PALLIATIVE & SUPPORTIVE CARE

Alternative Therapies in Cancer

Comfort, Evidence and Safety

A clear, evidence-based guide for palliative care, oncology and GP teaching — written to be kind to patients and safe in practice.

CORE MESSAGE

Use complementary therapies for **comfort, coping and wellbeing**. **Never** offer them as a cancer cure, and never let them replace proven treatment.

HELPFUL	UNPROVEN	HARMFUL
for symptoms	for survival	when it replaces treatment

Rebuilt from a 1991 creative-health reading list (Dr Sheila Cartwright, Cookridge Hospital, Leeds) and updated against current UK and international evidence.

June 2026

For postgraduate teaching. Not a substitute for oncology or specialist palliative care advice.

1 Three words to get right

Complementary · Alternative · Integrative

Patients try many things. Our first job is to **name the kind of therapy** in front of us. Three words decide whether a therapy is safe, risky, or somewhere in between.

USED ALONGSIDE CARE

Complementary

Sits beside proven cancer treatment. The aim is comfort — easing pain, anxiety, fatigue, nausea, sleep or low mood. It does not try to cure the cancer.

USED INSTEAD OF CARE

Alternative

Replaces proven cancer treatment. This is the high-risk zone. It can delay or stop effective care — the single biggest danger to survival.

THE SAFE MODEL

Integrative oncology

Proven cancer care *plus* selected supportive therapies. Built on open disclosure, safety checks and shared decisions.

WHY THIS FRAMING MATTERS

Most patients will not mention supplements or therapies unless we ask — often because they fear being judged. A warm, curious tone makes disclosure safe, and disclosure is what keeps patients safe.

What to say	Why it works
“Tell me what you are using — I will not judge.”	Patients hide therapies they expect us to mock. Permission to speak openly is step one.
“Some therapies ease symptoms. None has been shown to cure cancer.”	Protects honesty *and* hope at the same time.
“Please do not stop oncology treatment without speaking to your cancer team.”	Targets the main mortality risk: refusing or delaying proven care.
“Herbal and dietary supplements can interact with cancer medicines.”	‘Natural’ does not mean safe — especially with chemotherapy, immunotherapy, radiotherapy, anticoagulants or surgery.

TEACHING PEARL

This topic invites ridicule. Resist it. Patients reach for these therapies because they are frightened, want control, or are searching for meaning. Our job is to be **kind, curious and clinically safe**.

2 The evidence map

The one table to teach from

Keep the categories simple and memorable. Read each therapy through one question: does the evidence support comfort, or is someone claiming a cure?

Category	Therapies	Best use & teaching message
Helpful for some symptoms	Acupuncture / acupressure; massage; relaxation; mindfulness; guided imagery; music therapy; exercise & rehab; yoga or tai chi when safe.	Useful **adjuncts** for pain, anxiety, distress, sleep, nausea, fatigue and coping. Benefit is symptom-specific, not curative. Match to patient preference, risk and local availability.
Possibly helpful, not proven	Reflexology, aromatherapy, reiki / therapeutic touch, hypnosis outside procedural pain, spiritual healing framed as support.	May lift wellbeing for some, but evidence is mixed or low-certainty. Placebo, attention, touch and meaning may carry the benefit. Do not overclaim; if safe, patient-led use can be reasonable.
Not a cancer treatment	Homeopathy, flower remedies, crystals, colour therapy, energy-field diagnosis, chakras, magnetic healing, “detox” regimens.	No good evidence of cancer control. Becomes harmful if it replaces oncology care, costs money, creates blame or delays treatment. Be respectful but clear.
High-risk — actively warn	Alternative diets as a cure, high-dose supplements, unregulated herbs, laetrile / apricot kernels, black salve, ozone or alkaline therapies, “immune-boosting” cures.	Risk of toxicity, drug interactions, false hope, financial harm and treatment delay. Warn actively. Ask oncology or pharmacy before any use.

HELPFUL	UNPROVEN	HARMFUL
for symptoms	for survival	when it replaces treatment

3 What genuinely helps

Supportive therapies with reasonable evidence

These are **not cures**. They are supportive therapies that may reduce symptoms or improve quality of life. UK and international guidance now backs several of them for specific symptoms.

