

COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)

IN BRITISH NURSING PRACTICE, 1960-2000

by

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degree of DOCTOR OF PHILOSOPHY**

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ABSTRACT

Most nursing history has focused on the politics, identity and development of the profession. This study focuses on practice. It examines the surge of interest in complementary and alternative medicine (CAM) in British nursing during the second half of the twentieth century and explores how and why some nurses used CAM in their practice. It examines the therapies that nurses employed and how these practitioners were supported. The merit of this research lies in exposing evidence of a more clearly designed organisation of CAM in nursing than has been suggested previously and places it within a discrete timeframe, one already recognised as a period of reform in medicine. In using the methodology of oral histories, archives and nursing journals, the research is rooted in nursing history, importantly demonstrating that CAM practice in nursing was not only part of a shift in consciousness away from a medical model, but was an extension of the patient-centred nature of nursing culture in the late twentieth century. In presenting a movement that challenged the dominance of biomedicine, this thesis demonstrates the emergence of a changing model of healthcare and contributes an important perspective to the history of modern medicine and healing.

**Dedicated to JFG and AHG
My grandfather and grandson**

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ABBREVIATIONS

AHNA	American Holistic Nurses Association
BAHH	British Association for Holistic Health
BHMA	British Holistic Medical Association
BMA	British Medical Association
CAM	Complementary and alternative medicine
EBM	Evidence-based medicine
FDA	Food and Drug Administration
FIM	Foundation for Integrated Medicine
GHS	General Household Survey
GMC	General Medical Council
HAART	Highly active antiretroviral therapy
HNA	Holistic Nurses Association
HSM	Health social movement
ICM	Institute of Complementary Medicine
ITEC	International Therapy Examinations Council
LOS	Length of stay (hospital)
MBSR	Mindfulness-based stress reduction
NAHAT	National Association of Health Authorities and Trusts
NDU	Nursing Development Unit
NHS	National Health Service
NMC	Nursing and Midwifery Council (from 2002)
NAWCH	National Association for Welfare of Children in Hospital
OTC	Over-the-counter
RCN	Royal College of Nursing
RNG	Radical Nurses Group
RCT	Randomised controlled trial
UKCC	United Kingdom Central Council for Nursing (1983-2002)
WHO	World Health Organisation

CHAPTER ONE: INTRODUCTION

1.1 Introduction

[A] new spirit glows in the incredible explosion of interest in complementary therapies. You cannot get enough of them!

So, the *Nursing Times* editorial exclaimed to its readers in January 1997.¹ This comment on an explosion in the use of complementary therapies in British nursing practice followed a survey two years earlier, which had revealed that 58% of nurses who responded to a self-administered questionnaire were implementing complementary and alternative medicine (CAM) in their work.² While this evident surge in the use of CAM by nurses at the end of the twentieth century may have been perceived as part of an exciting ‘new spirit’, it has remained a surprisingly under-researched area in the field of the history of nursing, and reflects a gap in the general history of medicine. This neglect is apparent from resources that had remained untapped. Archives that had been previously untouched, oral histories from key individuals who had not shared their narratives, and articles and letters in nursing journals that had formerly been overlooked provided the data for the arguments in this thesis. In presenting these, the research offers an important and fresh contribution to nursing history and, by examining the relationship between CAM and biomedicine in this context, it will contribute to the understanding of the history of medicine, as well as to nursing and CAM, in the second half of the twentieth century.

¹ Jane Salvage, *Nursing Times*, 29 January 1997.

² *Nursing Times*, October 1995.

Against a background of developments in health and in culture it explains why nurses turned to CAM, what they incorporated in their practice and how they were supported in doing so.

Why does this matter? Over the past fifty years, it is notable that historians have focused on issues of politics, identity and development of the nursing profession,³ but have neglected nursing practice, leaving many ideologies and practices of nursing care unrecorded for the twentieth century. Nursing historians Gerard Fealy and Christine Hallett go so far as to state that the deficiency has triggered a 'skewed perspective' to the history of nursing, claiming that:

this lack has contributed to its [nursing's] crisis of identity....the profession lacked a clear sense of where it stood in a confused and shifting healthcare landscape.⁴

My thesis aims to address the omission by examining NHS nurses' use of CAM between 1960 and 2000. This introductory chapter presents the context of the research, outlines the existing gaps in knowledge and explains the objectives of the work. It will introduce and unpick key background themes, summarise the research design and conclude by explaining the shape of the thesis and outlining the data chapter contents which follow.

³ For example, Brian Abel Smith, *History of the Nursing Profession* (London: Heinemann, 1960); Christopher Maggs, *Nursing History: the state of the art* (Croom Helm, 1987); Anne Marie Rafferty, Jane Robinson and Ruth Elkan, eds, *Nursing History and the Politics of Welfare* (London: Routledge, 1997); Anne Borsay and Billie Hunter, eds, *Nursing and Midwifery in Britain since 1700* (Basingstoke: Macmillan, 2012).

⁴ Gerard Fealy, Christine Hallett and Susanne Dietz, eds, *Histories of nursing practice* (Manchester: Manchester University Press, 2015), introduction.

1.2 The aims of the thesis

The historical approach adopted in this study is used to show why nurses were motivated to implement CAM in their work and how they did so. The social context of nursing work was an important dimension and so the study also draws on some sociological literature and on nursing scholarship, which has been a major factor in understanding the background to the experience of nurses involved in this research. The combination has resulted in a rigorous approach and methodology which will lead to the interpretation of how nurses were supported and organised in their use of complementary therapies. In the conclusion, to complete the story, brief attention will be paid to the position of CAM in nursing post-2000. I explore to what extent there was a limited implementation of CAM in nursing by then and, if that was the case, why it was not sustained.

This work will help to expand the narrative of the history of the practice of nursing and will explore the extent of the CAM movement in the late twentieth century and show that implementation for nurses was not generally haphazard and *ad hoc*,⁵ but was more strategic in the last two decades. It is an element of past nursing practice that should be acknowledged and the benefit of this research is that it will add an important chapter to the account of the twentieth-century history of medicine and healing.

⁵ Sarah Cant, Peter Watts and Annemarie Ruston, 'The rise and fall of complementary medicine in National Health hospitals in England', *Complementary Therapies in Clinical Practice* 18 (2012) 135-139.

1.3 The context, the problems and the gaps in knowledge

In 2004, sociologist Bryan Turner described the undermining of the twentieth-century monopoly of allopathic healthcare by ‘new configurations of power’ and ‘new systems of knowledge, within which CAM will come to play an important part.’

The global revolution in healthcare will [...] compel the scientific community to reconsider and redefine the ends of medicine.⁶

The embryonic stirrings of this revolution in healthcare had been conceived almost half a century before, as I will show; its gestation was steady but vigorous – and complementary therapies in nursing were part of that development.

Discovering that it was a more structured development than I had imagined was unexpected. While there was little official policy regulating the implementation of CAM in nursing during this period (the UKCC Code of Conduct stipulated that nurses as ‘knowledgeable doers’ should rely on their own self-evaluated judgement of capability),⁷ data collected from Royal College of Nursing (RCN) archives and oral history interviews revealed that a measure of structure existed, demonstrated by the networks, unofficial training and (through associations and groups) the self-supporting nature of its practitioners. For example, the Royal College of Nursing (RCN) Complementary Therapies Forum, founded in 1994, was flourishing with a membership of nearly 11,500 members by 2000, establishing and arranging national

⁶ Bryan Turner ‘Introduction’, in Jon Adams and Philip Tovey, eds, *Complementary and Alternative Medicine in Nursing and Midwifery: towards a critical social science* (London: Routledge, 2008).

⁷ *Code of Professional Conduct for the Nurse, Midwife and Health Visitor* (United Kingdom Central Council for Nursing & Midwifery & Health Visiting, 1984).

workshops, producing codes of practice and organising conferences,⁸ all of which demonstrate a coherent supportive structure for nurses practising CAM. The research highlights the diversity of nurses' approaches to CAM and demonstrates the range of views on the terms 'alternative' and 'complementary' therapies, the use of which varied over the 40-year period of the study. The use of the two terms is discussed in Sections 2.3 and 4.2, where the terminological implications of 'alternative' and 'complementary' are unpicked. The expression 'CAM' (complementary and alternative medicine) is generally used throughout the thesis, with other terms employed when appropriate to the context. Whichever term is used for therapies by participants, what clearly emerges from the data is the prevalence of nurses' use of touch therapies.

Themes that are addressed in the thesis include the relevance of medical history and re-emergence of a pluralistic medical culture in a changing cultural *zeitgeist*,⁹ patient wellbeing, and the therapeutic relationship between patient and nurse. The background political context of nursing in the twentieth century, the challenges of technological medical developments, and the importance of the structures and organisations that supported nurses in their use of CAM are all considered in the thesis and in the development of its arguments.

Inevitably, during my research, examination of these issues expanded to include broader ones that emerged from data-gathering – issues such as those surrounding

⁸ Royal College of Nursing (RCN) Archives, Edinburgh, Complementary Therapies Forum papers, 3/38/1.

⁹ *Zeitgeist* is understood as the 'spirit of the age': the defining mood of a particular era comprising the moral, intellectual and general cultural climate of a period.

'caring' and 'healing', and whether a swing to holism (and thence to CAM) during the period was a change in consciousness or a paradigm shift. These complex and sometimes contentious concerns are fundamental to understanding the culture of healthcare in the second half of the twentieth century and specifically nurses' use of CAM. I will briefly unpick them in this introduction in order to set the scene and will address the issues in detail in Chapters Four, Five and Six.

There are unresolved matters, too, that will be addressed in, for example, discussion of the relationship between holism and CAM. These are terms that are often conflated and confused and, in doing so, convey ambiguities and sometimes obscure the issues and complicate the debate about the practice of CAM. The thesis examines the subtle relationship between holism and CAM in nursing practice and explores the complexities of their relationship, concluding that embracing the ideology of one does not necessarily lead to practice of the other. This will be explored in Chapter Six in the context of the organisations that supported holistic nursing and those that promoted nurses' use of complementary therapies, which were not necessarily collaborative activities. In doing so, the thesis attempts to rectify the gaps in knowledge that currently exist.

1.4 Background themes

1.4.1 Definition of CAM

The very definition of CAM is controversial; it is not a single entity and there is no one, universally-approved description of it. Moreover, it has often been classified in

terms of its 'otherness', as doctor and therapist Patrick Pietroni described when talking of the term 'alternative medicine':

If you want to use the scientific, the only rational, definition of the word 'alternative medicine' is 'everything that is not taught in the Western medical school is alternative medicine'. Which is like saying that 'everybody who is not English is foreign' and therefore all foreigners are the same. There was no discrimination between the different things that came under the umbrella of alternative medicine.¹⁰

CAM's distinctiveness from dominant conventional medicine was defined this way by the Cochrane Collaboration. Cochrane, as it is now known, is an international independent network of researchers, who collaborate to produce accessible health information which is independent of sponsorship or other conflicts of interest. This is based on review groups, networks, groups concerned with the methodology of systematic reviews and regional centres with the aim 'that healthcare decisions get better.'¹¹ Its definition of CAM was:

A broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health systems of a particular society or culture in a given historical period.¹²

This reflects the British Medical Association (BMA) description of CAM:

those forms of treatment which are not widely used by the conventional healthcare professions, and the skills of which are not taught as part of the undergraduate curriculum of conventional medical and paramedical healthcare courses.¹³

Even the CAM community has struggled to restrict CAM therapies to a refined list. In a memo between members of the management committee of the

¹⁰ Patrick Pietroni, interviewed 7 July 2015.

¹¹ www.cochrane.org

¹² Catherine Zollman and Andrew Vickers, 'ABC of complementary medicine; complementary medicine in conventional practice', *BMJ*, 319 (1999) 1422.

¹³ British Medical Association, 1999.

RCN Complementary Therapies Forum, the following draft definition was proposed:

Definition of Complementary Therapies

Complementary therapies may be defined as a range of therapies which can be of therapeutic benefit and support in addition to any other treatments and procedures offered to the patient in the orthodox health care setting.

Therapies which fall into this category may include:

1. Interventions carried out by practitioners eg: massage, homeopathy, aromatherapy, reflexology, hypnotherapy, shiatsu, therapeutic touch, relaxation techniques, osteopathy, acupuncture, healing.
2. Therapies learned and used for self help, eg yoga, tai chi, chi gong, meditation, breathing, relaxation and visualisation, self hypnosis.

*These lists of therapies are a general guide and are not designed to be exhaustive.*¹⁴

However, the 2000 House of Lords report on CAM formalised a 'Use of CAM' directory with the following list of the most commonly employed therapies, based on a survey undertaken the previous year (Figure 1). It was used as the basis of their Call for Evidence.¹⁵

Figure 1 Use of CAM in the United Kingdom in 1999

	1999 (%)
Use of any CAM in past 12 months	20
Of which: *	
Herbal medicine	34
Aromatherapy	21
Homeopathy	17
Acupuncture / acupressure	14
Massage	6
Reflexology	6
Osteopathy	4
Chiropractic	3

Source: House of Lords Select Committee of Science and Technology, 21 November 2000

¹⁴ RCN Archives Edinburgh, Memo to Caroline Stevensen from Celia Manson, 15/15/COM.

'I enclose a draft I have sent to Robert Smith, RCN Publicity Officer'.

Complementary Therapies Issues Series Document 17 July 1995.

¹⁵ *The Sixth Report on Complementary and Alternative Medicine*, House of Lords Select Committee of Science and Technology, 21 November 2000.

The first six therapies were those principally used by nurses, but the interviewees involved in this research also referred to other non-conventional modalities. The House of Lords report clarified that the term 'CAM' embraced therapies that may be provided either alongside conventional medicine (complementary) or which may, 'in the view of their practitioners, act as a substitute for it.'¹⁶

1.4.2 Medical context

A brief overview of medical history in the second half of the twentieth century and the emergence of a (limited) pluralistic culture provide the historical framework of this study. Many CAM practices are ancient forms of healing and historically had been undertaken in an unstructured culture where almost anyone could practise medicine in Britain.¹⁷ Herbalists and wise women had competed freely with physicians, surgeons and apothecaries.¹⁸ But when medical regulation was enacted in Britain in 1858 with the Medical Registration Act, biomedicine emerged and increasingly became the dominant practice.¹⁹ Strict regulation of licensing of practitioners defined the profession and those who practised a different form of medicine were perceived as unorthodox, with over 6,000 of these 'unorthodox' practitioners in Britain by mid-century practicing homeopathy, herbalism, phrenology, hypnotism and mesmerism.

¹⁶ *Ibid.*

¹⁷ Roberta Bivins, 'Histories of Heterodoxy', in Mark Jackson, ed., *The Oxford Handbook of the History of Medicine* (Oxford: OUP, 2011), 585; Deborah Brunton, 'The emergence of a modern profession' in Deborah Brunton, ed., *Medicine Transformed: health, disease and society in Europe, 1800-1930* (Manchester: Manchester University Press, 2004), 135.

¹⁸ Roy Porter, *Quacks, Fakers and Charlatans* (Stroud: Tempus, 2000), 187; Stephen Fulder, 'The Basic Concepts of Alternative Medicine and their Impact on our Views of Health', in Lee-Treweek *et al*, eds, *Perspectives on Complementary and Alternative Medicine: A Reader* (Buckingham: Open University, 2003), 3.

¹⁹ Mike Saks, 'The wheel turns? Professionalisation and alternative medicine in Britain', *Journal of Interprofessional Care*, 13 (1999) 129-138.

There is a dearth of studies of alternative medicine after 1858, when it is presumed the medical profession 'dealt' with this issue through the establishment of the medical register. Studies do not focus on the period post-registration and resume with some key sociological studies, not necessarily historical work.

While many believed and argued that the system of regulated medicine was radically wrong,²⁰ regulation introduced a scientifically-based model, founded on research and observation, followed later by technical and drug developments which sidelined natural remedies. As Louis Pasteur (1822-1895) urged,

Take interest in these sacred domains, so expressively called laboratories. Ask that there be more and that they be adorned, for these are the temples of the future, of wealth and well-being.²¹

Medical historian S.E.D. Shortt states that 'Medicine claimed prestige, not through enhanced therapeutic efficacy, but as a result of increasing public faith in the value of science' – of which the physician became the personification.²²

It was another hundred years before a gradual counter-culture movement and a change in consciousness led CAM to a limited revival following a period of marginalisation.²³ The years 1960-1980 saw increasing discussion about, and use of, CAM therapies and practices and by the early 1990s tensions had shifted not just

²⁰ Porter, *Quacks*, 319.

²¹ Quoted in E.M.T. el Mansi, *Fermentation, Microbiology and Biotechnology*, 3rd ed (CRC Press, 2011).

²² S.E.D. Shortt, 'Physicians, Science and Status: issues in the professionalization of Anglo-American medicine in the nineteenth century, *Medical History*, 27 (1983) 51-68.

²³ Geraldine Lee Treweek, *et al*, eds, *Perspectives on Complementary and Alternative Medicine* K221 Course Book (Buckingham: Open University, 2005), xiii.

to tolerance, but to limited collaboration,²⁴ described by complementary medicine academic Edzard Ernst as ‘diversifying the conceptual frameworks of medicine.’²⁵ Other societal changes such as prosperity and the rise of consumerism enabled patients to choose resources in healthcare,²⁶ and the decline of religion has also been seen as a contributory factor in the emergence of therapies by patients, searching for alternative forms of support and a new manner of spirituality.²⁷

1.4.3 Nurses and CAM

Records of the changing relationship between orthodox and unorthodox healthcare practices during this 40-year period reflect the views of the sociologist and medical professional, where medical and patient views have featured, but the voices of nurses have rarely been heard.²⁸ However, the nurse may have unwittingly supplied what is now considered one of the most basic complementary practices in, for example, applying massage as part of an instinctive contribution to patient wellbeing in everyday nursing tasks such as washing, applying creams and moving patients. How the significance of this came to be recognised will be examined. Demographic change during the period of the study – especially with reference to an ageing population – may have been a relevant factor in the increasing perception of the value of physical contact with patients and an influencing factor on the rise of complementary therapies as a way of delivering care. It is notable, however, that this

²⁴ Roy Porter, *The Greatest Benefit to Mankind* (London: Harper Collins, 1999), 688.

²⁵ Edzard Ernst, *et al*, ‘Complementary medicine: a definition’, *British Journal of General Practitioners*, 45 (1995) 506.

²⁶ Sally Hayes and Anne Llewellyn, *The Care Process: Assessment, Planning, Implementation and Evaluation in Health and Social Care* (Lantern Publishing Ltd, 2010).

²⁷ Lee Treweek *et al*, eds, *Perspectives*, 159.

²⁸ Karen Lee Fontaine, *Complementary & Alternative Therapies for Nursing Practice* (Upper Saddle River, N.J: Prentice Hall; London : Pearson Education [distributor], 2011), 201.

issue of demographic change was not mentioned by interviewees as part of the reason for growth of CAM, although they referred to the importance of touch to elderly patients, which is discussed in Section 5.2.1. Indeed, this importance to nurses of touch and its link to a therapeutic relationship is a theme that is central to this thesis in its connection with several complementary therapies and it will be discussed in Chapter Five.

Folk remedies were employed in nursing practice and the early part of this period appears to be one of a natural pluralism in the way that nurses used what are now considered complementary therapies, but were then customary treatment methods, alongside mainstream nursing practices. This will be explored in Chapter Four in informing the background to the timeframe of the study. By the last part of the period, many nurses in the UK were training in CAM and had a significant and empowered involvement in its implementation, representing a reorganisation of how healthcare came to be delivered by 2000.²⁹

I will show that by the 1980s nurses were drawn to alternative models of nursing care. In their 1986 work, nursing academics Alan Pearson and Barbara Vaughan claimed that the biomedical model was devaluing the human element of healthcare and was no longer appropriate. Instead, they claimed, 'alternative approaches are crucial.'³⁰ This is reminiscent of sociologist Nicholas Jewson's classic argument of

²⁹ Vincent di Stefano, *Holism and Complementary Medicine: Origin and Principles* (London: Allen & Unwin, 2006), 136.

³⁰ Alan Pearson and Barbara Vaughan, *Nursing Models for Practice* (Oxford: Butterworth Heinemann, 1986).

the 'disappearing sick man' in the late eighteenth and nineteenth centuries, when hospital medicine reputedly took over from bedside medicine and was itself eventually replaced by laboratory medicine.³¹ By the 1990s, nursing researcher Lisbeth Hockey acknowledged that complementary therapies had a place in the practice of nursing, albeit a controversial one,³² and nurse educator Kevin Kendrick described this, not just as a significant shift, but 'essentially paradigmatic'.³³ What, therefore, had been its attraction for nurses?

Use of complementary therapies challenged orthodox medicine, viewing it as Cartesian, that is, mechanistic and reductionist³⁴ – a model that focuses on illness rather than health, and assumes that the patient plays a relatively passive role in the process of healing.³⁵ The approach had become dominant and in his classic work, *The Social System* (1951)³⁶, the functionalist sociologist Talcott Parsons describes the 'sick role' as a necessary response to illness with 'rights and obligations of the sick man' [*sic*], which include him wanting to be well and being obliged to seek technically competent skills to facilitate recovery.³⁷ An examination of the therapeutic relationship between nurse and patient is central to this research – especially the change in attitude to physical contact over the 40-year period, which encourages an

³¹ Nicholas Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870', *Sociology*, 10 (1976) 225-44.

³² Richard McMahon and Alan Pearson, eds, *Nursing as Therapy* (Cheltenham: Nelson Thomas, 1991), introduction.

³³ Kevin Kendrick, 'Challenging power, autonomy and politics in complementary therapies: a contentious view', *Complementary Therapies in Nursing and Midwifery*, 5 (1999) 81.

³⁴ The French philosopher Rene Descartes (1596-1650) proposed that the mind and body are distinct phenomena.

³⁵ Annie Mitchell and Maggie Cormack, 'What is distinctive about complementary medicine?' in Lee-Treweek *et al*, eds, *Perspectives*.

³⁶ Talcott Parsons, *The Social System* (London: Routledge and Keegan Paul, 1951).

³⁷ Simon Williams, 'Parsons revisited: from the sick role to ...', *Health* 9 (2005) 124.

equal negotiating style and holistic approach,³⁸ and this is addressed in Chapter Five. It helps to explain the appeal to nurses of CAM, with its whole-body approach to caring in the provision of wellbeing and involving a process of self-healing in a relationship between patient and healer.³⁹ Interviews that I conducted with retired nurses reveal that touch and massage of patients were perceived as important elements of care and wellbeing, but that opportunities became scarcer as ‘hands off’ technical tasks increased on the hospital ward. ‘More time, more touch’ is what many nurses were seeking in order to improve the wellbeing of their patients. For a significant proportion of nurses, practising complementary therapies, I will argue, provided this opportunity.

1.4.4 Caring and wellbeing

Nurse educators John Costello and Monica Haggart claim that, in an effort to define nursing, the most common single description used is ‘caring’ – a term often revived, they say, during periods when nursing was perceived as losing ‘this essential art.’⁴⁰ It was indeed a topical and particularly emotive subject during the three years of my research, due to publication of the report of the 2013 Mid-Staffordshire NHS Trust Public Enquiry, following allegations against nurses and claims of failures in the quality of care of patients.⁴¹ Caring has developed into a high-profile subject, yet has been under-examined in an historical context, simply because it was taken for granted. For example, in guidance given to members of the RCN Complementary

³⁸ Chris Brooker and Anne Waugh, *Foundations of Nursing Practice: Fundamentals of Holistic Care*, (Edinburgh: Elsevier, 2007), 203.

³⁹ Lee-Treweek *et al*, *Perspectives*, 220.

⁴⁰ John Costello and Monica Haggart, ‘The Nature of Nursing: can we teach students how to care?’. *CARE*, 2 (2008) 41-55; www.healthquest.org/care/show.php?contentid=69. Accessed 23 May 2015.

⁴¹ Robert Francis, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (London: The Stationery Office, 2013).

Therapies Forum in 1993, it was claimed that caring in nursing was being researched at that stage for the first time because, before that, 'it has been assumed.'⁴²

Similarly, recognition of the value of wellbeing was a new concept in the mid-twentieth-century. The World Health Organization (WHO) defined health in its broader sense in 1946 as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.'⁴³ Here was one of the first authoritative attempts to define health as a multidimensional concept. The theme of wellbeing is significant in my research in the context of promoting a positive view of health and, furthermore, intimating that a holistic dimension should be incorporated.⁴⁴

The caring element – a humanistic, altruistic value system – is now seen as central to nursing and to the achievement of wellbeing,⁴⁵ but in evaluating the question of the nature of care, I attempted to examine earlier twentieth-century attitudes in nursing, although sources are sparse. Jacinta Kelly studied the nurse registers of Addenbrookes Hospital from 1942 to 1945 to determine what constituted a 'good

⁴² Royal College of Nursing (RCN) Archives, Edinburgh, Complementary Therapy Forum papers, 3/38/1.

⁴³ World Health Organization. 1946. [[www.who.int/bulletin/archives/80\(12\)981.pdf](http://www.who.int/bulletin/archives/80(12)981.pdf) *WHO definition of Health*. Accessed 24 January 2013], Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2,100) and entered into force on 7 April 1948.

World Health Organization. 2006. *Constitution of the World Health Organization - Basic Documents*, Forty-fifth edition, Supplement, October 2006. The WHO amended their definition in 1986 and this remains currently: 'Health is the extent to which an individual or group is able to realize aspirations to satisfy needs and to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and physical resources as well as physical capacities.'

⁴⁴ Chris Brooker and Anne Waugh, *Foundations of Nursing Practice: Fundamentals of Holistic Care*, 5.

⁴⁵ Charlotte Searle, *Ethos of Nursing and Midwifery* (Durban: Butterworths, 1987), 158 and 161.

nurse'.⁴⁶ Of the listed qualities of 'personal skills' (six), the qualities of 'functional skills' (five), and the qualities of 'practical skills' (seven), only one heading recorded in the hospital reports had any connection with holism or the relationship between nurse and patient – and that was the required quality of 'kindness to patients'.

Awareness of this quality is demonstrated in Jane Brooks' study of nurses in the World War II desert war (1940-1941), which illustrates that a caring approach and 'use of self' succeeded in creating a therapeutic relationship with the combatant patients, as evidenced by archived letters, diaries and memoirs.⁴⁷

Work by nursing scholars on 'caring' in the USA in the 1950s-1970s period demonstrates how awareness became heightened to this quality, although it was not widely incorporated into mainstream nursing and had limited influence on nursing in Britain.⁴⁸ For example, works include those of nursing theorist Hildegard Peplau's studies in the 1950s on the nurse-patient relationship,⁴⁹ psychologist Carl Rogers' research on the quality of the relationship between 'client and therapist' as a factor in clinical effectiveness,⁵⁰ and American nursing academic Jean Watson's seminal work on the development of caring culminating in *The Theory of Human Caring* (1979), in which she explores Nightingale's legacy of natural healing and caring.⁵¹

⁴⁶ Jacinta Kelly, 'What makes a good nurse "very good?"', *Bulletin of UK Association for History of Nursing*, 1 (2013).

⁴⁷ Jane Brooks, 'Nurses as therapeutic agents in the extreme environment of the desert war, 1940-1941', *Journal of Advanced Nursing* 71 (2015) 2520-2528.

⁴⁸ Hildegard Peplau, 'Professional closeness', *Nursing Forum*, 1969, viii, 343-60.

Baker (1998) cited in Stephen Tilley, ed., *Psychiatric and Mental Health Nursing: the field of knowledge* (Oxford: Blackwells, 1998), 61.

⁴⁹ Hildegard Peplau, *Interpersonal Relations in Nursing: a conceptual frame of reference for psychodynamic nursing* (New York: Putman, 1952).

⁵⁰ Carl Rogers, 'The Interpersonal Relationship: the core of guidance' in *Harvard Educational Review*, 32 (1962) 416-29.

⁵¹ Jean Watson, *Nursing: The Philosophy and Science of Caring* (Little Brown & Co., 1979);

American nursing academic Virginia Henderson, writing on the function of nursing, summarised it in stating: 'What most people seek in the nurse is that of a comforting presence. If there is a universal concept of nursing it embodies the characteristics of a service that is intimate, constant and comforting.'⁵²

However, one of my key informants, nurse and CAM therapist Annie Hallett, when interviewed, questioned the possible limitations of the understanding of caring by young British nurses in the 1970s:

I don't think my generation of nurses particularly understood it in the way that we do now. That is mostly to do with the way we were trained and the whole concept of having a psychological aspect to caring. Although it is age-old, from an educational and academic point of view, it is not part of the medical model. That isn't to say there were not a lot of nurses of my generation who were spontaneously very human and no doubt gave a lot in a very human way to patients. But it wasn't the culture.⁵³

It was not until the 1980s that British theoretical studies were undertaken on the subject of caring, with psychoanalyst Isobel Menzies Lyth's work which addressed the subject. Nurse educators Oliver Slevin and Carol Kirby reinforced this, summarising the 'nursing relationship as being essentially therapeutic'.⁵⁴ Alan Pearson was instrumental in encapsulating 'nursing as caring' concepts⁵⁵ following Celia Davis' work, defining caring in simple terms as 'attending, physically, mentally

P.J. Barker, W. Reynolds and T. Ward, 'The proper focus on nursing: a critique of the 'caring ideology'', *International Journal of Nursing Studies*, 32 (1995) 386-397.

