BRADFORD VTS TEACHING AIDS
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TEACHING AID
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SUPPORTIVE & HOLISTIC CARE · ONCOLOGY IN PRIMARY CARE

Caring for the Whole Person in Cancer

Good cancer care treats the **person**, not just the tumour. This teaching aid sets out how to deliver whole-person care in modern UK primary care — the assessments, conversations and practical support that make a real difference for people living with and beyond cancer.

3M+ people are living with or beyond cancer in the UK today[4]

4M projected by 2030 — most cared for close to home, in general practice[4]

1 The whole person — a working model

Caring for the "whole person" is the heart of good cancer care. You do not need a mystical model to do it — you need a practical one. Use the **biopsychosocial–spiritual model**: a person's health sits across four everyday areas, and cancer touches all of them. Assess each one, and you will not miss what matters most to the patient.

Physical
Symptoms, treatment side-effects, fatigue, function, other conditions.

Psychological
Worry, low mood, anxiety, fear of recurrence, coping.

Practical & social
Money, work, travel, family and carers, daily living.

Spiritual
Meaning, belief, hope, dignity — what matters most.

MEMORY HOOK
Picture **four rooms in one house — body, mind, life and meaning**. On every visit, look into each room. You are still treating one person; you are just not leaving any room dark.

2 The Holistic Needs Assessment (HNA)

The **Holistic Needs Assessment** is the NHS's structured way to check all four domains. It is a simple, repeatable conversation that turns a person's concerns into an agreed plan — the practical engine of personalised care.

You must offer every person living with and beyond cancer an HNA and a **personalised care and support plan** at key points on their pathway. This is a core commitment of the NHS Long Term Plan and NHS England's personalised care model.[1,2]

1. **Concerns checklist** — Patient flags what matters
2. **Supported conversation** — Prioritise together
3. **Care & support plan** — Actions, self-help, referrals
4. **Share & review** — To GP + MDT; revisit

Reassess at key points, because needs change: at or soon after **diagnosis**; at the **start** and **end** of treatment; at **relapse or progression**; as the person nears the **end of life**; and **whenever something changes**.

3 The GP's job: the Cancer Care Review

In primary care, whole-person care is delivered mainly through the **Cancer Care Review (CCR)** — a supportive conversation between the patient and their GP or practice nurse. It is the moment to pick up hidden distress and unmet needs after the hospital team steps back.

> **Two touch-points.** Make an **early offer of support within 3 months** of diagnosis, then hold a **fuller, structured review within 12 months**. Use Macmillan's national CCR template so all four domains are covered.[3]

What to cover in the review

- → **Understanding** — what the patient knows about their diagnosis, treatment and follow-up.
- → **Body** — symptoms, treatment effects, fatigue; a **medication review**.
- → **Mind** — mood, anxiety, fear of recurrence; screen and act on low mood.
- → **Life** — money, work, carers; signpost to benefits advice and Macmillan.
- → **Meaning** — what matters most now; note any spiritual or faith needs.

4 Supporting each domain in practice

Here is what "whole-person care" looks like at the desk — the common needs in each domain, and concrete actions you can take or arrange.

DOMAIN	COMMON NEEDS	WHAT YOU CAN DO
Physical	Pain, fatigue, nausea, breathlessness, treatment side-effects, deconditioning, other long-term conditions.	Optimise symptom control; refer for **prehabilitation / rehabilitation**; encourage activity; review comorbidities and reduce unnecessary polypharmacy; give prevention and lifestyle advice.
Psychological	Worry, low mood, anxiety, fear of recurrence, poor sleep, loss of confidence.	Normalise distress; use a **stepped approach** — information & self-help → structured support/ counselling → specialist psychology or psychiatry. Screen for and treat **depression and anxiety**; signpost peer support.
Practical & social	Money worries, work, travel to appointments, childcare, carer strain.	Arrange benefits advice early. For anyone who may be **nearing the end of life**, complete an **SR1 form** promptly (this replaced the DS1500) to fast-track benefits under the Special Rules. Support carers.[11]
Spiritual	Search for meaning, fear, questions of faith, wish for dignity.	Ask openly what gives them meaning and strength; offer **chaplaincy / spiritual-care services**; respect every belief system — and none.[10]

> **Psychological care — get the level right.** Most people cope with good information and support from their usual team. Reserve counselling for those who need it, and refer promptly to specialist psychology or psychiatry when distress is severe, persistent, or you suspect clinical depression. Match the support to the need — do not under-treat, and do not medicalise normal adjustment.

5 Two big, evidence-based wins

If you do only two extra things well, make them these — both have real evidence behind them and both suit primary care.

