# Fundamental Aspects of Complementary Therapies for Health Care Professionals

**Nicky Genders**

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*For mum and dad and my two children, Amy and Levi, for their unconditional love and unending patience, and to Joanne for her support and unfaltering belief in me.*

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# Foreword

This introductory book provides an overview of various forms of complementary and alternative medicine (CAM) that have been rising rapidly in popularity among the public in the UK over the past few years. Growing numbers of health professionals in areas such as general practice, nursing and midwifery are now using CAM – together with an increasing range of other therapists with varying degrees of training and experience. Self-help employment of CAM is also rife. Yet knowledge of many aspects of CAM is still quite limited. In this situation, it is vital that health professionals are at least aware of the nature of the different therapies involved and the existing evidence base so that they can make informed judgements for the benefit of patients. This book, as part of the fast-expanding literature base on CAM, will undoubtedly help them in this process, as well as acting as a resource for interested members of the public.

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July 2006

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CHAPTER 1

# Introduction

## What do we mean by complementary and alternative medicine?

A wealth of definitions exists for complementary and alternative therapies, all of which attempt to draw together the multitude of non-orthodox therapies available. The terms alternative and complementary are often used interchangeably to add to the confusion. Alternative therapies are those used as an alternative to orthodox therapy, for example, homeopathic medicine may be used as an alternative to orthodox treatments for specific conditions. Complementary therapies are just that: they complement conventional therapies. However, it is how the therapy is used that determines whether it is alternative or complementary and therefore much of the literature uses both terms and abbreviates them to CAM (complementary and alternative medicine).

If we are to acknowledge the breadth of complementary and alternative therapies the range we must consider is huge. From little known, rarely practised therapies to popular, almost conventional therapies we cannot begin to understand them all. Many therapies have little in the way of an evidence base and are seen as little more than 'quackery' while other therapies are gaining a valid evidence base and are forms of practice acknowledged in health care.

In March 2001 the Secretary of State for Health presented the Government Response to the House of Lords Select Committee on Science and Technology's Report on Complementary and Alternative Medicine (Department of Health, 2001). A key development within this report was the categorization of therapies into sections. These categories have become the outlines for Chapters 3 to 7.

Categorizing these therapies has provided some clarity within health care and the categorization serves to enhance the understanding health care professionals should have of a range of complementary therapies.

## Who is involved in CAM practice?

CAM practitioners may have arrived at their practice through a range of routes. Some therapies require years of study, i.e. traditional Chinese medicine, osteopathy and chiropractic, while other therapies may be passed down in one initiation session by a master within that art, i.e. reiki. It is important to recognize this variation in order to acknowledge the range of skills and their

perceived importance. For example, for many reiki practitioners the lack of scientific evidence in the practice does not detract from its perceived validity. The practitioner holds faith in the ability of the therapy to heal.

Many nurses, midwives and other health professionals have trained in complementary therapies in addition to their health care qualification but their numbers are difficult to quantify as health care professionals are not necessarily required to disclose or record their CAM qualifications if they are not using them within their practice.

## The political response to CAM and the impact on health care professionals

The use of complementary therapies within health care is growing. The role for many health care practitioners, including nurses, midwives and health visitors, in the context of these therapies will be to give information to patients keen to integrate CAM into their care.

So what are the contemporary issues around complementary therapies within health care? As a basis to our understanding of this growth area we need to be aware of the following:

- A large number of patients are using therapies to complement orthodox treatment (around one-third of cancer patients receive complementary therapy treatments and almost half of those who do not receive them would like to do so).
- Around 40% of GP practices in England provide access to CAM for NHS patients (Carter, 2003).
- Nurses, midwives and health visitors are practising complementary therapies both within the NHS and in private practice.
- As the use of CAM grows they are acknowledged within care plans in many areas of health care.