⁵² Virginia Henderson, 'The Concept of Nursing: *Journal of Advanced Nursing*, 3 (1978) 113-130, reprinted *Journal of Advanced Nursing* 53 (2006) 21-34.

⁵³ Annie Hallett, interviewed 18 May 2015.

⁵⁴ Carol Kirby and Oliver Slevin, 'A new curriculum for care' in O. Slevin and I. Buckenham, *Project 2000: The Teachers Speak – Innovations in the Nursing Curriculum* (Campion, 1992) 76.

⁵⁵ Alan Pearson, 'Nursing as Caring' in Richard McMahon and Alan Pearson, eds, *Nursing as Therapy*, (Cheltenham: Nelson Thomas, 1991).

and emotionally to the needs of another.⁵⁶ However, it was the Australian sociologist, Margaret Dunlop, in her research on the science of caring in 1986, who drew attention to a change in the word's definition and to a more modern affiliation with the virtue of empathy (and its aliases).⁵⁷ This important quality and its essence in therapeutic nursing and its relationship to the practice of CAM will be explored in Chapter Five.

I have emphasised the history of the concept of caring here, because the study of the nurse's role in enhancing patient wellbeing – and how this related to incorporating CAM – emerged as a dominant theme during my research. Many nurses now talk unconsciously about the caring skills that lie at the heart of wellbeing and nursing,⁵⁸ yet this 'most important and most elusive topic'⁵⁹ has been under-examined within the history of medicine.⁶⁰ Crucially, I will argue that it can underpin a holistic approach and how it relates to the practice of complementary therapies will be discussed.

Although a concept of wellbeing took several decades to be incorporated into health provision,⁶¹ the process of caring had been one of Florence Nightingale's basic tenets, as I came to understand. Any study in the history of nursing is likely to include reference to Florence Nightingale, and most do. I admit, I did not set out to

⁵⁶ Celia Davies, 'Competence versus Care? Gender and Caring World Revisited', *Acta Sociological*, 38 (1995) 17-18.

⁵⁷ Margaret Dunlop, 'Is a science of caring possible?', *Journal of Advanced Nursing*, 11 (1986) 661-670.

⁵⁸ Brian Mendyka, 'Exploring Culture in Nursing – a theory driven practice', *Holistic Nursing Practice*, 15 (2000), 32-41.

⁵⁹ Barbara Mortimer and Susan McGann, eds, *New Directions in the History of Nursing* (London: Routledge, 2004), Introduction.

⁶⁰ Christopher Maggs, 'A history of nursing, a history of caring', *Journal of Advanced Nursing*, 23 (1996) 630-5.

⁶¹ Highlighted by my choice of start date of 1960 – See Section 1.5.2.

do so, but the reference occurred largely because my participants and the archived material directed it that way.

1.4.5 Florence Nightingale (1820-1910)

During this research, a sentimentalised historical view was often evoked by interviewees, who cited Florence Nightingale and/or referred to a 'golden age' of nursing and then linked this traditional essence of nursing to CAM practice.

Sociologists Jon Adams and Philip Tovey are critical of the practice, claiming that this common type of referencing leads to an 'assumption of appropriateness of alignment' between nurses and their use of complementary therapies.⁶² They claim that such historical referencing has an impact on CAM's implementation in nursing; this is demonstrated by examination of contributions to journals,⁶³ the authors of which strategically employ nursing history or nostalgic (and nostophobic) references in order to validate and authenticate the relationship between nursing and 'new found practices' (i.e. CAM). This then provides legitimacy to the case for ongoing incorporation.⁶⁴ These arguments are relevant to discussions in Chapter Five, which examines the themes of the 'restoration' of holistic nursing practices. Nursing scholar Jean Watson claims that Nightingale laid the foundation of 'a caring ethic as

⁶² Philip Tovey and Jon Adams, 'Nostalgic and nostophobic referencing and the authentication of nurses' use of complementary therapies', *Social Science & Medicine*, 56 (2003)1470.

⁶³ *Nursing Times, Nursing Standard, Complementary Therapies in Nursing & Midwifery, Journal of Advanced Nursing*.

⁶⁴ Jon Adams and Philip Tovey, 'The authentication of CAM in nursing' in P. Tovey, G. Easthope and J. Adams (eds) *Complementary and Alternative Medicine in Nursing and Midwifery: towards a critical social science* (London: Routledge, 2008); Philip Tovey and Jon Adams, 'Nostalgic and nostophobic referencing and the authentication of nurses' use of complementary therapies', *Soc.Sci & Med.* 56 (2003) 1469-1480.

context for all health care; reintegration of the moral, the spiritual, the metaphysical',⁶⁵ and medical historian Charles Rosenberg concurs: 'Since the era of Florence Nightingale, holistic ideas of health, healing, and disease have been central to nursing self-conceptions. Physicians cure, nurses care.'⁶⁶ But whether this relates to a particular ideological *approach* in nursing, or to practical *interventions* has continued to be a controversial topic.⁶⁷

Nursing academic Kathleen Light argues that Florence Nightingale's attitude to health and healing related more to the philosophy of homeopathy⁶⁸ than to the mechanistic philosophy of allopathy, claiming 'nurses should be taught to think homeopathically – which would be more in keeping with Nightingale's beliefs.'

Furthermore, based on Nightingale's example, 'nurses should be out in the front, leading the move to complementary care.'⁶⁹ I challenge this in Section 2.4.

Nightingale's model was that of a holistic approach, not (necessarily) one that uses non-orthodox therapies. People have read her work and interpreted it in this light, reflecting more of her holistic nursing model than an interventionist, clinical one.

Nurse educator Annette Turton simply referred to her as 'holistic',⁷⁰ and nursing

⁶⁵ Jean Watson, 'Florence Nightingale and the Enduring Legacy of Transpersonal Human Caring-Healing', *Journal of Holistic Nursing*, 28 (2010) 107-108.

⁶⁶ Charles Rosenberg, 'Holism in Twentieth-century Medicine', in Christopher Lawrence *et al* (eds) *Medical Holism: the context* (Oxford: OUP, 1998), 344.

⁶⁷ M. Lerner, 'Healing and curing: the starting point for informed choice' in *Choices in Healing* (Cambridge, MA: MIT Press, 1994).

⁶⁸ Homeopathy is a system of medicine based on the Law of Similars (let like be cured by like). Medicines are produced from natural sources which are diluted many times in a water and alcohol base and the system relies on a careful and meticulous case-taking process. Anne Scott, 'Homeopathy as a Feminist Form of Medicine', *Sociology of Health and Illness*, 20 (1998) 191-214; Nicola Gale, 'From body-talk to body-stories: body work in complementary and alternative medicine', *Journal of Health and Illness*, 33 (2011) 237-251.

⁶⁹ Kathleen Light, 'Florence Nightingale and Holistic Philosophy', *Journal of Holistic Nursing*, 15, (1997).

⁷⁰ Annette Turton, interviewed 10 April 2014.

academic Stephen Wright acknowledged Nightingale's theory of healing: 'It is as old as the hills, as Florence Nightingale said, it's "putting the patient in the best position for nature to act."'⁷¹ Nurse Hermione Elliott, when discussing the early days of the Holistic Nurses Association, also noted that the model of holistic nursing was demonstrated first by Florence Nightingale:

I know a lot of people who were involved felt that there was something about... we were just tapping in somewhat to the essence of nursing actually. If you read some of Florence Nightingale, some of her early statements about what she felt nursing was were so apt, I think, for us.⁷²

This is illustrated in Nightingale's recommendation to:

Always sit down when a sick person is talking business to you, show no signs of hurry, give complete attention and full consideration if your advice is wanted.⁷³

I argue that Nightingale's example was one of a demonstration of empathy. Eeva Sointu's work on the centrality of 'recognition' for patient experience of CAM practice is relevant to this⁷⁴ and the issue will be discussed fully in Chapter Six in connection with how the theory of holism and the practice of CAM are linked but should not be assumed. Nightingale summarised her ideology in the conclusion to her work, *Notes on Nursing* (1859):

It is often thought that medicine is the curative process. It is no such thing; medicine is the surgery of functions, as surgery proper is that of limbs and organs. Neither can do anything but remove obstructions; neither can cure; nature alone cures. ... And what nursing has to do in either case, is to put the patient in the best condition for nature to act upon him [*sic*].⁷⁵

⁷¹ Stephen Wright, interviewed 16 January 2014.

⁷² Hermione Elliott, interviewed 12 November 2014.

⁷³ Florence Nightingale, *Notes on Nursing: what it is and what it is not* (1859), Chapter 4.

⁷⁴ Eeva Sointu, 'Recognition and the creation of wellbeing', *Sociology*, 340 (2006) 493-510.

⁷⁵ Nightingale, *Notes*, Conclusion.

Here, the important argument is that these references clearly refer to holism, not to interventions, nor to therapies. I will demonstrate later in the thesis how, for some nurses, holistic ideologies led to CAM practice – but not for all.

1.5 The research design: questions and timeframe

1.5.1 Research questions

My three main research questions are:

- (1) what was the attitude of nurses to CAM during this period?
- (2) why did some nurses use CAM in their work? and
- (3) how were they organised and supported?

The study was carried out, using primarily qualitative methods and analysis, by examining nursing journals (1960-2000), exploring archives and, appropriately for a modern history research project, using the contemporary method of undertaking 41 oral history interviews. A full explanation of the methodological approach follows in Chapter Three.

1.5.2 Timeframe (1960-2000)

I had originally planned to start the research by commencing in the inaugural year of the National Health Service (NHS), 1948. However, this transpired to be unrealistic, and it was more appropriate to delay the start point until the new model of national healthcare was embedded. The initiation of the NHS had led to increased patient turnover, an upsurge of patients with acute illness, and greater variation in the

workload on hospital wards.⁷⁶ Of these early days of the new NHS model, nursing academic Geertje Boschma writes that by the 1950s and 1960s, nursing leaders were beginning to recognise that psycho-social aspects of care were required,⁷⁷ and I have pinpointed this to two particular events in 1960, providing the rationale for the starting date of my research. The first is the publication of psychoanalyst Isabel Menzies Lyth's sociological examination of organisations and her exploration as to why, within large organisations, nurses had apparently stopped caring.⁷⁸ One of the claims in this classic paper is that 'the organisation' prevented nurses' involvement with patients by discouraging emotion or interest in them, and by breaking-down of routine nursing work into mundane tasks, rather than encouraging the close personal care of individual patients. This issue was often mentioned in interviews with my participants who recalled, as an example of poor caring attitudes, the tendency of nurses to refer to patients as 'the ulcer in bed 3'⁷⁹, or 'the hysterectomy in the cubicle.'⁸⁰ As sociologist David Armstrong claims, 'The patient was a biological object whose body was observed: the nurse was part of the machinery of surveillance which described and thereby objectified the body it monitored.'⁸¹

The second event in 1960 is the emergence of evidence that this flaw in patient care was recognised by the profession itself – which appeared to awaken at this time to

⁷⁶ Isabel E.P. Menzies, 'A Case-Study in the Functioning of Social Systems as a Defence Against Anxiety: A Report on a Study of the Nursing Service of a General Hospital', *Human Relations*, 13 (1960) 95-121. (She became Isabel Menzies Lyth in 1975).

⁷⁷ Geertje Boschma, 'Holism as a gendered ideology in nursing' in Anne-Marie Rafferty *et al* eds, *Nursing History*, 172.

⁷⁸ Isabel E. P. Menzies, 'A Case-Study in the Functioning of Social Systems as a Defence Against Anxiety: A Report on a Study of the Nursing Service of a General Hospital', *Human Relations*, 13 (1960) 95-121.

⁷⁹ Annette Turton, interviewed 10 April 2014.

⁸⁰ Hermione Elliott, interviewed 12 November 2014.

⁸¹ David Armstrong, 'The fabrication of nurse-patient relationships', *Social Science and Medicine*, 17 (1983) 458.

the value of education about the nurse-patient relationship and the necessity to implement relevant training. On 7 September 1960, a confidential memo was issued to members of the General Nursing Council (GNC) Education and Examination Committee, the body that controlled nurse training. It was concerned with changes in the preliminary and final examinations:

Miss Houghton reminded the Committee that the Board of Examiners for the Preliminary Examination had asked that they might be allowed to set questions which included applied psychology and the nurse/patient relationship and that it had been agreed that this should be considered when any changes were made in the examinations.⁸²

Archived GNC papers reveal that discussions had begun two years previously about possible changes to the preliminary examination, especially Part II, recommending that questions be included on those parts of the section of the syllabus relating to human behaviour and illness which deal with the 'effects of hospitalisation on the patient' and the 'nurse/patient relationship'.⁸³ This was a sea change in nursing practice, but a final decision to implement the change to the syllabus was not taken until 1960.

It is significant that these two events occurred in the same year. My research will show that an awareness of the importance of the nurse-patient relationship and the nature of the therapeutic effect of nursing increased from around this period, demonstrated, for example, by interest in doctor and psychotherapist Michael Balint's

⁸² National Archives of the United Kingdom, Kew, London (hereafter TNA), General Nursing Council for England and Wales, Preliminary Examination Guides to Syllabuses, 1960, DT38/155.

⁸³ TNA, DT38/155.

work on the potential value of the consultation experience itself and the doctor-patient relationship.⁸⁴

Insight about further significant changes in society's mood at this point lies in a comment made by historian Thomas Dixon about Christian apologist and scholar C.S. Lewis' book, *A Grief Observed*.⁸⁵ In examining the history of emotion, Dixon identified the year when Lewis' book was written (1960, although not published until the following year) as representing 'the passing of an age of emotional restraint and the birth of one of psychological introspection and therapeutic self-involvement.'⁸⁶ This comment sits well with my argument that 1960 is a particularly relevant year to commence the study. The research shows how sensitivities to caring and the essence of the practitioner-patient relationship developed over the following 40 years and how they had an influence on CAM practice in nursing. Finally, in 1960, the expression 'fringe medicine' was coined by writer and broadcaster Brian Inglis, and medical writer Geoffrey Murray, for what is now known as complementary and alternative medicine.⁸⁷ This was the first collective term for non-conventional medicine and followed a general reference to 'quackery', with its dismissive and negative connotations. The fact that the birth of this new group term coincided with key moments of change in nursing is not insignificant from the point of view of a start date for this research.

⁸⁴ Michael Balint, *The Doctor, the Patient and the Illness* (London: Pitman Medical, 1957, 1964).

⁸⁵ C.S. Lewis, *A Grief Observed* (London: Faber & Faber, 1961). *A Grief Observed* describes reflections on bereavement following the death of Lewis' wife in 1960.

⁸⁶ Thomas Dixon, *Weeping Britannia: portrait of a nation in tears* (Oxford: OUP, 2015), 252.

⁸⁷ Brian Inglis, *Fringe Medicine* (London: Faber & Faber, 1964), 271. This refers to Murray and Inglis, 'Fringe Medicine', *The Spectator*, 28 October 1960.

In terms of an end date, I claim that the apogee of CAM in nursing was in 2000. In this year, the House of Lords Select Committee of Science and Technology delivered its report on complementary and alternative medicine, in which nurses had been involved by providing evidence.⁸⁸ The report strongly urged the nurses' regulating body, the United Kingdom Central Council for Nursing (UKCC) and professional organisation, Royal College of Nursing (RCN), to collaborate in incorporating complementary and alternative therapies into the pre-registration nursing and midwifery curriculum. It also suggested provision of more specific guidance on appropriate education and training for integrating complementary therapies into nursing clinical care. This was a milestone indeed and an appropriate end to a 40-year period of increased activity in the development and practice of CAM in nursing and, therefore, the period of my research.

1.6 Thesis limitations and delimitations

Inevitably during the research, themes emerged that would have provided interesting avenues of investigation, but which need to be studies in themselves. Significant amounts of the data that were collected during this project have not been included in this thesis. This is both for reasons of low relevance to the research questions and for practical reasons of the needs to limit the scope and length of the final thesis. These data have been carefully archived so as to provide material and resources for future studies in this or related fields. Two delimitations were imposed by me – the first was the effect of British regionality on interest in and use of CAM by nurses.

⁸⁸ *The Sixth Report on Complementary and Alternative Medicine*, House of Lords Select Committee of Science and Technology, 21 November 2000.

Regional studies have proliferated in the field of medical history, such as John Pickstone's *Medicine and Industrial Society* (1985),⁸⁹ Jonathan Reinarz's *Medicine and Society in the Midlands 1750-1950*, (2007),⁹⁰ Anne Borsay's *Medicine in Wales 1800-2000*⁹¹ (2003) and Steve King's 'Nursing Under the Old Poor Law in Midland and Eastern England 1780-1834' (2014).⁹² I initially considered whether I should examine the possibility of a north-south divide, in terms of interest and involvement in CAM. The nurses in my research had trained and worked throughout the UK, although, by chance, the majority had trained in London hospitals. However, because I was not conducting a quantitative survey, and I was not seeking data based on regional factors, it was not a relevant aspect in my analysis, although it may be of value as a separate study.

The second theme was the possible influence from the USA on the issues I was examining. I had anticipated that the history of nursing practice in Britain could have been shaped by nursing in the USA. There are, indeed, some areas that were affected, such as the nursing process and nursing models, which are discussed in Chapter Four. However, the practice of CAM in nursing was not apparently especially affected by North American activity (with the exception of Therapeutic Touch, an energy healing modality, which originated in the US and was incorporated

⁸⁹ John Pickstone, *Medicine and Industrial Society: a history of hospital development in Manchester and its region, 1752-1946* (Manchester: Manchester University Press, 1985).

⁹⁰ Jonathan Reinarz, ed., *Medicine and Society in the Midlands 1750-1950* (Midland History Occasional Publications, 2007).

⁹¹ Anne Borsay, *Medicine in Wales, 1800-2000* (University of Wales, 2003).

⁹² Steven King, *Poverty and Welfare in England, 1700-1850: a regional perspective* (Manchester: Manchester University Press, 2000); S. King, 'Nursing Under the Old Poor Law in Midland and Eastern England 1780-1834', *Journal of the History of Medicine and Allied Sciences*, 69 (2014)1-35.

by some British nurses). In fact, nurse academic and CAM practitioner Caroline Hoffman⁹³ makes the point that:

In many ways, I don't think the States were leading the field. We were often teaching them, I feel.

She went on to highlight that several complementary therapies were developed in Europe:

In terms of aromatherapy, for example, and reflexology - that work was really coming out of ...this country and Europe. There were people like Hanne Marquardt, the German reflexology person, she was one of the key people who brought reflexology here. And of course aromatherapy came out of the French beauty movement.⁹⁴

Another study would benefit from a country-to-country comparison, with reference to legislative context but, again, this was not possible within the confines of this research. Sociologist Mike Saks in his recent work on international medicine has demonstrated how valuable this comparative approach can be.⁹⁵ Additionally, the impact of the nursing profession developing from an Anglo-centric to a more cosmopolitan body, with nurses joining from overseas, could be examined for the resulting possible impact on cultural attitudes to CAM. Regrettably, there was not the capacity to include it here.

During the period of the research, specialist hospitals such as the Royal London Homeopathic Hospital (established 1849, and renamed The Royal London Hospital for Integrated Medicine in 2010) and the Glasgow Homeopathic Hospital (which began as a dispensary in 1880), as well as the Bristol Cancer Help Centre (opened in

⁹³ *née* Stevensen.

⁹⁴ Caroline Hoffman (*née* Stevensen), interviewed 10 June 2015.

⁹⁵ Mike Saks, *The Professions, State and the Market: medicine in Britain, the United States and Russia* (London: Routledge, 2015).

1983) were offering alternative treatment models. Clearly, the nurses working there were using their CAM experience primarily, rather than as a secondary model. I chose not to include data from these establishments, although it would be an interesting investigation to undertake a comparative study with nurses in mainstream healthcare. I also confined the research to general nursing, rather than to nurses working in specific areas such as palliative care, where the incidence of CAM use was likely to be higher.⁹⁶ The history of the use of CAM by midwives could be another separate area for research, but has been excluded from this study.

1.7 The shape of the thesis

The following chapter reviews the published literature in the field and encompasses both nursing history and the history of CAM, with relevant history of medicine work. Chapter Three describes my methodology and how the study bases its findings on an analysis of oral history recordings, journals and documentary sources and archived records. I outline the scope of my research, and discuss the practical issues of my methodological approach. I also include discussion of a challenging phenomenon that I encountered during the interviews – that of the possible effect of nostalgic emotion on the quality of data recovered.

Three data chapters follow. I originally chose a crude structure of ‘why’, ‘what’ and ‘how’ for their foci. This helped me to concentrate on the basic qualitative research questions in examining all aspects of nurses’ use of CAM and, to some extent, in arranging the data. Organising these chapters, however, was not as straightforward

⁹⁶ Nathan Cherny *et al*, *Oxford Textbook of Palliative Medicine* (Oxford: OUP, 2015).

as these terms might suggest. Themes such as the relationship of CAM with holism were intricately interwoven in discussions about the why, the what *and* the how. (It is therefore referred to in the two first data chapters but only thoroughly discussed in the third, because it was particularly addressed by the groups and networks that are examined there). I have maintained the three basic questions of my original framework, but the chapters are more nuanced under the titles of Environment and Awakening (Chapter Four), Incorporation (Chapter Five) and Endorsement and Authentication (Chapter Six).

The first data chapter provides the context for the research in exploring the historical, cultural and nursing environment of the second half of the twentieth century. In the early post-war years, expectations of NHS provision were high. This, however, was followed by a wave of emerging dissatisfaction, compounded by doubt and distrust. Nurses were increasingly pressured by new management structures and processes, patient stays in hospital became shorter, technological developments increased and some nurses expressed frustration and disillusionment, which will be discussed. The data confirm that there was a shift in consciousness from a medical model to a holistic one – the recapturing of a mind, body, spirit approach and a rebellion against the repair-shop, high-tech mechanistic view of the body.⁹⁷ I argue that this, for some nurses who had been exposed to the potential of CAM, awoke in them the possibilities of how it could enhance their work and that all these factors combined as push-pull elements in the rationale for some nurses turning to CAM practice.

⁹⁷ Margaret Stacey, *The Sociology of Health and Healing* (London: Routledge, 1988), 167.

All of this follows examination of the history of the language of CAM and its relationship with the exercise of power in Western biomedicine.⁹⁸

Having set the scene in examining the reasons why some nurses used CAM, implementation is addressed in Chapter Five. The chapter examines how in mid-century, an awareness increased of the importance of the nurse-patient relationship and the nature of the therapeutic effect of nursing. I argue that this was formally recognised by nurse-educators only in 1960 and that, by the 1980s, putting the patient at the centre of care (as opposed to nursing-centred activity) was a recognised ideal. Enhanced empathy and its 'spiritual' elements developed from this and the importance of giving time, talk and touch to the patient, I argue, became increasingly acknowledged as central aspects to the therapeutic power of the nursing relationship with a patient, where 'being with' and 'doing to' have to coexist, with curing as the 'doing to' patients and healing as achieved by 'being with' them.⁹⁹

With the increasing use of technology in medical and nursing care during the twentieth century, physical touch of a patient – other than the 'necessary touch' of procedural activities – was declining.¹⁰⁰ Add to this the legalistic concerns following the introduction of the Code of Practice issued by the UKCC in 1983, and sensitivities to a transcultural perspective, and the importance of the issues surrounding physical

⁹⁸ Nicola Gale, 'The sociology of complementary, alternative medicine', *Sociology Compass*, 8 (2014) 805-822.

⁹⁹ M. Lerner, 'Healing and curing: the starting point for informed choice' in Lerner, *Choices in Healing* (Cambridge, MA: MIT Press, 1994).

¹⁰⁰ Jean Barclay, *In Good Hands: The History of the Chartered Society of Physiotherapy 1884-1994* (Oxford: Butterworth Heinemann, 1994); Sally Sims 'The significance of touch in palliative care', *Palliative Medicine*, 2 (1988) 58-61; Sandra Weiss 'The Language of Touch', *Nursing Research*, 28 (1979) 76-80.

contact are shown to be central to this research. The understanding of the importance of touch opened awareness to the potential of touch therapies, and I argue that some nurses were drawn to the use of massage for patients for reassurance and pain relief and for some, this developed into the particular use of aromatherapy and reflexology and then interest in other modalities.

Having established why nurses turned to CAM and which modalities were implemented in practice, in Chapter Six I examine the structures and networks that supported nurses' use of CAM. My research demonstrates that a momentum that originated from members of the nursing profession stimulated them to initiate and organise support systems. Networks, organisations, groups, conferences and journals were set up to reinforce their practice. While there was some overlapping of activities and duplication of effort, these groups were instrumental in the organisation of the practice of CAM in nursing. However, in terms of training, a less effective picture is presented; education in CAM for nurses was unsystematic and was bluntly criticised by the House of Lords in its 2000 Review.¹⁰¹ Regulation is another issue discussed in this chapter, which caused concern for some by the nature of its self-management (as endorsed by the UKCC Code of Conduct)¹⁰², rather than a system involving more formal oversight. However, I argue that, by 2000, there were strategies in place, poised to increase CAM use in the next century. Why this was prematurely optimistic, however, concludes the thesis.

¹⁰¹ *The Sixth Report on Complementary and Alternative Medicine*, House of Lords Select Committee of Science and Technology, 21 November 2000.

¹⁰² Code of Professional Conduct for the Nurse, Midwife and Health Visitor (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1983, 1992, 1994).

The 'explosion of interest' in CAM by nurses that gathered pace in the 1980s and 1990s and how (and why) this interest evolved into practice forms the frame of the thesis. This adds to the knowledge of nursing practice that is acknowledged as missing from recent nursing histories.¹⁰³ Moreover, the glowing of 'a new spirit' referred to in the *Nursing Times* editorial of 1997¹⁰⁴ suggests that the innovative force of CAM had a potential transformative influence on practice. CAM was part of a greater movement that was challenging the dominance of biomedicine in the late twentieth century, and this record of its practice by nurses contributes a fresh perspective to the contemporary history of medicine.

¹⁰³ Fealy, Hallett, and Dietz, eds, *Histories of nursing practice*, Introduction.

¹⁰⁴ Jane Salvage, *Nursing Times*, 29 January 1997.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This review aims to provide a critical appraisal of the literature in locating the issues and themes of the thesis in the context of published work on three key areas: the history of nursing, the position of CAM in the second half of the twentieth century, and its practice by nurses in line with the research questions. The data chapters that follow will focus on the questions themselves of why nurses turned to CAM, how they implemented it and the policies and support mechanisms that enabled it. This review of the literature has been approached from several historiographical perspectives. The parameters of the review include works within the timeframe (1960-2000), together with later publications, which offer an interpretation with the benefit of hindsight and recent research.

The subject of the history of CAM and its relationship with nursing has generally been under-researched. Indeed, there is a gap in the broader history where the history of nursing practice should be and to which I hope this thesis will contribute. This study must first engage with the complex story of nursing in the twentieth century in order to provide the historical context and I start the chapter with examination of this area of work. During the time of the study, changing nursing models and processes, together with technological and professional challenges all had a potential bearing on the attitudes of nurses to their work. Additionally, the concept of patient-centred care which entered nursing practice during the period is fundamental to my arguments

and how it is managed in the literature is reviewed here in order to understand the background of this particular theme. Other contexts will also provide perspectives on the topic – and issues such as the language of CAM, with its definitions and semantics and the significance of how they are used, the dynamics of the therapeutic relationship and the *zeitgeist* of self help and alternativism in the closing decades of the twentieth century will all have their place. What does the existing literature tell us about the topic and, in summarising and evaluating the viewpoints, how does it best provide a framework in which to place it?

2.2 History of Nursing

The rationale for starting with a study of the history of nursing lies in the argument that nursing's view of its own history changed during the period of this study, in the late twentieth century. The writing of history of any area of health policy or practice is undoubtedly affected by a sense of identity, position and the discourses of the day,¹ and in echoing how nursing itself developed, the literature on nursing history provides an appropriate starting place for providing context. Until the 1980s, nursing histories had generally been of a progressive Whiggish nature, where a focus on the politics and advancement of the nursing profession had overshadowed that of nursing practice. This was expressed in the language of progress and achievement and Jane Salvage describes the way in which this had been conveyed as 'a pageant of great and saintly ladies' who represented 'an idealised picture of past pioneers'.²

¹ Celia Davies, 'Rewriting Nursing History – Again?', *Nursing History Review* (2007) 15.

