Complementary therapy support in cancer survivorship: a survey of complementary and alternative medicine practitioners’ provision and perception of skills

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This study reviewed the confidence and perceived skills of complementary and alternative medicine (CAM) practitioners in providing care and symptom management for clients post cancer. An e-survey was mailed to approximately 21 000 CAM practitioners, targeted at those working with clients who were experiencing consequences of cancer and its treatments. Questions were asked about the main symptoms and concerns of clients, the confidence and current skill levels of practitioners and additional training requirements. Six hundred and twelve practitioners responded to the survey, 507 of whom were working with individuals experiencing the consequences of cancer and its treatments. Forty-five per cent (n = 134) had undertaken training in cancer prior to working with cancer patients, 61% (n = 182) had undertaken courses or study days relative to cancer care in the past two years. The most often treated symptoms or concerns of patients were those of a psychosocial nature, pain management and lymphoedema. CAM practitioners with limited knowledge and training are providing support to cancer survivors, particularly in services where the National Health Service has limited provision. CAM practitioners may fulfil a future role in providing long-term support for cancer survivors; however, in order to properly safeguard patients they are in need of further training and development.

Keywords: cancer, complementary and alternative medicine, education, evaluation, supportive care.

INTRODUCTION

Cancer today is primarily a chronic condition and many now believe that cancer should be more widely defined as part of primary and long-term healthcare conditions (Maher & Makin 2007). However, our current system of healthcare provision has placed its focus on managing cancer acutely, leaving many cancer survivors with a list of unmet needs (Armes et al. 2009). There is emergent policy and service development in cancer long-term management and the National Cancer Survivorship Initiative in their Vision document have clearly identified five key shifts in care provision to people affected by cancer (DoH et al. 2010, Richards et al. 2011). The focus of this change is on recovery, health and well-being, furthermore it seeks to engage all those involved in cancer care in defining new models of aftercare for people affected by cancer and its treatments.

Almost two million people in the UK have experienced cancer and have survived; a number which is set to increase by an average of 3% per year (Davies 2009, Breally et al. 2011). Although cancer survivorship is improving as a direct result of better screening, better management and more complex treatment regimes, a
cancer diagnosis can mean coping with both physical and psychological symptoms after the end of active treatment (Senkus-Konefka & Jassem 2007; Stocker & Cheong 2010; Senkus & Jassem 2011).

Macmillan state that ‘every single person who is diagnosed with cancer should have access to high-quality treatments and services that are appropriate to their needs . . . ’ (Macmillan Cancer Support 2010) and while many cancer centres now incorporate complementary and alternative medicine (CAM) as part of this service provision, much of the access is limited and only available during the active treatment phase of a patient’s cancer journey. However it is often during the survival phase of cancer that people seek help outside the realms of conventional medicine, when more support is needed and help from conventional medical services has been exhausted (Mao et al. 2008). Referrals to CAM practitioners are rare and this may be attributed to the lack of efficacy behind some CAM treatments (Tovey & Broom 2007). CAM practitioners may lack the skills necessary to triage to the appropriate services and even though knowledge of the long-term and late effects of cancer treatments is emerging, there is very little guidance in cancer care for managing these effects in adults (Greenfield et al. 2009). Furthermore, practitioners in both the oncology and complementary medical fields lack the expertise in cancer as a long-term condition.

Despite the many new treatment regimes on offer to cancer patients, side-effects from treatments may continue for months or years after treatment has ceased (Senkus-Konefka & Jassem 2007; Thomas & Davies 2007; Stocker & Cheong 2010; Senkus & Jassem 2011). Patients with advanced cancers are living longer and require more in the way of supportive care. Cancer patients are becoming more adept in exploring every possible option to manage their symptoms and while there have been a number of surveys demonstrating what CAM services cancer patients’ access (Rees et al. 2000; Vickers & Cassileth 2001; Scott et al. 2005; Gage et al. 2009) [Bishop et al. 2011], lack of communication between patients and their healthcare practitioners makes it difficult to effectively safeguard patients who choose to combine conventional and complementary treatments (Chatwin & Tovey 2004; Roberts et al. 2005).