Therapy	Evidence-informed role	Practical cautions
Acupuncture / acupressure	Recommended for **aromatase-inhibitor joint pain** in breast cancer; may help general or musculoskeletal cancer pain. Sometimes used for nausea, hot flushes or dry mouth, with benefit varying by symptom.	Use trained practitioners. Avoid needling through lymphoedema, infected skin, severe neutropenia or major bleeding risk without specialist advice.
Massage	May reduce pain, anxiety and distress in palliative or hospice care. Valued because it is human, calming and non-verbal.	Avoid deep pressure over bone metastases, thrombosis, fragile skin, radiotherapy fields or low platelets.
Mindfulness / meditation / relaxation	Can ease stress, anxiety, sleep problems and coping. A low-risk adjunct when taught simply.	Do not present as compulsory positivity. Some patients dislike introspective exercises.
Guided imagery / visualisation	May aid relaxation and reduce distress. Best framed as *calming the nervous system*, not killing cancer cells.	Remove any language implying a patient can “visualise the cancer away”.
Music therapy	May reduce anxiety, distress and perceived pain. Useful when speech is hard, including in advanced illness.	Needs patient choice. Not everyone finds music soothing.
Exercise / prehabilitation / gentle movement	Can improve fatigue, function, mood and confidence when tailored to performance status.	Avoid generic “keep active” advice. Tailor to frailty, bone disease, falls risk and goals of care.
Spiritual & existential care	Supports meaning, fear, guilt, hope, relationships and preparation for death. This is central to palliative care.	Do not impose beliefs. Ask what matters to the patient. Offer chaplaincy or faith support if wanted.

WHAT THE GUIDELINES SAY

The 2022 SIO–ASCO guideline on integrative pain management recommends **acupuncture** for aromatase-inhibitor joint pain, **acupuncture, acupressure or reflexology** for general or musculoskeletal cancer pain, **hypnosis** for procedural pain, and **massage** for pain in palliative or hospice care — all as adjuncts to standard care.

4 What is unproven or unsafe

False claims, hidden interactions, treatment refusal

The problem is rarely that a patient finds comfort in a ritual. The problem is **false claims, hidden interactions, refused treatment and patient blame**. Name the claim, explain the risk, and offer better wording.

Claim	Why it should not be offered as cancer treatment	Better wording
“Positive thinking cures cancer”	Not supported. It can make patients feel responsible if the disease progresses.	“Your mood is not your fault. Support can help you cope, but cancer biology is not controlled by attitude.”
Homeopathy / flower remedies	No credible evidence of treating cancer. Extreme dilution makes any specific drug effect implausible. NHS England no longer recommends prescribing homeopathy.	“If it brings comfort, tell us. Please do not use it instead of oncology care.”
Crystals, colour healing, chakras, energy-field diagnosis	No diagnostic or treatment role. May hold personal meaning, but it is not medicine.	“It may matter to you personally, but it does not diagnose or treat cancer.”
Herbal “anti-cancer” products	Quality, dose and contamination vary. Some interact with cancer drugs, anticoagulants, anaesthetics and radiotherapy.	“Please check every supplement with the oncology pharmacy first.”
Special diets as a cure: detox, alkaline, juicing, raw food	No reliable evidence as a cancer cure. Can cause weight loss, malnutrition, guilt and conflict around food.	“Food can support strength and enjoyment. It should not become another burden.”
Intuitive diagnosis / medical clairvoyance	Unsafe. It bypasses proper assessment, imaging, pathology and clinical reasoning.	“Diagnosis must rest on clinical evidence, not intuition.”

HIGH-RISK — WARN DIRECTLY

Laetrile / amygdalin (“vitamin B17”, apricot kernels) releases cyanide when broken down in the gut. There is no reliable evidence it treats cancer, and a Cochrane review judged its risk–benefit balance clearly negative. The same caution applies to black salve, high-dose unregulated supplements and ozone or alkaline “cures”.

> “I am not against comfort or meaning. I am against **false claims** and **unsafe delays**.”
>
> THE CLINICAL STANCE IN ONE LINE

5 Auditing the 1991 reading list

Keep the humane intention — remove the pseudo-medical claims

The original list was a product of its time. The kindness is worth keeping. The cure claims are not.