² Jane Salvage, *The Politics of Nursing* (London: Heinemann Medical Books, 1985), 32.

Salvage's seminal work, *The Politics of Nursing* (1995) was both controversial and influential in addressing the tensions in nursing in the previous decade, and it concludes:

Above all [progress] involves letting in the daylight, blowing fresh air through our stuffy corridors and taking a long, hard and honest look at who we are and at our place in the health service and society as a whole.³

(Salvage's role as editor of the *Nursing Times* (1996 – 2001), founder of the Radical Nurses Group and instigator of the 'new nursing' movement in the struggle for the progress she refers to is examined in Chapter Six). Sociologist Celia Davies had also attacked the conventional style that 'celebrated a path of advancement ... that needed to come into the open and face criticism and replacement.' She describes her own dissatisfaction with the way the history of nursing was recorded and her urge to present it differently and in line with how nurses felt at the time in the late 1970s: 'With the arrogance of the young, we believed we were at the cutting edge, at the start of something new',⁴ and declared, 'it was time for a new vibrant kind of history'.⁵ These works form a valuable insight into the culture that was challenging nurses in the late twentieth-century and which have a bearing on the themes in this thesis.

Broad histories such as Brian Abel-Smith's *History of the Nursing Profession*⁶ provided a solid background, which was enhanced by later works such as those by Robert Dingwall *et al* (*An Introduction to the Social History of Nursing*⁷),

³ Salvage, *The Politics of Nursing* (1985), 175.

⁴ Davies, 'Rewriting Nursing History – again?' *Nursing History Review*, 15 (2007).

⁵ *Ibid.*

⁶ Brian Abel-Smith, *History of the Nursing Profession* (London: Heinemann, 1980).

⁷ Robert Dingwall, Anne Marie Rafferty, Charles Webster, *An Introduction to the Social History of Nursing* (London: Routledge, 1988).

Christopher Maggs (*Nursing History: the state of the art*⁸) and more recently, Anne Borsay and Billie Hunter (*Nursing and Midwifery since 1700*⁹). Dingwall *et al*'s work is especially enlightening about nurse training and education and the challenges to nursing practice in the 1960s (which he briskly summarises as the period for nursing which was in 'a state of some disarray'¹⁰) and therefore is of particular value to this study. However, by the later decades of the twentieth century, a shift in nursing's self-perception seemed to inspire a new style in the writing of nursing history and by the end of the century, Anne Marie Rafferty described how the discipline was developing:

Nursing history is being transformed from an internalist and triumphalist form of professional apologetics to a robust and reflective area of scholarship.¹¹

In their own work of edited essays, Anne Marie Rafferty, Janet Robinson and Ruth Elkan expand the history model, showing how nursing evolved during the twentieth century in the context of ideologies, such as a holistic ideology or a professional ideology as, for example, in Geertje Boschma's chapter where she writes of holism as a gendered ideology.¹² This 'robust area of scholarship' is also demonstrated by further evidence of a renewed interest in the history of nursing, such as the establishment and growth of nursing history societies, national and international history of nursing conferences and a range of nursing history journals that have originated in the last twenty five years (such as *Nursing History Review* (1992),

⁸ Christopher Maggs, *Nursing History: the state of the art* (London: Croom Helm, 1987).

⁹ Anne Borsay and Billie Hunter, eds (Basingstoke: Macmillan, 2012).

¹⁰ Dingwall, *et al*, *An Introduction to the Social History of Nursing*, 121.

¹¹ Rafferty, *et al*, *Nursing History*, 1.

¹² Geertje Boschma, 'Holism as a gendered ideology in nursing' in Rafferty, *et al*, *Nursing History* Jane Robinson and Ruth Elkan, eds, *Nursing History and Politics of Welfare* (London: Routledge, 1997), 172.

International History of Nursing Journal (1995)¹³, and the UK Association for the History of Nursing (UKAHN)'s online *History of Nursing Bulletin* (2012)). A further development has been a focus on specialist areas of nursing with works such as those by Christine Hallett on war-time nursing¹⁴, Sue Hawkins on nursing and women's labour in the nineteenth century¹⁵ and Susan McGann *et al's* history of the RCN.¹⁶

More recently, Gerald Fealy, Christine Hallett and Susanne Dietz's work examines a fresh area of nursing history, that of nursing practices in an international context. In doing so, it highlights the fact that this area has generally been neglected in favour of a focus on politics, identity and development of the profession.¹⁷ Their collection of essays is a major addition to earlier publications of nursing history and focuses on a wide range of nursing approaches and clinical methods worldwide. It demonstrates the connection between global nursing values and procedures and is an important record of nursing practice in a field where, as it has been shown, the majority of nursing histories is concerned with the profession and the politics, rather than the practice. Annie Holmes, also writing in 2015, similarly observes that nursing history has been traditionally focused on events and processes linked to professionalisation,

¹³ Although it was short-lived, lasting only seven volumes.

¹⁴ Christine Hallett, *Containing Trauma: nursing work in the first world war* (Manchester, Manchester University Press, 2011).

¹⁵ Sue Hawkins, *Nursing and Women's Labour in the Nineteenth Century: the quest for independence* (London: Routledge, 2012).

¹⁶ Susan McGann, Anne Crowther and Rona Dougall, *History of the RCN: a voice for nurses* (Manchester: Manchester University Press, 2009).

¹⁷ Gerard Fealy, Christine Hallett and Susanne Dietz, eds, *Histories of nursing practice* (Manchester: Manchester University Press, 2015), Introduction.

rather than to nursing practice and urges a critical interpretation of past nursing practice in order to draw valuable lessons for the present.¹⁸

While Chris Brooker and Anne Waugh's work is useful in providing a broad brush overview of nursing history, its focus on twentieth-century developments, such as a move towards nursing theory in the 1960s and evidence-based practice in the 1990s, has been particularly relevant.¹⁹ Barbara Mortimer and Susan McGann's work²⁰ explores the issue of the history of caring in nursing,²¹ and, although in the introduction to the book, Mortimer admits that 'the history of nursing has been dominated, overshadowed and, at times, swamped by the iconic figure of Florence Nightingale', the chapter by Anne Marie Rafferty usefully traces the history of caring to Americans Mary Nutting and Lavinia Doc who argued for a biological basis for altruism and caring.²² The theme of caring was explored in Chapter One of this thesis, using these sources as a basis. Rafferty also claims that changes in British nursing came about 'only when the wider interests of government and politics coincided with the profession's aspirations.'²³ In that same chapter – and relevant to my research – is a comment on the value of history, when, in recording the history of caring in order to capture subjective views of practitioners, she quotes the oral history methodology by Helen Sweet and Rona Dougall in their PhD theses.²⁴ This is a point

¹⁸ Annie Holmes, 'Why history matters to nursing', *Nurse Education Today*, 35 (2015) 635-637.

¹⁹ Chris Brooker and Anne Waugh *Foundations of Nursing Practice: fundamentals of holistic care* (London: Moshy, 2007).

²⁰ Barbara Mortimer and Susan McGann, eds, *New Directions in the History of Nursing* (London: Routledge, 2005).

²¹ *Ibid.*, Introduction.

²² *History of Nursing* vols 1-IV. (1907-12).

²³ Mortimer and McGann, eds, *New Directions*, 10.

²⁴ *Ibid.*, 13. Helen Sweet, *District Nursing in England and Wales, 1919-1979*, unpublished PhD thesis, Oxford Brookes University, 2003; Rona Dougall, *Perceptions of change: an oral history of district nursing in Scotland 1940-1999*, unpublished PhD thesis, Glasgow Caledonian University, 2002.

also made by Anne Borsay and Billie Hunter in acknowledging the important role of oral history as a methodology: 'The capacity of oral history to rescue groups missing from the written record and to correct distorted images makes it an invaluable tool for the history of nursing and midwifery.'²⁵ The strength of oral history as a research tool is discussed further in Chapter Three in the context of my methodology for the study.

In her concluding essay in this work, Anne Marie Rafferty refers to the history of nursing having a strong political character, which, she claims, is typified by struggle and the challenge for recognition of a wide range of nursing skills.²⁶ This is reflected in Anita Fatchett's work in which she summarises the late twentieth-century political tensions in nursing:

Nurses are only too aware of just how difficult this period of recent internal change has been for them. They have endured the impacts of major political and managerial change within the NHS. Increasingly they have found themselves working within a commercialised and fragmented organization, and feeling the impact of shortages and strict rationing of resources.²⁷

Another three-volume work which raises political issues is that of Rosemary White who, writing at the height of activism in nursing, recognises that nurses were becoming increasingly engaged in politics, stating:

The health care system is about power: power of the doctors, power of the administrators, power of the nurses. In nursing it is about the power of the managers, power of the generalists and power of the professionalists.²⁸

²⁵ Anne Borsay and Billie Hunter, eds, *Nursing and Midwifery in Britain since 1700*. (Basingstoke: Macmillan, 2012), 11.

²⁶ *Ibid.*, Anne Marie Rafferty, 'Epilogue: Contemporary Challenges', 227.

²⁷ Anna Fatchett, *Politics Policy and Nursing* (London: Bailliere Tindall, 1994).

²⁸ Rosemary White, ed. *Political Issues in Nursing: past, present and future*, Vol.1. (Chichester: Wiley, 1985), 40.

She particularly focuses on education and training, which, she claims have ‘failed to fulfill nurses, to give them job satisfaction and confidence. [...] Most damaging of all, it has demeaned the value of clinical nursing and failed to allow the emergence of a clinical structure.’²⁹ This relates to expansion of the nursing role, which is discussed in the work of essays edited by Patricia d’Antonio and Sandar Lewenson which focuses on a range of interventions, demonstrating how nurses worldwide expanded their view and developed medical therapies to render effective nursing care.³⁰

Professional identity is an important theme in nursing history and it is the subject of Julia Hallam’s work in which she explores contemporary ideas of the image of the nurse and traces the influence of gender, race and class on professional identity.³¹ Similarly sociologist Celia Davies’ work has been influential in the field of nursing and professionalisation and interpreting the development of regulation in the late 1970s – 1990s, and in her classic book, she provides a valuable insight into these additional tensions of the time.³² The issue of professionalisation is one that arises intermittently throughout this study, as Sam Porter describes:

One of the most consistent strategies to achieve professionalisation for nursing has been the attempt to acquire a unique knowledge base, the possession of such knowledge being seen as one of the essential traits of a true professionalism.³³

Mike Saks has published extensively on professions, comparative healthcare and health research. He provides a sociologist’s perspective on the topic, and claims

²⁹ *Ibid.*, 41.

³⁰ Patricia d’Antonio and Sandar Lewenson, *History as Evidence: nursing interventions through time* (New York: Springer, 2011).

³¹ Julia Hallam, *Nursing the Image: media culture and professional identity* (London: Routledge, 2000).

³² Celia Davies, *Interpreting Professional Self-Regulation: a history of the United Kingdom Central Council for Nursing* (London: Routledge, 2000).

³³ Sam Porter, ‘The poverty of professionalisation’, *Journal of Advanced Nursing*, 17 (1992) 720-726.

among other things, that professionalisation issues surrounding the practice of CAM may be influenced by a defensive self-interest.³⁴ Sarah Cant offers an alternative perspective and asserts, on the contrary, that use of CAM by nurses did not give the autonomy, status and material gains that might have been expected, and states that it was an expression of professionalism, not professionalisation, which Cant defines as striving for a 'unique knowledge base'.³⁵ This issue is further discussed by Tom Olson in *Nursing History and the Politics of Welfare* (1997).³⁶

A key point in my argument for nurses turning to CAM is that the changing culture in the 1990s, when patient-centred care within clinical practice was introduced, had a strong effect on nurses wanting to enhance the care they offered to patients. Patient-centred care encompasses primary nursing³⁷ and therapeutic nursing³⁸ and is an area of nursing practice that has a wide body of literature which underpins my findings. One of the most influential works in the field is Richard McMahon and Alan Pearson's *Nursing as Therapy* (1991).³⁹ MacMahon first discussed nursing as a therapy in 1986, as a means of proactively developing the nurse-patient relationship⁴⁰ – 'nursing that deliberately has beneficial outcomes for patients.'⁴¹ He draws on the

³⁴ Mike Saks, *Alternative Medicine* (Oxford: OUP, 1995).

³⁵ Sarah Cant and Peter Watts, 'Negotiating competency, professionalism and risk: The integration of complementary and alternative medicine by nurses and midwives in NHS hospitals', *Social Science and Medicine*, 72 (2011) 529-536.

³⁶ Tom Olson, 'Ordered to care? Professionalisation, gender and the language of training, 1915-37 in Anne Marie Rafferty, Jane Robinson and Ruth Elkan, eds, *Nursing History and the Politics of Welfare* (London: Routledge, 1997).

³⁷ Stephen Wright, *My Patient – My Nurse* (London: Scutari Press, 1990).

³⁸ Richard McMahon and Alan Pearson, eds, *Nursing as Therapy* (London: Chapman and Hall, 1991).

³⁹ *Ibid.*

⁴⁰ *Ibid.*, 5.

⁴¹ *Therapeutic nursing, theory and practice*: paper read at first national conference on therapeutic nursing held in Oxford, 22 March 1989.

work of Lydia Hall,⁴² D.H. Tiffany⁴³ and G.J. Alfano,⁴⁴ whose ideas were developed further in the Nursing Development Unit movement of the following decade (and which is discussed in detail in Chapter Five). Interestingly from my perspective, McMahon also sees a link between therapeutic nursing and the use of complementary therapies, while not necessarily endorsing the practice of them.⁴⁵

Ironically, considering his known support of CAM at that time, Stephen Wright in *My Patient - My Nurse* (1990)⁴⁶ does not include discussion of therapies. However, he very clearly sets out the strength of primary nursing, describing it as the total and autonomous care of a patient, or group of patients, and which involves a close relationship between nurse and patient. Although the Department of Health nursing section had endorsed primary nursing in principle as an initiative to improve standards of care in 1989,⁴⁷ it was controversial and challenging in its approach to established practice and customs. However, Wright saw it as part of a necessary change ‘in which the inherent values of nursing are reawakened and its territory rediscovered and redefined.’⁴⁸ Alison Binney and Angie Titchen build on these concepts and offer a comprehensive study of the patient-centred model as demonstrated in Oxford,⁴⁹ a collaborative venture initiated in 1989 and supported by the John Radcliffe Hospital and National Institute for Nursing, with a grant from the

⁴² Lydia Hall, ‘Another view of nursing care and quality’ in M. Straub and K. Parker, eds, *Continuity of Patient Care: the role of nurses* (Washington DC: Catholic University of American Press, 1966).

⁴³ D.H. Tiffany, ‘Nursing organizational structure and the real goals of hospitals’, unpublished PhD thesis, Indiana University, 1977.

⁴⁴ G.J. Alfano, ‘A professional approach to nursing practice’, *Nursing Clinics of North America*, 3 (1969) 487.

⁴⁵ McMahon and Pearson, *Nursing as Therapy*, 11.

⁴⁶ Stephen Wright, *My Patient – My Nurse* (London: Scutari Press, 1990).

⁴⁷ *A strategy for nursing* (London: Department of Health, 1989).

⁴⁸ Wright, *My Patient* (1990), 104.

⁴⁹ Alison Binnie and Angie Titchen, *Freedom to Practise: the Development of Patient-centred Nursing* (Oxford: Butterworth Heinemann, 1999).

Kings Fund. Their book comprehensively addresses the theory and the practice of patient-centred nursing and, together with an overview of the project, it cites examples and data from interviews of nurses who were involved in this style of practice. The work also very valuably provides a theoretical background with summaries of American work on relationships and caring, such as the work of Carl Rogers,⁵⁰ Milton Mayeroff,⁵¹ Sidney Jourard⁵² and Marie Manthey⁵³ – all of whom elucidate and help to position the humanistic and holistic approaches of nursing, which are so relevant to this study. Rogers' work especially identified the therapeutic potential of the nurse-patient relationship, and his summary of patient-centred nursing was quoted in Binney and Titchen as 'the nurse's ability to be warm, open, accepting and empathetic towards a patient'.⁵⁴ A chapter on research is another particularly pertinent section, citing S. Reed's research on comparative levels of nurse job satisfaction and quality of care between two wards, one practising primary nursing and one that was not.⁵⁵

This work of Binney and Titchen develops that of Steven Ersser's two years earlier.⁵⁶ His book focuses on a micro-level study of hospital-based nurse-patient interaction, providing a framework for the concept of therapeutic nursing and its relationship to patient outcome.⁵⁷ The findings indicate that a nurse's practical actions are often related to expressive actions – an area of interpretation that he claimed had been

⁵⁰ Carl Rogers, *On Becoming a Person* (London: Constable, 1967).

⁵¹ Milton Mayeroff, *On Caring* (New York: Harper & Row, 1971).

⁵² Sidney Jourard, *The Transparent Self* (New York: Van Nostrand Reinhold Company, 1971).

⁵³ Marie Manthey, *The Practice of Primary Nursing* (Oxford: Blackwell, 1980), 19.

⁵⁴ Binney and Titchen, *Freedom to Practise*, 150.

⁵⁵ S. Reed, 'A comparison of nurse-related behavior, philosophy of care and job satisfaction in team and primary nursing.' *Journal of Advanced Nursing*, 13 (1988) 383-395.

⁵⁶ Steven Ersser, *Therapeutic Nursing* (Aldershot: Ashgate Publishing Company, 1997).

⁵⁷ *Ibid.*, 1.

neglected in the literature – and that these expressive actions have a particular significance and effect on a patient’s ability to cope.⁵⁸ One of his findings was the power of the therapeutic importance of the nurses’ ‘social chat’ with the patient, which reinforces how the ‘little things’ – the everyday taken-for-granted activities – have the potential to make an important difference to the wellbeing of patients⁵⁹ and this was an argument that he repeated in his interview (and is referred to in Chapter Five).

Most significantly in Ersser’s conclusion is his criticism of nursing education in respect of a lack of reflective practice – a concept that was emerging at this time and which has seen development in nursing practice since then.⁶⁰

Little attention has been given to the hypothetical relationship between the self-awareness raising potential of each strategy and the consequences this may have for the nurse’s therapeutic effectiveness.⁶¹

Emerging from papers presented at a conference on Patient-Centred Care in Oxford is an important work by Bill Fulford, Steven Ersser and Tony Hope,⁶² which offers wide-ranging perspectives on the topic and includes a patient’s viewpoint, with legal, ethical, education and administrative views, which gives valuable insight. It is especially important in referencing the Patients Charter and conveying a European

⁵⁸ *Ibid.*, 282.

⁵⁹ *Ibid.*, 302.

⁶⁰ For example, D. Kolb, *Experiential Learning: experience as the source of learning and development* (London: Prentice Hall, 1984).

⁶¹ Ersser, *Therapeutic Nursing*, 299.

⁶² Bill Fulford, Steven Ersser and Tony Hope, *Essential Practice in Patient-Centred Care* (Oxford: Blackwell, 1996).

perspective on patients' rights⁶³ in the framework of a general healthcare movement, first mooted by Carl Rogers in the 1960s in the context of psychotherapy.⁶⁴ In his chapter, GP Andrew Marks comments on how the technical procedure in healthcare had created a shift away from the personal interaction of professional with patient, which was also indicated in my data. Hope discusses the principle of patient-centred care in terms of medical application, reflecting the work of Michael Balint⁶⁵ which is examined in Chapter Five. Three chapters focus on patient-centred nursing (Ann Bradshaw on 'Recovering the Covenant Tradition of Patient-Centred Nursing', Angie Titchen on 'A Nurse's Perspective', and Steve Wright on 'The Named Nurse'). Bradshaw claims that compassion and sympathy have been devalued and the moral tradition of which they were a part has been destructed,⁶⁶ and she draws the conclusion that it is the spiritual legacy of Nightingale that influences practice: 'The quality of nursing care – its patient centredness – arises historically and theoretically [...] from genuine, altruistic service.'⁶⁷ This theme is explored in Chapter Five.

Bradshaw's own work on spirituality in nursing, published in 1994,⁶⁸ is critical of historians such as Celia Davies,⁶⁹ Monica Baly,⁷⁰ Dingwall *et al*,⁷¹ and Abel-Smith⁷²

⁶³ Committed by the European Parliament on 19 January 1984.

⁶⁴ Carl Rogers, *On Becoming a Person: A Therapist's View of Psychotherapy* (London: Constable, 1961).

⁶⁵ Michael Balint, *The doctor, his patient and the illness* (London: Pitman Medical, 1957).

⁶⁶ Ann Bradshaw. 'Recovering the Covenant Tradition of Patient-Centred Nursing', in Fulford, Ersser Hope, *Essential Practice in Patient-Centred Care*, 32.

⁶⁷ *Ibid.*, 32.

⁶⁸ Ann Bradshaw, *Lighting the Lamp: a spiritual dimension of nursing care* (Middlesex: Scutari Press, 1994).

⁶⁹ 1980.

⁷⁰ Monica Baly, *Nursing and Social Change* (London: Heinemann, 1980).

⁷¹ Robert Dingwall *et al*, *An Introduction to the Social History of Nursing* (London: Routledge, 1988).

⁷² Brian Abel-Smith, *History of the Nursing Profession* (London: Heinemann, 1960).

for highlighting professional nursing issues, rather than vocational ones,⁷³ pointing out that these writers are ‘the direct heirs of the tradition which they so disparagingly reject’.⁷⁴ She argues that sympathy and compassion were historic elements of nursing,⁷⁵ and uses the term ‘The Renaissance Nurse’, a nurse whose practice is built on a philosophy of practice of attunement.⁷⁶ Conversely, Em Olivia Bevis argues in her work that nursing was moving *towards* ‘humanism and holism’⁷⁷ and refers to the ‘awakening sense of power’.⁷⁸ These tensions between whether there was an intrinsic culture of compassion or whether a new awakening to it emerged only in the mid-late twentieth century is explored in Chapter Four.

Although in this thesis I avoid discussion of spiritual (as in religious) aspects in nursing, there is a non-physical element to the quality of empathy, which I discuss in Chapter Five. This relates to the ‘therapeutic use of self’, which was a phrase introduced by American scholar Joyce Travelbee.⁷⁹ Her work in the early 1970s on interpersonal nursing provided valuable background to my research and is one of the earliest books on nursing practice to highlight this aspect:

The nurse’s philosophical beliefs about illness and suffering or her [*sic*] spiritual values, will determine the extent to which she will be able to help ill persons find meaning (or no meaning) in these situations.⁸⁰

Nursing history has also to be placed in the context of the history of biomedicine in the second half of the twentieth century in order to understand the spirit of the age.

⁷³ Bradshaw, *Lighting the Lamp*, 165-168.

⁷⁴ *Ibid.*, 168.

⁷⁵ *Ibid.*, 223.

⁷⁶ *Ibid.*, 249

⁷⁷ Em Olivia Bevis, *Curriculum Building in Nursing* (Saint Louis: C.V.Mosby Co,1978), 36.

⁷⁸ *Ibid.*, 39.

⁷⁹ Joyce Travelbee, *Interpersonal Aspects of Nursing* (Philadelphia: F.A Davis Company, 1971), 19.

⁸⁰ *Ibid.*, 1.

Viviane Quirke and Jean-Paul Gaudillière describe the period 1945-1975 as the era of a new relationship between medicine, science and technology, demonstrated by the emergence and use of the term 'biomedicine' and a new system of medical innovation.⁸¹ But a growing disillusionment with biomedicine and the perceived wisdom of medical practitioners was becoming evident by the end of the period and it is into this milieu that increased interest in the alternative model of CAM emerged.⁸²

2.3 Complementary and Alternative Medicine (CAM)

I have explored the body of literature on the fast-moving development of CAM in this time period and resources included not just books, chapters and journals, but the many reports and articles that flourished. These were especially ubiquitous in the last two decades of the twentieth century, as acceptance, popular interest and research in CAM – albeit limited in the view of some – intensified and gained greater support. Its emergence, however, had begun earlier when, in the late 1960s and early 1970s, alternative medicine was beginning to be openly debated, and widely offered privately, as its name suggests, as an 'alternative' to biomedical practice. Nicky Genders⁸³ and Vincent di Stefano⁸⁴ claim that it was supported by a holistic view and a rise in consumer knowledge about health. Histories and accounts of CAM then began to flourish in the 1980s and 1990s, sometimes amounting to a handbook of therapies,⁸⁵ sometimes written in a clinical context for the orthodox practitioner,⁸⁶ but also to inform and challenge the general reader as to where the CAM trend was heading.⁸⁷ Was it merely fashion, a temporary fad, or could it

⁸¹ Viviane Quirke and Jean-Paul Gaudillière, 'The Era of Biomedicine: science, medicine and public health in Britain and France after the Second World War', *Medical History* 52 (2008) 441-452.

⁸² Joanna Trevelyan and Brian Booth, *Contemporary Medicine for nurses, midwives and health visitors* (Basingstoke: Macmillan, 1994).

seriously be the stuff of legitimacy and the means to a valid medical pluralism? This provides the background to discussion in Chapter Four.

It is crucial in this review to consider the terminology used for CAM because it reflects the contemporary perceptions of CAM practices which will be examined fully in Chapter Four. Until the early 1960s, there was no collective term for what is now known as CAM therapies (although 'quackery' was frequently used⁸⁸). Then the phrase 'fringe medicine' was coined, arguably inspired by the Fringe Festival at Edinburgh.⁸⁹ Roger Cooter makes the point that 'the 'fringe' has mostly been crudely edited in relation to the 'orthodoxy' that it was not.'⁹⁰ His is a useful, but occasionally esoteric, account of the rise of CAM and his line of reasoning about the shifting boundaries between orthodox and unorthodox over time is enlightening. Roberta Bivins more clearly demonstrates the distinctions between 'alternative', 'complementary', and 'orthodox' medicine and investigates how these distinctions arose.⁹¹ She also confronts the notion of medical orthodoxy and discusses the concepts of experience and experiment. This is further developed in her chapter

⁸³ Nicky Genders, *Fundamental Aspects of Therapies for Healthcare Practitioners* (Quay Books, 2006).

⁸⁴ Vincent di Stefano, *Holism and Complementary Medicine* (London: Allen and Unwin, 2006).

⁸⁵ *The Which? Guide to Complementary Medicine* (Consumer Association, 1997).

⁸⁶ George Lewith, *Complementary Medicine: an integrated approach* (Oxford: OUP, 1960); Denise Rankin-Box, ed., *The Nurses' Handbook of Complementary Therapies* (Edinburgh: Churchill Livingstone, 1995).

⁸⁷ Roger Cooter, *Studies in the History of Alternative Medicine* (Basingstoke: Macmillan, 1988); Mike Saks, *Alternative Medicine in Britain* (Oxford: OUP, 1992); Sarah Cant, Ursula Sharma, *A New Medical Pluralism?* (London: UCL Press Ltd., 1999).

⁸⁸ Joanna Trevelyan and Brian Booth, *Contemporary Medicine for nurses, midwives and health visitors* (Basingstoke: Macmillan, 1994).

⁸⁹ The Edinburgh Fringe Society was formally established in 1959.

⁹⁰ Cooter, *Studies in the History of Alternative Medicine*.

⁹¹ Roberta Bivins, *Alternative Medicine: a history* (Oxford: OUP, 2007), 34.

'Histories of Heterodoxy' in the *Oxford Handbook of the History of Medicine*,⁹² where she discusses orthodoxy and summarises the history of heterodox medicine incorporating illuminating global case studies. Recognising the struggle that is involved in finding appropriate language, she claims that these unorthodox systems and practices were commonly defined 'in relation to what they are not.'⁹³ She chooses the term 'heterodox', thereby encapsulating the 'oppositional qualities of alternative without insisting on them, and thereby ruling out "complementary."' She acknowledges that 'biomedicine' is also an imperfect term and introduces a third expression into the field of the history of this relationship – 'cross cultural medicine' – a term used by medical practitioners for patients who also employ non-biomedical healing modalities.

Bivins provides a valuable and extensive summary of the history of CAM from ancient times to the present in her book, *Alternative Medicine: a history*. She makes the point – building on that of Cooter – that the 'cross cultural transmission of medical knowledge and expertise is not a uniquely contemporary phenomenon.'⁹⁴ Nor is her perspective on alternative medicine confined only to the west. Having studied practices beyond Europe and North America, her work provides a broad view of the subject and a 'Further Reading' chapter, which concludes the book, contains a wealth of invaluable references and recommended works.

⁹² Mark Jackson, ed., *Oxford Handbook of the History of Medicine* (Oxford: OUP, 2011).

⁹³ *Ibid.*, 58.

⁹⁴ Bivins, *Alternative Medicine*, 2.

