitate patient management.

Trijsburg et al (1992) reviews twenty-two studies on the effects of psychological treatment on cancer patients. Behavioral interventions and hypnosis were effective with respect to specific symptoms such as anxiety, pain, nausea, and vomiting.

Leviton (1992) describes a number of specific applications of hypnosis within cancer care. Hypnosis has unique advantages for patients including improvement of self-esteem, involvement in self-care, return of locus of control, lack of unpleasant side effects, and continued efficacy (Leviton 1992)

Stetter et al (2002) carried out a meta-analysis to evaluate the clinical effectiveness of autogenic training. Seventy-three controlled outcome studies were found (published 1952-99). Sixty studies (35 randomized controlled trials [RCT]) qualified for inclusion in the meta-analysis.

10.6.2.2 Hypnosis in the context of cancer management

- Typically a person having cancer may encounter a series of 'pulses' of need for intervention as the disease and its treatment follow their course.
- Major concerns of the patient may be in relation to physical, psychological, emotional or spiritual distress.
- Interventions in the management of cancer – typically surgery, chemotherapy and radiotherapy – can be unpleasant, and will often become central to a

patient's fears, anxieties and concerns, and may be addressed using hypnosis.

- Certain concerns are not limited specifically to the cancer experience, but may be of a more general nature, for example panic attacks and needle phobia, and this will be evident in the references cited.
- In this brief paper I will attempt to identify the value of hypnosis in the management of some of the many crises occurring within the cancer journey.

10.6.2.2.1 Emotional response to cancer – coping ability

Spiegel (1990) states that patient resources for coping with breast cancer can be enhanced by attention to cognitive, affective, psychosomatic, and social components of the illness. Systematic studies of such treatment interventions have shown favourable results, including significant reductions in mood disturbance and pain.

10.6.2.2.2 Adjunctive to surgery – a meta-analysis

Montgomery et al (2002) carried out a meta-analytical review of studies using hypnosis with surgical patients. The results indicated that patients in hypnosis treatment groups had better clinical outcomes than 89% of patients in control groups. These data strongly support the use of hypnosis with surgical patients.

10.6.2.2.3 Chemotherapy – anticipatory nausea and vomiting

Marchioro et al (2000) reported on 16 consecutive adult cancer patients affected by chemotherapy-induced anticipatory nausea and vomiting who had received at least four treatment cycles: The experience highlights the potential value of hypnosis in the management of anticipatory nausea and vomiting.

Jacknow et al (1994) studied the effectiveness of hypnosis for decreasing antiemetic medication usage and treatment of chemotherapy-related nausea and vomiting in children with cancer. Results suggest self-hypnosis is effective for

decreasing antiemetic medication usage and for reducing anticipatory nausea during chemotherapy.

Burish T G et al (1983) report that some adverse side effects of cancer chemotherapy are attributed to the pharmacologic properties of the antineoplastic drugs, while others appear to be conditioned or learned. The literature suggests that behavioural relaxation techniques can significantly alleviate some conditioned side effects of chemotherapy including nausea, vomiting, and negative emotions such as anxiety and depression. These behavioural procedures are generally inexpensive, easily learned, and have few if any negative side effects.

Spiegel & Bloom (1983) studied the pain and mood disturbance of 54 women with metastatic carcinoma of the breast over the course of one year. Those who were offered the self-hypnosis training as well as group therapy fared best in controlling the pain sensation. Pain frequency and duration were not affected.

See also: Walker et al (1988) and Walker et al (1990).

10.6.2.2.4 Tolerance of scanning and radiotherapy procedures

Friday et al (1990) reported on the use of hypnosis as an intervention in M.R.I. procedure. Medical hypnosis has been an effective intervention in ten patients, permitting completion of their diagnostic procedure

In a study by Zeltzer L et al (1984) fifty-one children 6-17 years of age rated the severity of nausea, vomiting, and the extent to which chemotherapy bothered them during each course of chemotherapy. The data indicate that chemotherapy-related nausea and emesis in children can be reduced with behavioral intervention and that reductions are maintained after intervention has been discontinued.

See also: Steggles S (1999)

10.6.2.2.5 Pain

Syrjala KL. et al (1995) compared oral mucositis pain levels in 4 groups of cancer patients receiving bone marrow transplants. From results obtained the conclusion is that relaxation and imagery training reduces cancer treatment-related pain. The results from other studies also indicate that pain in cancer care responds well in hypnosis.

10.6.2.2.6 Terminal care

Lioosi. & White (2001) carried out research to evaluate the efficacy of clinical hypnosis in the enhancement of quality of life of patients with far-advanced cancer. The study concluded that hypnosis is effective in the enhancement of quality of life in terminally ill cancer patients.

Meares (1980) reports on the results of treatment of 73 patients with advanced cancer who have been able to attend at least 20 sessions of intensive meditation. There is reason to expect a ten per cent chance of quite remarkable slowing of the rate of growth of the tumour.

10.6.2.2.7 Immune response

Lynn et al (2000) report the results of an 18-month study of immune system and psychological changes in stage 1 breast cancer patients provided with relaxation, guided imagery, and biofeedback training. The results show that behavioral interventions can be correlated with immune system measures, thereby replicating the results of an earlier pilot study.

Spiegel & Moore (1997) report on a 10-year follow-up of a randomized trial involving 86 women with cancer which showed that a year of weekly "supportive/expressive" group therapy significantly increased survival duration and time from recurrence to death.

Johnson et al (1996) carried out a study with the following aims: (1) to evaluate the psychological and immunological effects of 3 weeks' relaxation practice; (2) to investigate the effects of relaxation training and hypnosis on the modulation of the immune response to an experimental stressor; and (3) to relate changes to hypnotic susceptibility. A conclusion was that hypnotisability, as assessed by the CIS, may be an important moderator of the psychoneuroimmunological response to relaxation training and exposure to acute stress.

