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Complementary therapists' training and cancer care: A multi-site study

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ABSTRACT

Purpose: To explore professional experience and training of complementary therapists working within cancer care.

Method: A Questionnaire survey of complementary therapists practising in three cancer care settings in North West England.

Results: Respondents (n = 51; n = 47 female; mean age 50 years, range 23–78 years) had varied career backgrounds; 24 were healthcare professionals who also practised as complementary therapists (nurse n = 19; physiotherapist n = 3; doctor n = 2) whilst 27 were complementary therapists with no prior healthcare background. Twenty-eight respondents reported working as therapists within a supportive and palliative care setting for over 6 years. Forty-seven respondents had undertaken healthcare-related continuing professional development in complementary therapies, although only just over half of the sample (n = 27) had received cancer-specific training. Cancer-related complementary therapy training related to the adaptation of therapies and comprised predominantly short courses. There was a lack of standardisation in the training received, nor was it clear how many courses were accredited.

Conclusion: Findings highlight the need for standardisation of training for complementary therapy provision in cancer care and statutory review of continuing professional development within this emerging field.

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Background

In many cases, complementary therapy (CT) services in hospices and cancer care settings began when healthcare professionals who were therapists started to provide CTs as an 'add on' to their existing roles (Gray, 2000; Stringer, 2000). These services were commonly led by nurses who had completed courses in complementary therapies, often offering therapies involving touch, such as aromatherapy, massage and reflexology (Rankin-Box, 2001). Complementary therapies have increased in popularity within healthcare (Ernst et al., 2006), with services growing in number and now being provided across a range of settings (Tavares, 2003). Crucial to this expansion has been the development of CT specific policies, which emphasise safe practice, assessment of risk and other clinical governance issues (Tavares, 2003). As services have grown, complementary therapists without nursing or medical qualifications have been recruited, initially as volunteers, but more recently in a paid capacity as well (Mackereth and Carter, 2006). Given the growth in service provision and the range of therapists providing care, consideration of the qualifications and experience of therapists, whether contributing in a voluntary capacity, or appointed as a paid therapist, is increasingly important.

'Fitness for practice' is a major clinical governance concern, not only to safeguard patient care, but also to prevent costly litigation in the event of poor and harmful practices (Stone, 2002). Traditionally, complementary therapists' training has focused on working with individuals, who, though often suffering from stress, are unlikely to be living with life threatening conditions (Mackereth and O'Hara, 2002). Therapists have usually been taught to view cancer as a contraindication to receiving touch therapies (Kassab and Stevensen, 1996). This perspective has been challenged by therapists with experience in healthcare settings, where practices



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have been adapted to accommodate complex physical and psychological symptoms associated with cancer (Mackereth and Carter, 2006; MacDonald, 1999).

(The Prince of Wales Foundation for Integrated Health, 2005) has published a guide for patients which gives information about CTs to enable a patient to choose a therapy which is 'right' for him or her. The guide also offers advice about how to find a 'properly' trained and qualified practitioner and advises that short training courses alone are not suitable as preparation for "practising professionally with patients" (p. 16).

Aside from training and prior experience, supervision and continuing professional development (CPD) have become key issues for coordinators and providers of complementary therapies at all stages of cancer care (Tavares, 2003; Mackereth and Carter, 2006). Ongoing CPD is judged to be a hallmark of professional self-regulation and is perceived to be a necessary process in ensuring safe and continual improvement of practice (Budd and Mills, 2000).

When recruiting therapists it is important to confirm that the establishment where they trained is accredited by a professional body, that practice has relevant insurance and that the therapist is professionally regulated (Mackereth and Carter, 2006). The more common therapies are adopting National Occupational Standards for training. For example, the Reflexology Forum has published its National Curriculum, with the course content providing guidance on working with people with cancer (O'Hara, 2006). A challenge for those recruiting therapists is not only having an understanding of the interventions being offered by therapists, but also the training and CPD requirements to work safely and competently in cancer care settings.

In light of these considerations, exploration of the training and professional experience of complementary therapists working in cancer care is both necessary and timely. This paper reports on the professional background, experience and training profiles of complementary therapists across three cancer care sites in North West England.