Mike Saks also presents an introduction to the history of CAM in the context of the era in which the challenges to orthodoxy were possibly at their height.⁹⁵ In the introduction to his book *Orthodox and Alternative Medicine: politics, profession and healthcare* (1992), he develops the issue of what is mainstream orthodox and what is alternative or fringe. While recognising that there are blurred boundaries, his definition of alternative therapies fundamentally embraces those that do not receive support from the medical establishment. He claims that orthodox medicine engages only the mechanistic approach; in simple terms, where the body is perceived as the machine whose parts can be repaired through intervention when breakdown occurs.⁹⁶ However, he acknowledges that ‘much of the alternative medicine in this country today has links with mainstream health practices of centuries past and may well be on course to become at least part of the new orthodoxy of the future.’⁹⁷ In the same volume, Ruth West develops this argument by examining what is fringe and what is orthodox.⁹⁸ Alluding to the ‘fringe’ culture of the 1960s and ‘alternative lifestyles’ of the time, West claims that the term ‘complementary’ introduces the important and powerful concept of partnership with orthodoxy.

The dilemma about terminology is also discussed in a 1997 NHS research paper,⁹⁹ and, although a common definition is accepted as ‘a therapeutic practice not taught at a conventional medical teaching institution’,¹⁰⁰ the report cautiously claims that the

⁹⁵ Mike Saks, *Orthodox and Alternative Medicine: politics, profession and health care* (London: Clarendon Press, 1992).

⁹⁶ *Ibid.*, 4.

⁹⁷ *Ibid.*, 4.

⁹⁸ *Ibid.*, 201.

⁹⁹ *Complementary Medicine in the NHS: managing the issues* (London: NHS Confederation, 1997), 4.

¹⁰⁰ *Ibid.*, 4.

argument about terms is a subjective one, reflecting individual attitudes which often lead to philosophical debates about the nature of healing processes.

The Director of the Research Council for Complementary Medicine Jonathan Monckton's introduction in Trevelyan and Booth's *Complementary Medicine for Nurses and Midwives* (1994) claims that 'fringe' had developed into 'natural', which he defines as being 'in tune with the back to nature hippy culture of the early part of the 1970s. The term 'traditional', he admits, is confusing in developed countries, where traditional can be interpreted as 'conventional' or 'orthodox'.¹⁰¹ Saks' later work develops this issue further¹⁰² and, in defining 'alternative medicine in terms of its political marginality'¹⁰³ draws attention to the fact that orthodoxy as embodied in the medical profession can itself not be viewed as an homogeneous entity, having many subdivisions and heretical elements; for example, he claims that, by the 1980s, there were 54 categories of hospital medical staff in Britain.¹⁰⁴ Saks makes some challenging suggestions in raising issues of gender among health practitioners (for example, nurses were generally female, and doctors were generally male) and questions whether hostility to and scepticism of CAM in the mid-twentieth century was due to self-interest on behalf of the medical profession or genuine protection of the public good. This work provides invaluable background material for the research. Usefully, Saks' comparison of US and UK historical attitudes to alternative medicine throughout the book offers a wider perspective on the topic.

Further context is provided by Stephen Fulder and Robin Munro in highlighting the

¹⁰¹ Joanna Trevelyan and Brian Booth, *Complementary Medicine for Nurses, Midwives and Health Visitors* (Basingstoke: Macmillan, 1994).

¹⁰² Saks, *Orthodox and Alternative Medicine*, 66.

¹⁰³ *Ibid.*, 66.

¹⁰⁴ *Ibid.*, 128.

contemporary attitude to the medical profession, which revealed that the percentage of people trusting the wisdom of doctors had fallen from 52% in 1978 to 39% in 1980.¹⁰⁵ This backdrop to attitudes to health provision is important in understanding the climate of public opinion and the opportunity that it opened to alternative possibilities, which is a theme that I examine in Chapter Six, 'Environment and Awakening'.

George Lewith, professor of complementary medicine at the University of Southampton, has written extensively on CAM over 20 years. His work *Complementary Medicine: an integrated approach* (1996) was aimed at the medical practitioner as a guide to CAM, and is especially valuable in providing a comprehensive and balanced overview of the range of surveys and reports on CAM in the 1980s and 1990s and the charting of significant developments in this period.¹⁰⁶ However, one important development that is surprisingly omitted – considering the book's target audience – is discussion of the foundation of the British Medical Holistic Association (BHMA) in 1983 for doctors and its later spin-off sister organisation for other health practitioners, the British Association for Holistic Health (BAHH), founded in 1984. It would have been valuable to have known from this work how these organisations were judged (although my interview with him as part of the current project provided some insight). They are examined in Chapter Six. Another paper that year by Lewith discusses nurses' practice of CAM, and outlines potential areas

¹⁰⁵ Stephen Fulder and Robin Monro, *The status of complementary medicine in the United Kingdom* (London: Threshold Survey, 1985).

¹⁰⁶ George Lewith, *Complementary medicine: an integrated approach* (Oxford: OUP, 1996).

for future development, both within the community and hospital-based medicine,¹⁰⁷ claiming optimistically that ‘the nurse as an independent therapist treating a variety of chronic illnesses is both a realistic and an attainable goal within the NHS.’¹⁰⁸

A further source of value is the published materials of the Open University course K221, ‘Perspectives on Complementary and Alternative Medicine’.¹⁰⁹ These comprehensive resources provide a detailed overview of the topic: from an historical point of view, a scientific perspective and a social and cultural angle, and with the advantage of a range of expert contributors, including some of the key academics whose work has been examined above. A particular quality of the course book lies in discussion about and evaluation of the therapeutic relationship involved with CAM, both historically and in current practice, which has a particular relevance to my argument and which is discussed in Chapter Five.

A later publication is that of Simon Singh and Edzard Ernst, written as a review of the efficacy of CAM.¹¹⁰ Ernst, the world's first professor of complementary medicine at the University of Exeter, has spent his professional career analysing evidence for and against CAM, and this work claims to deliver the ultimate judgment. Singh is a journalist. The authors are controversial in their approach with their scathing attack on the patronage of CAM (most especially royal patronage) and perpetrators who support ‘unproven medicine’. Ernst’s work, although ever-critical of lack of research

¹⁰⁷ George Lewith, ‘An account of nurses’ role using complementary therapies’, *Complementary Therapies in Nursing and Midwifery*, 2 (1996) 130-133.

¹⁰⁸ *Ibid.*, 132.

¹⁰⁹ Geraldine Lee-Treweek *et al*, eds, *Perspectives on Complementary and Alternative Medicine*, K221 (Buckingham: Open University, 2005).

¹¹⁰ Simon Singh and Edzard Ernst, *Trick or Treatment?* (London: Corgi, 2009).

into CAM in the UK, demonstrates the increased interest in the subject. In his earlier paper,¹¹¹ he draws attention to the growth in publications: a 560% increase in 2003 (319 papers listed) from 1994 (57 papers listed) which, according to his MEDLINE search, reveals that the UK is the second most productive country for peer-reviewed CAM literature following the US. Ernst gives the reasons for this as general interest in CAM, both by the public and healthcare professionals in this period, a better infrastructure in support for CAM research and the significance of the House of Lords' Report in 2000.¹¹² Ernst also draws attention to the issue of the *British Medical Journal* in January 2001, devoted entirely to a CAM theme.¹¹³ However, he adds that, while increased interest and attention was so evidently given to complementary therapies in this period, quality research was seriously lacking, together with a dearth of investment in it. He offers an analysis of the motivations for and against trying CAM, which is a useful backdrop to the whole issue of integration in healthcare and draws on the sociological literature – for example, that of Sarah Cant and Ursula Sharma – in listing the perceived motivations as effectiveness and safety, philosophical congruence (natural, holistic, spiritual dimension), patient control, 'high touch, low tech', patient-practitioner relationship, non-invasiveness, accessibility, and affluence with rejection of science, technology and 'the establishment', together with dissatisfaction with conventional healthcare and an element of desperation as the negative approaches.¹¹⁴

¹¹¹ Edzard Ernst, 'CAM research in Britain: the last 10 years', *Complementary Therapies in Clinical Practice*, 11 (2005) 19.

¹¹² Report by the House of Lords Science and Technology Committee: *Complementary and Alternative Medicine* (London: Stationery Office, 2000).

¹¹³ *BMJ*, 322 (2001).

¹¹⁴ Sarah Cant and Ursula Sharma, *A new medical pluralism?* (London: UCL, 1999), 191-194.

Offering an international aspect is the work of sociologists Philip Harris and Rebecca Rees whose paper is valuable in presenting a global view.¹¹⁵ They emphasise the need for an accurate assessment of review of CAM use in order to inform any discussion, regulation or research on the subject. Their systematic search of literature was made on two bibliographic databases, MEDLINE and CISCOP and the results provide an invaluable resource of relevant material. Importantly, they also highlight the difficulties in addressing previous surveys, partly because of the challenge in refining a definition, and partly due to the resulting ambiguity that surrounds the attempt to do so. It had often been, they say, a mixed bag of therapies 'ranging from self-care, to folk remedies native to a particular culture...' which highlights the challenge referred to above of the classification of CAM.

A more recent view on the increased use of CAM comes from the medical writer and acupuncturist, Helen Barnett, whose view is that social trends in the second half of the twentieth century were responsible for the increasing enthusiasm for CAM.¹¹⁶ She claims that the culture of patient choice and shared decision-making enabled its increased acceptance, and that the developing interest in complementary therapies began as early as the 1960s. Others such as Joanna Trevelyan give reasons for this as the public disillusionment with conventional medicine and a more person-centred, person-empowering approach to health, which was prevalent at the time.¹¹⁷

¹¹⁵ Philip Harris and Rebecca Rees, 'The prevalence of complementary and alternative medicine use among the general population: a systematic review of the literature', *Complementary Therapies in Medicine*, 8 (2000) 88-96.

¹¹⁶ Helen Barnett, 'Complementary and alternative medicine and patient choice in primary care', *Quality in Primary Care* (2007), 207-212, 207.

¹¹⁷ Joanna Trevelyan and Brian Booth, *Complementary Medicine for Nurses, Midwives and Health Visitors* (Basingstoke: Macmillan, 1994).

As Ernst, Cant and Sharma do,¹¹⁸ she succinctly summarises the contemporary consumer perspective with negative and positive reasons for using CAM: poor outcome of traditional medicine, drug side effects, negative GP relationship experience, and health views not aligned with the conventional medical model – together with good CAM outcomes, patient empowerment, positive experience with CAM practitioner relationship and health views in line with CAM model. This issue of patient motivations to use CAM is one that will be developed in the following chapters.

Sharma has been a prolific writer on CAM. With Cant, she confronts the issue of contemporary medical pluralism, claiming that it is nothing new.¹¹⁹ They discuss the diversity of medical provision in the historical context of pre-1858 medical registration and contest the assumption ‘that biomedicine and alternative medicines are involved in some kind of zero sum power contest’.¹²⁰ This work is an important summary of the issues and tensions and deals with attitudes, studies, patients, knowledge, mainstream medical involvement and a reference to nurses’ involvement. It focuses on the history of relations between biomedical and alternative medicine in Britain, paying attention to development in the late 1980s and early 1990s of a ‘more accommodating response’ and explains the shift. They quote Richard McMahon in referring to key features of the nurse-patient relationship being ‘intimacy, reciprocity and partnership...[as]...crucial to complementary medicine.’¹²¹ This is an important point in the data chapters of this thesis when I argue that the quality of the

¹¹⁸ Edzard Ernst, ‘The Role of CAM’, *BMJ* (clinical research edition), 321 (2000) 1133-5.

¹¹⁹ Sarah Cant and Ursula Sharma, *A new medical pluralism?* (London: UCL, 1999), 191-194.

¹²⁰ *Ibid.*, 14.

¹²¹ *Ibid.*, 102.

therapeutic relationship is what impacts the use of CAM in nursing. Sharma and Cant's argument about medical pluralism is made by others too, for, as Roy Porter observed: 'The rational recourse for a sick person was to try anything and everything.'¹²²

By the 1980s, a growing groundswell of interest in holism in health was becoming evident, with the use of complementary therapies by non-physician health practitioners, including nurses, some of whom were now undergoing training,¹²³ and by 1988, the Royal Society of Medicine recommended 'bridge-building' between orthodox and alternative medicine.¹²⁴ In his report on behalf of the Institute of Complementary Medicine in 1984, Peter Davies wrote of CAM as 'a new direction in man's [*sic*] ability to heal and to be healed.'¹²⁵ An accepted view is that implementation gradually moved towards its height at the end of the twentieth century and works that discuss this, such as Bivins and Lewith, have already been quoted. Bivins refines this view of so-called pluralism and the use of orthodox and heterodox medicine as a means to wellbeing, as 'functioning more like a continuous spectrum than distinct modalities'.¹²⁶

¹²² Susan Budd and Ursula Sharma, *The Healing Bond: the patient-practitioner relationship and therapeutic responsibility* (London: Routledge, 1994), 80.

¹²³ Rankin-Box, *A Nurses' Handbook of Complementary Therapies*, 60.

¹²⁴ Roy Porter, *The Greatest Benefit to Mankind* (London: Harper Collins, 1998), 690.

¹²⁵ Peter Davies, *Report on Trends in Complementary Medicine* (Hounslow: Institute of Complementary Medicine, 1984), Conclusion.

¹²⁶ Roberta Bivins, 'Histories of Heterodoxy' in Mark Jackson, ed., *Oxford Handbook of the History of Medicine* (Oxford: OUP, 2011), 592.

This statement is similar to the conclusion of Marlene Weise, Candice Oster and Jan Pincombe's paper, who summarise the shift in healthcare in this way:

The history of the relationship between complementary medicine (CM) and mainstream health care has shifted from the early days of pluralism, through hostility and exclusion, to one of grudging acceptance.¹²⁷

The literature on the sociology and legal aspects of CAM practice has been significantly developed by Nicola Gale and Jean McHale's work,¹²⁸ which is a valuable source of material for this research, especially the chapters concerning regulation of CAM and regulation of CAM in nursing. Cant's chapter 'The "Knowledgeable Doer": nurse and midwife integration of complementary and alternative medicine in NHS hospitals' is particularly relevant in discussing issues of self-regulation and nurses' competence.¹²⁹ The UKCC (1986) refers to the requirement of a nurse to be a 'knowledgeable doer', able to integrate theory and practice and apply analytical skills. This phrase had become associated with the technical and task-orientated features of nursing, rather than the caring ones, and the participants in Cant's study lamented the fact that technology and bureaucracy were dominating the work of nurses and midwives. This corresponds to the views of my interviewees too. Cant differentiates between professionalism, referring to the ethic of conduct, and professionalisation, involving occupation autonomy and which is grounded in a stated-endorsed monopoly of practice. She argues that since the late 1980s, CAM in nursing and midwifery had been involved in the enhancement of

¹²⁷ Marlene Weise, Candice Oster and Jan Pincombe, 'Understanding the emerging relationship between complementary medicine and mainstream health care: a review of the literature', *Health*, 14 (2010) 326-42.

¹²⁸ Nicola Gale and Jean McHale, eds, *Routledge Handbook of Complementary and Alternative Medicine: perspectives from social sciences and law* (London: Routledge, 2015).

¹²⁹ Sarah Cant, 'The knowledgeable doer' in Gale and McHale, eds, *Routledge Handbook of CAM* (2015), 98.

‘occupational jurisdiction, professional power and quality of work experience.’ Her argument also extends to gender power relations and issues surrounding the hegemony of masculine biomedicine and she recognises the relationship between this and the ideology of historically and conceptually male professionalism which, she claims, is ‘omnipotent and unassailable.’¹³⁰ Importantly for my research is the discussion that Cant adds about the lack of progress for CAM in nursing and midwifery in the twenty-first century. She acknowledges that modest success was achieved in the 1990s but that CAM ‘lacked the resilience to withstand the more demanding governance context which emerged in the first decade of the twenty-first century.’ This controversy and discussion on regulation has overshadowed CAM in the twentieth and early twenty-first centuries and I discuss how it relates to nursing practice in Chapter Six.

McHale’s chapter in *The Routledge Handbook*, ‘Legal frameworks, professional regulation and CAM practice in England’, discusses regulation as an independent oversight and its relationship to professionalism. In examining both the legal approach and the CAM regulatory framework, McHale concludes that the law, with its professional legitimacy, status and processes to safeguard the public, may be ‘a means of promoting effective and responsible regulation in CAM in the future.’¹³¹

Julie Stone’s chapter ‘Aspirations, integration and the politics of regulation in the UK, past and future’ also examines the regulatory climate of the practice of

¹³⁰ *Ibid.*, 99.

¹³¹ Jean McHale, ‘Legal frameworks, professional regulation and CAM practice in England’ in Gale and McHale, eds, *Routledge Handbook of CAM* (2015), 58.

complementary therapies. She argues that, while CAM still has popular appeal, it is unlikely to be officially embraced by the NHS because a lack of common purpose among the sector had resulted in missed opportunities for securing statutory regulation and that, realistically, this was now beyond reach. These arguments provide valuable context to how CAM was implemented in nursing practice.

2.4 CAM and nursing

The study of the nurse's role in providing care and enhancing wellbeing as part of the healing process underpins the research, and I will argue that it was the motivation for some nurses wanting to use CAM. The literature on caring is therefore central to providing the context. Brian Mendyka claims that most nurses believe that caring skills – the moral ideal – lie at the heart of nursing.¹³² Yet scholars such as Christopher Maggs agree that this has been under-researched within the history of medicine and a gap exists in the history of the nursing profession in relation to practice with therapies and, specifically, CAM.¹³³ While it is possible that there was always a latent and underlying pluralism with the use of traditional therapies such as leeches and honey, this has not received attention in the literature although it is suggested in Root-Bernstein¹³⁴ and supported by some primary sources,¹³⁵ as I will also show.

¹³² Brian Mendyka, 'Exploring culture in nursing: a theory-driven practice', *Holistic Nursing Practice*, 15 (2000) 32-41.

¹³³ Christopher Maggs, 'History of nursing, a history of caring', *Journal of Advanced Nursing*, 23 (1966) 630-5.

¹³⁴ R. and M. Root-Bernstein, *Honey, Mud, Maggots and Other Medical Marvels: science behind folk remedies and old wives' tales* (New York: Houghton Mifflin, 1997).

¹³⁵ For example, the transcription of interview by Helen Sweet of Betty Reid, 1.10.96 gives an example of early remedies used by nurses. RCN Archives Edinburgh, T/364..

By the 1970s and early 1980s, the 'nursing process' with a task-orientated approach, was at its height. But the mid-1980s also saw a concept of holistic support emerging at the heart of the nursing role and, with it came a growing affinity with using complementary therapies within nursing. Denise Rankin-Box claims that greater patient empowerment and self-determinism had increased demand for CAM and that the shift from the clinical gaze – the dehumanising medical separation of body from person – to nursing empathy had enhanced the therapeutic relationship. It was this, she maintains, that had had a significant bearing on integration of CAM with mainstream medicine.¹³⁶ Other priorities were threatening the caring role, as Lewith in the introduction to Jean Sayre-Adams' book on Therapeutic Touch described: 'Philosophically and culturally, nursing ...has been driven further and further down the technological road over the last 20 years. Nurses have difficulty caring and touching because this is somehow not seen as a useful task-orientated achievement.'¹³⁷ Work by de la Cuesta identified the way that patient care at this time had been broken down into a set of tasks: 'The patient was treated as a collection of unit tasks which encouraged superficial nurse/patient relationships,'¹³⁸ and Christine Hallett describes the consequent challenge: should a nurse be technically proficient or should a nurse meet the holistic needs of the patient?¹³⁹

Giving a US viewpoint, Joan Engebretson reasonably asks, 'Why are simple, nontechnical modalities gaining in popularity when technology and communication

¹³⁶ Denise Rankin-Box, 'Growth and development: the first year', *Complementary Therapies in Nursing and Midwifery*, 1 (1995) 157-158.

¹³⁷ Jean Sayre-Adams, *Therapeutic Touch* (London: Churchill Livingstone, 1995), Foreword.

¹³⁸ Dingwall *et al*, *An Introduction to the Social History of Nursing* (1988), 214.

¹³⁹ Christine Hallett, 'Time Enough! Or Not Enough Time? An oral history investigation of some British and Australian community nurses' responses to demands for 'efficiency' in health care, 1960-2000', *Nursing History Review* (2012) 136-161.

have become so advanced?’¹⁴⁰ She concludes that depersonalisation and dehumanisation had become partners with technological progress and the low-tech interventions of CAM appealed to the spiritual and comfort properties of healing, described by her as the ‘art of healing’. She also cites consumer empowerment and independence and easy access to health products and techniques as aspects of CAM use by nurses. An additional attitude is the shift in society’s values – away from modernism and towards a search for meaning which potentially involved nature, religion and spirituality. Nursing attitudes to holism are considered in her work in the context of nursing theories and she gives the example of the American Holistic Nurses Association (AHNA), which grew rapidly during the 1990s with 100 new members each month,¹⁴¹ mirroring the growth of the British nursing interest groups, discussed in Chapter Six.

With the increasing use of technology in medical and nursing care during the twentieth century, physical touch of a patient – other than the necessary touch of procedural activities – was declining, as argued by Helen Barnett.¹⁴² Gillian Johnson’s work adds to the discussion and she claims that as ‘back rubs’ went out, massage and other physical CAM modalities became popular with nurses as a means to remain, quite literally, ‘in touch’.¹⁴³ Her paper is an insight into a view that the techno-curative model of care had been introduced in striving for a scientific approach, but that the value and therapeutic nature of nursing were, in the

¹⁴⁰ Joan Engebretson, ‘Alternative and complementary healing: implications for healing’, *Journal of Professional Nursing*, 15 (1999) 214-223.

¹⁴¹ *Ibid.*

¹⁴² Helen Barnett, ‘Complementary and alternative medicine and patient choice in primary care’. *Quality in Primary Care*, 15 (2007) 207-212.

¹⁴³ Gillian Johnson, ‘Complementary therapies in nursing: implications for practicing aromatherapy as an example’, *Complementary Therapies in Nursing and Midwifery*, 1 (1995) 128-132.

mid-1990s, redefining the nurse's role. As already alluded to, with the increasing use of technology in medical and nursing care during the twentieth century, physical touch of a patient – other than the 'necessary touch' of procedural activities – was decreasing. This is reinforced by Stephen Wright who sees western culture as touch-deprived and who claims that nurses were a driving force in the CAM movement, by rejecting clinical coldness and the impersonal and distant approach that nursing had begun to adopt: 'Nursing, with its deep roots in caring and its unique historical pathway, seems to offer a special opportunity ... to help restore the heart into health care.'¹⁴⁴

Allied to this is the theme of the nurse-patient relationship, which is a significant focus in my research and the published literature on the subject provides the essential background to examination of this area. The literature most importantly includes work by Annie Altschul,¹⁴⁵ Richard McMahon and Alan Pearson¹⁴⁶ and Steven Ersser.¹⁴⁷ Annie Altschul based her seminal work on nurses' feelings about patients (and their sense of a 'relationship' with a patient) on interviews she conducted with nurses, balancing those undertaken with patients. This was early work in the study of therapeutic relationships and is of great value. Richard McMahon's chapter on 'Therapeutic nursing: theory, issues and practice' in his and Alan Pearson's work¹⁴⁸ also summarises the value of the therapeutic nursing process which is 'potentially a

¹⁴⁴ Stephen Wright, 'Bringing the heart back into nursing'. *Complementary Therapies in Nursing and Midwifery*, 1 (1995).

¹⁴⁵ Annie T. Altschul, *Patient-Nurse Interaction* (Edinburgh: Churchill Livingstone, 1972).

¹⁴⁶ McMahon and Pearson, eds, *Nursing as Therapy*.

¹⁴⁷ Steven Ersser, *Nursing as a Therapeutic Activity* (Aldershot: Ashgate Publishing Company, 1997).

¹⁴⁸ Alan Pearson, 'Therapeutic nursing: theory issues and practice', in McMahon and Pearson, eds, *Nursing as Therapy* (1991).

major force in achieving health of the patient.¹⁴⁹ As nursing researcher Lisbeth Hockey wrote in the foreword to the 1991 edition, 'a calculated relationship purporting to have a healing effect is a fundamental form of therapeutic nursing.'¹⁵⁰

Hypotheses such as these assume a natural alliance between a nurse and CAM therapies. A nurse cares, a nurse touches, a nurse massages; therefore nurses would surely and naturally want to expand a therapeutic, touching role? This is frequently perceived to be based on Florence Nightingale's defining image of nursing as 'putting the patient in the best position for nature to act.' However, a controversial approach from Jon Adams and Philip Tovey in a number of works strongly challenges this assumption and the accompanying rhetoric of integration by nurses. While recognising that there was a tendency for GPs to delegate alternative practice to nurses 'who were enthusiasts',¹⁵¹ they argue that not enough scrutiny is given to the differing modalities of CAM and that there is an all-too-easy assumption in published pieces that CAM became a natural progression for nurses; thus they claim that 'Nursing advocates of CAM integration have tended not to present a critical perspective to inquiry or reflection, instead assuming the appropriateness and benefits of continued alignment with CAM.'¹⁵² While not disputing the high levels of support for CAM among nurses, they seek to provoke debate and deeper critical examination and to dispute the automatic acceptance of alignment of nursing and CAM. They also question the nostalgic and nostophobic elements of memory when

¹⁴⁹ *Ibid.*, 1.

¹⁵⁰ *Ibid.*, xii.

¹⁵¹ Philip Tovey, 'Contingent legitimacy', *Social Science and Medicine*, 45 (1997) 1129-34.

¹⁵² Jon Adams and Philip Tovey, eds, *CAM in Nursing and Midwifery: towards a critical social science* (London: Routledge, 2008), 2.

using nurses' oral histories.¹⁵³ However, while this was considered during the research and is very relevant to my research questions, there is an argument that relates more to a holistic approach than to the practice of CAM specifically. The two are conflated, as they are often are, and one aspect of interpreting the data from my research was to identify the difference between holism as a set of concepts and CAM as a set of techniques.¹⁵⁴ While certain CAM approaches can be seen as concepts or philosophies too, the use of the term is often confused and embracing the ideology of one does not necessarily lead to practice of the other. Tovey and Adams argue further that the presentation of Florence Nightingale's philosophy and therapeutic approach is almost interchangeable with the broad principles of CAM in the way it is perceived and it thereby legitimises the nurse's use of complementary therapies.¹⁵⁵

The extent to which the practice of CAM was executed is explored by Cant, who maintains that the evidence of limited use of CAM by nurses in NHS hospitals was confined to the mid-1980s to late-1990s period and that it was carried out on an *ad hoc* basis. After initial optimism and success, Cant argues that a decline in service provision followed.¹⁵⁶ She bases this on a qualitative study which explored the nature and extent of integration of CAM into NHS hospitals and data from interviews with nurses and midwives was thematically analysed with this aim. She argues that, because of the individualised nature of the way CAM services had been introduced, it left those nurses who wanted to use complementary therapies vulnerable when

¹⁵³ Philip Tovey and Jon Adams, 'Nostalgic and nostophobic referencing and the authentication of nurses' use of complementary therapies', *Social Science and Medicine*, 56 (2003) 1469-1480.

¹⁵⁴ O. Carl Simonton in Lawrence LeShan, *Holistic Health: how to understand and use the revolution in medicine* (Wellingborough: Turnstone, 1984). 205.

¹⁵⁵ Adams Tovey, eds, *CAM in Nursing and Midwifery*, 166.

¹⁵⁶ Sarah Cant and Peter Watts, 'The rise and fall of complementary medicine in NHS hospitals in England', *Complementary Therapies in Clinical Practice*, 18 (2012) 135-139.

stricter governance regimes emerged. Regulation had been based on nurses' competency and a paper by Fiona Mantle¹⁵⁷ stresses that nurses' competence to practice complementary therapies was founded on a sound knowledge base; she argues that their professional training to make solid judgements should not be devalued.

A positive viewpoint is presented by Pauline Stuttard and Elizabeth Walker, who, writing in 2000, claim that (limited) integration in healthcare had taken place by the end of the decade, and that the holistic care that was thereby offered was a welcome progression from nursing protocols and care plans.¹⁵⁸ Stuttard and Walker analysed data from evaluation sheets and discussions with nursing students of workshops at the Faculty of Health, University of Central Lancashire from 1995 to 1999 (16 workshops, 350 students), which taught the basics of CAM and outlined use of a range of therapies. They comment that the potential for skill development and greater integration was very promising, remarking that the 1999 RCN conference had emphasised the importance of incorporating CAM in nurse training, suggesting greater use in nursing. Their 'insider' view as nurse educators has to be acknowledged, together with the comparative timing of their research (2000), while Cant's external perspective of twelve years later offers the benefit of hindsight. The extent to which the optimism of Stuttard and Walker was realised will conclude my thesis.

¹⁵⁷ Fiona Mantle, 'Nursing practice makes perfect', *Complementary Therapies in Nursing and Midwifery*, 4 (1998) 123-124.