See also: Walker (1992); Walker and Eremin (1995)

In summary, a large body of evidence exists for the use of clinical hypnosis. Hypnosis may be useful in supportive and palliative care for in the following ways:

- **To enhance the immune response**
- **As an adjunct to more conventional forms of psychotherapy**
- **To enhance coping ability**
- **To enhance recovery from surgery**
- **To reduce chemotherapy-related nausea and vomiting**
- **To increase tolerance of scanning and radiotherapy procedures**
- **To reduce pain**
- **In mood disturbance**
- **To improve quality of life**
- **To reduce anxiety and depression**

10.6.2.3 Hypnosis in S&PC

10.6.2.3.1 Contraindications

10.6.2.3.1.1 The Clinician

Clinicians should not work outside their own areas of training and competence.

Stanley et al (1998) state: "Increasingly there is developing a conviction that the hypnotic state or process itself poses no inherent dangers for patients but that its

inexpert use may.” The solution to prevent potential patient harm is to ensure that all clinicians of whatever discipline have adequate and appropriate clinical training prior to being allowed to practice.

10.6.2.3.1.2 The patient

- Psychiatric status: where any psychiatric condition exists which may lead to unpredictable behaviour and responses, hypnosis is contraindicated.
- Emotional status: depression is often a concomitant of cancer. Effective treatment of depression in cancer patients results in better patient adjustment, reduced symptoms, reduced cost of care, and may influence disease course (Spiegel D 1996). When using hypnosis, the lack of clinical expertise specifically in working with the depressed person may only serve to compound their problem.
- Inappropriate age: the major criterion is that the patient is aware of the process and its aims. This will tend to exclude the very young (possibly below six years) and the very old (although chronological age is less relevant than overall awareness).

10.6.2.3.2 Precautions

“With....real authorities, agreement is almost unanimous that dangers (of hypnosis) are minimal and can be avoided. In some instances there have been bad results, but they have come because of personality difficulties of the hypnotist, authoritative, coercive use of hypnosis, or lack of knowledge. Patients will protect themselves from harm when the therapist shows respect for their ability to do so” (Cheek DB & Le Cron LM 1968).

- It is essential to explain to the patient the likely process of the hypnotic intervention, to remove any doubts and fears, and to obtain the approval and consent of the patient.

- Obviously the clinician should be acutely aware of the legal implications of working with a patient who is in a state of hyper-suggestibility, and who (generally) will have their eyes closed.
- Abreaction, a (possibly powerful) emotional response to recalled images and feelings, may be triggered in hypnosis. This is particularly likely where the patient is already under considerable emotional pressure. The clinician should be trained and competent in using skills to protect and work with the patient, and to re-orientate the patient following an abreaction.
- Before 'alerting' a patient, any suggestion other than those intended to be posthypnotic should be removed. For example, if anaesthesia had been produced it is important to terminate it. (Cheek DB & Le Cron LM 1968)
- Post hypnotic suggestions should be time and situation specific.
- The patient should be brought out of the hypnotic state gradually, and it is important that the clinician ensures that the patient is fully awake and alert before concluding that session.

10.6.2.4 Practitioner Training and Qualifications

10.6.2.4.1 Training

The British Society of Medical and Dental Hypnosis (BSMDH) is a national and federal organisation which offers training in hypnosis to professionals with a conventional health care qualification who are employed in a substantive post with the NHS. Training is at basic, intermediate and advanced levels, and members are encouraged to pursue training towards accreditation by BSMDH.

The core curriculum is set at national level, and training is organised at branch level. In order to maintain consistent standards, a selection of (branch level) courses are attended annually by observers from other branches. Details of training courses can be obtained from the BSMDH national office – Tel/Fax 07000 560309, E mail: nat.office@bsmdh.org, website: www.bsmdh.org

BSMDH view hypnosis as an additional skill / tool for professionals with a conventional health care qualification, to be used alongside their primary role (eg as a doctor, dentist or nurse), and within the expertise of their primary qualification. From the perspective of BSMDH, the ethics and clinical responsibility that comes with working with a person in a hypnotised state is such that those practising hypnosis should already have a primary professional relationship the patient, be able to accept clinical responsibility for their actions, and have indemnity cover. Some members of BSMDH go for further training in psychotherapy / hypnotherapy.

The British Society of Experimental and Clinical Hypnosis (BSECH) works closely with the BSMDH and offers some courses, but does not accredit practitioners. Although open to other professionals, membership comprises mainly psychologists who may or may not be trained in hypnosis.

The Department of Hypnosis at University College London offers training to appropriate (conventional) health care practitioners to diploma and MSc level in Clinical and Applied Hypnosis (contact Dr. David Oakley at ucjtcpl@ucl.ac.uk). Graduates are eligible for membership of BSMDH/BSECH, and also to apply for accreditation. Glasgow Caledonian University have introduced a diploma course this year.

Apart from the BSMDH, hypnotherapists also train at a large number of other establishments / professional organisations. The level of training varies, and there is at present no agreed standard or core curriculum. The second edition of

National Occupational Standards for Hypnotherapy (NOS Hypnotherapy) is currently being developed. NOS are the minimum agreed standards to which practitioners should be able to work. However, similar to other therapies with NOS, there is no agreed mechanism for 'matching' NOS to the available courses.

10.6.2.4.2 Regulatory Bodies

BSMDH and its branches, and BSECH are the two professional organisations in the U.K. whose members practice hypnosis integrated with the professional's primary (conventional) health care role. Members are answerable to, and follow the codes of ethics, conduct, etc of their own (primary) professional body, eg General Medical Council, and Nursing and Midwifery Council.

Members of the BSMDH are encouraged to work towards accreditation, and accredited members are listed on the BSMDH Referral Register. Details can be obtained from the national office.