Aims

The study aims were to:

- Identify the initial complementary therapy training received by a sample of complementary therapists working in cancer care settings.
- Identify the healthcare-related continuing professional development undertaken by the sample.
- Explore the professional backgrounds and experience of the sample.

Design and methods

Study design and data collection methods

The study design was a cross-sectional questionnaire survey. Questionnaires were distributed to the total population of complementary therapists (n = 75) practising in three cancer care centres in North West England. The questionnaire, which explored therapists' training and professional experience, was developed de novo for the study, following consultation between the study site CT service co-ordinators and the research team. It was piloted, and minor modifications were made, prior to distribution to the sites. Data collected included initial CT training; healthcare-related continuing professional development in complementary therapies; therapies practised and demographic data about the respondent. The survey formed part of the fieldwork within a multiple, three

case design evaluation of complementary therapy provision for persons with cancer.

Study sites

The sites were situated in the North West of England and had a history of working collaboratively. All three sites had documented policies and procedures and induction/orientation programmes for new therapists. The policies included referral criteria, guidelines for assessing patients, ensuring safe adaptation of therapies for patients living with supportive and palliative care needs, and supervision arrangements for all therapists. One site had Standard Operational Procedures (SOPs) for specific interventions such as acupuncture, aromatherapy and chair massage. A brief description of each of the sites is as follows.

Site 1 was a hospice, comprised of buildings in three different locations. Two of the sites offered in-patient, day therapy and outpatient services. The third site was a specialist rehabilitation unit which supported individuals with cancer from diagnosis onwards. The complementary therapy service was perceived as a core element of the care given and was facilitated by a part-time complementary therapy coordinator, employed for three days a week. Across the three locations, the service was delivered by six nurse therapists who had time allocated to practice complementary therapies and 11 'sessional' therapists who worked for 3-6 h a week each. Therapies offered were aromatherapy, massage, reflexology, reiki, adapted Indian Head Massage, CranioSacral TherapyTM, homeopathy and acupuncture.

Site 2 was an acute cancer hospital; a tertiary referral centre for surgery, chemotherapy, and radiotherapy. The complementary therapy service was facilitated by two registered nurses designated as clinical lead specialists. At the time of the data collection, 33 therapists contributed sessional hours during weekdays (range 4-30 h per week). Within the team, 15 therapists offered their time in a voluntary capacity; some of the 18 paid therapists also provided unpaid sessions. Therapies provided included massage, aromatherapy, reflexology, Therapeutic Touch[™] and relaxation techniques.

Site 3 was a cancer care centre which provided psychosocial support through the provision of 12 week programmes for patients and carers. The centre was open from Monday to Friday, with service users attending for between one half to a full day per week. Ten of the 24 therapists were paid; these included a part-time nurse manager/therapist, three full-time nurse therapists and six sessional complementary therapists. Paid sessional workers provided 14–30 h per week. There were 14 volunteers, typically contributing at least 3 h per week. Therapies offered included reflexology, massage, aromatherapy and reiki.

Ethical considerations

Access to the study population was agreed at each site and relevant management approvals obtained. Formal ethical approval was obtained from the Local Research Ethics Committee (Stockport Local Research Ethics Committee, Manchester) as well as from the project's academic base. Questionnaires were anonymised and respondents' confidentiality in reports and papers was assured. Three of the project team were CT service co-ordinators at the sites. However, these were not involved in data collection or in handling data prior to anonymisation.

Data analysis

Data were entered into SPSS V13.0 and analysed descriptively. Owing to the study's descriptive design and the small sample size, inferential testing was not employed.

Results

Of the 75 questionnaires distributed, 51 complete returns were received (68% response rate). These were fairly evenly distributed across the three sites - 18 of the respondents worked at Site 1, 18 at Site 2 and 15 at Site 3; data for the three sites have been combined to protect respondents' confidentiality.

Table 1 presents respondent characteristics. The sample was predominantly female with an age range of 23–78 years. The duration of experience as a CT practitioner was variable, ranging from less than one year (n = 2), to more than 11 years (n = 11). The majority of respondents (n = 28) reported working as therapists within a supportive and palliative care setting for over 6 years.