¹⁵⁸ Pauline Stuttard and Elizabeth Walker, 'Integrating complementary medicine into the nursing curriculum', *Complementary Therapies in Nursing and Midwifery*, 6 (2000) 87-90.

This review has demonstrated that there is a range of literature that has framed my study of CAM in nursing practice in the twentieth century. Scholarship has focused on important related areas and published work has provided a wealth of valuable background material on the topic. However, as Roberta Bivins comments, there is a lack of research on heterodox medicine from the patient's perspective and through the lens of practice.¹⁵⁹ This study will go some way to remedy that – at least from a nursing viewpoint – and I believe it can provide historical material to integrate with what has been already accomplished. Some research on the theme of CAM in nursing is closely related to what I have undertaken, but it has not always been situated in the context of nursing history and politics and this, I argue, is an important element of understanding why nurses turned to CAM. It will be examined in the following data chapters.

¹⁵⁹ Roberta Bivins, 'Histories of Heterodoxy' in Mark Jackson, ed., *Oxford Handbook of the History of Medicine* (Oxford: OUP, 2011), 592.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

The previous chapter has outlined the secondary literature and its relevance to my research by providing the baseline and the background to the project. In this chapter, I present a reflexive account of my theoretical assumptions and detail how my research work was undertaken, together with the rationale for methodological choices. I aim to anticipate queries and support the validity of the research.¹⁶⁰ The strengths and weaknesses and theoretical underpinning of each method will be examined, together with the personal challenges I faced in practice.

A multiple methods approach – interviews, archives and nursing journals – offered the possibility of triangulation of data to validate and to be more confident about results. I was, however, mindful of the sociologist and methodologist David Silverman's claim that it is short-sighted to expect that multiple methods in research are likely to reveal 'the whole picture'.¹⁶¹ Celebrate instead, he says, 'the partiality of your data and delight in the particular phenomena that it allows you to inspect.' This sense of an open-minded, explorative attitude to sources as they unfolded appealed to me at the outset of the research and I was open to whatever data might have emerged. Recording oral histories provided the largest amount of empirical data in literally giving a voice to the participants in the story of the use of CAM in nursing. This, of course, seemed an obvious method to uncover the views of nurses in the

¹⁶⁰ David Silverman, *Doing Qualitative Research* (London: Sage, 2000), 303.

² *Ibid.*, 22.

period 1960-2000. But I sought, not only to do the detective work of discovering facts, dates and evidence (what sociologist Nick Fox would classify as a modernist, detective or Sherlock Holmes approach¹⁶²), but to catch the atmosphere of the period and to try to tap into the spirit of the age. No textbook, nor account, was likely to evoke the *zeitgeist* in the way that personal memories did to enlighten me about the cultural mood and an appreciation of change in healthcare attitudes. The Annales historians promoted a social scientific approach. For example, French historian Marc Bloch's classic work, *The Royal Touch* (1924) about the sovereign's power to heal, explored the *mentalité* of a community: in short, an exploration of how people saw the world around them.¹⁶³ The method reveals how human culture changes and affects opinions and events.¹⁶⁴ That was what I was hoping for.

Nursing journals also provided a vital primary source for the late twentieth century. Their limitations are discussed, but the reason for choosing them was to reflect on the involvement of contributors and editors and what they were aiming to present and share. And, finally, examination of archival material, including reports, minutes of meetings and training curricula gave an invaluable insight into the contemporary attitudes to CAM of the nurses and others who were involved in this period. In examining whether a private prejudice existed in respect of my attitudes, beliefs and experience, a brief personal assessment concludes the chapter.

¹⁶² Nick Fox, 'Becoming' in N. Fox, *Beyond Health: postmodernism and embodiment*. (University of Michigan: Free Association Books, 1999). An approach based on truth and rationalism, contrasted with a postmodern Nomad method.

¹⁶³ Marc Bloch, *Les Rois Thaumaturges* (1924), his doctoral dissertation, translated as *The Royal Touch: Monarchy and Miracles in France and England* (Dorset Press, 1990).

¹⁶⁴ Mark Donnelly and Claire Norton, *Doing History* (London: Routledge, 2011), 46.

This project emerged from my MA dissertation on the use of electricity for nervous disorders, 1780-1860.¹⁶⁵ Some of that research examined the extent to which electricity – or galvanism in its nineteenth-century term – was considered an orthodox approach or mere quackery and explored the history of the relationship between the two. The topic of this study is, to some degree, an extension of that.

During the undertaking of this research I reflected on the example of my mother (1916-1999), who told me about folk medicines used in her youth, especially family herbal remedies. Then, during my lifetime, I was aware of her increasing reliance on biomedical treatments for a variety of conditions and for pain control. Towards the end of her life, she was also again employing a range of natural over-the-counter (OTC) remedies such as garlic, lemons, honey products and Bach flower remedies, and these, together with acupuncture for pain relief, were part of her integrated health practice at the end of the century as she aged. I believe now that it was the power of being able to help herself towards perceived better health that was the principal motivator, and the expectation of effectiveness that was at the heart of her belief. This is supported by Sarah Cant and Ursula Sharma's challenge, 'Have we seen the traditional patient of healthcare ...becoming a 'consumer', choosing the services they desire and seeing themselves as active decision-makers?'¹⁶⁶ These periods of subconscious observation of my mother over my adult lifetime neatly mirror the story of CAM in the forty years of the study. The three healthcare models – traditional natural folk remedies, then biomedical dominance, followed by an element of integration and greater consumer choices – summarise the history of

¹⁶⁵ Christine Gowing, *Shocking Treatment: electrotherapy for mental and nervous disorders in Britain, 1780-1860*. Unpublished MA dissertation (Oxford Brookes University, 2004).

¹⁶⁶ Sarah Cant and Ursula Sharma, *A new medical pluralism?* (London: UCL Press Ltd., 1999), 23.

medicine in the second half of the twentieth century. This, in the first two respects at least, also remarkably echoes *Mothers and Daughters* (1982), the work of sociologists Mildred Blaxter and Elizabeth Paterson in their three-generational study of health attitudes and behaviour in Scotland.¹⁶⁷ The influence of the new NHS on the women in their study was enlightening and relevant to the timescale of my own. I realised how much I had taken this for granted, having been born only the year after the inception of the NHS, whereas the impact of it on my parents' generation would have been extraordinary, with free (at point of use) medicine and medical services being available and accessible.

3.2 Oral histories

By preserving the stories lying beneath the often opaque surface of the written record, the oral history interview reveals the role of influential personalities, the 'accidents' of time and place, and the context of critical decisions. In other words, oral history can restore an element of human agency to the complex world of modern medicine.¹⁶⁸

It was exactly this element of human agency that I sought in using the methodology of oral history. I felt that no amount of archival material, nor journal articles would give enough flavour of the time in order to develop the accounts of CAM in nursing. What I was seeking was an enhanced personal perspective on textual sources and, given that oral history was an option, it would have been a wasted opportunity not to develop and enrich my data set with that approach.

¹⁶⁷ Mildred Blaxter and Elizabeth Paterson, *Mothers and Daughters: a three-generational study of health attitudes and behaviour* (London: Heinemann, 1982).

¹⁶⁸ Nancy Tomes, 'Oral History in the History of Medicine', *The Journal of American History*, (1991) 610.

Sociologist Paul Thomson, regarded as a pioneer in oral history as a research methodology, comments that, 'with the help of oral sources we can re-examine well-documented spheres through new perspectives.'¹⁶⁹ And, of course, it goes further than this. These spheres are also enriched, enhanced and enlarged by personal stories.

Using oral history as a methodology in a history of medicine research project may be considered a particular strength in providing a first-hand source. Kate Fisher sees the rise in the use of oral history since 1990 as a significant benefit in bringing:

individual experiences and human agents into the historical frame, humanising our understanding of the national and international institutions, professions, governments and organisations that shape medical history.¹⁷⁰

But oral history, she argues, also needs to record the relationship of the structures of medicine and human experience. In undertaking interviews with nurses of all levels and ages, I aimed for this research to reflect exactly that. Recording the stories of nurses working in the early days of the NHS to century-end will provide a lasting testimony of the relationship between them.¹⁷¹ The democracy of oral history gives access to voices and opinions beyond those reached through official channels to underpin the story of the nurses' changing experiences and attitudes towards complementary therapies, as Barbara Mortimer and Susan McGann support: 'Oral history has proved to be a particularly rich source from which the subjective views of

¹⁶⁹ Joanna Bornat, *et al*, ed., *Oral History Health and Welfare*, (London: Routledge, 2000), 4.

¹⁷⁰ Kate Fisher, 'Oral testimony and the history of medicine' in Mark Jackson, ed., *Oxford Handbook of the History of Medicine* (Oxford: OUP, 2011), 599.

¹⁷¹ Christopher Maggs, 'A History of Nursing, a History of Caring', *Journal of Advanced Nursing*, 23 (1996) 630-635.

practitioners can be captured.¹⁷² Paul Thompson's and Alessandro Portelli's theories on capturing voices that would otherwise not be heard bear on this approach.¹⁷³

The aim of the use of oral history in this research was specifically to reveal individuals' experiences, attitudes and responses to CAM. The American historian Nancy Tomes champions this approach in promoting the use of interviews to augment what she sees as the 'curiously barren' documentary record of modern biomedicine, thereby exposing 'the historian...to a more familiar and believable world of human beings' and to 'go beyond charting biomedical successes.'¹⁷⁴ Tomes argues that:

the overwhelming amount and complexity of the information available in print makes it imperative to use 'native informants', that is, human beings who generate and use such print sources, to sort out the significant from the inconsequential.¹⁷⁵

Virginia Berridge describes the 1950s-1990s as 'comparatively virgin territory for health historians' and argues that the use of oral history is especially valuable to help capture this.¹⁷⁶ My 'native informants' were indeed a vital source of help in assisting me to correlate their stories with the significance of other resources. However, there are arguments against using oral history as a methodology and its critics tend to focus on three main issues.¹⁷⁷ The first is that of selection of the sample of candidates, the second is the interview method and the third is the possibility of

¹⁷² Barbara Mortimer and Susan McGann, eds, *New Directions in the History of Medicine: international perspectives* (London: Routledge, 2005), 13.

¹⁷³ Hugo Slim *et al* in Robert Perks and Alistair Thomson, *An Oral History Reader* (London: Routledge, 1998), 145.

¹⁷⁴ Nancy Tomes, 'Oral History in the History of Medicine', *Journal of American History*, 78 (1991) 610.

¹⁷⁵ *Ibid.*, 608.

¹⁷⁶ Virginia Berridge, *Health and Society in Britain since 1939* (Cambridge: Cambridge University Press, 1999), 3-4.

¹⁷⁷ Ronald Grele, 'Movement without an aim: methodologies and theoretical problems in oral history,' in R. Perks and A. Thomson, *Oral History Reader* (London: Routledge, 1998), 40.

distortion by faulty memory when sources are used distant from the events of the topic.¹⁷⁸ I will examine my response to each of these criticisms in turn.

3.2.1 Sampling

The literature on the topic and my own analysis show that evidence of use of CAM by nurses in NHS hospitals was at its height in the period mid-1980s to late 1990s,¹⁷⁹ and then after optimism and success, a decline in service provision followed the millennium. I was hoping to locate participants from not only this period, but earlier, and this provided a challenge to the proposed research because of the possibility of insufficient evidence from personal interviews in the early period. No database of nurses who practised CAM exists. I was aiming to design a field with as wide an input as possible and striving to find older nurses to involve in the project might, I thought, be hard. Some sampling bias was unavoidable (all participants were volunteers willing to talk to me for example), but I was aiming for diversity and a range of ages and regions to be represented and so I recruited participants through two methods: first by finding an initial cohort of personal contacts by purposive sampling,¹⁸⁰ followed by a snowball technique. I planned to involve a range of participants – principally nurses, but also CAM practitioners and academics – in order to provide a broad spectrum of experiences. I was not necessarily aiming for a large sample but, as per Michael Patton’s methodological guidance: ‘the validity, meaningfulness and insights of qualitative research have more to do with richness of

¹⁷⁸ Alessandro Portelli, ‘Critical developments’ in Robert Perks and Alistair Thomson, *Oral History Reader* (London: Routledge, 1998), 37.

¹⁷⁹ Sarah Cant, ‘The rise and fall of complementary medicine in NHS hospitals in England’, *Complementary Therapies in Clinical Practice*, 18 (2012) 135-39.

¹⁸⁰ David Silverman, *Doing Qualitative Research* (London: Sage, 2000).

cases selected and observational/analytical capabilities of the researcher than the sample size.¹⁸¹

As well as my snowballing approach, I was contacted by people, mainly retired nurses, who had heard about the study and who volunteered to be interviewed. They had not necessarily been heavily involved in CAM in their work, but wanted their nursing stories of the period and their attitude to complementary therapies to be included. I considered whether this had had a connection with the publication of the Francis Report in February 2013,¹⁸² which was exactly the time I was starting to look for participants. The report had much to say about the need for compassion and caring to re-enter the culture of nursing, together with a shift to patient-centred care¹⁸³ and the media storm that surrounded the publication of the report had resulted in high profile awareness of these issues. Had it stirred the memories of older nurses and activated reminiscences? (Many interviews included comments on the 'golden days of nursing' or were brought to a close with participants bewailing current nursing practices, in spite of my emphasis on the 2000-end point). However, I believed that the range of participants who were finally involved in the study was highly appropriate to provide access to the knowledge I was seeking. Unfortunately, two people I approached were not able to take part due to pressure of work and relocation and, regrettably, Margaret Becker who had trained nurses in reflexology at the

¹⁸¹ Michael Patton, *Qualitative Research and Evaluation Methods*, 2nd edn, (London: Sage, 1990), 245.

¹⁸² On 9 June 2010, the Secretary of State for Health, Andrew Lansley MP, announced a public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of the serious failings of Mid Staffordshire Foundation NHS Trust resulting in patient suffering. The inquiry was chaired by Robert Francis QC, who presented recommendations to the Secretary of State based on the lessons learnt from Mid Staffordshire.

¹⁸³ Robert Francis, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (London: The Stationery Office, 2013).

QE Hospital Birmingham in the 1980s died, after agreeing to be interviewed but before we could meet. I was grateful for her enthusiastic encouragement when we originally spoke.

Having examined minutes and notes of the British Association for Holistic Health (BAHH) and the Royal College of Nursing (RCN) Complementary Therapies Forum archives, I noted names of speakers at conferences and members of committees and attempted to trace them – with mixed success. In one case, a coincidental factor occurred while searching for a particular individual, when I found references online to her sister-in-law, who, by chance, had the same name (Pat Turton). As it happens, she had also been involved in CAM throughout her working life in healthcare and so I interviewed her too. (A practical problem followed, however, in differentiating the two in my notes and the interview references and therefore, to avoid confusion, it was agreed that I would use the middle name of one (Annette), under which she had written her PhD thesis, and which is quoted in this work). A plotting exercise enabled control of a spread of ages of the candidates, and the period within which they were engaged in nursing practice,¹⁸⁴ as well as regions in which they trained or practised. Inevitably it was harder to interview nurses in the older age range. Of the 31 nurses I interviewed, over half had trained in London.

¹⁸⁴ Appendix B.

3.2.2 The Interview

The oral historian Ronald Grele raises the issues of interviewing techniques, research standards and sample size, credibility, bias and reliability – or ‘generalizability’, as David Silverman describes it.¹⁸⁵ Grele asserts that, in early oral history work, the power dynamic and the interpretation lies with the interviewer and that the relationship between interviewer and interviewee is potentially unequal and distanced because of this dynamic and he worked to advocate one of shared authority.¹⁸⁶ The power question also arises in the question of the ‘insider’ and ‘outsider’ status of interviewers, where for example, they share (or do not share) the same nationality, profession, culture, or ethnicity as the interviewee. ‘Insiders’ have the potential advantage of being able to use their knowledge for greater insight, whereas ‘outsiders’ are likely to be perceived as being neutral, which may result in information being conveyed that may not otherwise be shared with an insider.¹⁸⁷

Using interviewing for an empirical data source has the advantage of flexibility: subjects respond to specific questions but prompts can be used to develop themes and enlighten the topic in a far more meaningful way than a fixed written document.¹⁸⁸ There is an argument, too, for employing a flexible, semi-structured interview method, as used in this research project, in providing freedom to interviewees to develop themes. Equally, topics can be developed by the interviewer

¹⁸⁵ Silverman, *Doing Qualitative Research* (2004), 304; Paul Alasuutari, *Researching Culture: qualitative method and cultural studies* (London: Sage, 1995), 143.

¹⁸⁶ Ronald Grele, *The History of Oral History*, <http://www.youtube.com/watch?v=voPIGiv3sIQ>, accessed 29 Nov 2013

¹⁸⁷ Beverly Mullins, ‘Insider or outsider, both or neither: some dilemmas of interviewing in a cross-cultural setting’, *Geoforum*, 30 (1999) 337-350.

¹⁸⁸ Alessandro Portelli. A., ‘What makes oral history different?’ in R. Perks, and A. Thomson, *Oral History Reader* (1998), 39.

which were unknown beforehand, increasing the potential of useful data resulting from an exploration of areas that were fresh to the interviewer. However, I used the same basic framework of enquiries in each case to control the quality of the questions, provide consistency across interviews and enable comparisons to be more easily made in the data analysis stage and a more efficient coding approach. The schedule of questions is at Appendix D. An adapted version of the life-story qualitative research method¹⁸⁹, was used in order to establish how attitudes were formed and techniques of care learned.

3.2.3 Memory

The issue of memory and reliability of memory is probably the most controversial and most debated aspect of taking oral histories for empirical data. Criticism is sometimes levelled at oral history as an unsound methodology for its supposed flawed credibility, but as Alessandro Portelli states: there is a prejudice 'which sees factual credibility as a monopoly of written documents'.¹⁹⁰ He expands this by claiming that many written sources are recorded after the event and also undergo the distortion of faulty memory. Paul Thompson argues that it is not only oral history that may be affected by memory; other documentation used for historical research often undergoes a similar process of retrospective selection.¹⁹¹

Saul Benison develops this debate and adds that the questionable nuances of

¹⁸⁹ Hugo Slim *et al* in R. Perks and A. Thomson, *An Oral History Reader*, 145.

¹⁹⁰ *Ibid.*, 37.

¹⁹¹ Paul Thompson, 'Oral history and the historian', *Oral History Association of Australia Journal*, 5 (1992-3) 41-47.

remembered stories and interpretations are not without value:

The collection of half-truths, myths and prejudices is as valuable for history as pristine truth if they are appreciated and evaluated adequately. Often they lead to contradictions. In fact, it is the contradictions that emerge from such material which pose the nicest historical problems.¹⁹²

I encountered an example of this in my study with Inga Newbeck, a nurse-tutor, whom I interviewed as a founder member of the British Association of Holistic Health. In my archival work, I examined minutes of the organisation and discovered several references to her. I tracked her down and she agreed to give me an interview, which was extremely valuable in her description of the atmosphere of the early days of trying to implement CAM in nursing. It was beneficial to compare references to Newbeck in the BAHH records with the comments made in her interview, 30 years later. On one occasion, she is quoted in the minutes of the organisation with an honestly frustrated comment, suggesting occasional disharmony between their association and that of the British Holistic Medical Association (BHMA) with whom they were trying to work collaboratively:

[Inga] stated that every meeting and conference we hold seems to degenerate into discussions and complaints about conflicts between the BHMA and the BAHH. She felt it was time that we got going and did something instead of talking all the time.¹⁹³

However, in her interview, Newbeck had a different memory of their relationship.

Even without my directly asking her about it, she described collaboration and mutual

¹⁹² Saul Benison, 'Oral History: a personal view', in Edwin Clarke, ed., *Modern Methods in the History of Medicine*, (London: Athlone Press, 1971), 292.

¹⁹³ Wellcome Library, London, Special Collections, Papers of the BAHH, committee minutes 11 April 1986, SA/BHH/A5 Box 1.

support, and did not suggest any tension at all:

There was a whole lot more sharing than might appear on paper and we had conferences together and held each others' hands.¹⁹⁴

She talked warmly about individuals in the other organisation and any frustration was not recalled. In this case, I query the memory in challenging the written record. I believe that the nostalgic view may have tempered the probability that there were tensions between these organisations, and this was, in fact, supported by another interviewee who referred to it.

How an experience is reconstructed and interpreted subjectively by means of memory has been an academic topic in itself, and indeed works of fiction have also dealt with the nuances of reminiscence as crucial to story development.¹⁹⁵ The way in which twists of memory, with the combination of fact and opinion, affect interpretations of the past has to be confronted in including oral histories as a methodology. Philip Tovey and Jon Adams directly challenge the legitimacy of memory of nurses when talking of CAM. In their article 'Nostalgic and nostophobic referencing', they argue that by this referencing, researchers are using a resource that presents 'a view of the history of nursing that is partial (selective), at times romanticised and open to debate.'¹⁹⁶ To a limited extent, this was indeed borne out in some of the interviews I conducted. Phrases such as 'that was real nursing back then ... those were the days when nurses knew what caring really meant'¹⁹⁷ and 'we

¹⁹⁴ Inga Newbeck, interviewed 30 March 2015.

¹⁹⁵ P. Hamilton, 'The Oral Historian as Memorist', *Oral History Review*, 32 (2005) 11-18.

¹⁹⁶ Philip Tovey and Jon Adams, 'Nostalgic and nostophobic reference: the authentication of nurses' use of complementary therapies', *Social Science and Medicine*, 56 (2003) 1470.

¹⁹⁷ Shirley Watkins, interviewed 6 November 2013.

were called ‘angels’ back then¹⁹⁸ support the impression of the sentimentalised ‘golden days’ of nursing being those in the idealised past. In their paper, Tovey and Adams argue that nostalgia promotes a view that, with hindsight, periods of the past appear better in comparison with an uncertain present and that, conversely, nostophobia gives ‘an assessment of the past as essentially negative and of the future as an opportunity to recall its limitations.’¹⁹⁹ This interpretation is supported by Karen Gillett’s work on ‘golden era discourse’ in the media, with nostalgic references to a more caring nursing culture in a perfect past and comparisons made with present dissatisfactions.²⁰⁰

The issue of memory and nostalgia has been addressed in articles in the Oral History Society’s journal, *Oral History*, and one such article, ‘The Memory and History Debates: Some International Perspectives’ discusses the recurring deliberations about memory, which are ‘principally concerned with physical deterioration and nostalgia in old age, personal bias of interviewer and interviewee and influence of collective and retrospective versions of the past.’²⁰¹ Alistair Thompson, Michael Frisch and Paula Hamilton address the issue of painful and difficult oral history topics and highlight the tensions that may arise when subjects think back and remember traumatic details. Other *Oral History* articles confront emotion and the effect that it may have on memory and the direction of oral history interviews.²⁰² This is a new challenge in oral history as a methodology and led me to consider an area that had

¹⁹⁸ Alison Ellis, interviewed 8 November 2013.

¹⁹⁹ Tovey and Adams, ‘Nostalgic and nostophobic reference’, *Soc. Sci. and Med.*, 56 (2003).

²⁰⁰ Karen Gillett, ‘Nostalgic constructions of nurse education in British national newspapers’, *Journal of Advanced Nursing*, 70 (2014) 2495-2505.

²⁰¹ Alistair Thomson, Michael Frisch and Paula Hamilton, ‘The Memory and History Debates: Some International Perspectives’, *Oral History*, 22 (1994) 33.

²⁰² Jenny Harding, ‘Talk about care: emotions, culture and oral history’, *Oral History*, 38 (2010) 33-42.

concerned me as a result of my interviews, which was the effect that nostalgia may possibly have on oral history narratives about organisations, and whether it added value or threatened the significance of the data extracted from my interview transcripts. In the interviews I undertook, when some participants moved from talking about facts to nostalgically recalling memories of their involvement in organisations, they became emotional. This mystified me: in these interviews, I was hoping for data for my work on organisational histories and expecting to glean hard facts and figures and descriptions of their experiences. I invited them to tell their life stories chronologically and some interviewees ended their narratives with reflection about their personal histories, drawing parallels with their professional histories. This resonated with Michael Bevan's work in interviewing GPs to ascertain the reasons for their career choice where, similarly (apparently), quite separate personal issues emerged.²⁰³

As Portelli argues – ‘the importance of oral testimony may rely not in its adherence to fact, but rather in its departure from it, as imagination, symbolism and desire emerge.’²⁰⁴ I considered whether nostalgia plays a part in this. Nostalgia in oral histories has been examined in the context of school segregation in the USA,²⁰⁵ of educational politics and practice²⁰⁶ and of US railroad oral histories.²⁰⁷ In my own

²⁰³ Michael Bevan, ‘Family and vocation: career choice and the life history of general practitioners’ in Joanna Bornat *et al*, eds, *Oral History, Health and Welfare* (London: Routledge, 2000).

²⁰⁴ Alessandro Portelli, ‘What makes oral history different?’ in R. Perks, and A. Thomson, *Oral History Reader* (1998), 39.

²⁰⁵ Barbara Shircliffe, ‘“We Got the Best of that World”: a Case for the Study of Nostalgia in the Oral History of School Segregation’, *Oral History Review*, 28 (2001) 59-84.

²⁰⁶ Michalinos Zembylas, ‘Reclaiming nostalgia in educational politics and practice: counter-memory, aporetic mourning and critical pedagogy’, *Discourse: Studies in the Cultural Politics of Education*, published online 26 Oct 2011.

²⁰⁷ Charles Morrissey, ‘More than embers of sentiment: railroad nostalgia and oral history of the 1920s and 1930s’, *The Public Historian*, 15 (1993) 29.

subject area, the Tovey and Adams article is the only one I am aware of that directly addresses the issues of the impact of nostalgia in a healthcare context on the quality of data and their contribution is especially relevant in respect of the methodological approach of using journals to collect their data (a text analysis of 80 papers). I am not aware of studies having been undertaken on the effect of nostalgia in researching healthcare institutions.

Nostalgia - *nostos* (home) and *algia* (pain) - includes an element of homesickness; a wistfulness in yearning for something that is irrecoverable. I recognise that the nostalgia involved in reminiscing is powerful and is generally used in a one-dimensional sense of sentimentalising the past, or, as sociologist Fred Davis says, 'memory with the pain removed'.²⁰⁸ And it is inevitably a potent part of the process of 'life review', a phrase coined by the American psychiatrist and gerontologist Robert N Butler in 1961.²⁰⁹ Butler identified this as a normal aspect of older adult development, believing that memories, reminiscence and nostalgia were a natural part of the route by which a person evaluates his or her life by giving meaning to it. This is relevant to what happened in my interviews. Two case studies illustrate my point, one with an acupuncturist and one with a nurse; both were founder members of organisations that supported nurses wanting to use CAM in the 1980s and 1990s, and both were aged between 65 and 75 when I interviewed them.

²⁰⁸ Fred Davis, *Yearning for Yesterday: a sociology of nostalgia* (London: Collier Macmillan, 1979).

²⁰⁹ Robert Butler, 'The life review: an interpretation of reminiscence in the aged', *Psychiatry*, 26 (1963) 65-70.

Because of the structure of the interview, the first participant depicted events chronologically, describing the formation of the Association and its progress, alongside an account of his own professional and personal life. He described how successful he believed the organisation was, amid many challenges, and he gave the sense of it being part of a growing 'movement' for CAM. He also described his own professional development and how the two were intertwined, the one giving the other meaning. He then became more reflective and emotional as if something had been aroused in him.

We are talking about ... as far as I am concerned, we are talking about a part of my life that went on really for a very long time, and was not a blind alley but was a part of a structure of the person I am now.

I believe this realisation is what emotionally moved him. 'Part of the structure of the person I am now' encapsulates Butler's theories of life review – that evaluating one's personal history gives meaning and a sense of identity. But, because of this, could the enthusiastic and positive response in the interview about whether the organisation had achieved its aims have been influenced by his nostalgic reflection on the meaning and value of his own professional and personal life? Because, of course, he would have wanted to portray it as a success. I questioned, therefore, whether the data were threatened by the reflection on the person 'I am now'.

In the second interview, I used the schedule of questions – as in all my semi-structured interviews – to explore her background, her professional training and her attitudes to health. I then developed the questioning to ask about how she became involved in the organisation of which she was a founding member. She was very

animated as she explained how the ideals of holistic nursing – which she had nurtured for some years – had become shared and embraced by others. She described excitedly how the organisation grew and flourished. And then she reflected, sadly, on how it gradually wound down as it became hard to find people prepared to take on the leadership roles. As we finished, she became thoughtful. Her work now is with people at their end-of-life, and it seemed that talking about the founding of a holistic nursing organisation had reinforced the significance she gives to relationships in sensitive situations. And this appeared to give a *meaning* to her life story and a sense of her life's purpose. She ended the interview referring to a 'thread' running through her life and it seemed to me that, by nostalgically looking back over her life and career, she had detected a pattern that was newly exposed to her as she had recalled events.