Hypnotherapists who are also psychotherapists are registered with the United Kingdom Council for Psychotherapists (UKCP). Information can be obtained by writing to the UKCP (e mail: UKCP@psychotherapy.org.uk)

There are a large number of professional organisations that register hypnotherapists who have trained with organisations other than the BSMDH. The UK Confederation of Hypnotherapy Organisations (UKCHO) is the umbrella body for a number of organisations (see www.ukcho.org). There are also hypnotherapy organisations who are not members of UKCHO. The regulation of hypnotherapists under a single regulatory body is at an early stage and a working group, that is inclusive of all the different organisations and facilitated by an independent chair, has not been agreed. Further information can be obtained from The Prince of Wales's Foundation for Integrated Health.

10.6.2.4.3 Insurance

Members of the BSMDH and BSECH should be insured to practice within their primary role (ie as a doctor, dentist, nurse or psychologist).

Non-medically qualified hypnotherapists should hold professional indemnity and public liability insurance.

10.6.2.4.4 Continuing Professional Development

Members of the BSMDH and BSECH are required, within their primary role, to undertake activities for continuing professional development.

Hypnotherapists should receive induction, supervision and/or additional training for working in palliative care, the level of which depends on their experience of working with patients with a life-threatening condition, and their experience of practising hypnotherapy.

10.7 HEALING / SUBTLE ENERGY TECHNIQUES

The term 'healing' is from the Saxon root 'Haelen', meaning to make whole, and is not seen as a desire to cure or as an attachment to a particular outcome (Hallett 2002).

The term 'subtle energy techniques' is also used in the context of healing (MacDonald 1999). There are a number of energy healing systems, and this document focuses on the use of reiki, therapeutic touch and spiritual healing.

10.7.1 REIKI (Hawkins 2002)

10.7.1.1 Brief description

Reiki is a method of healing that was rediscovered by Dr Mikao Usui in Japan in the 1800's. Central to this system of healing is the concept that an energy flow exists within living beings which supports life by helping to maintain homeostasis. This energy is known as Ki. When Ki is diminished ill health can arise. The other important concept is that Ki can be channelled from its originating source by a reiki practitioner and passed onto a recipient. The original source may be referred to as the universal source which in Japanese is Rei, hence the name Reiki. The main aim of reiki is to bring about balance in mind, body and spirit to improve well-being. There are no religious connotations within reiki therefore no belief system is necessary to practice or receive this method of healing.

Reiki was primarily developed as a system for 'healing oneself', as well as being used to help others, therefore practitioners are encouraged to practise 'self-healing' on a regular basis. A Reiki treatment, to oneself or to another, involves the practitioner placing his/her hands either on or just above certain points on the body, the recipient may sit or lie and remains fully clothed. Reiki can also be used as a method of distant healing during which the practitioner works using visualization techniques. With both methods recipient consent is of paramount importance. Reiki energy is channelled for the 'greatest and highest good' of the recipient, and is understood to flow in response to the needs of the recipient. Recipients often report a feeling of deep relaxation during and following the therapy.

10.7.1.2 Evidence base

Although there is some emerging evidence supporting the claims of both spiritual healing and therapeutic touch the evidence for Reiki to date is very small and there appears to have been no studies carried out in palliative care.

Wardell & Engerretson's (2001) study examined the biological correlates of reiki healing. Twenty three healthy subjects received reiki lasting thirty minutes. The biological markers related to stress reduction response were measured pre and post reiki. These markers included breathing rate, pulse rate, blood pressure and salivary IgA. Significant biochemical and physiological changes in the direction of relaxation were noted. Although acknowledged as small this study suggests that reiki would be a useful intervention for relaxation which warrants further study.

Despite lack of scientific evidence on the effects of reiki, anecdotal evidence suggests that reiki can assist with

- **Relaxation**
- **Inducing feelings of peace**
- **Reducing/ altering perception of pain**
- **Reducing stress, fear and anxiety**

10.7.1.3 Reiki in S & PC

Reiki is a non-invasive therapy, for which there are no known side effects, and which can be used alongside other treatments, conventional or complementary.

Reiki practitioners with limited experience in supportive and palliative care will need guidance and supervision (see Section 6 on Supervision) on modifying treatment. As reiki can be given with the recipient sitting or lying either on a couch or in bed for a time period ranging from 10 mins to 1 hour, it could be considered to be a fairly portable 'do anywhere' therapy. The recipient does not need to be actively involved therefore reiki may be suitable for those who are very ill.

The main concern with reiki may be the misinterpretation of the word 'healing' by novice practitioners and recipients who are looking for a magic cure. Hence the need for appropriately trained and experienced practitioners who are able to adequately inform

recipients of the benefits of reiki without implying false hope.

As Reiki can be learnt by anyone, from a Reiki Master, it may be appropriate to consider offering patients / carers the opportunity to learn for themselves. Other members of a clinical team can also be trained to integrate reiki with their primary role.

10.7.1.4 Practitioner Training and Qualifications

10.7.1.4.1 Training

Reiki training is available at 3 progressing levels: level 1, 2 practitioner level, and level 3 Master/teacher. Practitioners of reiki in supportive and palliative care should be trained to practitioner level. At present, the standard of courses vary greatly. The UK Reiki Federation is currently leading the development of a core curriculum, and information can be found on their website: www.reikifed.co.uk. The organisations which register reiki practitioners (see 10.7.4.2.1) are being consulted on the core curriculum.

It is recommended that the reiki practitioners who do not hold a registered qualification in another complementary therapy, for which they are also insured to practice, should have 'transferable skills' / other relevant experience that would enable them to assess a patient's suitability for reiki treatment, and relate to vulnerable adults who are seriously or chronically ill.