Health care practitioners face a growing agenda around consumer choice. With the increase in the use of complementary therapies nurses, midwives and health visitors need to understand the therapies used by their patients and see complementary therapies as another aspect of patient choice. The following points highlight the considerations for health care professionals around the use of CAM in health care:

- Utilize appropriate ‘research’ as part of a developing evidence base.
- Ensure that nurses, midwives and health visitors always work within the Code of Professional Conduct (Nursing and Midwifery Council, 2002)
- Ensure local policies/protocols are developed.
- Communicate need with the multidisciplinary team.

However, for many health care professionals integrating complementary therapies into care packages just having a reasonable level of knowledge about the therapies may be limited. The role of the professional bodies in supporting nurses, midwives and other health care professionals to develop their understanding of CAM was acknowledged in the Department of Health Select Committee Report (Department of Health, 2001) with the following statement

> *'We recommend that the UKCC (now NMC) works with the Royal College of Nursing to make CAM familiarization a part of the undergraduate nursing curriculum and a standard of competency expected of qualified nurses, so that they are aware of the choices that their patients may make.'*

And for those nurses working in areas where complementary therapies are currently used, the following statement was added:

> *'We would also expect nurses specializing in areas where CAM is especially relevant (such as palliative care) to be made aware of any CAM issues particularly pertinent to that speciality during their postgraduate training.'*

This recommendation, linked with the clear statement in the Code of Professional Conduct (Nursing and Midwifery Council, 2004) around the use of complementary therapies and the necessity to involve the multidisciplinary team in the decision regarding their use, has led to many developments in the use of complementary therapies in the health care setting. The Nursing and Midwifery Council (2002) states

> *'You must ensure that the use of complementary or alternative therapies is safe and in the interests of patients and clients. This must be discussed with the team as part of the therapeutic process and the patient or client must consent to their use.'*

The acknowledgement of the growth of CAM within health care has led to the acknowledgement of a number of issues around the integration of complementary therapies. These include:

- Knowledge of therapies, including research and regulation.
- Consent.
- Patient information.
- Policy formation.
- Guidelines for professional accountability.

It is envisaged that this book will enhance knowledge of a range of therapies and the evidence base for some of these therapies and encourage thought and debate around the areas of consent, patient information, policy formation and professional accountability.

Understanding the basis on which these therapies now exist for consumers is equally important, after all, for many people these therapies have been a routine way of life for many years.

## Challenging Western views on health

Western health care has for centuries had its basis in biomedicine but this was not always the case. In ancient times accepted forms of health care would include the use of herbs and other plant extracts, hands on healing and ritualistic approaches to many health problems. Many healers during this time were women and specific examples include midwives. These women, who were often also healers, were found in many communities (Garratt, 2001). However during the middle ages the rise of Christianity called into question the role of the lay healer with the belief that only God could heal. The following rise of medicine as a male dominated profession with its specialist knowledge and science led to the further oppression of lay healing (Ehrenreich and English, 1973).

The development of the biomedical approach in the West grew as a result of the new found scientific knowledge about the human body. As the medical profession grew the lay healer became more and more marginalized. With the introduction of a free health service in the 1940s the public's desire to utilize scientific orthodox approaches had grown to become the mainstream route to 'health'.

The rise in popularity of CAM over the past few decades has been influenced by a rise in consumer knowledge about health and possible treatment regimes. A lack of faith in the efficacy of some orthodox treatments for chronic health conditions has also led to challenges to the medical model.

Although now not part of the medical approach to health many therapies have existed in a variety of forms over centuries in the UK and Europe with many more arriving to the West from Eastern cultures as travel became more popular. A large proportion of these therapies have their origins dating back over thousands of years.