Conventional medicine often underestimates the support provided by CAM practitioners to patients and is unable to recognise how or where it could be harnessed more effectively. CAM is prevalent in many chronic illness areas, such as multiple sclerosis (Esmonde & Long 2008; Bowling 2011), arthritis (Lapane et al. 2012) and chronic pain management (Konvicka et al. 2008). There is an increased awareness of integrated therapies in mainstream medicine, particularly in a supporting role (Featherstone & Hammick 1999; Fewell & Mackrodt 2005; Gage et al. 2009). It is therefore becoming more important that CAM practitioners have an increased awareness of the complications and consequences of cancer and its treatments so that issues around governance and integration may be moved forward.

Training and development

Lack of efficacy in CAM is one of the reasons for non-referral to CAM practitioners, but there is also a reluctance to promote CAM without clear National Health Service (NHS) guidelines on the advice to give patients who may be interested in using it (Tovey & Broom 2007). Despite these concerns CAM therapies are available in some NHS institutions where such services are often supported by cancer charities (Gage et al. 2009). There is however, a limited availability of specialist training for CAM practitioners working with clients who experience long-term adverse effects of cancer treatments; any that are available tend to cover adaptation techniques in the touch-based therapies such as body massage, reflexology and aromatherapy (Mackereth et al. 2009). Furthermore, there are no developments in the Quality and Credit Framework with regard to complementary therapists working in cancer care, because it is considered too ‘niche’ for a national qualification (Sector Skills for Health 2011).

This study set out to evaluate the perceived skills and confidence of CAM practitioners currently working with clients following a cancer diagnosis; furthermore it explored the support provided in managing the late and long-term effects of cancer. The term ‘late effects’ is described here as any adverse symptom that may occur within or more than 12 months following the completion of active treatment (chemotherapy, radiotherapy, surgery). Long-term effects refer to any symptom or concern arising past the end of active treatment and which may coexist with sequelae relating to advancing years (Maher & McConnell 2011). More importantly this research sought to establish the current level of training and education of CAM practitioners working within this area of practice.

METHODS

This survey of training needs utilised a ‘Tailored Design Method’ introduced by Dillman which is based on the theory of social exchange (Dillman 2007). It assumes that respondents will participate more readily in a survey where the questionnaire is constructed to highlight the
importance and usefulness of responses and that completion of the questionnaire will provide solutions to a problem.

Data were collected by e-survey utilising the Survey Monkey web platform from CAM practitioners working with patients who seek help and support with the late and long-term effects of cancer treatments (≥12 months after treatment). An online questionnaire was available using an electronic web link between April and May 2011. Web links were disseminated via a network of CAM organisations (Complementary and Natural Healthcare Council, The Federation of Holistic Therapists, The Association of Reflexologists, Complementary and Alternative Medicine Research Network and the Integrated College of Medicine) creating a snowball effect throughout their databases and providing the potential for approximately 21 000 practitioners to participate in the study. The initial invitation e-mails included an information letter with a preface that cancer survivors were defined as individuals who had completed treatment and were disease free ≥12 months post treatment (classified as surgery, chemotherapy and radiotherapy) together with a screening question which would identify those eligible to take part. Late effects were defined as ‘physical and/or psychosocial problems occurring after the completion of active treatment’. All questionnaire responses were anonymous and confidentiality was assured.

The primary focus of the questionnaire was to establish what treatments were provided and which symptoms their clients most often sought help for following their cancer treatment. The secondary aim focused on the skills and confidence of practitioners working to support patients experiencing the long-term and late effects of treatment and the training practitioners felt they required.

Ethics

This study was carried out as part of a larger study to healthcare professionals within oncology, haematology, community and allied health professions. Ethical approval was sought from the NHS committee and the University of Surrey ethics committee in order to define the services provided and to evaluate the training needs of practitioners working with patients in follow-up after cancer treatment. Both committees confirmed that ethical approval to approach this group of professionals was not required for this ‘service evaluation’ study.

Sampling

One of the objectives of the survey was to establish how many CAM practitioners provided care and support to clients with a diagnosis of cancer in the follow-up after treatment. A similar survey was carried out by Mackereth et al. (2009) to a select group of professionals from the North West of England, unfortunately that study did not provide any guidance of the anticipated response rates one might expect from a national survey of this nature. However, Dillman (2007) suggested that approximately 40% will respond positively to a questionnaire on training needs if there is a vested interest in the outcome. Of the potential 21 000 CAM practitioners surveyed only a small percentage reported working with clients in follow-up after cancer treatments, providing a response rate of 2.5% (n = 507).