10.7.1.4.2 Regulatory Bodies

The UK Reiki Federation is the developing regulatory body for reiki practitioners. However, there is, as yet, no single register. It is recommended that practitioners of reiki, who are not also a registered practitioner of another complementary therapy, should be registered with one of the following professional organisations:

- The Reiki Alliance
- UK Reiki Alliance
- UK Reiki Federation (Professional)

- National Federation of Reiki Practitioners
- Guild of Complementary Practitioners (GCP)
- ITEC Professionals
- Institute of Complementary Medicine (ICT / BRCP)
- British Complementary Medicine Association (BCMA)
- Complementary Medical Association
- Independent Professional Therapists International

10.7.1.5 Insurance

Practitioners should be insured to practice reiki.

10.7.1.6 Continuing Professional Development (CPD)

Practitioners of reiki should be able to demonstrate their commitment to their own professional development.

10.7.2 THERAPEUTIC TOUCH (Hallett 2002)

10.7.2.1 Brief description

Therapeutic Touch (TT) emerged in the 1970's, being introduced into the mainstream nursing education by Dr. Dolores Krieger, then Professor of Nursing at New York University. Krieger had experienced the 'laying on of hands', and was convinced that this was a natural potential inherent in everyone, which could be realised if the intention to help or heal was present. TT is without religious association, has been studied and researched within a healthcare framework, and has been introduced into nursing programmes, in the USA, at masters and doctorate levels.

TT has been considered as a contemporary interpretation of several ancient healing practices. Whilst honouring and respecting the influence of other traditions, it is within a framework which uses the insight of modern quantum physics that TT is described (Chopra 1989, Rogers 1983). It has also been described as an attempt to focus completely on the well-being of the patient in an act of unconditional love and compassion (Quinn & Strelkkaukas 1993). This is not seen as a desire to cure or as an attachment to a particular outcome.

TT is not regarded as involving a channelling of energy or an energy exchange but as a mutual process, a healing meditation. It has been suggested that being in this process with a practitioner who is 'centred' (ie in a calm, alert and open state of consciousness with a clear sense of oneself and being connected to the holistic nature of healing) (Sayre Adams & Wright 2001) brings about a change with the practitioner acting as a template to facilitate this change towards wholeness (Quinn 1992).

During a treatment, the practitioner's hands are moved in a rhythmic, downward movement, a short distance away from the body of the client, starting at the head and working towards the feet. During this process the practitioner makes an assessment and may become aware of some imbalances in what is described (not without controversy) as the energy field.

The practitioner then works towards 'clearing' these areas and promoting a sense of harmony and wholeness. Clients usually experience a deep relaxation response and anecdotal evidence suggests that they can become clearer about problems they are facing and feel less anxious generally.

10.7.2.2 Evidence base

The following are studies relevant to palliative care and which provide evidence on the efficacy of therapeutic touch. A full overview and analysis can be found in the text by Sayre Adams & Wright (2001).

10.7.2.2.1 Relaxation Response

Krieger et al's (1979) study demonstrated a deep relaxation response being present in clients receiving TT. This was verified by ECG, EEG and electro-oculographic responses. Electro-myographic, hand temperature and galvanic skin responses were also recorded. Interestingly, the EEG of the practitioner demonstrated a predominant amount of fast synchronous beta activity, demonstrating intense concentration. Patients showed a high amount of alpha activity, which indicates a deep state of relaxation. This was a small study and has some flaws in its design. However, its findings are not without significance.

In Heidt's (1981) study ninety hospitalised cardiovascular patients were randomised into three groups. One group received TT for five minutes, another group (control) received casual touch and the third had a nurse who talked to them for the five minutes test time. Pre and post test anxiety was assessed using the Spielberger self evaluation tool. The experimental group was found to have a statistically significant greater reduction in state anxiety scores than the other two groups. A criticism of this study is that the experimental group were aware that they were having TT, therefore the placebo effect cannot be ruled out.

Quinn's (1982) sixty hospitalised patients with cardio-vascular conditions were randomly assigned to two groups. One group received a mimic treatment from three nurses with no knowledge of TT, the other received TT.

Both lasted for five minutes. Quinn's hypothesis that the TT group would have a greater reduction in post test trait anxiety scores (using the Spielberger STAI assessment tool) was supported. This result also indicated that TT involves an energy inter –action, but does not attempt to draw conclusions as to defining its exact nature.

Quinn (1989 b) replicated the above study, with thirty-eight women and one hundred & fifteen men, all awaiting open heart surgery the following day, who were treated with either mimic TT or TT. The same STAI assessment was used as previously. Blood pressure and heart rate were recorded pre and post test using separate analyses of covariance. Although no significant differences were recorded between the two groups, all post test measures did move in the predicted direction.

It must be noted that, whereas in the 1982 study mimic TT was given by nurses with no knowledge of TT, in this study TT and mimic TT was given by TT practitioners. Therefore it is possible that this influenced the small differential between groups. Similarly the length of treatment has been questioned. (i.e. that it was too short).

Olsen's (1992) study took place in the two months following Hurricane Hugo in the United states. A convenience sample of twenty three volunteers, who had all experienced personal stress was used. A repeated session design was used with data collected before during and after each session. Physiological measurements such as blood pressure and skin temperature were included. The psychological variables were state anxiety (stress felt at that time) and trait anxiety (stress felt 'normally'). These were tested by two visual analogue questionnaires. The findings showed that mean state anxiety scores decreased significantly after the TT sessions, but that trait anxiety scores remained similar pre and post test. Physiological outcomes indicated a trend towards relaxation but these were not statistically significant.

10.7.2.2.2 Pain

Using a sample of sixty people, one group was treated with mimic TT and the other with TT (Keller & Bzdek 1986). The hypothesis was that the TT group would experience

greater relief from headache and that this would persist for four hours post treatment. The research design was rigorous, appropriate assessment tools were used. The hypothesis was supported, with statistically significant results.