Prehabilitation

Getting fit for treatment — before it starts

- Needs-based **exercise, nutrition and psychological support** before and during treatment.
- Leads to **fewer complications**, better tolerance, and more people **completing treatment**.
- Improves fitness, mood and quality of life — benefits can appear in **as little as two weeks**.
- It does not extend survival — and that is fine. It improves how people cope and recover.[5]

Prevention

About 4 in 10 UK cancers are preventable

- **Don't smoke** — the single biggest preventable cause.
- **Keep a healthy weight** — obesity is linked to 13 cancers.
- **Cut down alcohol** — a Group-1 carcinogen; less is safer.
- **Move more**, eat more fibre and veg; take up **screening** and HPV/HBV vaccination. Brief advice in primary care works.[6]

6 Talking honestly — hope without false promises

Whole-person care raises hope, and that is good. Keep the hope **honest** and it stays powerful. Three anchors keep you on safe ground:

→ **We can** improve symptoms, coping, dignity and quality of life. Psychological support genuinely helps people live with cancer.[7]

→ **We must not** promise that a positive attitude or "fighting spirit" prolongs survival — the evidence does not support it, and it can leave patients feeling blamed.[7]

→ **We must not** tell patients that stress or emotions caused their cancer — they did not. Saying so plainly lifts real guilt.[8]

Complementary therapies — respectful and safe

Many complementary approaches (massage, relaxation, mindfulness) are **safe alongside** conventional care and can genuinely aid wellbeing. Be honest that "energy" therapies do not treat the disease itself.[9]

> **Red flag & safety-netting.** If a patient is **delaying, stopping or refusing** effective treatment in favour of an alternative therapy, treat it as a safety concern and address it directly.

When the illness is advanced

Ask yourself the **"surprise question"**: would you be surprised if this patient died within the next 12 months? If the answer is no, start **advance care planning**, consider a palliative care referral, and complete an **SR1 form** to unlock end-of-life benefits.[11]

Six things to remember

1. Care for the **whole person** — body, mind, life and meaning. Check all four at every key point.
2. Offer an **HNA and care plan** to everyone living with and beyond cancer.
3. In primary care, deliver it through the **Cancer Care Review** — offer within 3 months, review within 12.
4. Use the two big wins: **prehabilitation** and **prevention**.
5. Support coping and quality of life — **do not promise attitude changes survival**, and never say stress caused the cancer.
6. For advanced illness, ask the **surprise question**; plan ahead and complete an **SR1**.

ABOUT THIS TEACHING AID

Where it came from — and what we left behind

The original document

This aid is adapted from a teaching document by **Dr Sheila C. Cartwright**, Consultant in Radiotherapy & Oncology, Yorkshire Regional Radiotherapy Centre, **Cookridge Hospital, Leeds** (ref. SCC1/CF/JUNE1991). It comprised an "E for Energy" handout, a holistic-medicine questionnaire, and two 1991 lecture scripts — "Holistic Approaches to Cancer Medicine — The Spiritual Dimension" (Yorkshire Regional Pain Relief Service Symposium, Ripon & York St John's College, 15 June 1991) and "Holistic Approaches to Cancer Medicine — Spiritual Nutrition" (Oncology Interest Group, British Dietetic Association, Cookridge Hospital, 14 October 1991).

Its central instinct — treat the whole person, attend to psychological and spiritual distress, protect dignity and quality of life — was ahead of its time and is exactly what this aid preserves. But it framed that care within a 1991 "energy medicine" model, and several of its specific claims have since been overturned by evidence. Those have been left out, and are listed below for teaching honesty.

What was removed, and why:

CLAIM IN THE 1991 ORIGINAL	WHY IT HAS BEEN LEFT OUT
Emotions or stress cause cancer	No strong evidence links stress to cancer; a UK study of >100,000 women found no link with breast cancer. Telling patients this causes needless guilt.[8]
A "positive attitude" / "fighting spirit" prolongs survival	A 10-year follow-up of the study that coined the term found no survival benefit; a 2010 review judged the survival claims "bad science." It also blames patients who cannot stay positive.[7]
Homeopathy, crystal, colour, magnet and Bach-flower therapies treat disease	The NHS and NICE find no good-quality evidence homeopathy works for any condition; NHS funding ended in 2017. The others have no supporting evidence.[9]
Five "energy bodies", chakras and auras as anatomy; $E=mc^2$ as proof of "vibratory energies"	These are metaphors, not physiology. $E=mc^2$ describes nuclear mass–energy equivalence, not human "energy fields."
Death as "a change of vibratory rate"; illness "curable from within"	Metaphysical claims a clinician should not assert as fact; "curable from within" risks steering patients away from effective treatment.

KEY SOURCES

1. NHS England — Personalised care & the NHS Long Term Plan (holistic needs assessment as a core intervention).
2. Macmillan Cancer Support — Holistic Needs Assessment (HNA) & personalised care and support planning. macmillan.org.uk
3. Macmillan / QOF — Cancer Care Reviews in primary care: early offer within 3 months, structured review within 12 months. macmillan.org.uk
4. Macmillan / BJGP — over 3 million people living with or beyond cancer in the UK, rising to ~4 million by 2030.
5. Macmillan — Prehabilitation for people with cancer: clinical & implementation guidelines (2025); exercise, nutrition, psychological support.
6. Cancer Research UK — preventable cancers (~4 in 10 UK cases; smoking, weight, alcohol). cancerresearchuk.org
7. Coyne & Tennen, Ann Behav Med 2010 (with Watson 10-year follow-up) — attitude/"fighting spirit" does not change survival; support coping and quality of life.
8. Cancer Research UK — Does stress cause cancer? No strong evidence; >100,000-woman UK study. cancerresearchuk.org
9. NHS — Homeopathy (no good-quality evidence; NICE does not recommend; NHS funding ended 2017). nhs.uk
10. NICE CKS — Palliative care (assess spiritual needs at key points); GMC — Personal beliefs and medical practice.
11. GOV.UK / DWP — The Special Rules for end of life: the SR1 form replaced the DS1500 (from July 2025).