Development of the questionnaire

The questionnaire was developed around four key domains. These were selected specifically to identify practitioners who were providing a supportive service to cancer patients, to focus on the symptoms and concerns of clients who most often sought help, to find out how confident practitioners felt with their current skill level and to establish what additional training may be required by them in the future to address support of clients with cancer as a chronic illness. An expert panel of community practitioners, specialists in oncology and late effects educators reviewed the questionnaire for content and construct validity. The questionnaire contained a mix of uniform questions suitable to all practitioner groups and unique questions relevant only to CAM practitioners. A pilot was made available to CAM practitioners whose comments were then used to refine the questionnaire.

Data analysis

The data were coded and analysed using a combination of Excel 5.0 spreadsheets and the statistical package SPSS v18 (SPSS Inc., Chicago, IL, USA) for Windows. Frequencies, means and range were calculated where appropriate. Open box comments were analysed qualitatively using qualitative framework analysis with a process of data coding in order to identify themes and to provide a comparative content analysis. Where data were missing from any particular question, for example, where a practitioner had marked a ‘don’t know’ response to a question, they were treated as if they had not answered the question at all.

RESULTS

Demographics

A total of 612 practitioners responded to the survey, 507 of whom were providing a service to clients with late or
long-term effects of cancer treatments. The mean age of practitioners \( n = 298 \) was 60 years \( \text{(range 20–60+)} \), identifying them as part of a mature population of therapists. They had been in practice on average for 10 years and provided support to clients with cancer for less than 5 h per week. Ninety-eight per cent \( n = 292 \) held an undergraduate qualification which encompassed diploma or degree level courses. The duration of the diploma courses varied between 9 and 12 months, although 3\% \( n = 9 \) held CAM qualifications which were awarded after less than 6 months training. Most of these courses incorporated the touch-based therapies such as aromatherapy, reflexology and body massage, a further 5.4\% \( n = 16 \) were at degree level. A small percentage of practitioners \( 7.72\% - n = 23 \) had undertaken post-graduate qualifications at MSc and PhD level in acupuncture or nutrition. A few of the practitioners were also qualified nurses, general practitioners or paramedics. Forty-five per cent \( n = 134 \) had undertaken training in cancer prior to working with clients with cancer and 61\% \( n = 182 \) had undertaken courses or study days relative to cancer care in the past 2 years.

**Provision of services**

Seventy-eight per cent \( n = 369 \) of the 471 who answered the question on service provision said they were providing reflexology, 42\% \( n = 197 \) body massage, 40\% \( n = 188 \) healing or reiki and 38\% \( n = 178 \) aromatherapy, thus indicating that the majority of services utilised were in the touch- or mind-body-based therapies with many of the practitioners offering more than one service. Ninety-four per cent \( n = 455 \) of CAM services were provided in private practice either from a home-based clinic or as an outreach service at the clients’ home, while a further 29\% \( n = 134 \) were employed or provided a voluntary service in hospices. Some practitioners were providing services in more than one location.

**Skills and confidence**

Practitioners were asked to mark on a scale \( \{ \)never, occasionally and often\( \} \) how frequently their clients with cancer sought help for symptoms and concerns post treatment. The data were coded into four categories: physical, psychosocial, sexual and lifestyle. The data shown in Figure 1 illustrate the symptoms and concerns for which clients with cancer most often seek help from CAM practitioners. Both physical and psychosocial symptoms feature predominantly but stress was identified as the most often treated symptom \( 83\%, n = 341 \) followed by fatigue \( 79\%, n = 323 \), anxiety and depression \( 75\%, n = 308 \), sleep problems \( 70\%, n = 288 \) and general pain management \( 63\%, n = 261 \). Thirty-three per cent \( n = 137 \) often treated clients with lymphoedema while 48\% \( n = 199 \) treated this problem occasionally.

Practitioners were then asked to state how skilled they felt they were in managing the long-term and late effects of cancer treatments. They were asked to mark on a scale of statements that which best reflected their skill level for managing a number of health-related issues which have been identified as symptoms and concerns to patients. The Likert scale provided five choices – strongly agree, agree, neither agree nor disagree, disagree and strongly disagree. The categories for strongly agree and agree were merged and of the 385 practitioners who answered this question 86\% \( n = 331 \) said that they possessed the skills to manage sleep problems, 85\% \( n = 327 \) anxiety and depression, 84\% \( n = 323 \) fatigue and 75\% \( n = 288 \) general and specific \( 62\%, n = 239 \) pain issues. Skills they were less likely to have were identified in the areas of sexual health, weight management and the cardiac effects of cancer treatments.