What did this imply for me and how did it affect the quality and value of my interview with her? I thought that it might be possible that earlier, as she unfolded the story of her working life to me, she could have been subconsciously giving it significance, layering meaning on to her developing narrative and contributing to a sense of purpose. However, in this case, I do not believe the element of nostalgia distorted or affected the value of the data. I could see that a sense of her life's purpose came at the end of the interview and the earlier narrative about her work with the founding of the organisation was not modified to fit this deduction.

In conclusion, I came away from my interviews feeling that the individuals had portrayed their involvement in these organisations with pride in their accomplishment.

They had described risks and challenges – from other individuals and from the establishment – but they also showed a passion for having introduced innovative ideas against the tide of conventional thought. In both of these cases, they were individuals who had not ‘formally’ discussed their story before, as far as I am aware. I had come to them with my questions and allowed them to describe their life’s work and had, therefore, loaded it with significance in addition to the emerging nostalgic aspects of their histories.

I saw nostalgia also having another effect, in a sense of experiencing nostalgic mourning (as in loss), as described by Janelle Wilson and Andrea Deciu Ritivoi.²¹⁰ The two institutions discussed in these interviews each lasted only a few years before becoming absorbed into another. So there was perhaps an inevitable sense of bereavement by my interviewees – not only for their own participation, but for the very thing they had helped to create and that they had valued. Individuals may identify with the institutions to which they belong, but my interviewing experience also demonstrated to me how deeply an individual is connected emotionally to an organisation, if instrumental in its birth and early development. Fred Davis claimed that nostalgia is ‘one of the more readily accessible psychological lenses we employ in the never ending work of constructing, maintaining and reconstructing our identities.’²¹¹ It was this potential identity-enhancing power that I felt might have the capacity to influence the oral history narratives I had recorded. The interviewees saw the organisations in which they were so intimately involved as *successful and*

²¹⁰ Janelle Wilson and Andrea Deciu Ritivoi, ‘Comparing cultures, sharing narratives: exploring the relationship between reminiscence and identity’, Conference paper at Reminiscence and Life Review Conference (New York, 1999).

²¹¹ Fred Davis, *Yearning for Yesterday: a sociology of nostalgia* (London: Collier Macmillan, 1979).

achieving, even though they were not sustained. I queried whether the fact that they had created the organisations had pressured the participants to present a success story – not just their successful *personal* story, but a success story for the organisation which they helped to form and in which they had invested so much. Once I had recognised this, I was able to look carefully at the data and challenge my interpretation of it. However, I ask myself, ‘Would I have challenged it if participants hadn’t become emotional?’ The fact that the interviews were ‘encounters’ and my data collection was not sourced only from transcribed sanitised texts highlights the importance of the value of oral histories. My interviewees’ emotion was a surprise to me, and the intensity of their reaction alerted me to a cautionary signal that there could be other possible layers and meanings to what was being recalled and recounted. The literature on the subject of interviews as a therapeutic encounter in themselves throws some light on emotional response on the part of interview participants, such as B.Lee Murray’s article ‘Qualitative research interviews: therapeutic benefits for the participants’,²¹² which also recognises the importance of rapport and trust in the researcher-participant relationship in enabling the best possible engagement.

The study of emotions in an historical context is emerging as a new academic field and the issue for me of emotion in my interviews raised my awareness of this area of research. In a 2013 lecture, historian William Reddy addressed the question of ‘Do emotions have history?’, stating: ‘Some emotions, like fear or anger, may trigger physiological changes. Others, like pride or nostalgia, do not.

²¹² B. Lee Murray ‘Qualitative research interviews: therapeutic benefits for the participants’ *Journal of Psychiatric and Mental Health Nursing*, 10 (2003) 233-236; Jerry Gale ‘When research interviews are more therapeutic than therapy interviews’, *The Qualitative Report* 1 (1992) 1-4.

Are emotions hard-wired? Or are they subject to cultural or historical variation?²¹³

These stimulating ideas have informed my understanding of nostalgia. Importantly, they have heightened my awareness of the value, or threat, of nostalgic memory in oral histories.

Oral history as a methodology provides desired subjectivity, for, as Ronald Grele claims, a purely objective view is 'a view from nowhere.'²¹⁴ This subjective interpretation of memory is not seen as a flaw, but a resource, and corresponds to oral historian Portelli's view, who argues that oral narrators often use stories that have been repeated and repeated in a community, thereby reinforcing detail and giving sense to the past.²¹⁵ This may, of course, result in the likelihood of what I call 'embedded embellishment', where exaggerations, nuances or falsehoods are reinforced and given legitimacy by repetition or where opinions become facts. Just because a statement is repeated does not make it true, although Portelli claims that 'wrong' statements are still psychologically 'true' and that this truth may be equally as important as the factually reliable accounts.²¹⁶ Although I did not observe this in the data, these issues were the potential challenges I kept in mind.

²¹³ William Reddy, 'Do emotions have a history? The example of romantic love.' Public lecture, 14 March 2013, University of Melbourne, www.events.unimelb.edu.au, accessed 14 May 2015.

²¹⁴ Ronald Grele, *International Annual of Oral History: Subjectivity and Multiculturalism* (London: Greenwood Press, London, 1992).

²¹⁵ Alessandro Portelli, 'What makes oral history different?' in R. Perks and A. Thomson, *Oral History Reader* (London: Routledge, 1998), 37.

²¹⁶ Alessandro Portelli, 'On the peculiarities of oral history', *History Workshop Journal*, 12 (1981) 96-107.

3.2.4 Practicalities

The Wellcome Trust has especially advocated the use of oral history as a methodology in researching the history of medicine and the move into the twentieth century by historians of medicine has led to establishing and sponsoring courses in the techniques and a greater use of this methodology in research. I was offered a place on the Wellcome Trust's Oral History of Medicine residential week course before starting my study.²¹⁷ The course addressed practicalities of interviewing techniques, as well as discussions on both the potential and the challenges of oral history projects, archiving and digitisation. This developed my skills following an Oral History Society introductory course at the British Library for a community history project that I had previously managed. Key people from the time period were sought, including members of nursing and CAM organisations, retired clinicians, academics and CAM practitioners. In order to ensure transparency and open information, a fact leaflet was provided and informed consent was obtained from all participants before face-to-face, semi-structured interviews were conducted (see Appendix C). Skype was used as an alternative to face-to-face interviews in four cases, because of geographical distance or lack of mutually convenient dates to meet. The purpose of the study was discussed immediately prior to the interview to ensure that consent was truly informed. Interviews were carried out between 2014 and 2016 and were digitally recorded, using ZoomH4n equipment. (On one unfortunate occasion, both this equipment and the back-up recorder failed and the interview had to be repeated.

²¹⁷ Initially presented in 1990, 'the five-day residential has become a well-established feature in oral history as well as the history of medicine and health policy in Britain. It remains the only course of its kind in the UK. The course makes a significant contribution to preparing researchers in their own diverse projects; projects that draw upon a range of lay and professional recollections of experiences, health policies and medical practices.' (www.royalholloway.ac.uk, Royal Holloway, University of London website, accessed 11 October, 2014).

However, with the interviewee's permission, I used data from verbatim notes of her original interview, as well as the transcript of the second. The 'burnt story'²¹⁸ is one that can lose its detail and impact the second time it is told, and I did not want to waste its value). The topic guide for questions included the following themes: nursing background, family life and attitudes to health, nursing life, attitudes to CAM practice by nurses in the NHS, experiences of integrating CAM with conventional practice, perceptions of the role of CAM, both therapeutically and in the context of professional development, issues of training (see Appendix D). A probing and funnelling technique of enquiry was employed, with questions, then prompts, with a natural flow to obtain more detailed responses.²¹⁹ In total, 41 people were interviewed. After 31 interviews of retired nurses, I believed that saturation had been reached from their point of view because the same responses and views were being repeated. Fifteen interviews were held with key individuals working in CAM (there was an overlapping of roles in five cases). Each interview was transcribed verbatim and further notes were made of impressions from the transcriptions.²²⁰ The data were analysed thematically – initially manually, and then using the software tool NVivo for Mac [version 10.0.4] for more detailed coding. Consistency in coding was necessary, in order to ensure robust analysis and themes were identified early in the research. Each themed segment, usually a word or short phrase, was labelled on the transcript. Field notes were kept, recording the atmosphere of the interview and evaluating the salient points that had emerged, as well as noting any issues that I planned to follow up subsequently with the participants. Being reflexive in this

²¹⁸ The 'burnt story' is an Arabic phrase for the phenomenon of a narrative being spoiled by repetition.

²¹⁹ www.le.ac.uk/emoha/training/no2.pdf University of Leicester oral history website: 'Interviewing for research', accessed 5 December 2013.

²²⁰ P. Alasuutari, *Researching Culture: qualitative method and cultural studies*, (London: Sage, 1995), 179.

enabled a rigorous appraisal of the interview process by considering each one and making comparisons with other interviews. Participants were provided with a transcript of their interview and opportunity for additional comment by participants. The Royal College of Nursing requested that the recordings and transcripts be deposited in their archives at the end of the research, where they will be made available for other researchers (with the exception of three participants who, for personal reasons, requested that their recordings or transcripts not be archived). For the others, I felt a sense of obligation to ensure that the recordings were archived and preserved in this way. They were not my memories to keep.²²¹

3.2.5 Challenges

A perceived challenge for the research was my background as a researcher and the issue of power – the insider or outsider position²²² in the interviewer/interviewee relationship.²²³ I have no clinical experience, neither in nursing, nor in practising complementary therapies, and any experience of CAM is purely from life observation and this research. This seemed a possible drawback when preparing for the interviews, which required groundwork in order to become familiar with nursing

²²¹ G. Eeles and J. Kinnear, 'Archivists and oral historians: friends, strangers or enemies?' *Oral History journal*, 17 (1989).

²²² Beverly Mullins, 'Insider or outsider, both or neither: some dilemmas of interviewing in a cross-cultural setting', *Geoforum*, 30 (1999) 337-350.

²²³ E.g. L. Archibald and M. Crnkovich, 'Intimate outsiders feminist research in a cross-cultural environment', in S. Burt, and L. Code, eds, *Changing Methods Feminist Transforming Practice*, (Ontario: Broadview Press, 1995), 126; P. Hill-Collins, 'Learning from the outsider within the sociological significance of black feminist thought', in M. Fonow and J. Cook, eds, *Beyond Methodology Feminist Scholarship as Lived Research*, (Bloomington: Indiana University, 1990), 35.

terminology and nursing culture, prior to the process. It initially felt like entering a slightly alien world and trespassing in unfamiliar territory with vocabulary, structures and attitudes that were unknown. Conversely, however, it offered an objectivity where I, as the 'outsider- researcher', was distanced from the topic. I openly represented myself as an 'outsider', and this self-confessed status as historian, rather than clinician, may have given me a perceived objectivity that could have been harder to sustain with a healthcare background. This possible strength was commented on by several participants, who were generous in their willingness to give explanations of nursing issues. (There was one exception when a participant was initially concerned that I, as a non-nurse, would not be able to represent the viewpoint of her organisation. Her unease was later retracted). Interviewees were generally sympathetic with my naivety on nursing matters and I believe this engendered a sense of impartiality. I believe it is also likely that my being an outsider made it less likely that participants would say what they thought I would like to hear or would wish to please me by their responses, a factor of which I was mindful. I particularly felt this was true when asking about touch. 'How important do you feel touch is?' feels likely to draw a response that is positive, however hard I tried to ask in an open way. (A fresh view was offered when one participant admitted that touch was not something she liked, so she had had a different attitude to offering it to a patient.²²⁴)

All these were issues that admittedly I had not much considered at the outset of the research. The first hurdle had been the application for ethics approval. The university ethical review application for my research was challenged and it was

²²⁴ Fiona Mantle, interviewed 3 April 2014.

initially recommended that participants should be anonymised. However, the standard way to work in the discipline of history is not to anonymise and I believed it important that interviewees should be identifiable; several were eminent in their role in the story of CAM and nursing and they were content to be identified. Their stories' legitimacy required an historic and identifiable base, giving context to their accounts. The decision not to anonymise was accepted. The trend of suspicion surrounding oral history especially pervades issues of health and Oral History Society chair Graham Smith suggests drolly that, 'it might take a little effort to persuade ethics committee members that interviewing people about their pasts does not entail the same risks as conducting medical experiments.'²²⁵ Kate Fisher also discusses the challenge of being caught between sociological approaches and those of health research and the pressure to apply anonymity, which is 'assumed' in the latter.²²⁶ She confronts the subject of the potentially intimidating information and consent forms that are involved in gaining interviewee consent. This was also one of my concerns in the early stages, believing that candidates for interview may be deterred by the bureaucratic appearance of all the necessary consent paperwork but this did not appear to daunt them.

²²⁵ Graham Smith, 'Focus on research', *Oral History* (Historical Insights, 2010).

²²⁶ Kate Fisher, 'Oral Testimony and the History of Medicine' in *The Oxford Handbook of the History of Medicine* (Oxford: OUP, 2012), 606.

3.3 Archives

It is important to think about documents in relation to their production (authorship) and their consumption (readership) but one should note that in textual terms, these are not coterminous with the particular individual social actors who read and write. We need to play close attention to the implied readers and to the implied claims of authorship.²²⁷

During my research, I reflected on Atkinson and Coffey's caution against over-interpretation of official documents. They go on to say:

We cannot treat records, however official, as firm evidence for what they report... we have to approach them for what they are and what they are used to accomplish.²²⁸

This view has been supported through reflections of officials such as the minister, Richard Crossman, who commented that government cabinet minutes were 'a travesty [which] do not pretend to be an account of what actually takes place in cabinet.'²²⁹ In the same way, historical annual reports of hospitals give an official view, which must be critically scrutinised and viewed in the context of their creation and not necessarily accepted as what actually takes place.²³⁰ This was advice that I especially kept in mind as I worked, for example, through the files of the RCN Complementary Therapies Forum, held by the RCN archives in Edinburgh, which I visited three times.

²²⁷ P Atkinson and A Coffey in Silverman, ed., *Qualitative Research*, (2000), 56-75.

²²⁸ *Ibid.*

²²⁹ Richard Crossman, *The Diaries of a Cabinet Minister* (London: Hamilton: Cape, 1975).

'The truth is that, useful as they can be, cabinet minutes are notorious for concealing almost as much as they reveal.' Hugh Pemberton: Review of Macmillan Cabinet Papers:

<http://www.heacademy.ac.uk/assets/documents/subjects>, accessed 4 February 2014.

²³⁰ Mark Donnelly and Claire Norton, *Doing History* (London: Routledge, 2011), 77.

My interviews with Stephen Wright, Jean Sayre-Adams and Denise Rankin-Box illuminated the official records I had examined about the formation of the Forum and their parts in it, by referring to the challenges they had faced at the time, both with colleagues and officials. These are the significant and interesting minutiae that inevitably fall between the lines of official committee minutes.

Similarly, The British Association for Holistic Health (BAHH) records held in the Wellcome Collection Archives and those held privately may not be complete²³¹, but they provide evidence of the early years of the movement (1984-86) and the push for the use of CAM in nurses' work. In my interviews with Annette Turton and Inga Newbeck, it was revealing to hear their memories of the period in which they were involved with the BAHH and to compare them with the minutes of meetings. Although there were no major contradictions, as in the example already given, there was one comment made that the collaboration with the BHMA had been straightforward and pleasant, where the minutes had reflected occasional tensions,²³² an opposite experience of Crossman's. The understanding of the committee's aims and early activities were enhanced in hearing the reminiscences in interviews and confirmed the advantages of a multi-methodological approach. The risk was that their view may have shifted my interpretation.

²³¹ I have since been given more files by Roger Beeching, which will be added to those in the Wellcome Library archives at the conclusion of this research.

²³² Wellcome Library, London, Special Collections, Papers of the BAHH, SA/BHH/A5 Box 1.

Jacques Derrida writes of 'archive fever', where the desire for the archive 'is presented as part of the desire to find, or locate, or possess that moment of origin, as the beginning of things.'²³³ Reading that led me to reflect on what I felt when I was handed a box of documents at the archive issue desk. I would be expectant and optimistic that the package, 'the beginning of things', would reveal something extraordinary. The truly extraordinary never happened during this research²³⁴, but what lay instead in those bundles of papers was a gratifying unravelling of the story of how CAM in nursing developed and became more influential throughout the 1980s and 1990s. This became clear from records of the increased numbers of people joining CAM groups and the raised profile of those groups in, for example, the RCN Forum.²³⁵ Examining the original meeting minutes and memoranda, along with scribbled notes on crumpled envelopes, the story slowly emerged in an engaging way. American historian Deborah Symonds discusses the value in handling original documents which enables an 'empathetic contact with the past itself' in touching and smelling the papers directly.²³⁶ And that is how it felt to me. Someone had squirrelled those papers in a file (and someone else had donated them to the archives - did they ever consider the significance of that action?). In the case of the BAHH, the box of papers had been accumulated by one of the founders, David Mayor. He had made the decision to retain a number of personal notes, including comments about individuals, which gave a useful insight into the atmosphere of the organisation and added colour to the black and white facts (for example, personal

²³³ Carolyn Steedman, *Dust* (Manchester: Manchester University Press, 2001), 3.

²³⁴ Carolyn Steedman goes further by referring to the 'everyday disappointment that historians know they will find there', *Dust*, 9.

²³⁵ For example, membership of the RCN Complementary Therapies Forum is recorded in annual reports as increasing from 1,077 (1994) to 11,424 (2000).

²³⁶ Cited in Keith Jenkins and Alan Munslow, *The Nature of History Reader*, (London & New York: Routledge, 2004) and cited in Mark Donnelly and Claire Norton, *Doing History* (2011), 76.

noted comments such as ‘What are the risks of becoming Jacks and Jills of all trades? Can we respect fragmentation yet be aware of the wider context?’²³⁷ reflect the tensions of the early group).

In addition to the archives of the RCN and Wellcome Collection, I examined other archived records, including those at the National Archives at Kew, London for nursing documents, and daily newspapers in the British Library for some contextual stories of nursing and CAM. Most archives preserve records of individuals that one has no expectation of encountering. However, in this case, the papers of the BAHH at the Wellcome archives and the RCN Complementary Therapies Forum at the RCN archives, enabled an introduction to the key players of the CAM movement in nursing. They sometimes comprised a list of names in meeting minutes, or were recorded as individuals making pertinent points at the meetings. Occasionally, there was more detail, which offered an insight into human frustration and relationships. Most of these individuals were still alive and I was able to track down a number of them to interview, although surprisingly few of them had remained in contact with each other, perhaps having moved into different areas of healthcare. These were the principal people involved in CAM in nursing in the 1980s and 1990s, some of whom had left the healthcare profession, some of whom had developed their interest in CAM, and several of whom had become very influential in later groups.

Jane Brooks writes of the chance factor when researching in archives for the history of nursing because of the scarcity of sources. She claims that searching through

²³⁷ Wellcome Archives, London, Special Collections, BAHH papers, SA/BHH/A4.

archives for documentary evidence is akin to doing the lottery,²³⁸ and although twentieth-century archives are obviously more likely to produce a winning ticket, I understood the sentiment about the chance factors of finding useful material. On my last archive visit to Edinburgh, I was hoping to access one final, very small piece of data regarding the RCN forums in the 1990s which would support my oral history interviews that suggested that the Complementary Therapies Forum was one of the most successful and popular RCN forums to have been created. It was a long trip and on the train there, I reflected on the frustration of that and the trade-off between cost, time and effort with only a potential result. On the return train, having found the sought data, I then understood that the value of the excursion north had been a 'beginning of things' and a metaphorical journey too.

3.4 Nursing Journals

How did the source come into existence in the first place and for what purpose? What person, or groups of person, created the source? What basic attitudes, prejudices, vested interests would he, she or they be likely to have? Who was it written or addressed for?²³⁹

This cautionary quotation comes from a framework of research checks and is one of seven questions, which the historian Arthur Marwick refers to as a 'catechism' for the use of the historical researcher. While the other six questions are also valuable reminders of the authenticity of the source, its type, legitimacy of the author and its

²³⁸ Jane Brooks, 'Ghost of the past: capturing history and the history of nursing', *International History of Nursing*, 5, 2000, 36-41.

²³⁹ Arthur Marwick, *The New Nature of History* (Basingstoke: Palgrave, 2001), 179.

relation to other sources, this point about the validity of the creation of the source was perhaps the most relevant when considering the use of journals for this research. When examining a sample of nursing journal articles, I was conscious of the question, 'But who wrote this and why was it written? What was the motivation: was it commissioned or was it submitted independently?' The reader may never know without being able to ask that question. However, my interview with Jane Salvage (*Nursing Times* editor, 1996-2001) helped to clarify it and an archived interview with Peggy Nuttall (editor 1960-1975)²⁴⁰ also provided very helpful background to this aspect, which is discussed in Chapter Six. Jane Salvage described how the reading public was guiding the content of the *Nursing Times*:

By the manuscripts you get sent, you can really see more and more ... what is flavour of the month really. So suddenly we were getting more and more articles about complementary medicine, it was coming up in readers' surveys and it was coming up as a topic that people were interested in.²⁴¹

I initially examined a selection of twentieth-century nursing journals, namely the *Nursing Times*, *Nursing Standard* and *British Journal of Nursing*, held in the RCN archives in Edinburgh and the RCN library in London. The history of the nursing journal is complex and I examined the background and history of each of those which were in circulation. I take the *Nursing Times* as an example. To what extent did the publication reflect the views of the nursing profession? Jane Salvage commented on its aims for accessibility, 'Because nursing is such a broad church, they [editors] want something in it for the new student nurse and something in it for the chief nurse at the

²⁴⁰ British Library Sound Archives, interview with Peggy Nuttall by Anne Marie Rafferty, 20.7.1987, C545/25/01-02.

²⁴¹ Jane Salvage, interviewed 11 May 2015.

Department of Health so there is always something for everyone.²⁴² It was also important for me to establish whether there was a political agenda that I was not aware of. The *Nursing Times* was indeed originally involved with the RCN but in the mid-1960s, the journal increasingly distanced itself from its 'establishment' ties and became a more radical medium for nurses' voices. By 1966 all connections had been severed; the *Nursing Times* wanted to be able to criticise the RCN if it needed to.²⁴³ In 1997, the *Nursing Times* published its mission statement, claiming:

Nursing Times is the independent voice of nursing. It is radical, challenging and professional and aims to inform, inspire and entertain. It campaigns for a better deal for patients and for the nurses, midwives and health visitors who care for them.²⁴⁴

'The history of medical journalism has largely been ignored, yet who can deny its immense impact?' writes Bynum.²⁴⁵ Yet very little has been researched and written about the history of medical journals, nor nursing journals, although the current AHRC project 'Constructing Scientific Communities: Citizen Science in the 19th and 21st centuries', which is examining journals from the nineteenth-century onwards to chart scientific progress, is addressing this.²⁴⁶

Because of its status as the 'independent voice of nursing', I focused on the *Nursing Times* as a sample journal. I searched CINAHL and MEDLINE databases for references to complementary therapies in *Nursing Times* in the years 1960-2000 and, having noted the height of activity being between 1984-2000, I examined the

²⁴² Jane Salvage, interviewed 11 May 2015.

²⁴³ British Library Sound Archives, interview with Peggy Nuttall (*Nursing Times* editor at the time) by Anne Marie Rafferty, 20 July 1987, C545/25/01-02.

²⁴⁴ *Nursing Times*, 29 October, 1997.

²⁴⁵ William Bynum, Stephen Lock and Roy Porter, *Medical Journals and Medical Knowledge* (London: Routledge, 1992), Introduction.

²⁴⁶ www.conscicom.org, accessed 17 May 2016.

884 issues during this period by hand, hard copy by hard copy. Further details of the findings from this process are found in Chapter Six. It was an intensely valuable experience to explore within the covers of nursing writings and, thereby and vicariously, to experience other issues in the culture of the nursing profession. Close reading resulted in finding letters from nurses seeking support and information about therapies, comments in editorials about CAM and even relevant adverts that I would otherwise have missed because they are not items that would be listed on a database. Encountering cartoons was an additional benefit and the extent to which they reflected issues affiliated to this research is relevant. While it is obvious that cartoons have a wide popular appeal, they are also an important part of social discourse and are useful tools for sociological, historical and semantic research.²⁴⁷ I argue that this is significant evidence for the level of contemporary interest in the topic of CAM. Cartoons have a status in communication²⁴⁸ and it is relevant that the issues surrounding nursing care, holistic approaches and complementary therapies were communicated in nursing journals in this satirical way, demonstrating a level of confidence in the expected shared understanding and appreciation by the audience. The appeal of the humour relies on the audience's familiarity with the context of the cartoon²⁴⁹ and the relevance of editorial support is additional evidence for the level of interest in the issues involved, as discussed by Miriam Ginman:

Cartoons are selected for publication by editors with a view to the receptivity of the audience. An editor might not publish a cartoon thought to be too controversial, abstract, or banal for the readership. The profit goal of the cartoonist and publisher is also a factor. Therefore, a sample might have characteristics that reflect not only

²⁴⁷ Ellen Giarelli and Lorraine Tulman, 'Methodological issues in the use of published cartoons as data', *Qualitative Health Research*, 13 (2003) 945-956, 945.

²⁴⁸ Miriam Ginman, 'Cartoons as information', *Journal of Information Science*, 29 (2003) 69-77.

²⁴⁹ A.A. Berger, *An anatomy of humor* (New Brunswick, NJ: Transaction Publishing, 1993).

cartoonist's messages but also the beliefs of the editorial and publishing staff of the written medium.²⁵⁰

A selection of pertinent cartoons from the *Nursing Times* is included at Appendix E. They illustrate how, through visualisation, specific issues that are addressed in this thesis – such as the practice of complementary therapies, the nurse-patient relationship, attitudes towards patients and the identity crisis of nursing in this period – are wittily and engagingly depicted.

Digital humanities – an academic field which, by use of computational tools, enhances humanities research – is a buzzword of the moment.²⁵¹ In my case, it could have greatly eased the data mining challenge of finding relevant journal articles via an online database search and electronic downloading of articles, all from the comfort of a sofa at home, using a laptop. But that seems far more detached from the experience of closely reading each brown-edged, thumbed-through, thirty-year-old issue of the *Nursing Times*. I had, instead, a sense of the culture of the time, each issue reflecting the priorities, tensions and anxieties of the period. CAM articles were placed in the context of topics such as Project 2000,²⁵² the Griffiths Report,²⁵³ the nurse's professional image and other preoccupations of nursing, all of which add important context to my analysis of how complementary therapies fitted within nursing practice at the time. The umbrella term, 'digital humanities', is not just about documents, however, and other media, such as sound recordings in the RCN and Wellcome Collection archives and the British Library, enhanced this study.

²⁵⁰ Ginman, 'Cartoons as information', 948.

²⁵¹ Andrew Prescott, 'The buzzword of the moment', British Library workshop, 17.1.14; Steven Jones, *The Emergence of Digital Humanities* (London: Routledge, 2014).

²⁵² *Project 2000: a new preparation for practice* (London: UKCC, 1986).

²⁵³ *NHS Management Inquiry* (London: DHSS, 1983).

The journals incorporated many articles on nursing and CAM and a variety of modalities and therapies. Taking the example of the *Nursing Times* of 26 March 1986, this issue included an article by Robert Dingwall on the profile of modern nursing ('We want to stop nurses thinking themselves anything more than they are, namely, the faithful carriers out of the doctor's orders'), and another article focused on training for a varied career ('Nursing is seen rather as a craft rather than a profession'). The editorial was written on the topic of image and the role of nursing ('Nurses are confused – they are trying to create new roles for themselves and break through stereotypes'.²⁵⁴)

These articles demonstrate the concerns that were cohabiting in journal pages alongside other articles which encouraged nurses to adopt CAM therapies, such as an article about massage, 'Getting the massage'²⁵⁵ and one on visualisation, 'All in the mind's eye'²⁵⁶, together with promotion for the second Holistic Nursing Conference, 'looking at how holistic nursing could be used...and giving nurses an opportunity for "hands on" experience'.²⁵⁷ Confidence in presenting items on CAM is demonstrated by inclusion of a parody of a complaining letter responding to this trend. It was penned by the occasional phantom ironic contributor to the journal, 'Sister Plume of Ward 10, St Hilda's Hospital',²⁵⁸ and it lamented the rise in complementary therapies being offered by 'cranks, quacks and lunatics'. It is an amusing letter, which of course was the intention. In the process of its satirical approach, CAM – the object of its apparent derision – was both vindicated and

²⁵⁴ *Nursing Times*, 5 March 1986, Editorial.

²⁵⁵ *Nursing Times*, 26 November 1986.

²⁵⁶ *Nursing Times*, 19 February 1986.

²⁵⁷ *Nursing Times*, 19 February 1986.