Original section	Verdict now	What to do
Positive thinking	Mostly remove. Supportive optimism is fine; “mind over cancer” is not.	Replace with coping, distress management and compassionate communication.
Self-healing	Mostly remove. Too much illness-blame and non-evidence-based healing language.	Keep only reflective writing that helps doctors understand suffering.
Visualisation	Keep cautiously. Helpful as relaxation; not a cancer treatment.	Rename as guided imagery / relaxation. Drop tumour-control claims.
Subtle bodies / magnetic healing / chakras	Remove as clinical content.	Mention only under “beliefs patients may hold”.
Intuitive diagnosis	Remove. Clinically unsafe.	Replace with symptom assessment, red flags, decision-making and uncertainty.
Spiritual growth	Rewrite. Spiritual care belongs in palliative care — not as an imposed belief system.	Use meaning, fear, forgiveness, hope, culture, faith and chaplaincy.
Counselling skills	Keep and modernise.	Retain active listening, breaking bad news and family meetings.
Diet and nutrition	Rewrite completely.	Focus on cachexia, appetite, comfort feeding, taste change and food-related distress.
Bereavement and dying	Keep the theme; update the sources.	Add anticipatory grief, complicated grief and support for children and families.
Complementary-medicine journals / courses	Do not endorse uncritically.	Use critical appraisal, safety, disclosure and interaction checking.

6 A modernised teaching structure

A safer way to teach this topic on a palliative care course

Section	Include	Avoid
1 · Core palliative care	Current symptom control, deprescribing, care in the last days, advance care planning, frailty, dementia and organ failure.	Old alternative-medicine manuals as core reading.
2 · Communication	Serious-illness conversations, breaking bad news, uncertainty, shared decisions, family meetings, anger and silence.	Scripts that sound robotic or manipulative.
3 · Psychological care	Anxiety, depression, demoralisation, dignity therapy, meaning-centred care, CBT/ACT-informed and trauma-aware approaches.	“Think positive or get well” messages.
4 · Spiritual / existential care	Meaning, hope, guilt, forgiveness, fear of dying, faith needs, rituals, culture and chaplaincy.	Claims that one spiritual method heals cancer.
5 · Complementary therapies	Evidence map, safety, communication, interactions, symptom-specific use and local referral pathways.	Endorsing cures, detoxes, energy diagnosis or costly unproven products.
6 · Nutrition and function	Cachexia, anorexia, taste changes, mouth care, comfort feeding, fatigue, gentle movement and rehab.	Restrictive diets framed as cancer treatment.
7 · Bereavement	Anticipatory grief, normal grief, complicated grief, family systems, children and staff grief.	One-size-fits-all “stages of grief” teaching.

SUGGESTED MODULE TITLE

“Complementary Therapies in Cancer: Comfort, Evidence and Safety.”

7 A safe consultation script

Six steps for a kind, non-judgemental conversation

Ridicule makes patients hide things. Warm curiosity makes safety possible. Move through these steps in order.

1

“Many people try supplements, diets or complementary therapies. Are you using anything like that?”

ASK OPENLY Normalises disclosure so the patient feels safe to speak.

2

"What are you hoping it will help with?"

EXPLORE MEANING Finds the real goal: cure, symptom relief, control, fear, family pressure or meaning.

3

"Some things can help comfort. None has been shown to cure cancer."

SEPARATE COMFORT FROM CURE Keeps honesty without crushing hope.

4

"Let's check this against your cancer medicines and blood thinners."

CHECK SAFETY Prevents interactions and avoidable harm.

5

"Please do not stop oncology treatment unless your cancer team agrees."

PROTECT TREATMENT Targets the main mortality risk — refusal or delay of proven care.

6

"For your anxiety, pain or sleep, these options have a stronger evidence base."

OFFER ALTERNATIVES Redirects gently to safer supportive care.

