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The rise and fall of complementary medicine in National Health Service hospitals in England

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Abstract

Whilst Complementary and Alternative Medicine (CAM) has never been systematically integrated into National Health Service (NHS) provision, there has been some limited evidence of a developing presence of CAM in NHS hospital based nursing and midwifery. This paper reports on a qualitative study that sought to document the nature and extent of such integrative practice in England, and the interpersonal and organisational factors that facilitated or impeded it. The data revealed a history in which attempts to integrate CAM had some initial success underpinned by the enthusiasm of individual practitioners and a relatively permissive organisational context. However, this was followed by a decline in service provision. The fact that the services were established by individuals left them vulnerable when more restrictive funding and governance regimes emerged. Whilst the data revealed a consistent story about CAM within the NHS, it must be recognised that the use of a snowball sample limits the generalizability of the findings.

1. Introduction

Attempts to integrate Complementary and Alternative Medicine (CAM) into the National Health Service (NHS) have tended to be more successful within primary care than within the hospital sector, reflecting the dominance of biomedical knowledge and power in secondary and tertiary care. Nevertheless, CAM has had an increasing presence within nursing and midwifery training and practice within NHS hospitals since the early 1990s. There are a number of possible reasons for this. Firstly, there has been a growth in demand for CAM services from the public. Second, practitioners themselves have been drawn to CAM: this is partly because there is a putative alignment between nursing and midwifery and CAM, in that they share an orientation towards care and holism and partly because CAM has been perceived as affording an opportunity to extend and enhance their professional jurisdiction.

Such opportunities have always been somewhat uncertain, however, as there has never been a clear, governmental policy directive on the incorporation of CAM into the NHS. This fact afforded the space for motivated nurses/midwives to develop services, but without formal recognition or support. Moreover, The Royal College of Nursing and Nursing and Midwifery Council guidelines stipulate that as ‘knowledgeable doers’ nurses and midwives are responsible for establishing their own competency to practice CAM, but do not specify what this competency should involve. This situation is further complicated by the fact that within CAM more widely there are few universal standards defining competency to practice, practitioners being largely reliant on voluntary self-regulation. As such, CAM occupies a position of ‘mainstream marginality’ – popular, but not funded or sanctioned by the state, and marked by internal inconsistency over knowledge and training. It was within this context that CAM provision by nurses and midwives emerged. This paper reports on a qualitative study that sought to document the nature and extent of such NHS hospital based integrative practice in England, and the interpersonal and organisational factors that facilitated or impeded it.

2. Methodology

The project focussed on hospital based nurses and midwives because they comprise the largest group of health professionals using CAM in their NHS hospital practice. The study was exploratory and employed a qualitative methodology. Ethical approval was granted by both the University at which the research was based, and relevant NHS Trusts. Interviews were conducted using a semi structured guide derived from an extensive review of the literature and focused on the history, nature and extent of the

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respondent’s practice; their training, financing of the service, collegial support, organisational and policy factors and their views on the impact and value of CAM.

Data were collected in two phases. Firstly, eighteen in-depth telephone interviews were conducted with current and former hospital based nurse and midwife CAM practitioners across England. As there is no formal register of such practitioners, a snowball technique was used to attain the sample, drawing from initial contacts within the National Nursing and Midwifery Complementary Medicine Forum. These telephone interviews yielded data from a geographically broad spread of CAM practitioners ranging from the South West, through London and the Midlands to the North East. In the second phase, case studies were undertaken in hospital based midwifery and birthing centres, pain clinics and oncology wards in three district general hospitals in one county in the South East of England. This yielded nine face-to-face semi-structured interviews with nurses and midwives who practice CAM.

The samples in both phases shared demographic characteristics in that all but one of the respondents were women and all were aged between their mid forties and approaching retirement and as such had achieved a position of relative authority in the NHS. Interviews were tape recorded, transcribed verbatim, anonymised and allocated reference numbers. In addition a variety of relevant documents such as Trust policies and guidelines on CAM practice were collected. All interview and documentary data were analysed thematically by two members of the research team. This involved using an iterative process of detailed reading and re-reading of the transcripts according to the principles of qualitative content analysis. Key themes to emerge included: the extent of CAM practice in interview data, enhancing the reliability and validity of the study, a strong congruence between the face to face and telephone practice, both therapeutically and occupationally. There was a strong congruence between the face to face and telephone practice, both therapeutically and occupationally. There was a strong congruence between the face to face and telephone practice, both therapeutically and occupationally.