Although CAM practitioners are not directly involved in follow-up after cancer treatment, in order to ascertain their perceived confidence levels they were asked to mark on a scale of 1–10 how easy or difficult a particular task was for them \( 1 = \) easy/10 = difficult\). The questions reflected tasks performed by conventional healthcare practitioners. Table 1 illustrates the results. Sixty-seven per cent \( n = 215 \) of the 320 CAM practitioners who answered this question felt they were most able to recognise psychosocial problems, provide psychological support \( 56\%, n = 179 \), refer to the multidisciplinary team \( 54\%, n = 173 \) and provide symptom management for mild to moderate side-effects \( 52\%, n = 167 \). Results illustrate similar confidence levels to those of conventional healthcare practitioners working in follow-up after cancer treatments and highlight a need for additional training across both conventional and complementary medicine.

**Training and development**

One of the aims of this research was to identify future training and development needs of CAM practitioners working with clients experiencing the late and long-term effects of cancer and its treatment. When practitioners were asked – ‘What areas of cancer care would you like to know more about to help you manage your patients care?’ over 50\% \( n = 144 \) showed an interest in developing their knowledge about the biological and pathological basis of cancers, 76\% \( n = 202 \) the long-term health effects of cancer treatments, 69\% \( n = 184 \) the prevention and man-
agement of cancer induced bone loss and joint pain and 69% (n = 184) on the effects of cancer therapies on the endocrine system. More than 60% were interested in learning more about the potential cardiac effects of chemotherapy and hormone therapies and self-management techniques but there was much less interest in learning about medications management, sexual problems, screening in the long term, telephone follow-up, return to work

Figure 1. Symptoms and concerns for which patients most often seek help from CAM practitioners (n = 411).

Table 1. Complementary and alternative medicine practitioners perceived levels of confidence in their ability to carry out specific follow-up tasks normally managed by healthcare practitioners (N = 320)

<table>
<thead>
<tr>
<th>Task</th>
<th>Confident</th>
<th>Unsure</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognise symptoms associated with late effects</td>
<td>178</td>
<td>129</td>
<td>47</td>
</tr>
<tr>
<td>Recognise psychosocial problems</td>
<td>215</td>
<td>107</td>
<td>32</td>
</tr>
<tr>
<td>Review and assess independently &amp; then consult with clinician</td>
<td>133</td>
<td>116</td>
<td>105</td>
</tr>
<tr>
<td>Independently review and assess</td>
<td>140</td>
<td>116</td>
<td>98</td>
</tr>
<tr>
<td>Inform &amp; discuss potential long-term health effects of treatments</td>
<td>105</td>
<td>124</td>
<td>125</td>
</tr>
<tr>
<td>Review medications &amp; advise patients on potential effects</td>
<td>60</td>
<td>66</td>
<td>228</td>
</tr>
<tr>
<td>Refer patients to the multidisciplinary team</td>
<td>173</td>
<td>78</td>
<td>103</td>
</tr>
<tr>
<td>Effectively teach self-management &amp; self-monitoring</td>
<td>103</td>
<td>118</td>
<td>133</td>
</tr>
<tr>
<td>Create individualised long-term plan of care</td>
<td>121</td>
<td>126</td>
<td>107</td>
</tr>
<tr>
<td>Provide psychological support</td>
<td>179</td>
<td>122</td>
<td>53</td>
</tr>
<tr>
<td>Provide symptom management for mild to moderate side-effects</td>
<td>167</td>
<td>123</td>
<td>64</td>
</tr>
<tr>
<td>Provide complex symptom management for severe symptoms</td>
<td>66</td>
<td>109</td>
<td>179</td>
</tr>
<tr>
<td>Recognise the potential late effects of my client group</td>
<td>114</td>
<td>143</td>
<td>97</td>
</tr>
</tbody>
</table>

Answered the question: N = 320
Table 2. Perceived training needs of complementary and alternative medicine practitioners who are working with cancer patients, following cancer treatments \( N = 266 \)