Professionally, just over half of the respondents (n = 27) described themselves as 'professional complementary therapists', whilst the remainder (n = 24) were healthcare professionals, the majority of these being nurses (n = 19). Previous careers for respondents who described themselves as 'professional complementary therapists' included teaching, beauty therapy, business management and engineering.

Table 2 details therapists' initial training and continued healthrelated professional development. Out of the 51 respondents 47 reported having undertaken one or more qualifications/training programmes after completing their initial training. For example, out of 25 respondents with reflexology training, ten respondents had completed initial massage training, and then gained a later secondary qualification in reflexology. An additional five therapists completed a short course in 'adapting reflexology for cancer care'. A higher number of therapists (n = 19) reported CPD in 'adapting chair massage for cancer care'. Some respondents also reported training in creative imagery and relaxation skills (n = 13). Some therapists (n = 12) identified attending 'HEARTS' training, which utilises a combination of adapted techniques drawn from touch therapies and creative imagery to support patients and their carers (Carter, 2006).

Twenty-seven respondents had undertaken one or more cancerspecific CT training courses. However, only five of these had completed an extended course of study (listed as 'Diploma CTs' and 'BA (Hons)' in Table 2) which involved physical and emotional aspects of cancer care. This 12-day Diploma in 'Complementary Therapy in Cancer Care' included compulsory days on the nature and treatment of cancer and psychological aspects of the illness, as well as clinical placement days at Site 1 of this study. Other courses, identified by respondents, focused on teaching therapists how to adapt treatments for people living with cancer.

Table 1

Demographic characteristics of the sample (n = 51).

Demographic characteristic	Number of respondents
Age (years) ^a	
Mean	50.2
Range	23-78
Gender	
Female	47
Male	7
Professional background	
Professional complementary therapist	27
Nurse	19
Doctor	2
Physiotherapist	3
Years practising CTs	
<1	2
1–5	21
6–10	17
11 or more	11

^a n = 47, as three respondents did not provide their age.

itial compleme	ntary therap	oy training	; and hea	althcare-related	l continuii	ng professiona	l develop	ment in com	plementary th	herapies in the	sample (n =	= 51).				
ackground of terapist	Aromath	erapy Rei	ki Massa	ge Reflexolog	/ Indian head massage	Acupuncture	Healing	Therapeutic Touch	Homeopathy	/ CranioSsacral therapy	Adapting chair massage for cancer	Relaxation creative imagery	HEARTS	Adapting , reflexology for cancer care	Aromatherapy Modul CTs in cancer care	rr BA (Hons) complementary medicine
rofessional	14	18	15	15	14	0	3	0	0	2	6	7	5	2	1	2
complementa: theranist	y															
(n = 27)																
urse $(n = 19)$	14	6	6	10	8	0	1	1	0	0	6	5	9		0 2	0
octor $(n = 2)$	0	-	0	0	0	1	0	0	1	0	0	0	0	0	0 0	0
hysiotherapist	2	0	2	0	0	1	0	0	0	0	1	1	1	с С	0 0	0
(n = 3)																
otal $n = 51$	30	28	26	25	22	2	4	1	1	2	19	13	12			2
ey	Initial coi	mplement	ary thera	ıpy training (n.	b. some re	spondents rel	ported ini	tial training i	in more than	one therapy)	Continuing received m	g professiona nore than one	l develor e form of	ment (n.b. s CPD)	ome respondents repo	rted having

Table :

It was not readily apparent from the data whether the courses which therapists referred to (initial, secondary qualifications and CPD) were 'in-house' training/short courses or accredited courses from registered bodies/associated with formal academic qualifications. The exception was the 12-day Diploma CTs course, which was also available as a clinical module for second and third year students studying for a BA (Hons) in Complementary Medicine. It was also unclear whether there was an increasing level of specialisation, or whether individuals had undertaken multiple courses at a comparable level of skill/specialisation.

Discussion

The profiling exercise identified a diversity of backgrounds, prior exposure to healthcare and healthcare-related training. There was evidence of on-going commitment to continuing professional development. However, there was also a clear lack of standardisation in the type of healthcare/cancer-related training which these therapists, all practising in cancer care settings, had received.