The rise of CAM in hospital settings

3.1. The rise of CAM in hospital settings

Our data indicated that from the mid-1980s to the late 1990s nurses and midwives had had some success in establishing NHS hospital based CAM services. Practice was generally limited, however, to a restricted range of settings: specifically normal pregnancy and labour (within midwife led units); pain management; dermatology; and oncology services (within general nursing). The therapies which had achieved the most success in integration were: aromatherapy (10 midwives and 7 nurses); reflexology (5 nurses and 5 midwives); massage (2 midwives and 5 nurses); and acupuncture (4 midwives and 2 nurses). Marginal use was also reported of yoga, hypnosis, moxibustion, Bach flower remedies and diet therapy. Whilst several respondents expressed an interest in homeopathy none had attempted to establish services. Respondents reported using a wide range of therapies, with individuals often practicing several different modalities.

Despite this level of interest, the provision of CAM services was highly uneven, comprising ad hoc initiatives driven by individuals rather than central policy. Moreover, those individuals who managed to establish services were distinguished by their high levels of enthusiasm and energy:

“These are very unusual nurses. They are nurses that are going to get ahead anyway. There is something about them... they are natural leaders, they take initiative, they are not afraid to take risks. Your average nurse, you know, they think it’s a good idea, but then it doesn’t get much further than that really.” (Telephone: Nurse 03)

Their enthusiasm for CAM was grounded in the fact that they saw it as affording the opportunity to offer creative and individualised care. This stood in contrast to their day to day practice which they described as increasingly bureaucratic, impersonal, instrumental, technical and pressurised. For instance, one respondent recalled the following:

“In 1991 I started working on an oncology ward for children and young people... so quite a high dependency ward... and after about five years I just felt like a technician. I was just doing chemotherapy, just giving out drugs all the time, and the parents on more than one occasion did say that they were doing the nursing care and we just give out the drugs, which was absolutely true. And to say that to a nurse, it was like a knife.” (Telephone: Nurse 22)

And another stated that:

“...I did become a nurse, it sounds corny, to look after people... that need to nurture fulfils a need in me, but obviously in nursing it’s appropriately channelled... when I go into a ward, any of the wards now, at times I actually feel quite ashamed to be a nurse. The fundamental, the most basic, elements of nursing care just aren’t happening.” (Face to face: Nurse 26)

CAM, in contrast, afforded the respondents an alternative mode of engagement with their clients. As one midwife commented:

“You can see it [CAM] as a way of reversing the interest that health professions had in technology, and softening delivery suite atmosphere... it can transform most of the midwives' ability to care, and also the whole attitude of the mother.” (Face to face: Midwife 05)

In particular, CAM created spaces for the practitioners to devote time to their clients:

“They say it’s [CAM] taking up nurses’ time – well nursing is time, that’s what it is. It’s not filling in forms and running round, it is time with the patient.” (Telephone: Nurse 04)

Another midwife stated that practicing CAM:

“...is very different because you get the luxury of time that you don’t get in a general NHS environment when you are whisking through... when they are lying there with their needles in, I’m sitting there and having a little chat with them, I’m catching up, it’s much calmer.” (Face to Face: Midwife 25)

For success however, personal commitment had to be bolstered by other factors. Our respondents all held positions of relative authority in the hospital hierarchy, and were adept at negotiating professional boundaries and the formal and informal organisational contexts of the hospital. Respondents sought to establish services only where biomedical intervention had limited effectiveness or where biomedical practitioners showed little interest. Even then, those therapies that were introduced were presented in modest terms, making limited claims with respect to their efficacy and risk. For example, one midwife described her efforts to introduce an aromatherapy service in the following terms:

“I wrote to the consultants to tell them what I was intending to do with the stance that it would be a tool to aid coping with childbirth, you know, for relaxation and helping with the...
contractions… and just to say that I intend to do that, and that whilst I obviously wouldn’t be encouraging on [the] medical arena without their permission.” (Telephone: Midwife 19)

This was not simply deference to the medical profession, however, but also reflected the lack of a robust evidence base supporting CAM interventions. As such practitioners would limit the extent of the service, therapeutic claims, as illustrated in the following example:

“I presented my ideas [for acupuncture in midwifery] at a Directorate meeting and there wasn’t a single person there who was against the idea. I think because I presented it pretty much hand in hand with sort of conventional Western medicine, saying, you know, the idea is just to have something different to offer alongside what we do already, rather than replace what is already going on.” (Telephone: Midwife 10)

Practitioners would also limit the range of remedies offered:

“…we played very safe to begin with so our aromatherapy guideline really just covers six oils…” (Telephone: Midwife 13).