## The role of the health care practitioner

Within the biomedical approach to health, nurses, midwives, health visitors and other health care professionals have played a key role in 'caring' for patients/clients. At times throughout history these professionals may have had the term 'healer' applied to their practices. However, what is caring, and are

health professionals in the best position to integrate complementary therapies into their practice? Health professionals, whether they like it or not, have been part of the medicalization of health. The medical model has embraced a scientific basis for knowledge pushing forward boundaries of science and developing our understanding of the human body, health and disease. The adoption of protocols and guidelines for conditions within orthodox medicine has, some believe, moved medicine away from individualized treatment plans and responses to ill health. It has been suggested that it is this lack of an individualized approach that has fueled the rise in numbers of people seeking diagnoses from CAM practitioners. A further suggestion is the nature of holism applied to the individual. A CAM practitioner is likely to take an approach that focuses on the mind, body and spirit of the patient in diagnosis and treatment. This may be in contrast to orthodox symptom control or disease management.

Health care practitioners are directly involved in assessing health care needs, planning treatment/care approaches and evaluating care delivery. In the main this is within a medical model using orthodox treatment regimes. However, two themes are emerging.

1. A growing number of health care practitioners, particularly nurses and midwives, are delivering care where CAM therapies are part of the treatment regime, e.g. palliative care, acupuncture clinics for pain control, and use of TENS (transcutaneous electrical neural stimulation) in midwifery practice.
2. The increase in patient knowledge about, choice of and access to CAM has led to many patients and clients receiving complementary therapies alongside orthodox care.

In the current climate it is therefore imperative that nurses understand the issues surrounding the use of CAM by patients and clients in their care. This may range from having an understanding of the therapies through to wishing to train in a particular therapy in order to integrate it within practice. There are a number of key issues to consider, including the development of an appropriate evidence base to support the use of therapies within health care. Chapter 2 looks at some of the issues around research and the development of an appropriate evidence base.

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CHAPTER 2

# Developing a research evidence base in CAM

## Evidence-based practice

One of the common phrases around in health care today is that of evidence-based practice. Very few would doubt the need for practice to be based on sound evidence but what do we mean by evidence: evidence of cause and effect, evidence of patient satisfaction, evidence of cure? The answer to these questions is all of these and more. Within health care we need to be able to provide the evidence for many aspects of the care we give, not just whether or not a particular treatment works but also how patients feel about the treatment.

Clinical governance within health care has reinforced the importance of evidence-based care with Yvonne Moores, the then Chief Nursing Officer at the Department of Health, stating in 1999 that wherever possible clinical care should be based on sound evidence. The use of electronic resources, National Service Frameworks and organizations such as the National Institute for Clinical Excellence (NICE) were advocated to encourage nurses to seek this evidence base. Where it is difficult to find that evidence Moores suggests, 'Nurses, midwives and health visitors should base their care on consensus opinion of best medical practice.' Moores also suggests that through identifying areas of patient care that need improvement, by actively evaluating nursing contributions and by sharing good practice, the development of an evidence base will be supported.

Evidence-based practice should inform clinical effectiveness, i.e. the extent to which a treatment does what it says it should within available resources. But both evidence-based practice and clinical effectiveness do not rely solely upon available literature and other external evidence they also rely on the clinical judgement of the practitioner.

This combination of external evidence and sound clinical judgement enables the practitioner to develop evidence-based care. McSherry and Haddock (1999) in an article in the *British Journal of Nursing* outline a series of steps that can be taken to assist the development of evidence-based care:

- Step 1: Identify the problem or clinical question from the specific area of practice.

- Step 2: Seek the most relevant evidence from the information available.
- Step 3: Critically appraise that evidence in relation to validity and reliability.
- Step 4: Utilize relevant findings into clinical practice and monitor outcomes, including patient views.

Using these steps, examples of how the evidence for therapies can be explored using this structured approach are illustrated below

## Developing an evidence base

Although within health care the randomized controlled trial (RCT) has often been seen as the 'gold standard' in research design this has been because many of the questions we have asked in the past have been about cause and effect: does A cause B? The RCT is probably an appropriate research design in this case but it does depend upon the question being asked. A range of research methods exist and these should be chosen according to the information you want to gain. When gathering evidence ensure that the studies have used the right method for the question being asked. *Table 2.1* gives examples of some questions that may be asked and possible research designs.

