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

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A B S T R A C T

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.

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 out-patient 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 Therapy™, 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.