Moreover, despite their interest in CAM, the respondents maintained a strong, practical and epistemological commitment to biomedicine. In situations where the respondents had to judge the appropriateness of a given intervention, biomedical understandings would invariably take precedence. In midwifery, for instance, CAM interventions were restricted to pregnancies defined as normal in biomedical terms.

The opportunities to develop the services also reflected a specific regulatory and training context. In the period from the 1980s to the 1990s, CAM services did not necessarily require formal authorisation. One midwife commented that:

“…I got permission from my manager to use the therapies, I mean in those days we didn’t have to, you know, we didn’t have to write loads of policies…” (Telephone: Midwife 11).

While another noted that:

“…of course these were the days before evidence based medicine and clinical governance were really thought of.” (Telephone: Midwife 13)

Furthermore, no formal prerequisites to practice were required by the nurses’ and midwives’ professional associations. For instance, the Nursing and Midwifery Council’s (NMC) guidelines stipulate that as ‘knowledgeable doers’, nurses and midwives can judge themselves competent to practice CAM; the responsibility for training and regulation also rests with the practitioner and is not dictated by external bodies. Our respondents described this lack of prescription as problematic, however, because it left them dependent on informal advice as to which training courses to undertake and which regulatory bodies within CAM to register with.

“So that’s what I did…a two year part time course to become registered with the International Federation of Aromatherapists…… the Trust’s never quite sure what it does require because it does not really know that much about it.” (Face to Face: Nurse 26)

This often made the respondents feel anxious about their insurance status and insecure about whether they could rely on professional support in cases of litigation. Further, the absence of formal professional guidelines also meant that when protocols and policies were required, it usually fell to the individual practitioners to write them.

Such organisational support as was made available was limited, uneven and precarious. Although in most cases Trusts would be prepared to give over physical space for CAM delivery, and would occasionally pay for training, the respondents generally had to fit CAM provision around their normal work-load, and were unsupported financially. Indeed, respondents reported being reliant on donations, having to fund the services themselves, or having to find creative ways to sustain their practice. Such initiatives included: cake sales; pamper evenings; quiz nights; the sale of umbilical cords for research purposes; sale of relaxation CDs; and realising unspent credit from hospital television cards.

In summary, then, hospital based CAM provision in the NHS experienced a period of relative success, stimulated by a number of factors: the dissatisfaction of a particular generation of nurses and midwives with the changes taking place in their practice; the presence of energetic, committed individuals who had reached a level of seniority sufficient to be able to enact change; the absence of restrictive policy; and the careful management and portrayal of the remit of CAM. However, the lack of formal support for CAM provision rendered it ultimately tenuous.

3.2. The fall of CAM

The optimism that characterised efforts to integrate CAM in the 1990s proved premature, however. The study revealed a decline in hospital based NHS CAM provision through the first decade of the twenty-first century, reflecting individual and organisational factors.

With respect to the former, services proved vulnerable simply because they were initiated and sustained by individual nurses and midwives. As such, the absence or departure of a practitioner would often lead to the closure of the service:

“I’m on my tod really so if I’m on holidays there is no clinic. If I was sick… the service wouldn’t run.” (Face to Face: Midwife 25)

Of greater significance, though, have been a number of changes in the organisational culture of the NHS. The last decade has seen greater stringency in NHS budgets, and increasing emphasis on clinical governance, both of which have served to restrict CAM provision. For instance, one nurse reported that following a decade of running a successful CAM service:

“…I got a letter saying that the hospital had a 60 million pound over-spend, and thanks so much but we don’t require your services anymore.” (Telephone: Nurse 22)

Increases in managerial scrutiny also required the writing and passing of new guidelines, policies and protocols, supplemented by strong clinical evidence. While the practitioners accepted the need for such regulation, they often found the processes involved to be overly bureaucratic, time-consuming and frustrating, especially given the lack of institutional support, and of a robust evidence base for CAM. One midwife described how the documentation she was required to produce had to:

“…cover everything from what aromatherapy, what the definition [was] the… UKCC rules and regulations defining practice… quality control, stock control, criteria for use and criteria for... contra-indications and cautions, and then how we were going to use it… basically how many drops and things like that and what oils I was going to use, the properties of those oils.” (Telephone: Midwife 19)