This was a single, randomised control trial to determine the effect of TT on osteoarthritis of the knee (Gordon et al 1998). This was a small sample of twenty five, but significant difference were found in improvement in function and pain for those who received TT.

In addition to supporting the hypothesis relating to pain, these studies also support the hypothesis that there is an energy interaction occurring during TT.

10.7.2.2.3 Sleep

Using the Sleep Quality questionnaire as a measure, it was found that five out of six elderly subjects had a better quality of sleep during nights when TT had been administered to them at bed time (Braun et al 1986).

10.7.2.2.4 Audit & Evaluation of service

Hallett's (1996) survey with oncology patients, following TT,

- 75% said they were coping better (20% coping the same)
- 70% reported feeling less anxious
- 47.5% felt happier
- 75% felt more peaceful and calm

Other responses included coping better with chemotherapy and radiotherapy (32.5%) 40% reported feeling more in control and 37.5% felt TT had helped them to adjust to their diagnosis.

A similar survey was conducted (Hallett 2000) and findings were very similar. Patient comments included:

“TT was like an oasis of relaxation and clearing of my mind in what is now a life of fear and anxiety”

In summary both research and anecdotal evidence indicate that TT is helpful from a quality of life perspective and for some can be perceived as a deep and meaningful experience.

- **facilitating a relaxation response**
- **reducing anxiety & stress**
- **emotional and spiritual support**
- **contributing to the alleviation of pain (it is not advised to assume that TT should be the only method of pain control.)**
- **contributing to a sense of general well being**
- **provides comfort to the dying and to their relatives and carers**

10.7.2.3 Therapeutic Touch in S & PC

There are no specific contraindications, but there are some conditions in which therapeutic touch needs to be used with sensitivity. For example:

- With people who, because of their personal history, disease progression or medication, may have an altered perception of reality, either emotionally or mentally.
- The relaxation response can act as a releasing mechanism, which can sometimes generate strong emotions. This can be alarming for the patient.
- An experienced TT practitioner can generally recognize when TT is completed in a particular session. It is important that sessions are not overlong.

10.7.2.4 Practitioner Training and Qualifications

10.7.2.4.1 Training

Training in therapeutic touch is available at two levels. A two-day introductory course introduces health care professionals to the main principles of TT, and is a pre-requisite to the full/advanced practitioner training. The course that leads to full/advanced practitioner status takes 8 months and can be undertaken as an independent module or as a module within the degree for health care studies. The course is run in conjunction with St. Martin's College, Lancaster.

Information on training can be obtained from the website of The Sacred Space Foundation (www.sacredspace.org.uk)

10.7.2.4.2 Regulatory Bodies

It is a requirement for all practitioners of therapeutic touch to be registered with the British Association of Therapeutic Touch (BATT) (www.ttouch.org.uk). Health care professionals who have completed a 2-day introductory course can also be a member of the British Association of Therapeutic Touch, but will not have achieved practitioner status. Only courses approved by BATT fit the criteria for registration with BATT.

10.7.2.5 Insurance

Practitioners must show evidence of insurance to practice therapeutic touch and, often, this is within their insurance to practice as a health care professional (usually nurses and doctors).

10.7.2.6 Continuing Professional Development (CPD)

It is a requirement of BATT that practitioners show evidence of on-going education and clinical supervision which pertains to therapeutic touch. This is provided through BATT.

10.7.3 SPIRITUAL HEALING

10.7.3.1 Brief description

Spiritual healing is an ancient therapy which has been used throughout recorded history. Pythagorus (6 BC) considered healing to be the noblest of his pursuits and integrated it into his considerations of ethics: mind and soul (Benor 2001). Spiritual healing, often referred to simply as healing is a completely natural process that promotes better health, through the channelling of healing energies through the healer to the patient (NFSH 1998). Healing quickens the body's natural healing processes on all levels (Neate and Neate 2001). Healing is a supportive approach which may involve light touch or no touch at all, depending on the recipient's condition and wishes.

Healers view human life as four-dimensional, comprising body, emotions, mind and spirit. They are drawn to the work because of their interest in the spiritual dimension of life, and because they find they can transmit healing energy. Healers draw upon the finer energies of the universe, and they may or may not follow a particular religion. Many healers may embrace a spiritual understanding based on unconditional love (Neate and Neate 2001).

Healing is becoming accepted as a valid and credible therapy, offered in some medical centres as a complement to conventional medical treatment (BMA 1993). The healer provides time for the patient to discuss problems, in order to gain some understanding of it; subsequently the patient may be asked to lie or sit down for the treatment (Ernst 2001). Recipients often experience deep relaxation and the sensation of being energised.

10.7.3.2 Evidence base

At the moment there is a paucity of clinical trials to support the efficacy of spiritual healing. Benor (2001) writes about the scientific validation of healing, giving brief descriptions of 191 'controlled' studies across a broad range of conditions and organisms. Over 50% of the trials are said to result in significant outcome in favour of

healing. However, Benor himself points out the methodological flaws, and his interpretation of the evidence is unconventional (Abbott 2002). Other authors reporting on the same trials conclude that the findings cannot be relied on to draw firm conclusions about the efficacy or inefficacy of healing (Abbot 2000).