Rather than undertaking research studies themselves many practitioners perform literature searches/reviews to gather evidence. This constitutes the second step in McSherry and Haddock's structured approach – identifying the most relevant evidence. This process of search and review of the

**Table 2.1: Matching the question to the research design**

| Question practitioner may want to ask | Possible research design |
|---|---|
| Does acupuncture reduce the effects of migraine headaches? | Randomized controlled trial |
| Is tea tree essential oil effective against head lice? | Laboratory-based study |
| How many people use acupuncture for pain control and why? | Surveys, interviews, focus groups |
| Does aromatherapy massage improve the perceived quality of life for patients in palliative care? | Interviews (using self-rating scales), qualitative case studies |

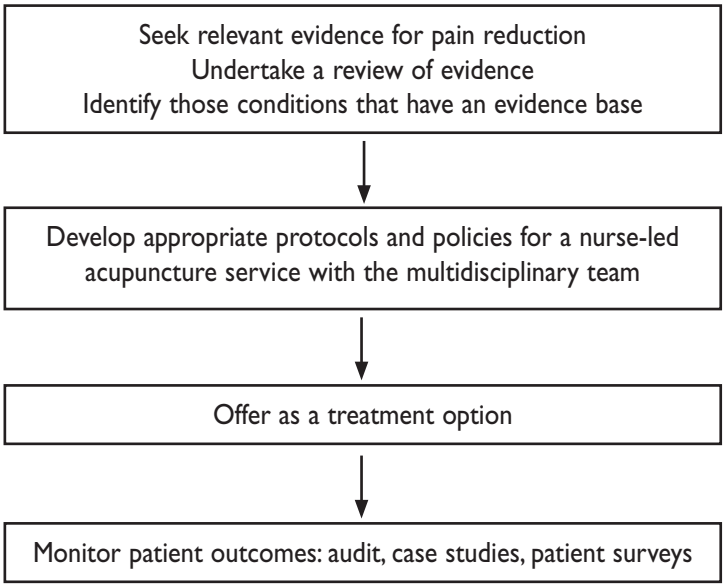


*Figure 2.1: Process for the introduction of acupuncture into an outpatient clinic.*

literature has over the years been made easier through the use of online databases, search engines and online journals. The initial search may need to be focused to ensure a manageable search can be undertaken. For example, a search for 'massage in nursing' will produce thousands of 'hits' whereas 'the benefits of massage in palliative care' may produce more focused results. Using the most up-to-date literature is also important as new findings are emerging all the time.

The use of a review tool such as the Cochrane Review may also give the practitioner a head start in choosing appropriate literature and studies. Once literature has been gathered a process of filtering must take place to ensure that the evidence is relevant to the question you want to ask.

Once the literature has been filtered, McSherry and Haddock's Step 3 may take place whereby the relevant literature is critically reviewed. This is a further filtering stage but with a more in depth look at the studies. This stage requires an examination of the literature to ensure validity and reliability and to check back against the question to ensure the studies are still generating the evidence required. It is important to review a number of studies to decide whether there is enough evidence to utilize the findings in practice. This then leads to Step 4. Protocols and guidelines may need to be agreed within the multidisciplinary team and policies may need to change to accommodate the introduction of a new treatment option or care intervention. Patient outcomes would also need to be measured alongside patient views.

*Figure 2.1* illustrates the process for the introduction of a nurse-led acupuncture service for pain control in a busy outpatient clinic.

## The research base in CAM practice

Evidence-based practice is more easily achieved where an existing high quality evidence base exists. Within the area of CAM it has already been acknowledged that in order for therapies to be recognized and integrated into health care a robust evidence base must exist (Department of Health, 2001). In grouping therapies within the Department of Health Select Committee Report the need for a stronger evidence base for many therapies was reinforced.