While another abandoned her CAM service when faced with such demands:

“…the biggest barrier is getting it past the Trust and I just became fed up with the hassle… I am disappointed and disillusioned because… I paid for all my training and I do not have
Many of the respondents and midwives portrayed practitioners as relatively autonomous, however, attempts to enhance the occupational standing of nurses resulted in holistic, time-rich relationships with their clients. Simultaneously, the technical and administrative dimensions of their practice, at the in this study perceived such changes as resulting in a promotion of the service being closed, her manager expressing the view that: “We are not sure about litigation and all this sort of thing. So we don’t mind you doing it, but you can’t do it while you’re working as a midwife, you can only do it when you’re off duty – so I just retired from the NHS.” (Telephone: Midwife 17)

This was not an isolated case. Several of the respondents reported their frustration being so great that they decide to abandon the NHS and set up private CAM practices instead, as illustrated in the following extract, concerning a nurse’s ultimately unsuccessful attempt to write a policy for her Trust:

“[it is]...a long and very sad story and ultimately it led to me leaving the NHS... I put together very small working groups because you have to have things to support the policy, and over four years we re-wrote, re-wrote, re-wrote, re-wrote, and eventually we got a policy... we went to the Medical Staff Committee, we went to parent and child groups... it went to the legal department... it got the whole way, it had everybody’s approval, it had been to the executive, it had been to the executive board and they had agreed... the last hurdle was the clinical negligence group... and I wasn’t allowed to attend that meeting... Oh it took me four years. Four years and then they threw it... I was crossing every t and dotting every i and still fell flat on my face” (Telephone: Nurse 06)

In sum, the data suggest that the potential for establishing integrative medicine in NHS hospitals has been markedly curtailed.

4. Discussion

Despite high levels of membership amongst nurses and midwives of the Complementary Medicine Forum, this study challenges the assumption that CAM practice is widespread in NHS hospitals. Rather, the data suggest that opportunities to establish formal, durable services have always been marginal, and are now very limited. Moreover, they suggest that the very factors that facilitated the growth of NHS hospital CAM services towards the end of the last century also account for their subsequent decline.

From the 1980s onwards CAM was seen by many nurses and midwives as an attractive way to augment their practice, stimulated by particular historical factors. The late 20th century saw concerted attempts by both nurses and midwives to enhance their professional and occupational standing. Many of the respondents in this study perceived such changes as resulting in a promotion of the technical and administrative dimensions of their practice, at the expense of those aspects associated with care and intimacy. In contrast CAM was seen to afford the opportunity to develop holistic, time-rich relationships with their clients. Simultaneously, however, attempts to enhance the occupational standing of nurses and midwives portrayed practitioners as relatively autonomous ‘knowledgeable doers’, able to develop their expertise in clinical settings and establish their competency, without deferring to the authority of either biomedicine or their own professional associations. This afforded the practitioners the space to develop CAM services.

However, such services were always marginal and vulnerable. While the lack of clear policy directives allowed motivated individual practitioners to develop CAM services, it also led to fragmented, inconsistent and ultimately unsustainable provision. The longevity of the services was also compromised by the absence of formal support both from the NHS and the practitioners’ professional associations — CAM services were permissible, but not endorsed. As such CAM services always remained marginal. This marginality was partly organisational — in that services were rarely funded or timetabled — but it was also partly epistemological. The fact that CAM lacks an experimental evidence base, and is characterised by inconsistencies within and between different modalities regarding status, competency and training, limited the therapeutic claims that nurse and midwife practitioners were able to make. Additionally, despite attempts to professionalise, nursing and midwifery ultimately remain subject to biomedical epistemologies, and therefore to biomedical authority. Indeed, successful integration was often dependent on biomedical indifference. Overall, then, CAM only ever extended rather than enhanced the practitioners’ occupational standing.

Moreover, this extension of occupational space through CAM proved vulnerable to changing historical circumstances. Contemporaneous NHS services are subject to tightening financial regimes, more stringent clinical governance, and demands for evidence based practice. In this cultural context, CAM services in NHS hospitals have become increasingly difficult to sustain.

Overall, this exploratory study revealed a consistent historical picture but is limited in terms of generalisability reflecting the qualitative methodology employed. Future research might focus on systematic analysis of Trust polices pertaining to CAM practice and explore other domains where CAM integration has taken place such as mental health, primary and hospice care.

Conflict of interest statement
None declared.

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