The average age of the therapists in the sample was 50 years. They were mostly female, which has been noted in other studies (Andrews, 2003; Garnett, 2003). Some therapists may have retired and were remaining active, contributing their time and skill as volunteers on a regular basis. There were a number health professionals (n = 24) who completed the questionnaire, most notably nurses, with a small number of physiotherapists and doctors, who are likely to have brought a range of clinical skill and knowledge to the role of therapist. It needs to be acknowledged from the outset that this sample could only be viewed as representative of the three study sites. The influence of prior life experience, including a relevant healthcare background, also warrants further exploration.

Two sites used volunteers alongside paid sessional workers, whilst one did not. The reason for this difference was not investigated. Therapists may have begun working in cancer settings as volunteers and then sought paid employment, should funding have become available. There are clearly financial benefits to organisations in utilising volunteers, but it is important to recognise that volunteers are not contractually obliged to give notice of non attendance, or take clinical or managerial responsibilities or accountability within a team. Concerns about sustainability and accountability have been raised by complementary therapy coordinators in relation to dependence on volunteers (Molassiotis et al., 2006). Tavares (2003) has argued that in safeguarding professional complementary practice, volunteers must be given the same careful recruitment, clinical support and supervision and access to continuing education as paid therapists.

A problem with interpreting responses was conflicting information from respondents; therapists sometimes included CPD activities in their answers to questions on initial CT training. Examples include attendance at local 2-day 'adapting aromatherapy in cancer care' courses and completing a 12-day Diploma course in complementary therapies and cancer care as noted above. Whilst we were able to disentangle the information, this was only possible due to there being project team members with 'local knowledge' and good awareness of the courses available/undertaken. This has methodological implications for others undertaking comparable work. It also reflects a broader issue, in terms of the plethora of CT training programmes available to and undertaken by therapists. Much of the training was short courses, often bespoke or in-house training. Few of the courses were accredited. This has clear relevance for those managing therapists and commissioning CT services, as well as governance implications.

In a similar vein, there was a wide range of experience within the site teams; there was variation in the length and breadth of training, and little standardisation of the type of training, particularly in relation to cancer. The picture was also complicated by the high numbers of health care professionals (HCPs), who may have had a prior knowledge of cancer and its treatments. Therapists in this study had access to a complementary therapy training unit at one of the sites, which specialises in cancer care, attracts students nationally and internationally, and has links to local university complementary medicine degree programmes. However, such provision is neither nationwide nor mandatory. Indeed, there are no standard training requirements for complementary therapists working in cancer, or in any healthcare setting. This is an issue of concern, particularly for complementary therapists with no healthcare background. Since cancer affects one in three of the UK population (DoH, 2000) and between 25% and 50% of cancer patients are reported to utilise a complementary therapy of some kind (Corner and Harewood, 2004; Ernst, 2003), an argument could be made for inclusion of basic cancer-related information in all CT training courses. An alternative approach might be the model adopted elsewhere in healthcare, i.e. development of 'specialist' roles. However, this poses several questions-for example, if formalised training standards were to be introduced for 'specialist' therapists working in cancer care, which organisation would be responsible for approving or monitoring courses? Additionally, there is also the question of who pays for the training; again, this is currently left to individual therapists and their employers.

A key area for cancer specific training is the need to equip therapists to adapt existing skills to practice safely. For example, when patients are breathless, offering chair massage (a popular training identified in this study) can be an ideal way of providing treatment. There is no need for the patients to remove their clothes and they can receive treatment in an upright and seated position (Campbell et al., 2006). Therapists in the study reported attending a cancer specific training in reflexology. This would seem appropriate; as Hodkinson et al. (2006) argued; traditional training in reflexology does not prepare therapists to provide comfortable treatments to patients with cancer. Disease and treatment related symptoms, such as lymphoedema, fatigue and weight loss, require treatments to be gentle, shorter and tailored to the individual. An interesting observation is the use of treatment combinations such as 'The HEARTS Process', for which 12 therapists had completed the training. Originating in the North West, HEARTS is a flexible approach to therapy, combining elements from several specific therapies. HEARTS has become a popular modality in other UK cancer care centres (Carter, 2006).