<table>
<thead>
<tr>
<th>Which areas of cancer care would you like to know more about?</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of long-term health effects of cancer treatment</td>
<td>202</td>
<td>75.9%</td>
</tr>
<tr>
<td>Prevention &amp; management of cancer induced bone loss &amp; joint pain</td>
<td>184</td>
<td>69.2%</td>
</tr>
<tr>
<td>Endocrine effects of cancer treatment</td>
<td>183</td>
<td>68.8%</td>
</tr>
<tr>
<td>Self-management techniques</td>
<td>167</td>
<td>62.8%</td>
</tr>
<tr>
<td>Potential cardiac effects of chemo &amp; hormone therapies</td>
<td>163</td>
<td>61.3%</td>
</tr>
<tr>
<td>Tests and investigations</td>
<td>154</td>
<td>57.9%</td>
</tr>
<tr>
<td>Long-term consequences of cancer treatments in older age</td>
<td>149</td>
<td>56.0%</td>
</tr>
<tr>
<td>Managing psychosocial aspects of long-term cancer survival</td>
<td>145</td>
<td>54.5%</td>
</tr>
<tr>
<td>Co-ordinating long-term follow-up</td>
<td>145</td>
<td>54.5%</td>
</tr>
<tr>
<td>Cancer biology/pathology</td>
<td>144</td>
<td>54.1%</td>
</tr>
<tr>
<td>Cancer surgeries &amp; effects on physiological &amp; functional processes</td>
<td>142</td>
<td>53.4%</td>
</tr>
<tr>
<td>Diet/lifestyle</td>
<td>136</td>
<td>51.1%</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>129</td>
<td>48.5%</td>
</tr>
<tr>
<td>Assessing/managing pelvic problems post surgery/radiotherapy</td>
<td>114</td>
<td>42.9%</td>
</tr>
<tr>
<td>Benefits of exercise</td>
<td>110</td>
<td>41.4%</td>
</tr>
<tr>
<td>Assessment &amp; screening for cancer patients longer term</td>
<td>100</td>
<td>37.6%</td>
</tr>
<tr>
<td>Medications management and adherence</td>
<td>96</td>
<td>36.1%</td>
</tr>
<tr>
<td>Assessment of sexual dysfunction and fertility</td>
<td>82</td>
<td>30.8%</td>
</tr>
<tr>
<td>Return to work issues</td>
<td>89</td>
<td>33.5%</td>
</tr>
<tr>
<td>Telephone follow-up techniques</td>
<td>71</td>
<td>26.7%</td>
</tr>
<tr>
<td>Finance and benefits</td>
<td>59</td>
<td>22.2%</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>7.9%</td>
</tr>
<tr>
<td>Answered the question:</td>
<td>266</td>
<td></td>
</tr>
</tbody>
</table>

Issues and the finance and benefits that may be available for cancer patients. Table 2 illustrates these results.

DISCUSSION

This survey was carried out to establish the perceived skills and confidence of CAM practitioners working to support individuals following cancer treatments and to identify CAM practitioners training needs. Support for chronic illness management in cancer survivors is growing partly because of neo adjuvant therapies and longer illness trajectories but also because of consequences of cancer treatment requiring symptom management. CAM use continues to rise in cancer care and in the past two decades has been utilised in supportive healthcare among patients with chronic illness (Sirois 2008). Cancer patients however use CAM services for a variety of reasons (Scott et al. 2005) but may be using it following their cancer treatment because of a number of unmet needs (Mao et al. 2008; Gage et al. 2009).

Obstacles of clinical referral in engaging CAM practitioners within the NHS are high, in part this is due to the scepticism of Oncology professionals, the justifiable concerns around efficacy and costs associated with service provision (Kam et al. 2012). Other barriers include the inherent difficulties for oncology professionals in discussing CAM due to their lack of knowledge of the services available and in keeping up to date with the latest scientific evidence (Schofield et al. 2010). Such reluctance to refer patients may restrict the desire for a more holistic approach to care in the long-term management of cancer survivors and this in turn may prove to be an important issue for the ever increasing population in this area of chronic illness (Knott et al. 2012). However, a higher standard of training and a more evidence-based research approach may help alleviate at least some of these concerns.

Over the past decade reflexology was shown to be the most utilised service by cancer patients (Bell & Sikora 1996; Cant et al. 2011) and this research has seen this reflected in the responses of practitioners who have indicated that reflexology was highest on the list of treatments offered to their clients’. Previously, CAM provision was mainly utilised via a voluntary service within palliative care (Penson 1998) but 82% (n = 416) of the practitioners responding to this survey indicated that they are now working with cancer survivors, albeit within private practice and for less than 5 h per week. Whether this reflects the growing body of evidence for CAM (Jeffs et al. 2006; Molassiotis et al. 2007; Eremin et al. 2009) or a general increase in client use (Scott et al. 2005) is not clear from this self-selected sample of practitioners.