²⁵⁸ *Nursing Times*, 28 January 1987.

validated. This is reminiscent of earlier examples of medical practitioners adopting Latin pseudonyms to parody medical inventions or using macaronic (a mixture of Latin and vernacular) poetry to parody practices,²⁵⁹ as in Gian Guacomo Bartollotti's (1491-1530) macaronic poem 'Marcaronea medicinalis', about a porter who becomes a doctor, which opens with an invective against quacks.

Perhoché più non se extima un vero et continuamente medico, ma più presto biasmato et private et publice, et li imperiti et ignoranti sommente sono comendati.

A full-time physician is no longer esteemed, but rather blamed both privately and publicly and the untrained and the ignorant are highly praised.²⁶⁰

Similarly, Sister Plume bemoaned the rise in CAM, which, she maintained, was an 'orchestrated strategy to wrest influence and esteem from the medical establishment.'²⁶¹

In summary, the strength of the methodology I used lies in the collection of data by three methods: from oral histories, from archives and from journals of the time, and the process of how these were analysed to provide a rigorous interpretation forms the next section.

²⁵⁹ Sime Demo, 'When Latin gets sick: mocking medical language in macaronic poetry', *JAHHR: European Journal of Bioethics*, 4 (2013).

²⁶⁰ William Schupbach, 'Doctor Parma's Medicinal Macaronic: Poem by Bartolotti', *Journal of the Warburg and Courtauld Institutes*, 41 (1978) 147–191.

²⁶¹ *Nursing Times*, 28 January 1987.

3.5 Analysis

The data from the oral history transcripts were thematically analysed using the software NVivo. Phrases and words were coded and each themed segment was entitled and the themed phrases were then combined so that portions of text from different participants could be examined. As I examined the journals, I noted parallel themes in articles and quotations and stored these electronically so that they could be retrieved effectively by subject. This was also the case with archived records, where notes were made electronically so that they could be digitally searched. I also photographed articles and other items in *Nursing Times* (permitted by the archivist) and set up a cross-referencing system, based on the date of the library visit and the date of journal, to enable the retrieval of items that would be of relevance to the emerging themes. All the themes were based on my three research questions.

As the study developed, supplementary themes became evident, often as a result of items in journals. An example of this was the interview with Dawn Primarolo, the Labour shadow health secretary, about her party's support for nurses' use of CAM.²⁶² I had not encountered reference to this party political element in nursing and CAM elsewhere in the literature. Similarly, the promotion of conferences on the topic of complementary therapies was evident in the *Nursing Times* journals and discussion of these was also contributed by the participants whom I interviewed, together with reference to debates in meeting minutes about the organisation of the same events.

²⁶² *Nursing Times*, 14 July 1993.

Continual reflection enabled the themes to be refined and congruence between data from all these methods strengthened the reliability of my findings.

Selecting appropriate quotations from the oral history transcriptions to illustrate the arguments was important. Doing so empowered the participants by giving them a voice, provided supporting material for my interpretation and enlivened the thesis-reading experience although, naturally, there were constraints on the number and length of quotes due to word limits. The question of achieving a balance in weaving text with voice also had to be taken into account. Having considered these aspects, at the end of the first draft of the thesis, I undertook a re-reading of all the *verbatim* transcripts which had been made after the interviews but prior to their coding, to ensure that views had been fully represented and I had not been over-selective with a biased choice of quotation which may have skewed the perspective. At this stage, I added quotations that I judged would enable further elucidation to the interpretation. Naturally, there were some participants who were more articulate or more loquacious than others and I was mindful to try not to overuse their quotations, and, as far as I am able, I feel confident that words were included from all those who took part and I believe I used the data correctly and appropriately and presented sufficient examples to support the findings.

Limitations of the research are based on sample size, although I believed saturation point was reached in terms of data collection from nurses who had been practising in the time frame, especially in the earlier period. However, it is of course possible that different participants may have presented different views, as with any qualitative study. Nevertheless, in addition to nurses, I felt confident that I interviewed and

collected data from the principal individuals who had been involved in the organisation of CAM in nursing in the research period and that they essentially represented the views of the drivers of the time. Data from these interviews, together with those from examining hard copies of nursing journals and archived material, provided a robust methodology and the consequent triangulation of data obtained from the three sources enabled a rigorous analysis. During this process, I knew it was also important to understand why I was making certain choices and acknowledge any possible personal influences on the way the data was analysed and I sought continually to reflect on how the research was progressing.

3.6 Personal Reflections

Researchers are urged to discuss their experiences, choices and actions during the research process and so demonstrate transparency and understanding of the decisions that are made during it.²⁶³ In acknowledging them, any implicit bias is revealed and evidence shown of how experiences and values may have influenced research.²⁶⁴ I began a personal log a year before the study began and which became increasingly important as a reflexive tool, providing a means to track perceived progress and confidence in the project, as well as recording the way I was thinking about it and keeping my reasoning 'transparent'.²⁶⁵ I found it a practical means to monitor ideas, plans and commitment to proposed actions and it enabled

²⁶³ Michelle Ortlipp, 'Keeping and Using Reflective Journals in the Qualitative Research Process', *The Qualitative Report*, 13 (2008) 695-705; K. Mruck and F. Breuer, 'Subjectivity and Reflexivity in Qualitative Research', *FQS*, 4 (2003) 3.

²⁶⁴ Harrison MacGibbon and Morton, 'Regimes of trustworthiness in qualitative research: The rigors of reciprocity', *Qualitative Inquiry*, 7 (2001) 325, quoted in Ortlipp, 'Keeping and Using Reflective Journals', *The Qualitative Report*, (2008) 695-705.

²⁶⁵ Silverman, *Doing Qualitative Research*, 249.

me to maintain a critical distance by recording experiences and observations, as well as evaluations of how the project was developing.

My personal choice of health remedies, natural or biomedical, is based on an open mind. While not having any conscious motivation in undertaking this project because of wanting to promote CAM, I recognise that I am interested in the potential of alternatives. I concede that there could be energies beyond the material and that mind-body strategies may well challenge a biomedical scientific paradigm as the only possible template for health provision as well as, arguably, supporting self-healing.²⁶⁶ I have questioned whether this perspective has influenced my research and the analysis of it, and I have challenged myself as to whether I have consciously or subconsciously wanted those nurses in my study to defy orthodoxy, in striving to find evidence for their use of CAM. Was I silently hoping to find them bucking the medical model? But, because of my lack of clinical and nursing experience, I know that I had no preconceived ideas about the use of CAM by nurses. And in being conscious of possible influences, and transparent about them, I hope I have negated their effects on partiality. Personal beliefs have undoubtedly made my research of greater interest, but they have not, I believe, resulted in any influential bias on the findings. These findings now follow in three data chapters, the first of which examines the reasons for nurses' awakening to the potential of CAM use in their work and explores the historical, cultural and professional contexts in which this occurred.

²⁶⁶ Brian Inglis, *Fringe Medicine*, 266; George Lewith, *Complementary Medicine: an integrated approach*, 90; Mike Saks, *Alternative Medicine in Britain*, 226.

CHAPTER FOUR: ENVIRONMENT AND AWAKENING

4.1 Introduction

Why should nurses have turned to using complementary and alternative medicine in their work? By examining existing literature, new empirical data and archival sources, this chapter responds by considering the historical environment and the contexts of healthcare, culture and nursing. It provides the foundation for this thesis by arguing the relationship between push and pull factors that encouraged the use of CAM and the correlation between the late twentieth-century *zeitgeist*, political developments in nursing and the emergence of complementary therapies.

Exploration of this particular combination contributes to the knowledge about CAM in British nursing practice in 1960-2000 by setting the cultural and healthcare scene of the time which adds to the wider discussion around public discontent with medicine in the second half of the twentieth century.

The chapter is constructed in three parts. It opens with consideration of the terminology of CAM, which changed throughout the period of this study. These variations have been briefly discussed in the literature review (Chapter Two) but, because of the way the language significantly reflects the attitude to its practice, I believe it is important to focus on it again here. Changes in terminology were not just a convenience of vocabulary, but, I argue, a reflection of the development in *perception* of CAM over forty years. In analysing the interview data, this was an issue that frequently emerged and it is appropriate to address it first. It provides an

important background to the period and enlightens the understanding of nurses' attitudes to CAM.

The second and main part of the chapter investigates the historical context and is arranged in three sections. It opens with an examination of the historical perspective of healthcare and discusses the debate, doubt and distrust in medicine, which emerged in the 1960s and 1970s. The re-awakening of holistic concepts is examined and a discussion on whether this was a change in consciousness or a paradigm shift in healthcare is developed. In the second section, I suggest that the cultural *zeitgeist* in the 1980s resonated with a heightened awareness of self-responsibility, a mood of openness and expressiveness and the establishment of 'new experts'. The emerging consciousness of – and national interest in – CAM provided the opportunity for consumers, including healthcare professionals such as nurses, to explore it. Having investigated the healthcare element and the cultural component, the third section focuses on the nursing context of the study. Examining distinctive periods of nursing history within the timeframe of this research provides a framework of nursing developments and political changes and how they affected CAM use. The particularly relevant years are in the latter part of the period (mid-1980s-2000) when nurses began to incorporate complementary therapies and which coincided with changes in the health service which fundamentally had a great effect on nursing.

The chapter concludes by examining the pluralistic heritage of late twentieth-century nursing practice and summarises the major push-pull reasons for nurses turning to

CAM, which include disillusionment, frustration, role enhancement and a desire for a heightened element of rapport in nursing practice. The effect of the growing use of technology and mechanistic procedures on nurses' work increasingly threatened the implementation of holistic models, and I argue that the resulting marginalised care element in nursing provided an affinity with marginal CAM therapies, leading to its implementation by some nurses.

4.2. Terminology

Nurse-writers and proponents of CAM Joanna Trevelyan and Brian Booth claim that, in 1950, there was no collective term for what are now called CAM therapies, although 'quackery' was the word much used by doctors.¹ In 1960, the expression 'fringe medicine' was coined by the historian and journalist, Brian Inglis and the medical writer, Geoffrey Murray.² Murray, in his earlier work on medical unorthodoxy,³ had struggled with a simple term, referring instead to practitioners as 'healers', working 'outside the frontiers' (and also conversely described biomedicine as 'outside the inevitable lunatic fringe'⁴). This image of exclusion and working beyond the boundary of orthodoxy continued to be employed in all later terms for CAM, as medical historian Roger Cooter, medical historian Roberta Bivins and social historian Marijke Gijswijt-Hofstra observe when noting that the terminology for the systems and products of what are now called CAM were predominantly defined

¹ Joanna Trevelyan and Brian Booth, *Complementary Medicine for Nurses, Midwives and Health Visitors* (Basingstoke: Macmillan, 1994), 1.

² Brian Inglis, *Fringe Medicine* (London: Faber & Faber, 1964), 271, referring to article 'Fringe Medicine', *The Spectator*, 28 October 1960.

³ Geoffrey Murray, *Frontiers of Healing, the story of medical unorthodoxy, its achievements, its leaders and its future* (London: Max Parrish, 1958).

⁴ *Ibid.*, 249.

relative to what they were *not*, quoting the terms ‘unconventional’, ‘unorthodox’, and ‘marginal medicine’.⁵ Even defining the content of CAM is not without controversy, and health geographers Marcus Doel and Jeremy Segrott term it ‘a chaotic conception without taxonomic closure’.⁶

This question of terminology has been discussed in the literature review (Chapter Two) but I examine it again here. In order to refine the periods for the timescale of the changing terminology, I used the phrase-searching graphing tool Google Ngram⁷ and this reveals that the terms ‘alternative medicine’, ‘complementary medicine’ and ‘CAM: complementary and alternative medicine’ were first used in British English texts in 1970, 1977 and 1990 respectively. The Ngram graph (at Appendix F), although limited in its scope in tracking language, indicates the steady and parallel increase in use of ‘alternative’ and ‘complementary’, in spite of ‘CAM’ being now the more accepted term among researchers.⁸

The British Medical Association (BMA) made a significant change in the titles of its two important reports on non-orthodox medicine. Their 1986 report was simply entitled, *Alternative Therapy*, but by 1993 the tone had changed (and so, too, the more conciliatory content of the report) with the title, *Complementary Medicine, New*

⁵ Roger Cooter, ed., *Studies in the History of Alternative Medicine*, (Basingstoke: Macmillan 1988); Roberta Bivins, ‘Histories of Heterodoxy’, in Mark Jackson, ed. *Oxford Handbook of History of Medicine* (Oxford: OUP, 2011); Marijke Gijswijt-Hofstra, ‘A sense of gender: different histories of illness and healing alternatives’ in Robert Jutte, Motzi Eklof and Marie Nelson, *Historical Aspects of Unconventional Medicine* (Sheffield: European Association for the History of Medicine and Health Publications, 2001), 39.

⁶ M Doel and Jeremy Segrott, ‘Self, Health, and Gender: complementary and alternative medicine in the British mass media’, *Gender Place and Culture*, 10 (2003) 131.

⁷ Google Ngram Viewer charts the yearly count of selected *n*-grams as found in 5.2 million books digitised by Google Inc.

⁸ Nicola Gale ‘The sociology of traditional, complementary and alternative medicine’, *Sociology Compass*, 8 (2014) 805-822.

Approaches to Good Practice. Sociologists Sarah Cant and Ursula Sharma claim that this change in terms was a deliberate strategy to develop perception from a scientific to a co-opting one.⁹ These developments in language demonstrate the evolution towards a mollified perception of CAM over the period of this study – from an excluded practice situated outside the mainstream to an accepted practice which, in the later period of the study, was increasingly referred to as ‘integrative’ or ‘integrated’. However, health sociologist Nicola Gale is critical of the integration discourse as it is invariably biomedical-centric.¹⁰ (I deliberately avoid the phrase ‘integration’ of CAM in the thesis. Because of the possible confusion with other definitions of the word, such as the integration of medical and social care, I have chosen instead to use the terms ‘implementation’ or ‘incorporation’, rather than ‘integration’ when referring to the use of CAM in mainstream healthcare).

Participants in my research, who represent a range of working periods, themselves raised the question of terminology, in spite of the fact that the issue was not introduced in my questions. During the later part of the study, the terms ‘alternative’ and ‘complementary’ were in use concurrently (the combined term ‘complementary and alternative medicine’, or CAM, was not in general use until the 1990s, as shown), but several interviewees emphasised that for them, there was a distinction.

‘Complementary or alternative?’ retired nurse Julia Ayres asked me, in order to clarify one of my questions.¹¹ Her implication was that an ‘alternative therapy’ was one that rejected a biomedical approach, whereas ‘complementary’ suggested its

⁹ Sarah Cant and Ursula Sharma, *A new medical pluralism: alternative medicine, doctors, patients and the state* (London: UCL Press Ltd, 1999).

¹⁰ Nicola Gale, ‘The sociology of traditional, complementary and alternative medicine’, *Sociology Compass*, 8 (2014) 805-822.

¹¹ Julia Ayres, interviewed 1 February 2014.

cooperative use with biomedicine. Several other participants grappled with this distinction. Nurse Peter Mackereth spoke of CAM accordingly: 'to me it's very *integrated*, it doesn't have to be *alternative*. I don't like that word ...'¹²

The term 'holism' was also discussed by participants. In defining her understanding of the term holism, nurse Elizabeth Cranham described it simply as, 'Treating the patient as a whole - taking *all* things into consideration, not the specific reason that they're in hospital for.'¹³ Nurse Inga Newbeck, writing in the *Nursing Times* in February 1986, argued that the words 'alternative' and 'complementary' were not interchangeable with 'holistic', stating that it was the framework in which you worked that was important, emphasising that it was 'not so much what you do, but how you do it'.¹⁴ This theme is an important one and is explored more deeply in Chapter Six. Nurse and therapist Jean Sayre-Adams also referred to the controversial topic of holism and CAM and the way in which the terms are confused and conflated:

If you are talking about holistic, then it isn't something ... I mean, holistic is complementary, but complementary is not holistic. So what words do you use? I haven't really come to one.¹⁵

In this context, nurse educator Annette Turton challenged me early in her interview:

I think we have to start by asking, 'what do we mean by complementary therapies? And it is complicated... it depends in which arena you are talking as to whether it is complementary, whether it is holistic, whether it is just what we do.... I like the word complementary – it means what it says.'¹⁶

¹² Peter Mackereth, interviewed 30 January 2014.

¹³ Elizabeth Cranham, interviewed 4 June 2014.

¹⁴ *Nursing Times*, 19 February 1986.

¹⁵ Jean Sayre-Adams, interviewed 15 January 2014.

¹⁶ Annette Turton, interviewed 10 April 2014.

Ruth Sewell, founder of the Holistic Nurses Association, developed this further by giving a clear explanation of how the introduction of the term ‘complementary’ clarified what was being offered. She explained that it does not provide a conflicting therapy, but an additional one.

Then the term 'complementary' started to come in and that was much better, politically speaking, because it wasn't trying to put the boxing gloves on with allopathic medicine. You were saying, 'In addition to your radiotherapy, in addition to your statins, why don't we give you reflexology for your problems? Why don't we give you massage? Why don't we give you English herbal medicine to support what else is being done for you?

Some of the interviewees wanted to clarify the language even further. For example, nurse Alison Ellis was keen to contradict a hippy ‘fringe’ perception, as shown here in her distinction between an offbeat image (by introducing her own flippant term) and a professional one:

It was not sort of happy-clappy, dippy stuff. We were all professional women who felt that some of these therapies were of benefit to our patients.¹⁷

And midwife/therapist Denise Tiran, too, stressed that she approached her CAM practice in ‘a professional way, a fairly scientific way’, disowning the perception of it as a ‘sort of airy fairy thing that complementary therapies sometimes have...’¹⁸

These comments from interviews provide evidence of how nurses challenged perceptions. Both of the above participants were clear to distance themselves from stereotypes about CAM — pejoratively dismissing the terms ‘happy-clappy’, ‘dippy’ and ‘airy-fairy’ and contrasting them in each case with mention of ‘professional’ connections, acknowledging that *public* perception of CAM was sometimes

¹⁷ Alison Ellis, interviewed 12 May 2014.

¹⁸ Denise Tiran, interviewed 18 June 2014.

recognised as hippy or mystical, but that *their* involvement was proficient and serious. Sarah Cant and Peter Watts have engaged with the issue of professionalisation of nursing and its relation to CAM, claiming that aspirations for professional autonomy led to a wave of interest in CAM (while full autonomy was never achieved).¹⁹

Having discussed a range of terms in her interview, Annette Turton added her own straightforward and pragmatic definition in concluding:

Complementary therapy, holistic care, is trying to think out of the box of ways you help the situation - without doing more harm than good.²⁰

I reflected on whether ‘thinking out of the box’ had been a possible concept in nursing in the early part of the period of this research, or whether practice had been constrained to match the scientific model. To consider this, it was necessary to understand the historical context of these possibilities, and how attitudes to healthcare developed at the time is the next theme that I discuss.

¹⁹ Sarah Cant and Peter Watts, ‘The knowledgeable doer’ in Nicola Gale and Jean McHale, *Routledge Handbook of Complementary and Alternative Medicine; perspectives from social science and law* (Routledge, 2015).

²⁰ Annette Turton, interviewed 10 April 2014.

4.3 Historical Context

4.3.1 Healthcare

‘Medicine reached the height of its prestige in the 1950s’, claims medical historian Keir Waddington. There was, he says, ‘a sense that medicine was contributing to an improving society.’²¹ This perception of medical progression and confidence had been encapsulated in the President of the British Medical Association, Lord Horder’s assuredly optimistic reply in 1949 to the question of where medicine was heading, when he declared ‘Straight ahead!’²² In his address to the West London Medico–chirurgical Society, he added:

[Medicine will be]... forging still more weapons with which to conquer disease, taking still more toll of science in the interest of humanity, adding more and more culture to more and more learning, improving both the art and the crafts. Medicine has only just begun its task...²³

However, Horder’s supreme confidence in medicine was to be contested. In the 1960s (and only a decade after the public was introduced to miracle drugs such as penicillin), challenges to heightened expectations of medicine emerged from three separate sources. I summarise these as stemming from debate, from doubt and from distrust, all of which left the door open for new approaches. I purposely include media quotations in this section in order to demonstrate that the debate extended beyond the academy and profession, to society in general. In addition to scholarly views and the personal observations of my interviewees, the press comments here reflect the public mood. Debates commenced in the early 1960s and 1970s when

²¹ Keir Waddington, *An Introduction to the Social History of Medicine* (London: Palgrave Macmillan, 2011), 184.

²² Lord Horder, ‘Whither Medicine’, *British Medical Journal*, 1 (1949) 557-60, 558.

²³ Quoted D. Todd, ‘Medicine: quo vadis’, *Hong Kong Medical Journal*, 5 (1999) based on his Halnan Lecture, 26 November 1998.

scholars and thinkers confronted the medical model and I will outline three key individuals who vigorously ‘shook the medical establishment cage’ with their critiques of medicine – Ivan Illich, Michel Foucault and Thomas McKeown.

‘The greatest threat to health in the world is modern medicine’ argued the Austrian social critic Ivan Illich (1926-2002).²⁴ He claimed that iatrogenic disease – disease caused as a consequence of medical treatment such as the side effects of medication – threatened patient safety. He stressed the value and virtue of responsibility for self, claiming that the medical profession had medicalised many natural processes, such as pregnancy, birth and death, thereby reducing the value of human experience in applying medical knowledge to social experience and behaviour which is not necessarily medical or biological.²⁵ Although iatrogenesis was first introduced in Illich’s work²⁶ and that of Irving Zola²⁷ and Thomas Szasz²⁸, among others, it was Illich who argued that the doctor caused ill-health and that the promise to end pain and eliminate disease was a ‘tragic de-humanising confidence-trick.’²⁹ By intervening in natural human processes, doctors led individuals to a diminution of human endeavour,³⁰ Illich claimed.

²⁴ Ivan Illich, Lecture 1974, quoted by Richard Smith in ‘Review of *Limits of Medicine: Medical Nemesis*, expropriation of medicine’, *Journal of Epidemiology & Community Health*, 57 (2003) 928.

²⁵ Kevin White, *An introduction to the sociology of health and illness* (London: Sage, 2002), 42; P. Conrad, *The Medicalization of Society* (Baltimore, Md; London: Johns Hopkins University Press, 2007), 4.

²⁶ Ivan Illich, *Limits to Medicine: medical nemesis: the expropriation of health* (Harmondsworth: Penguin, 1976).

²⁷ Irving Zola, ‘Medicine as an institution of social control’, *Sociological Review*, 20 (1972) 487-504.

²⁸ Thomas Szasz, *The Myth of Mental Illness* (London: Secker and Warburg, 1962), *Law, Liberty and Psychiatry* (New York: Macmillan, 1963).

²⁹ Illich, *Limits to Medicine* (1976), 22, quoted in Patrick Pietroni, *The Greening of Medicine* (London: Gollanz, 1990), 36.

³⁰ The legacy of this argument continues, evidenced by *BMJ* special issue on Illich, 13 April 2002.

A further challenge to the medical model came from the French philosopher, Michel Foucault (1926-1984), particularly in his work of the early 1980s. Claiming that the medical profession used its knowledge and authority (*le savoir*) to 'shore up the status quo and segregate, stigmatise and pathologise recalcitrant groups',³¹ Foucault claimed that this concentration of knowledge in a privileged group was brought about when 'writing and secrecy were introduced.'³² The resulting medical gaze, Foucault argued, funnelled the patient's problems into the biomedical model of the doctor's expectations, creating an abusive doctor-centred power structure.³³

From 1955, Thomas McKeown (1912-1988), British Professor of Social Medicine at the University of Birmingham (UK), had argued – and later published – ideas which would become known as the 'McKeown Thesis',³⁴ claiming that disease in the nineteenth century had started its decline long before the proliferation of effective biomedicine, and that living and nutrition standards were instead responsible for declining mortality.³⁵ His work was to have much impact on health planning in the 1970s and 1980s and justified the shift from 'high tech' hospital-based medicine towards primary care³⁶ (a shift which Illich also felt was necessary). This was

³¹ Jonathan Reinarz and Rebecca Wynter, eds, *Complaints, Controversies and Grievances in Medicine: historical and social science perspectives* (Routledge, 2014), 13.

³² Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (London: Tavistock Publications, 1973).

³³ David Misselbrook, 'Foucault', *British Journal of General Practice*, 63 (2013) 312.

³⁴ James Colgrove, 'The McKeown Thesis: an historical controversy and its enduring influence', *American Journal of Public Health* (American Public Health Association) 92 (2002) 725–9.

³⁵ Thomas McKeown, *The Role of Medicine: Dream, Mirage or Nemesis* (London: Nuffield Provincial Hospitals Trust, 1976).

³⁶ Virginia Berridge, *Health and Society in Britain since 1939* (Cambridge: Cambridge University Press, 1999), 57.

reinforced by the Black Report of 1980, which highlighted inequalities in healthcare, caused by economic inequality.³⁷

Finally, there was doubt. Medical historian Jonathan Reinarz claims that queries about the effectiveness of healthcare began to emerge in mid-century contrasting with the expectation of success and advancement referred to by Kier Waddington: 'By the 1960s, people were increasingly beginning to question rising expenditure on medical technologies that seemed to offer diminishing returns in terms of quality of life,' he says.³⁸ Sceptical concerns about procedures, about drugs and about professional values added to the growing misgivings about medicine,³⁹ and the thalidomide drug case was one such tragic episode. Thalidomide was introduced by German pharmaceutical firm Chemie Grunenthal in 1956 for use by pregnant women, but it was only five years later that its disastrous effects of causing phocomelia, a crippling deformity, affecting some 10,000 babies, became apparent. Only 50% of them survived.⁴⁰ A restriction on the introduction of new drugs resulted and episodes such as this, together with adverse medical results and disillusionment when spectacular successes with curing disease did not continue to increase, compounded the sense of doubt and lack of confidence in the public.

Indeed, sociologist Helen Jones claims that the 'window of optimism' in healthcare existed only between 1948 and 1975.⁴¹ Biomedicine was 'hoisted on the petard of

³⁷ *Inequalities in Health: report of a research working group* (DHSS, 1980).

³⁸ Reinarz and Wynter, eds, *Complaints, Controversies and Grievances in Medicine*, 12.

³⁹ Waddington, *Introduction to the Social History of Medicine*, 184; Andrew Malleon, *Need Your Doctor Be So Useless?* (London: Allen & Unwin, 1973).

⁴⁰ Frederick Cartwright, *A Social History of Medicine* (London: Longman, 1977), 187.

⁴¹ Helen Jones, *Health and Society in Twentieth-Century Britain* (London: Longman, 1994).

its own propaganda', claims medical sociologist Keith Bakx.⁴² Cancer, heart disease and the common cold prevailed and, some suggested, would remain with humans into subsequent generations. In 1977, a General Household Survey (GHS) was conducted by 'careful sampling of the whole British population' and reported that 56% of all men and 70% of women suffered from chronic health problems. Of these, 67% of men and 71% of women testified that they had to take some continuous form of special care because of their chronic ill health.

In rough round figures, this means that of a population of 56 million, 35 million people now consider themselves chronically ill. And 24 million of the population of Britain are constantly preoccupied with the special care they need because of their poor health.⁴³

Distrust of healthcare followed and, by the 1970s, the role of medicine was under strain.⁴⁴ By 1980, a UK poll found that the percentage of people trusting in the wisdom of doctors had fallen from 52% in 1978 to 39% in 1980.⁴⁵ Further challenges arose and belief in the power of medicine took several further hits, not least with the emergence of HIV/AIDS. AIDS was first diagnosed in 1981⁴⁶ and its pattern was characterised by uncertainty and change, and viewed as 'a profoundly threatening medical crisis'.⁴⁷ Moreover, as with other chronic diseases, the failure of modern

⁴² Keith Bakx, 'The 'eclipse' of folk medicine in western society', *Complementary Therapies in Medicine*, 7 (1999) 116-118.

⁴³ Arabella Melville and Colin Johnson, *Cured to Death* (London: Secker and Warburg, 1982), 92.

⁴⁴ *Ibid.*, 55.

⁴⁵ Ruth West and Brian Inglis, 'If the mind is fit, the body will cure itself', *The Times*, 8 August 1983, quoted in Stephen Fulder and Robin Monro, 'Complementary Medicine in the United Kingdom: patients, practitioners, and consultations', *Lancet*, 7 September 1985.

⁴⁶ i.e. it was first clinically observed in 1981, first named 'Human Immunodeficiency Virus' infection and 'Acquired Immune Deficiency Syndrome' in 1982. Randy Shilts, *And the Band Played On: politics, people and the AIDS epidemic* (New York: Penguin Books, 1987).

⁴⁷ *Ibid.*, xxiii, quoted in Annette Turton, unpublished PhD thesis, *To identify the community nursing service needs of patients with HIV/AIDS related illness; to evaluate the care given; and to make recommendations for improving the service*, 19.