Ensuring that practice around complementary therapies is evidence based presents many challenges. Three particular challenges include the nature of research and other external evidence, the skills of the CAM practitioner in developing an evidence base and the role of the health care practitioner in using CAM within the health care environment.

Research within the field of complementary and alternative medicine has a history of lack of funding. Rankin Box (2001) quotes a study by Ernst that identified that only around 0.08% of funding for research in the NHS is for complementary therapies. This lack of funding not only has an impact on the types of study possible, but also on their validity and reliability.

There are a range of other barriers to research that may affect projects within the CAM field including attitudes to qualitative studies, ethics committee guidelines and the strength of the orthodox medical community. However, a range of research methods can be utilized within the field of CAM and studies over recent years have become accepted within health care.

It has been suggested by the Department of Health (2001) that CAM practitioners should build an evidence base from research methodologies demonstrating the same rigour as that required for conventional medicine using RCTs and other forms of quantitative research. And for those therapies claiming diagnostic abilities, this must be proved beyond the placebo effect. It does however need to be acknowledged that many of the 'orthodox' approaches used within medicine lack a rigorous research background that has proved them effective beyond the placebo effect.

This has been difficult within the area of CAM as a lack of funding and the complex nature of these therapies has often prevented this type of research being undertaken.

However difficult this is, a number of quantitative studies have been undertaken within the CAM area, including RCTs. Laboratory-based studies often provide very specific evidence of efficacy and many of the studies within the pharmaceutical, cosmetic or food industry have utilized this approach. The effects of essential oils, for example, in a range of cosmetic preparations are common forms of laboratory-based studies undertaken by large resource-rich pharmaceutical companies. These types of studies, however, are very limited within the field of complementary therapies because the complex nature of both

the therapies and the practitioner/client relationship often precludes this type of laboratory-based approach.

Qualitative methodology is intended to provide meaning to a question, for example the perceived effect of reflexology on a client with advanced cancer or the experience of massage in patients with Parkinson's disease (Paterson et al, 2005). Qualitative research generally does not set out to prove cause and effect. Many studies in the CAM area utilize this approach to attach meaning to the patient/client experience of a therapy and to its perceived effects. However, these studies are often criticized for their lack of scientific rigour and funding is often difficult to acquire. However, this approach often generates valuable insight into the needs of clients/patients and their perceptions of the complementary therapies being investigated.

For many CAM practitioners research training is limited and, as in any field, the appropriate knowledge and funding will determine the quality of any research study. Nurses may have developed a range of skills within the field of research and may need to consider the research required in the field of CAM in order to support the development of a research base.

Understanding research findings and being able to identify appropriate studies to use as an evidence base to support the integration of CAM into practice are skills that health care professionals need to develop and maintain. A number of specialist journals exist to promote the dissemination of research findings in the area of CAM and health care. One such journal, *Complementary Therapies in Clinical Practice* (previously *Complementary Therapies in Nursing and Midwifery*) published by Elsevier, has a long history of disseminating peer reviewed articles. Specialist journals within each discipline of complementary therapy also exist. However, these may be more difficult to access for health care professionals. A number of databases also produce results for research studies.

Carter (2003) gives an overview of the challenges posed to RCT design. These include:

- Randomization.
- Blinding.
- Matching controls/interventions.
- Shams and placebos.
- Symptom/disease processes.
- Inclusion/exclusion criteria.
- Standardization/protocols.
- Drop out issues.
- Use of sound outcome measures.
- Practitioner–client relationship.
- Influence of practitioner.
- Variability between practitioners.

Health care professionals who have concerns regarding research design and the validity of design are recommended to examine Carter's (2003) article describing a number of fundamental challenges to the RCT approach.