Among the list of unmet needs of cancer patients living beyond the end of active treatment, psychosocial issues remain high (Armes et al. 2009). Macmillan have identified a lack of psychosocial support services for cancer patients across the UK, reporting that 54% of cancer survivors still suffer psychological issues 10 years after the end of active treatment, placing an increased burden on mental health services (Corner 2008; Macmillan Cancer Support 2011). In this study practitioners report that clients are accessing psychosocial support from CAM services and that CAM practitioners perceive they have the skills and confidence to recognise and support patients in this area of health. In contrast, CAM practitioners perceived they had weaknesses in managing sexual health issues which may reflect the stigma and difficulty in discussing sexual issues also experienced by healthcare practitioners working in cancer care (Faithfull & White 2008). It is well known within studies of self-reporting of skills that where skills are observed by others competence is lower than when self-reported (Blanch-Hartigan 2011). It
is therefore debateable whether in practice skills identified offer a true reflection on ability.

Other than unmet needs of a psychosocial origin (Armes et al. 2009), cancer patients can also experience symptoms and functional effects. The wide provision of lymphoedema management within CAM in this survey may reflect a currently unmet need, particularly of women with breast cancer, who are often unable to obtain it within their local NHS provision (Breakthrough Breast Cancer 2011). On a national level there are only 143 lymphoedema specialist posts available within the NHS, yet there is a demand in breast cancer alone for an estimated 311 specialists (Breakthrough Breast Cancer 2011). This is a much neglected area of cancer care and one which could be made more available through CAM practitioners. Eighty-two per cent \( (n = 336) \) of 411 CAM practitioners said that they either occasionally or often provided manual lymphatic drainage treatments to clients with cancer. While this evidence suggests they may be helping to fill a needs gap, the concern is, at what skill level, especially when only 7% \( (n = 33) \) claim to hold specific qualifications in manual lymphatic drainage techniques. The discrepancy between availability and demand for lymphoedema services may provide opportunities for CAM practitioners who are trained in manual lymphatic drainage, but in order to do so, competency levels may need to be improved so that they reach the clinically appropriate standards required.

The House of Lords Select Committee on Science and Technology (Parliament 2000) identified the need for good-quality education and training and highlighted that therapists need to refer to other healthcare professionals (Rankin-Box 2002). This survey has shown some general disparity in the length of training provided to CAM practitioners with the majority holding qualifications at a diploma level. Cancer-specific training focused on communication skills, the long-term consequences of cancer treatment and fear and recurrence issues with only a 31% uptake in these additional training modules. One might speculate that for many CAM practitioners clients with a cancer diagnosis represent only a small percentage of their client base. If this is so, and especially in today’s economic climate, then the cost of training when offset against the likelihood of paid employment is neither motivation nor reward for participation. Improvements in the competency infrastructure will help increase CAM practitioners’ knowledge of the long-term and late effects of cancer and its treatment on individual, but only if education is made available and these competencies are clearly identified. The impact of these changes may help identify how healthcare organisations can utilise and plan for the use of practitioners skills in integrative practice, particularly as CAM practitioners are already providing a service to cancer patients. The need to up-skill and fix levels of competency is important, especially when the ability to identify adverse effects of treatment impact on patient well-being and particularly so where the services are linked with integrated care centres.

New initiatives are needed in managing long-term and late effects of cancer therapy and CAM practitioners perceive that they have the skills and confidence to support those experiencing symptoms in the longer-term management of cancer. However, CAM practitioners need to be able to recognise their role limitations within the cancer care continuum while still providing much needed support to patients. Furthermore, where there is insufficient provision within the NHS, such as in lymphoedema services and psychosocial support, CAM practitioners could have the ability, with additional training, to provide support, thus easing the burden on an already overstretched NHS resource. CAM practitioners could be harnessed to supplement existing NHS services more efficiently by improving their levels of competency and skill, thus making integration easier and improving confidence and consistency in training. As cancer as a disease, moves from an acute to a chronic illness model, an awareness of the role that CAM practitioners can play in supporting patients is vital to their contribution in a longer-term supportive care role.

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REFERENCES


Macmillan Cancer Support (2011) *Psychological and emotional support provided by Macmillan professionals: an evidence review* [‘Electronic version’].


among three chronic illness groups: associations with psychosocial factors and concurrent use of conventional healthcare services. Complementary Therapies in Medicine 16, 73–80.