Despite the lack of evidence, spiritual healing remains one of the most popular therapies in supportive and palliative care (Macmillan 2002). Spiritual healing may be helpful in the following ways in supportive and palliative care (Neate and Neate 2001):

- **To restore balance and harmony on an inner level – through stillness**
- **To creative realistic positive thoughts about the illness/ condition**
- **To enhance well-being and clarity of thought**
- **To relieve pain**
- **To improve quality of life**
- **To promote relaxation**
- **To reduce stress and anxiety**
- **To reduce the side effects associated with chemotherapy and radiotherapy for cancer patients**
- **To support the patient in the dying process – to die with dignity and in peace**

10.7.3.3 Spiritual Healing in S&PC

- As well as the above mentioned ways in which spiritual healing can be helpful, patients in the terminal stages of cancer often find spiritual healing comforting and soothing.
- Spiritual healers are sensitive to the needs of the patient, and healing can be given in any position that the patient finds comfortable, rather than the customary positions of sitting in a chair or lying flat on a couch. Spiritual healing can also be delivered by the simple touch of a hand, rather than by the more usual movement (scanning) of the healer's hands around the patient's body.

- It is customary only to give spiritual healing in response to a request from the patient or someone on the patient's behalf, and to seek the patient's consent prior to giving healing.
- Healing can bring to the surface hidden or suppressed emotional issues; emotions can be 'released'. Therapists need to allow time and have the skills to relate to patients who may be emotionally distressed during or following a treatment. Spiritual healers who are undergoing training are known as 'probationary healers'. It is advisable for probationary healers to practise in an environment where a fully qualified healer is available for advice.
- As spiritual healing involves a flow of energy, it is not usually offered to individuals suffering from epilepsy or those fitted with cardiac pacemakers.

10.7.3.4 Practitioner Training and Qualifications

10.7.3.4.1 Training

Training for spiritual healers is currently provided by the many professional organisations, and usually takes about two years. This period involves attendance at formal training courses, supervised healing practice and documented records of on-going personal development. During the training period healers are variously known as 'probationary healers', 'student healers' or trainees. The development of standards of good practice, by UK Healers, along the lines of the National Occupational Standards for Complementary and Alternative Medicine Therapies, is underway.

10.7.3.4.2 Regulatory Bodies

Probationary, student or trainee healers are assessed by a panel prior to acceptance for registration with a regulatory body. UK Healers (www.ukhealers.info) is the body under which the many professional organisations are collaborating to develop a single regulatory body.

Spiritual healers should be registered with one of the following professional organisations:

- The Spiritualists National Union (SNU)
- The British Alliance of Healing Associations (BAHA)
- The World Federation of Healing (WFH)
- The School of Insight and Intuitions (School of Insight)
- Greater World Christian Spiritualist Associations (Greater World)
- White Rose Foundation (White Rose)
- Holistic Healers Association (Holistic Healers)
- White Eagle Lodge
- United Spiritualists
- National Federation of Spiritual Healers (NFSH)
- Northern Healers Forum (NHF)
- Confederation of Healing Organisations (CHO)
- Association of Therapeutic Healers (ATH)

10.7.3.4.3 Insurance

Spiritual healers are usually insured under their professional organisation to practise spiritual healing.

10.7.3.4.4 Continuing Professional Development (CPD)

Spiritual healers are committed to their on-going personal development, and should be able to demonstrate evidence of continuing professional development for working in supportive and palliative care.

11. GUIDELINE DEVELOPMENT PROCESS

11.1 Steering Group

The steering group for the project was drawn from major stakeholding organisations and professionals within palliative care, service users and representatives from a range of service delivery organisations.

Michael Fox (joint chair)	Chief Executive, The Prince of Wales's Foundation for Integrated Health
Eve Richardson (joint chair)	Chief Executive, National Council for Hospice and Specialist Palliative Care Services
Marianne Tavares	Project Manager, Complementary Therapies in Palliative Care, The Prince of Wales's Foundation for Integrated Health
Judy Abbott	Service user, Sheffield
Angela Avis MBE	Chair, Complementary Therapies Forum, Royal College of Nursing; Lecturer, Oxford Brookes University
Ann Carter	Complementary Therapy Co-ordinator, St. Ann's Hospice, Manchester
Liz Hawkins	Complementary Therapy Co-ordinator, St. Christopher's Hospice (until Sept 2002); Lecturer, University of Westminster; Complementary Therapy Practitioner, Harley Street Clinic
Jean Hindmarch	Head of Education, Training and Awards, Help the Hospices
Dr. Jenny Kitchen	Consultant in Palliative Medicine, The Shropshire and Mid Wales Hospice (until Sept 2002) St. Peter's Hospice, Bristol (from Sept 2002)
Dr. Michelle Kohn	Medical Adviser (Comp. Therapies) Macmillan Cancer Relief
Peter Mackereth (from March 2002)	Lecturer/Practitioner (Comp. Therapies) Christie Hospital NHS Trust, Manchester; Lecturer, Salford University

Freda Magee (from June 2002)	Chair, National Association of Complementary Therapists in Hospice and Palliative Care
Dr. Andrew Manasse	Clinical Lead, The Cavendish Centre for Cancer Care, Sheffield
John Pickett	Service User, London
Jan Wilkinson (until June 2002)	Vice Chair, National Association of Complementary Therapists in Hospice and Palliative Care
Dr. Susie Wilkinson	Head of Caring Services Research, Marie Curie Palliative Care RND Unit; Senior Lecturer, Department of Oncology, Royal Free University College Medical School

11.2 Gathering Information and Evidence

11.2.1 Existing Guidelines, Policies and Standards

500 organisations, as listed in the Directory of Hospice and Palliative Care Services, 2001, were approached for their existing guidelines, policies and standards on complementary therapies. Policies were received from about 100 organisations. Another 20 replied that they either did not offer complementary therapies, or were currently developing/updating their policies.

The most widely provided therapies, and issues addressed in local policies were identified from the sets of guidelines received. Using the information provided, a draft outline of the national guidelines was drawn up, and sent to the wider consultative group for the project.