Consumer choice may well steer the research agenda as an increasing number of people access CAM. The role of the NHS in supporting this choice has been acknowledged within the Department of Health (2001) Select Committee Report through the recommendation:

> *'If a therapy does gain a critical mass of evidence to support its efficacy then the NHS and the medical profession should ensure that the public have access to it and its potential benefits.'*

It is clear from the Government's response within the Select Committee Report that there is a commitment to acknowledging therapies that have a proven evidence base. The ongoing issue within many aspects of nursing research, not just that around CAM, is the notion of research validity and methodological approaches. The randomized clinical trial may not be the most appropriate form of research methodology for many complementary therapies. Qualitative studies may be more effective but still need to be rigorous in their approach. In general, though funding for research in the area of CAM is limited. A tiny percentage of the budget for research each year is awarded to research into CAM and many authors suggest that change is necessary in order to develop the necessary evidence base around efficacy.

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CHAPTER 3

# Therapies in focus: Osteopathy, chiropractic, homeopathy and acupuncture

## Osteopathy

Osteopathic medicine has a history dating back to the 1800s when American doctor Andrew Taylor Still developed the fundamental principles of osteopathic medicine and subsequently opened the first osteopathic medical school. Today osteopathy forms one of the UK Government's 'big five' in complementary and alternative therapies and achieved its status as a regulated profession under the 1993 Osteopaths Act.

### *What is osteopathy?*

Osteopathy is often described as one of the manipulative therapies using both manual and mechanical techniques to redress abnormalities in the bones, joints and muscles. This is thought to re-establish normal functioning to the body's activities. Within osteopathy the view is held that abnormalities in the body's structure and function may lead to much of the pain people suffer. This therapy also works within a holistic framework, acknowledging the body's ability to heal and the link between mind, body and spirit. It has been estimated that over 100 000 people visit an osteopath every week in Britain. A wide range of conditions is treated including low back pain, which, for over half of those seeing an osteopath, is the reason for their visit.

Many patients visiting an osteopath are elderly people and are seeking relief from conditions related to ageing, for example, arthritis. Osteopaths also treat patients for a range of work-related conditions which are often a result of poor posture, poor manual handling or are due to repetitive strain injuries.

A detailed medical history is taken from the patient and diagnosis may include the use of X-rays. An initial examination will focus on the person holistically and not just the presenting condition. Therefore, posture, balance and muscle tone may all be assessed as part of the examination.

### Cranial osteopathy

Cranial osteopathy is a specialist form of osteopathy using gentle, subtle techniques to manipulate the cranial bones. Developed in the 1930s this technique has been used for headaches, sinus problems and with babies and children for a variety of conditions.

### Training, education and regulation

All osteopaths must be registered with the General Osteopathic Council and it is illegal to describe oneself as an osteopath without registration with this body.

Osteopaths undergo lengthy training on a range of pathways from four to five years on an honours degree programme to postgraduate training for medical practitioners. All programmes are accredited by the General Osteopathic Council. Osteopaths are also, in common with many therapists, required to undertake a programme of continuing professional development.

### Osteopathy within health care

An increasing number of osteopaths are working alongside GPs in the primary care arena. A GP may refer a patient to an osteopath for treatment using NHS funding and many private health insurance companies provide cover for treatment by an osteopath. A growing evidence base for this treatment exists particularly around back pain, arthritis and osteopathy in pregnancy.

### Case study: Osteopathy

*by Maggie Brooks*

*History*

A male patient, aged 25 years, height 192cm, normal weight, presented with pain to the right of the thoracic spine radiating around to the sternum, which he described as very acute at times, particularly when tired. The pain spreads as a band around his chest to the sternum and then slowly fades. His job as a nurse in an intensive care unit involves lifting. He works night shifts at which time he is particularly aware of the pain. The pain eases on rest.

Consultation and history taking gave a picture of a healthy individual who exercised by walking his dog, ate sensibly and was in a good relationship. There was no medical history of note. He had not consulted his doctor about this problem as past experience had shown him that all he would be given is tablets. He came on recommendation of a work colleague.