Very few of the therapists in this study had undertaken courses which included management of psychological and emotional aspects of cancer care. Many people living with cancer experience psychological morbidity with high levels of anxiety and depression being reported (Fallowfield et al., 2001; Hoptoff et al., 2002; NICE (National Institute for Clinical Excellence), 2004). The paucity of preparation and training of therapists to deal with these issues is notable. There are important governance and 'fitness for practice' issues, which need careful consideration as provision of CTs in cancer care expands. Likewise, maintenance of therapists' well-being is an important consideration. It is recognised that working with people who have cancer is emotionally demanding (Heaven et al., 2006); hence there is a need to ensure that therapists are adequately prepared and supported for these demands. It could be argued that therapists' initial training and non-cancer work, which may often be with people experiencing stress, provides such preparation. However, within healthcare, there is recognition of the especial demands of working in oncology, particularly in supportive and palliative care (Heaven et al., 2006). Those training and employing complementary therapists therefore need to address preparation and support of therapists (e.g. through clinical supervision) to work in these demanding healthcare environments.

This study identified a mix of lay therapists (practitioners without statutory healthcare qualifications) and healthcare professionals who practise complementary therapies at the three sites. A recent report on Clinical Governance and Complementary and Alternative Medicine (CAM) to the Department of Health identified that there was an 'emerging landscape of opportunities' for lay complementary therapists to be included in the NHS mainstream (Wilkinson et al., 2004). A recent survey of 149 GPs by (van Haselen et al., 2004) found that 82% of respondents favoured CAM therapies being provided by therapists who were also state regulated health professionals, whilst only 26% of respondents agreed with CAM being provided by lay therapists. If CAM services are to expand in the NHS, providers of services need to consider clinical governance issues in developing employment contracts for suitably trained lay complementary therapists. This raises questions about what constitutes 'suitable' training and how this should be provided/acquired. Wilkinson et al., 2004 suggested that employing therapists without a healthcare background on NHS contracts will require good systems of registration, revalidation and local accountability (clinical governance) to facilitate integration within the wider healthcare team. These issues are key to increasing acceptance and willingness to refer by healthcare teams.

Limitations

This study has provided valuable insights, but its limitations must also be acknowledged. Whilst the study does provide information about CT training and CPD for complementary therapists in cancer care, it does not quantify the duration and quality of training. Data were not collected on whether respondents were volunteers or paid therapists (in order to facilitate respondent anonymity), although some did provide this information. The profile of volunteers as a subgroup could therefore not be reported.

Box 1. Recommendations for future research, policy and practice development

- There is a need to identify and agree minimum standards of training/competence for complementary therapists working in cancer care.
- There is a need to investigate therapists' CPD activities and their relevance to cancer and supportive care.
- Data could be gathered from therapists, training organisations and service providers to inform understanding of 'fitness for practice' as a benchmark for working in cancer care.
- The ways in which therapists feel they make a difference/offer choices to patients should be explored further, possibly through focus groups, in order to help clarify their roles and hence better focus the content of training programmes.
- The role of the volunteer therapist could be investigated, together with recruitment, training and supervision needs specific to this group, especially in relation to working in healthcare settings.
- Examination of therapists' motivation for practising in cancer care, and how this might impact upon the provision of funding for complementary therapy services and training for therapists working in these, is needed.

The study itself was based in North West England, which may limit the generalisability of the findings to other localities. However, this project did raise a number of important considerations for practice. These include policy and research, particularly in relation to the need for standards of training, skills and experience, that can help build a profile of 'fitness for practice' of complementary therapists in cancer care; CPD requirements for cancer care; and the profile and role of volunteers (see Box 1).

Conclusion

This paper has identified and reported on the varied profiles of complementary therapists, which demonstrated evidence of continued professional development and academic links with a local university. The training programmes and CPD activities were largely delivered in the North West and appeared to be specific to treatments available at the three centres. The study highlighted the need for benchmarking and standardisation in practice to ensure 'fitness for practice' for therapist working in cancer care. Additionally, the role support and educational needs of volunteer therapists needs to be investigated further. However, from this study we do not have a view of national or international data on training and CPD for therapist in cancer care. This is an important area for development to ensure safe, effective and accountable care in this emerging field.

Conflict of interest statement

The authors state there are no conflicts of interest related to this paper.

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