11.2.2 Consulting professional organisations for complementary therapies

The professional organisations for massage, aromatherapy, reflexology, acupuncture, homeopathy, hypnotherapy, and healing were invited to contribute to the development process. Contacts were identified from the Regulation Programme of The Prince of Wales's Foundation for Integrated Health, and the following information was requested:

- Brief description
- Evidence base, especially for palliative care

- How patients can benefit from use of the therapy in palliative care
- General contraindications / precautions for the therapy
- Specific contraindications / precautions for using the therapy in palliative care
- Modification of approach in palliative care
- Other issues for consideration
- Practitioner – training and qualification, regulatory bodies

11.3 Consultation and Peer Review

11.3.1 Symposia

Three symposia were held in London, Bristol and Manchester, involving about 100 service users and professionals with responsibility for developing complementary therapy services. Services users were approached via Cancerlink, and professionals were invited from a range of providers (hospitals, hospices, and cancer support centres) in different parts of England and Wales. The experience of service providers ranged from those in the early stages of developing complementary therapy services to centres of excellence. Appendix L gives the list of participants in the three symposia. The workshops identified important areas for inclusion in the guidelines.

11.3.2 Experts_

Drafts of the relevant sections were sent to different experts and experienced practitioners of the therapy within supportive and palliative care (see Appendix N). Some experts contributed to the writing of the drafts.

11.3.3 National consultation

The national consultation process for the draft document is as follows:

- Publication of the draft document on the websites of The Prince of Wales's Foundation for Integrated Health, and the National Council for Hospice and Specialist Palliative Care Services
- Sending the document to the participants of the symposia (Appendix L), the professional bodies for the therapies included in the guidelines, the wider consultative group (Appendix M), the list of experts (Appendix N), and as requested.

11.3.4 External Evaluation

Professor Jessica Corner will be evaluating the usefulness of the guidelines following publication of the document.

Participants at the three symposia**Appendix L**

Judy Abbott	Service User, London
Dr Julian Abel	Weston Hospicecare, Weston-super-Mare
Angela Avis MBE	RCN Complementary Therapies Forum
Jane Bailey	Salisbury Hospice
Jill Bailey	Trafford MacMillan Centre
Elizabeth Baines	CancerCare Dorset
Ann Barnes	Arthur Rank House, Cambridge
Marlene Barry	Springhill Hospice, Rochdale
Maggie Brain	Hospice in the Weald, Tunbridge Wells
Veronica Bratt	The Primrose Hospice and Cancer Help Centre, Bromsgrove
Jeremy Browne	Service User, Hampshire
Nadia Brydon	The Haven Trust, London
Stella Carmichael	Newcastle PCT
Angela Chisholm	Arthur Rank House, Cambridge
Ann Carter	St. Ann's Hospice, Manchester
Helen Cooke	Bristol Cancer Help Centre
Anna Craven	Service User, North Yorkshire
Sara Crisell	Service User, Essex
Peter Cross	Service User, Cumbria
Lilibet Czyzewska	Service User, Bradford
Dr Rosy Daniel	Healthy Bristol
Tricia Darnell	The Prince of Wales's Foundation for Integrated Health
Beverley de Valois	North Middlesex University Hospital NHS Trust
Tony Dougan	Cancer Care (North Lancs and South Lakes)
Diana Dunrossil	The Prince of Wales's Foundation for Integrated Health

Norman Dunsby	Willowbrook Hospice, Prescot
Jeannie Dyer	Royal Marsden Hospital, London
Carole Farah	Service User, Swansea
Gwyn Featonby	Butterwick Hospice Care, Stockton-on-Tees
Frances Fewell	Anglia Polytechnic University
Pauline Galloway	Teeside Hospice Care Foundation
Terry Gentry	Service User, Middlesbrough
Tina Glynn	St. George's Healthcare NHS Trust, London
Roma Grant	National Council for Hospice and Specialist Palliative Care Services
Russell Hart-Davies	South Leeds PCT
Betty Heslop	Service User, Northumberland
Dione Hills	The Prince of Wales's Foundation for Integrated Health
Sally Hughes	Prince of Wales's Foundation for Integrated Health
Pat Hunter	The Peace Hospice, Watford
Sandra Hurd	University Hospital of Leicester NHS Trust
Pamela Jack	The Prince of Wales's Foundation for Integrated Health
Val Jarvis	Beechwood Cancer Care Centre, Stockport
Richard Kane	North Devon Hospice
Dr Jenny Kitchen	The Shropshire and Mid Wales Hospice
Dorothy Lambeth	Robert Ogden MacMillan Centre, Leeds
Dr Richard Lamerton	Hospice of the Valleys, Tredegar
Wendy Leach	Mount Edgcumbe Hospice, Cornwall
Dr. Graham Leng	Hospice of the Good Shepherd, Chester
Gina Long	South Leeds PCT
Karen Loxton	Richard Dimpleby Cancer Information & Support Service, London

Peter Mackereth	Christie Hospital NHS Trust, Manchester
Dr. Andrew Manasse	The Cavendish Centre for Cancer Care, Sheffield
Patricia McDermott	Edenhall Marie Curie Centre, London
Deirdre McGuigan	Bristol Children's Hospital
Louise Meadan	Marie Curie Centre Holme Tower, Vale of Glamorgan
Dr. Alison Morrison	Ardgowan Hospice, Scotland
Libby Mytton	The Primrose Hospice and Cancer Help Centre, Bromsgrove
Kate Nadkarni	Bradford Cancer Support
Gillian Peace	The Cavendish Centre for Cancer Care, Sheffield
Lev Pedro	Immune Development Trust, London
Margot Pinder	The Prince of Wales's Foundation for Integrated Health
Howard Plummer	Sandville Court Self Help Centre, Bridgend
Gwyneth Poacher	Sandville Court Self Help Centre, Bridgend
Judith Powell	Wakefield Hospice, West Yorkshire
Noel Ratcliffe	The Peace Hospice, Watford
Dr. Dai Roberts	St. Ann's Hospice, Manchester
Robert Ross	Service User, Oxford
Serena Scrine	St. Luke's Hospice, Plymouth
Sue Smith	Mustard Tree Macmillan Centre, Plymouth
Dawn Solomon	Newcastle PCT
Dr Dingle Spence	St. Peter's Hospice, Bristol
Jacqui Stringer	Christie Hospital NHS Trust, Manchester
Jackie Syrett	Dove House Hospice, Hull
David Tapper	St. David's Foundation, Newport
Elizabeth Taylor	Holistic Resources, Lancashire
Gillian Thomas	Edenhall Marie Curie Centre, London