8 One-page teaching summary

The whole guide in a single table

Question	Answer
Can complementary therapies help?	Yes — some ease symptoms, coping, anxiety, pain, fatigue, sleep or wellbeing. Benefits are usually modest and patient-specific.
Can they cure cancer?	No complementary health approach has been shown to prevent or cure cancer.
What is the biggest danger?	Using **alternative** therapy instead of proven treatment, or using supplements that interact with cancer medicines.
What should we remove from old reading lists?	Positive-thinking cure claims, homeopathy as treatment, crystals, colour therapy, chakras, energy fields, magnetic healing, intuitive diagnosis, detox diets and all cure claims.
What should we keep?	Communication skills, reflective writing, bereavement, spiritual and existential care, relaxation, mindfulness, guided imagery and selected evidence-based supportive therapies.
Best clinical phrase	*"I am not against comfort or meaning. I am against false claims and unsafe delays."*

9 Key evidence sources

What this guide is built on

1. **NCCIH** — *Cancer and Complementary Health Approaches*: no complementary approach has been shown to prevent or cure cancer; some may ease symptoms and side-effects.
2. **National Cancer Institute (NCI)** — *Complementary and Alternative Medicine*: distinguishes complementary from alternative use; notes use for side-effects, stress and attempts to treat cancer.
3. **SIO–ASCO guideline (Mao et al., J Clin Oncol 2022)** — integrative medicine for cancer pain: symptom-specific recommendations for acupuncture, acupressure / reflexology, hypnosis and massage.
4. **Johnson et al., JAMA Oncology 2018** — complementary medicine use was linked to refusal of conventional treatment and a roughly two-fold higher risk of death, with the excess risk driven by treatment refusal or delay.
5. **NCI PDQ & Cancer Research UK** — herbs and supplements can interact with cancer therapies; laetrile / amygdalin carries cyanide-toxicity risk and is not a reliable cancer treatment.
6. **NHS England (2017–18)** — ceased to recommend prescribing homeopathy on the grounds of no robust evidence; upheld by the High Court in 2018.
7. **WHO — Palliative care**: addresses physical, psychosocial and spiritual problems across life-threatening illness.
8. **Source document** — *Creative Health: Selected Reading List*, Dr Sheila Cartwright, Cookridge Hospital, Leeds (1991).

A note on UK guidance. NICE does not publish a dedicated guideline on complementary or alternative therapies in cancer. Where NICE is silent, this guide relies on named specialist and national sources — the SIO–ASCO pain guideline, NHS England, Cancer Research UK, NCCIH and NCI — alongside NICE's palliative care framework and WHO. All clinical claims were checked against these primary sources before writing.

What we changed, and why

Transparency log of clinical updates

Every clinical update is listed here with its source, so it can be cross-checked. Wording and structure were modernised for teaching; the changes below affect clinical content.

ADDED **UK contextualisation of homeopathy**

Added that NHS England no longer recommends prescribing homeopathy. This anchors the “not a cancer treatment” category in current UK practice.

Source: NHS England prescribing guidance (2017), upheld by the High Court (2018).

UPDATED **Survival risk made precise**

Clarified that the higher risk of death linked to complementary medicine is mediated by refusal or delay of conventional treatment — not by the supportive therapy itself. This keeps the safety message accurate without overstating harm.

Source: Johnson SB et al., JAMA Oncology 2018.

UPDATED **Acupuncture role specified**

Made the acupuncture recommendation evidence-specific: strongest for aromatase-inhibitor joint pain, with a role in general or musculoskeletal cancer pain. Replaces a more general claim.

Source: SIO–ASCO guideline, Mao JJ et al., J Clin Oncol 2022.

UPDATED **Laetrile risk strengthened**

Added that a Cochrane review judged the risk–benefit balance of laetrile / amygdalin clearly negative, reinforcing the cyanide-toxicity warning.

Source: Cancer Research UK; Cochrane review of laetrile / amygdalin.

CONTEXT **NICE remit flagged**

Stated plainly that NICE has no dedicated guideline on complementary therapies in cancer, and named the specialist sources used in its place.

Source: NICE topic coverage; SIO–ASCO, NHS England, Cancer Research UK, NCCIH, NCI, WHO.

Unchanged where already sound. The source document was already evidence-based and humane. Its core message, evidence categories, consultation framework and reading-list audit were preserved. Edits focused on clarity, UK relevance, and tightening clinical precision.