Dr Elizabeth Thompson	Bristol Homeopathic Hospital
Dr. Elizabeth Thompson	St. Margaret's Somerset Hospice
Anna Thomson	The Prince of Wales's Foundation for Integrated Health
Chris Walker	Service User, Northumberland
Mina West	Cherry Lodge Cancer Care, Barnet
Dr Susie Wilkinson	Marie Curie Palliative Care R&D Unit, Royal Free University College Hospital, London
Jane Wilkinson	School of Integrated Health Care, University of Westminster
Lorraine Williams	<i>The Prince of Wales's Foundation for Integrated Health</i>
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Andrew Wilson	Marie Curie Centre Holme Tower, Vale of Glamorgan
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WIDER CONSULTATIVE GROUP**Appendix M**

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Prof. S.J. Closs	University of Leeds
Prof. Jessica Corner	University of Southampton
Dr. Michael Dixon	NHS Alliance
Dr. Peter Fisher	Royal London Homeopathic Hospital
Helen Frances	St. Luke's Hospice, Plymouth
Sharon Haffenden	MS Society
Sue Hawkett	Department of Health
Prof. Irene Higginson	King's College London
Caroline Hoffman	Royal Marsden Hospital
Wendy Hoy	Macmillan Butterfly Centre, Epsom
Dr. Sosie Kassab	Royal London Homeopathic Hospital
Steve Kirk	St. Gemma's Hospice, Leeds
Gillian Leng	NICE
Rosemary Lucey	The Lynda Jackson Macmillan Centre
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Dr. David McGavin	Blackthorn Medical Centre and Trust
Heidi MacLeod	MND Association
Lynne Morrison	Cancerlink
Dr. Charlotte Paterson	Warwick House Medical Centre
Helen Press	Sue Ryder Care
Prof. Alison Richardson	King's College London
Diane Robinson	St. Catherine's Hospice, Scarborough
Sheila Scott	Parkinsons' Disease Society
Dr. Maire Shelly	South Manchester University Hospitals
	NHS Trust
Peter Smith	National Association of Primary Care
Margaret Stevenson	Scottish Partnership Agency
Peter Tebbit	National Council for Hospice and Specialist Palliative Care Services
	Bristol Cancer Help Centre
Pat Turton	St. Michael's Hospice, Basingstoke
Debbie Veel	
Aromatherapy Regulatory Working Group	
Reflexology Forum	
General Council for Massage Therapy	
Council for Registering Homeopaths	
The Faculty of Homoeopathy	
Acupuncture Association of Chartered Physiotherapists	
British Medical Acupuncture Society	
British Academy of Western Acupuncture	
British Acupuncture Council	
British Society of Medical and Dental Hypnosis	
UK Confederation of Hypnotherapy Organisations	
UK Reiki Federation	
British Association of Therapeutic Touch	
UK Healers	

Appendix N

List of experts

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Angie Buxton	University College Hospital, London
Ann Carter	St. Ann's Hospice, Manchester
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Dr. Raj Chopra	Christie Hospital NHS Trust
Sara Crisell	Service User
Peter Cross	Service User
Jeannie Dyer	Royal Marsden Hospital
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Stephen Gordon	Society of Homeopaths
Prof. John Gruzelier	Imperial College London University
Sharon Haffenden	MS Society
Annie Hallett	Ipswich Hospital NHS Trust
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Betty Heslop	Northumberland Cancer Support Group
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Dr. Jenny Kitchen	St. Peter's Hospice, Bristol
Lyn Lamont	Northern Ireland Cancer Centre, Belfast
Dr. Graham Leng	Hospice of the Good Shepherd, Chester
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Dr. Andrew Manasse	The Cavendish Centre for Cancer Care
Gill McCall	St. Thomas' Hospital
Dr. McIlmurray	Royal Lancaster Infirmary
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Dr. David Oakley	University College Hospital
Jacky Owens	University College Hospital
Brenda Peace	UK Healers
Jean Sayre-Adams	Sacred Space Foundation
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Serena Scrine	St. Luke's Hospice, Plymouth
Linda Shuttleworth	St. Gemma's Hospice, Leeds
David Simons	The Cavendish Centre for Cancer Care
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Prof. Alan Thompson	Nat. Hospital for Neurology & Neurosurgery
Celia Tudor-Evans	College of Traditional Acupuncture
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Joyce West	Aromatherapy Organisations Council
Frank Westell	General Council for Massage Therapy
Dr. Susie Wilkinson	Marie Curie Palliative Care R&D Unit
Julia Williams	University College Hospital
Maureen Williams	Nursing and Midwifery Council
Dr. Ann Williamson	Br. Soc.for Medical and Dental Hypnosis
Prof. Steve Wright	Sacred Space Foundation
Reflexology Forum	
Aromatherapy Regulatory Working Group	
General Council for Massage Therapy	
Council for Registering Homeopaths	
British Acupuncture Council	
Acupuncture Association of Chartered Physiotherapists	
British Academy of Western Acupuncture	
British Medical Acupuncture Society	
British Society for Medical and Dental Hypnosis	
British Association of Therapeutic Touch	
UK Reiki Federation	
UK Healers	

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