Western medicine to produce a cure was devastating. Annette Turton in her 1997 PhD thesis claimed:

The advent of a new and fatal infectious disease and fears of a resulting catastrophic epidemic [...] forced a re-evaluation of Western society's mores and organisational response to crisis.⁴⁸

In 1984, the U.S. Health and Human Services Secretary Margaret Heckler, announced that the probable cause of AIDS had been discovered and a vaccine would be available within two years. Great expectation in medicine's ability to find a cure followed and some patients in the USA worked with organisations such as the Food and Drug Administration (FDA) to test new drugs. However, others – both in the US and UK – increasingly turned to CAM remedies in the face of biomedicine's apparent failure, in order to regain control over their illness.⁴⁹ Self-help groups and networks were established to share lay information and other support mechanisms were created in which alternative therapeutic models were examined such as CAM.⁵⁰ In 1996, the introduction of highly active antiretroviral therapy (HAART) radically changed the outcome of HIV/AIDS in industrialised countries, but prior to this, people living with HIV/AIDS followed a predictable pattern where destruction of the immune

⁴⁸ *Ibid.*, 19.

⁴⁹ S.E. Barton *et al*, 'Complementary therapies used by people with HIV infection', *AIDS*, 6 (1994) 561; Richard Palmer, 'Use of complementary therapies to treat patients with HIV/AIDS', *Nursing Standard*, 22 (2008) 35-41; Richard De Visser, Douglas Ezzy, Michael Bartos, 'Alternative or Complementary? Nonallopathic remedies for HIV/AIDS', *Alternative Therapies in Health and Medicine*, 6 (2000) 44-52.; R. and M. Root Bernstein, *Honey, Mud and Maggots: science behind folk remedies and old wives tales* (New York: Houghton Muffin, 1999), 248; Carrie E. Foote-Ardah, 'The meaning of complementary and alternative medicine practices among people with HIV in the United States: strategies for managing everyday life', *Sociology of Health and Illness*, 25 (2003) 481-500; Dorothy Pawluch, Roy Cain, and James Gillett, 'Lay constructions of HIV and complementary therapy use', *Social Science and Medicine*, 51 (2000) 251-64; Rachel Thorpe, 'Integrating biomedical and CAM approaches: the experiences of people living with HIV/AIDS', *Health Sociology Review*, 17 (2008) 410-418.

⁵⁰ Virginia Berridge, 'Health policy, health and society 1974-1990s' in Virginia Berridge, *Health and Society in Britain since 1939* (Cambridge: Cambridge University Press, 1999), 73.

J.P. Liu, E. Manheimer, and M. Yang, 'Herbal medicines for treating HIV infection and AIDS', *Cochrane Database of Systematic Reviews*, 3 (2005).

Also described by Peter Mackereth, interviewed 30 January 2014.

system led to inevitable death.⁵¹ Barton *et al* recognised that:

the use of alternative treatments reflects the failure of traditional medicine to produce a cure for HIV infection. Furthermore the low rate of reported side effects contrasts sharply with those associated with most drugs taken by patients with HIV infection and may be an important factor in the popularity of alternative medicine.⁵²

Interest in holistic health and use of CAM by people with AIDS is well documented,⁵³ not only in their hope of a cure but as a means of boosting immune systems.⁵⁴ Pat Turton described how ‘for patients with HIV, in that epidemic, when there wasn’t a lot that people could do, that was a time when people turned to CAM as being something they *could* do.’⁵⁵ A 1999 study by Agnoletto *et al* into CAM use among HIV-positive people, conducted in the pre-HAART era, ‘showed CAM usage was commonly reported by individuals who had experienced at least one AIDS-defining illness’ quoted Richard Palmer in his article in *Nursing Standard* on the history of CAM use in HIV/AIDS patients.⁵⁶

Behind this specific example of biomedicine’s failure to treat a chronic illness lies an underlying contemporary reductionist understanding about the body and it is important to examine it here in order to appreciate the demand by some for change. I have argued that the public had become increasingly frustrated and disillusioned

⁵¹ Richard Palmer, ‘Use of complementary therapies to treat patients with HIV/AIDS’, *Nursing Standard*, 22 (2008) 35-41.

⁵² Barton *et al*, ‘Complementary therapies used by people with HIV infection’, *AIDS*, 6 (1994) 561, quoted in Annette Turton’s PhD thesis (1997), 50.

⁵³ Annette Turton, 324.

⁵⁴ Vittorio Agnoletto *et al*, ‘Use of complementary and alternative medicine in HIV-infected subjects’, *Complementary Therapies in Medicine*, 14 (2006) 193-199.

⁵⁵ Pat Turton, interviewed 9 June 2014.

⁵⁶ Vittorio Agnoletto, M. Martini and L. Hollander, ELECTIV: European Level Evaluation of Complementary techniques in HIV. 7th European Conference on Clinical Aspects and Treatment of HIV Infection. October 23-27 1999, Lisbon, quoted in Richard Palmer, ‘Use of complementary therapies to treat patients with HIV/AIDS’, *Nursing Standard*, 20 (2008) 35-41.

with biomedical healthcare and this was encapsulated in 1964 in a comment made by the journalist Gerda Cohen who dramatically declared in her book, 'Patients are becoming impatient: of being treated like chipped flowerpots in for repair; of queues; of being kept in ignorance.'⁵⁷ In 1980, the academic health lawyer, Professor Ian Kennedy, in his Reith lectures, also summarised the reductionist healthcare approach, stating:

Modern medicine has taken the wrong path. An inappropriate form of medicine has been created, in large part by doctors and medical scientists, and eagerly accepted by a willing populace. I will go further. The nature of modern medicine makes it positively deleterious to the health and wellbeing of the population...

The image created of medicine has increasingly been that of a curative science in which the model of the doctor is that of the engineer-mechanic curing a sick engine.⁵⁸

This was not just a topic for academic focus, but one of popular discussion, as the following newspaper articles demonstrate. Developing Kennedy's mechanical metaphor, historian Roy Porter in *The Observer* stated:

And if you view ailments as medical breakdowns (here some tubes blocked, there a screw loose), all that's left for the patient is to lug his body along to the surgery, as though he is taking his car for a service.⁵⁹

Physician Patrick Pietroni, quoted in the same article, articulated the need to rebalance medicine:

Scientific medicine like the tower of Pisa, started slightly off-centre, has leaned further and further at an angle and now is toppling over and we have got to bring the balance back.

⁵⁷ Gerda Cohen, *What's Wrong with Hospitals?* (Harmondsworth: Penguin, 1964), 9.

⁵⁸ Ian Kennedy, Lecture 2: *The New Magicians*, transmitted 12 November 1980 as part of Reith lecture series *Unmasking Medicine*, BBC Radio 4, published as *The Unmasking of Medicine* (London: George Allen and Unwin, 1981).

⁵⁹ 'On Doctor Orders', *The Observer*, 18 September 1983.

These types of comments publicly challenged the dominance of biomedicine and suggested that another model should be explored. It is significant that the public mood reflected this culture. *The Times* in its March 1985 leader, 'Holistic Healing', said:

Treating the body as a machine subject to mechanical malfunctions proved a very rewarding approach up to a point. But repair shop methods tempted doctors to lose sight of other truths that a patient is a person, integrated and unique, and should be treated as an ally rather than an object ...⁶⁰

The reductionist model – or the 'Let's fix it approach' – of technical care⁶¹ continued to be challenged and these public stirrings of disquietude in the 1980s were reflected in my fieldwork results. Clearly, health practitioners themselves were challenging this prevailing model, as doctor and CAM researcher George Lewith described:

A doctor with a range of skills was popular in the 90s – that is what people want ...they want somebody who will listen and understand, not put them in a box but build the box around them...Rather than say 'this is the box and you will fit into that, whether you like it or not.'⁶²

What emerges from the data from nurse interviews is a sense of unease alongside an aspiration to extend, expand and enhance nursing practice. Nurse-come-reflexologist Angela Taylor put it simply in saying that, within the biomedical model, 'things weren't quite right':

Conventional medicine was more tablet-driven and a lot of the research results were funded by the drug companies. And there was a growing suspicion – unease – that things weren't quite right, possibly... There was a lot of questioning ...⁶³

⁶⁰ *The Times*, 13 March 1985.

⁶¹ Jane MacNaughton, University of Durham; podcast 23 Apr 2013, accessed 4 October 2014.

⁶² George Lewith, interviewed 8 February 2016.

⁶³ Angela Taylor, interviewed 11 February 2014.

Other nurses also recalled their unease and suspicion, as nurse-academic Professor Stephen Wright explained:

We were following a trend that should have indicated that perhaps not all was well with mainstream medicine, punters were looking for something else, something that the mainstream system wasn't providing - that personal touch, that possibility of healing and wellbeing when the system or the drugs or the treatment can't fix you.⁶⁴

The Holistic Nurses Association (HNA) founder, Ruth Sewell, also recollected her apprehension: 'I can remember as a young person thinking, "It is all moving too fast, we are losing each other in this!"'⁶⁵ Some nurses were looking for alternatives and reflecting on how health and wellbeing could be improved, claimed Alison Ellis, who suggested there were other ways:

[of] opening up people's sensibilities to the fact that not everything needs a doctor or a magic bullet. That there are so many more ways that health can be maintained and helped.

In 1984, health policy scholar J. Warren Salmon wrote of a 'specter of alternative approaches to health and healing haunting scientific medicine',⁶⁶ echoing the view of some nurses and health workers that, as nurse Hermione Elliott said, 'there is much more to support healing than I had realised....'⁶⁷ By the early 90s, the limitations of biomedicine were broadly acknowledged. Medical historian Andrew Wear summarised it more pessimistically: 'Government has taken on board the idea that

⁶⁴ Stephen Wright, interviewed 16 January 2014.

⁶⁵ Ruth Sewell, interviewed 26 January 2015.

⁶⁶ J. Warren Salmon, ed., *Alternative Medicines: Popular and Policy Perspectives* (New York; London: Tavistock, 1984), Introduction.

⁶⁷ Hermione Elliott, interviewed 12 November 2014.

scientific medicine may not be able substantially to improve health status.⁶⁸ Keith Bakx claimed biomedicine was 'undergoing a major crisis',⁶⁹ and public health historian Virginia Berridge also acknowledged this threat. She viewed the challenge to biomedicine and the incorporation of alternative medicine in British healthcare as 'part of the attack on medical imperialism.'⁷⁰ I would argue that it was less a strategic attack, than welcoming an emerging alternative resource. Nurses Hermione Elliott and Pat Turton expressed their hunger for another approach:

I began to question Western medicine - this was in my mid 20s - and thinking, 'This can't be it! This isn't the whole deal.'⁷¹

[It] was not really so much the therapies - although that came later for me - it was the idea of a holistic model of health so that mind, body, spirit model of health ... seemed to me a very powerful way of helping people to understand how to keep well, to improve their health, how to manage their health and wellbeing. And it is not always very helpful the way it's done in the Health Service – 'have these pills and you'll be fine.'⁷²

This growing awareness of the possibility of an adjustment in healthcare culture grew. From a sense of unease with the prevailing model came a powerful urge for change in the 1980s. By the late 1990s, 75% of the public supported NHS access to CAM.⁷³ Had this emerged in a change in consciousness or something more? Could it be deemed a paradigm shift?

⁶⁸ Andrew Wear, *Medicine in Society: historical essays* (Cambridge: Cambridge University Press, 1992), 320.

⁶⁹ Bakx, Keith, 'The 'eclipse' of folk medicine in western society', *Sociology of Health and Illness*, (1991) 31.

⁷⁰ Berridge, *Health and Society*, 81.

⁷¹ Hermione Elliott, interviewed 12 November 2014.

⁷² Pat Turton, interviewed 9 June 2014.

⁷³ Research Council for Complementary Medicine Information Service (1997).

4.3.2. A paradigm shift or an awakening?

A paradigm shift – a term introduced by science historian and philosopher Thomas Kuhn⁷⁴ – is a change in perspective, or a process of transitioning of values, often painfully and in a revolutionary way. For some, holism had indeed effected a sudden impact and American author Marilyn Ferguson described the new approach as ‘a paradigm shift’,⁷⁵ saying: ‘No one had realised how vulnerable the old medical model was. Within a few short years, without a shot’s being fired, the concept of holistic health has been legitimized ...’⁷⁶ In 1990, the American nursing scholar, Professor Mary B. Johnson wrote:

Today’s healthcare system is being affected by a paradigm shift... a holistic viewpoint...The new paradigm, labelled by many as the holistic paradigm of health, is a major innovation in today’s rapidly changing health care system.’⁷⁷

Johnson had used the theory of ‘the diffusion of innovations’⁷⁸ in order to develop methods to research and explain the rise in holistic approaches. This system was based on the work of sociologist Everett Rogers, who in 1983 employed a ‘framework to conceptualize social change’ in measuring how the rate of new ideas and ideologies spread through cultures. My methodology in using a very basic bibliometric system of recording the increase in articles on holism and CAM in Britain during the period of study shows that a ‘diffusion’ is indeed noticeable in the

⁷⁴ Thomas Kuhn, *The Structure of Scientific Revolutions* [photo reprint of 1962 edition] (Chicago; London: University of Chicago Press, 1964).

⁷⁵ Marilyn Ferguson, *The Aquarian Conspiracy* (London: Routledge & Kegan, 1981), 241.

⁷⁶ *Ibid.*, 242.

⁷⁷ Mary Johnson, ‘The Holistic Paradigm in Nursing: The diffusion of an innovation in Research’, *Nursing & Health*, 13 (1990) 129-139, based on Everett Rogers, *Diffusion of Innovations* (New York: Free Press; London: Collier Macmillan, c1983).

⁷⁸ Mary Johnson in personal communication (3 November 2014) and ‘The Holistic Paradigm in Nursing: The diffusion of an innovation in Research’, *Nursing & Health*, 13 (2014) 129-139.

mid-1980s to 2000, and this will be examined later. But if the definition of paradigm is that of an innovation that replaces an existing system, in Britain this was not so. Biomedicine continued to maintain the hegemonic upper hand in the twentieth century. I claim it was a holistic movement, as Annette Turton supports in writing of it in 1984 as an idea ‘whose time had come’:

It has been said that there are few things as powerful as an idea whose time has come. I believe holistic care is just such an idea.⁷⁹

Two years later, in 1986, Inga Newbeck, a nurse-tutor at the Royal Free Hospital, wrote in the *Nursing Times* of how holistic ideas were beginning to shape nursing practice, referring to it as ‘a change in consciousness.’⁸⁰ Inga described how holistic nursing – which she saw as a change in the relationship with the patient and the development of time, talk and listening – was an approach in ‘a new dimension’. However, holistic approaches were not radically new. Nursing scholar Ann Bradshaw believed that they had always been present:

Throughout history nursing was founded on an ethic and practice of spiritual care embodied in the nurse’s vocation... Compassionate, altruistic care of the person, physically, socially and mentally, was the spiritual expression of care. This ethic is still implicit in nursing. Spiritual care as understood and practised by nursing tradition was not articulated by nurses; it was lived out in the daily actions of care.⁸¹

The medical director of the former Foundation for Integrated Medicine, Dr Michael Dixon, referred to the holistic *New Medicine* as a very old medicine – ‘a rediscovery’.⁸² In 1981 Marilyn Ferguson, too, wrote: ‘The holistic ideal is hardly

⁷⁹ *Nursing Times*, 11 July 1984.

⁸⁰ Inga Newbeck, ‘The whole works’, *Nursing Times*, 23 July 1986.

⁸¹ Ann Bradshaw, ‘The Legacy of Nightingale’, *The Nursing Times*, 92 (1996) 42-43.

⁸² Michael Dixon and Kieran Sweeney, *The Human Effect in Medicine* (Abingdon: Radcliffe Medical, 2000), 3.

new⁸³, quoting examples of essays by George Engel,⁸⁴ in which he pointed out that the approach had been attempted at Johns Hopkins medical school before 1920, and also by the physician, Arnold Hutschnecker, who made a vigorous case for body-mind medicine in 1950.⁸⁵ Evidence of this is also seen in 1945, when the following comment was noted at a Royal College of Nursing Southport meeting:

The dressing that the nurse applies to the mind is constituted by what she says and does – or does not say – by her tone of voice, her facial expression, her gestures and by the moment and setting that she chooses for impinging her personality on that of the patient.⁸⁶

Holistic nursing practices were therefore not new to the later twentieth century and, I believe, did not constitute a paradigm shift. But there was an *awakening* of interest in holism, together with a vocalisation of it and a strategic deployment of holistic approaches, which led to interest in CAM. This is what was new.

Stephen Wright developed this further in describing the emergence of ‘The Fifth Wave’, a term coined by David Reilly, in health care:

But in the 80s and 90s, there was just this explosion going off of interesting things ...What my view of what was going on was that we were entering a new phase in health care - what David Reilly calls ‘The Fifth Wave’ - where we are seeing vast amounts of illness now that the antis can’t do anything about - the antibiotics, the antiarrhythmics ... We don’t have good resolutions to chronic fatigue syndrome, multiple sclerosis, cancers - and also what arises with that in people - which I think complementary therapies in part - particularly with their spiritual dimension - would tap into....⁸⁷

⁸³ Ferguson, *The Aquarian Conspiracy*, 266.

⁸⁴ George Engel, ‘The Need for a New Medical Model’, *Science*, 196 (1977) 129-136.

⁸⁵ Arnold Hutschnecker, *The Will to Live* (London: Victor Gollanz, 1952).

⁸⁶ Quoted in *Bulletin of History of Nursing*, 2 (2013).

⁸⁷ Stephen Wright, interviewed 16 January 2014.

This comment illustrates the sense of an exploration of new ways, new thinking, and new approaches in healthcare. This was translated in practical terms in 1991 when general practitioners became fundholders, and had the discretion to determine the services that were offered to patients and CAM became available on the NHS.⁸⁸

It is relevant to note here another development in the context of the re-emergence of holistic culture: that of the rise of the hospice movement, which began in the 1970s. Nurse, social worker and, later, physician Cicely Saunders had established the first hospice in 1967 and others followed in the 1970s. This was an innovative approach to palliative care and the concept of 'total pain' was introduced among Saunders' basic tenets. It included the recognition of physical, spiritual, and psychological discomfort in people who were dying⁸⁹, a further illustration of renewed holistic awareness in healthcare. Palliative care continued to be one of the areas in which CAM has been widely integrated and valued and one in which nurses have been greatly involved,⁹⁰ as nurse and therapist Annie Hallett describes:

I think that the hospice movement and the culture that the holistic culture that the hospice movement perpetuated and drove was important. I think that in 1994/95 there was the Calman Hine report on cancer nursing which was hugely important in the whole direction that cancer care - not just cancer nursing - took. But it actually talked about the need to give psychological support. It was the first proper report from the Department of Health that gave direction about the direction

⁸⁸ Roberta Bivins, 'Limits and Liberties: CAM regulation and the medical consumer in historical perspective' in Nicola Gale and Jean McHale, eds, *Routledge Handbook of Complementary and Alternative Medicine: perspectives from social science and law* (London: Routledge, 2015), 25.

⁸⁹ Stephen Lutz, 'The History of Hospice and Palliative Care', *Current Problems in Cancer*, 35 (2011) 6.

⁹⁰ I.G. Finley and O.L. Jones, 'Hypnotherapy in Palliative Care', *Journal of the Royal Society of Medicine*, 89 (1996) 493-496; R.A. Gray, 'The use of massage therapy in palliative care', *Complementary Therapies in Nursing and Midwifery*, 6 (2000) 77-82; Gary Deng and Barrie R. Cassileth, 'Complementary Therapies in Pain Management', in Nathan Cherny and Marie Fallon, eds, *Oxford Textbook of Palliative Medicine* 5 edn (Oxford: OUP, 2015).

that cancer care should take. And it certainly promoted a holistic perspective.⁹¹

CAM, however, was not exclusively confined to this area of practice, in spite of a view that this was the case.⁹² The hospice movement became somewhat co-opted by the medical profession and linked to the secondary and tertiary care units, which prophetically suggests what also happened to CAM at the end of the period of this study.

This 'new approach' to healthcare also involved a new sense of personal responsibility for health, as Pat Turton and Stephen Wright describe:

It was round about the end of the 1980s where ... they were getting very interested in personal health ... people taking responsibility for their own health and so on and so forth.⁹³

...after the Second World War as people were moving out of deference to authority and 'whatever the system does is OK' into 'what I want', consumerism, defining myself ... All that kind of stuff was going on. That's the backdrop, a cultural shift of which nursing was a part...⁹⁴

It is unlikely to be coincidental that these individualistic views on self-responsibility were being expressed about a time when politically, inequalities of health were being denied⁹⁵ and a push for personal responsibility for health was being made.

It was a time when chronic disease was threatening to bankrupt the NHS, and this focus on individual responsibility worked well for the Conservative government.⁹⁶

⁹¹ Annie Hallett, interviewed 18 May 2015.

⁹² N. Mizrachi, J. Shuval and S. Gross. 'Boundary at work: alternative medicine in biomedical settings, *Sociology of Health and Illness*, 27 (2005) 20-43.

⁹³ Pat Turton, interviewed 9 June 2014.

⁹⁴ Stephen Wright, interviewed 16 January 2014.

⁹⁵ With suppression of the Black Report (Sir Douglas Black, *Report of the Working Group on Inequalities in Health* (DHSS, 1980)).

Medical historian Roger Cooter confirms this challenge to organised medical authority in the way that self-help and choice in medical consumerism was developing,⁹⁷ and sociologist Mike Saks asserts that it is illustrated in the way that some patients were turning to complementary and alternative medicine⁹⁸ due to the ease of purchase of over-the-counter (OTC) CAM remedies. Alison Ellis described this too:

I just started looking more and more ...going into health food shops and reading about different ways to cope with everyday illnesses that we all come across from time to time; bruises, use of antiseptics, mild viral infections... just by reading and looking...⁹⁹

These well-informed ‘smart consumers’¹⁰⁰ had become ‘new experts’ with ‘new knowledge’ sources that sociologist Anthony Giddens describes of this late modern time. He argues that new groups of people became ‘experts’ in particular topics, such as how to be healthy and the use of therapies, moving away from orthodox sources of information – and a ‘set hierarchy of knowledge’ imposed by medical control.¹⁰¹ William Bloom’s succinct description, ‘the new buffet of information’,¹⁰² reflects this accessibility of knowledge for consumption as well as available choices: ‘You can say, “Try it and if this is what you like, if you feel good then that’s fine. If you don’t, there may be another therapy that will help”’, described nurse-therapist

⁹⁶ Virginia Berridge ‘The Black Report: interpreting history’ in Adam Oliver and Mark Exworth, eds, *Health Inequalities: evidence, policy and implementation* (proceedings of the Health Equality Network (Nuffield Trust, 2003).

⁹⁷ Roger Cooter, *Studies in the History of Alternative Medicine* (Basingstoke: Macmillan, 1988).

⁹⁸ Mike Saks, *Alternative Medicine in Britain* (Clarendon Press, 1992), 153.

⁹⁹ Alison Ellis, interviewed 2 May 2014.

¹⁰⁰ Janine Wiles and Mark Rosenberg, ‘Gentle caring experience: seeking alternative health care in Canada’, *Health and Place*, 7 (2001) 221.

¹⁰¹ Anthony Giddens, *The Consequences of Modernity* (Cambridge: Polity, 1990) quoted in Geraldine Lee-Trewick, ‘Changing Perspectives’ in *Perspectives on Complementary and Alternative Medicine* (Buckingham: Open University, 2005).

¹⁰² William Bloom, *The Endorphin Effect* (2001), vi., quoted in Geraldine Lee-Trewick, ed., ‘Changing Perspectives’ in *Perspectives on Complementary and Alternative Medicine*, (Open University, 2005).

Angela Taylor, in explaining the availability of therapies on offer.¹⁰³ Jill Vincent develops the idea of individual empowerment in exploring the upsurge of self-help groups in health at this time, concluding that they were a protest against society's dominant values and institutions and that they met needs that were not being supplied by existing institutions¹⁰⁴, exemplified by the HIV/AIDS groups already examined.

However, it was not just individual motivation or the growth of self-help groups that was changing society, but government policy. NHS consumerist policies focused on individuals, providing support for them to make healthy choices and holding people responsible for their own health.¹⁰⁵ The public's questioning and uneasiness with orthodox medicine encouraged the growth of alternative approaches and belief in the healing power of nature¹⁰⁶ and provoked 'reconceptualisations of health, healing and human existence'.¹⁰⁷

The Institute of Complementary Medicine (ICM) undertook a survey in 1983, which expressed the new approach and a new confidence:

There can be no doubt that the last decades of this century are marking out a new direction in man's ability to heal and be healed.¹⁰⁸

¹⁰³ Angela Taylor, interviewed 11 February 2014.

¹⁰⁴ Jill Vincent, 'Self-Help Groups and Health Care in Contemporary Britain' in Mike Saks, ed., *Alternative Medicine in Britain* (Oxford: OUP, 1992), citing M. Morgan, M. Calnan and N. Manning, *Sociological Approaches* (London: Croom Helm, 1995).

¹⁰⁵ Christine Hogg, *Citizens, Consumers and the NHS* (Palgrave Macmillan, 2008), 4.

¹⁰⁶ Waddington, *An Introduction to the Social History of Medicine*, 86.

¹⁰⁷ J. Warren Salmon, *Alternative Medicines* (New York; London: Tavistock, 1985), 7.

¹⁰⁸ P. Davies, *Report on trends in complementary medicine*, Institute of Complementary Medicine (1984).

But it was also a product of the *zeitgeist*, the counter-culture that was influencing British society in the 1970s and 1980s. The public was seeking alternatives in every aspect of lifestyle, not just health, but ‘fashions, drugs, meditation, mysticism, natural existence,’ asserts Mike Saks¹⁰⁹ and this is what I now examine.

4.3.2 The *Zeitgeist*

In the Methodology Chapter (Chapter Three), I describe the value of taking into account the *mentalité* of a community in historical study, in exploring how people see the world around them, and how human culture changes and affects the opinions of society and the way in which events are influenced.¹¹⁰ The previous section has focused on influences, views and practices of healthcare in the second half of the twentieth century and I now turn to the general spirit of the age and the significance of that in the growth of alternative models.

American author Marilyn Ferguson, in her classic work on New Ageism, *The Aquarian Conspiracy*, claims that the social climate in the 1980s was producing a movement that represented a ‘realignment’.

She describes it as:

...broader than reform, deeper than revolution, this benign conspiracy for a new human agenda has triggered the most rapid cultural realignment in history.¹¹¹

Ferguson believed that this realignment would usher in a millennium ‘of love and light’ – and that it was about to commence. Although her bold vision was not

¹⁰⁹ Mike Saks, *Orthodox and Alternative Medicine* (London; New York: Continuum, 2003), 107.

¹¹⁰ Mark Donnelly and Claire Norton, *Doing History* (London: Routledge, 2011), 46

¹¹¹ Ferguson, *Aquarian Conspiracy* (1981), 23.

realised, her perspective is illuminating along with her ideas about how the increasing open-mindedness of society was relevant to the acceptance of CAM and holistic approaches, for as CAM-practitioner nurse, Caroline Hoffman commented: 'There was a real sense of openness in health care at that time.'¹¹²

This view reflects that of medical writer and acupuncturist Helen Barnett, who suggests that this attitude in the second half of the twentieth century was responsible for the intensified interest in CAM, claiming that the culture of patient choice and shared decision-making enabled its increased acceptance.¹¹³ The contemporary 'natural' hippy culture¹¹⁴ chimed with the *natural* nature of non-orthodox therapies, the *natural* element of healing and a belief that the body heals *naturally*, contrasting with an increasing emphasis on evidence-based medicine,¹¹⁵ which focuses on Western scientific notions of a singular, asocial truth.¹¹⁶ Guenter B. Risse and John Harley Warner's work on the historical experience of the healing power of nature, describe it as, 'the inherent capacity for self-recovery of the human organism' in which nature fulfils its healing course.¹¹⁷

¹¹² Caroline Hoffman (*née* Stevensen), interviewed 10 June 2015.

¹¹³ Helen Barnett, 'Complementary and alternative medicine and patient choice in primary care', *Quality in Primary Care*, 15 (2007) 207-212.

¹¹⁴ Nicholas Campion, *The New Age in the Modern West: Counterculture, Utopia and Prophecy from the late Eighteenth Century to the Present Day* (New York: Bloomsbury Academic, 2016), 101.

¹¹⁵ Hans Baer, 'The Work of Andrew Weil and Deepak Chopra - two holistic health/New Age gurus: a critique of the holistic health/New Age movements', *Medical Anthropology Quarterly*, 17 (2003) 233-250.

¹¹⁶ Nicola Gale, 'Sociology of traditional, complementary and alternative medicine', *Sociology Compass*, 8 (2014) 805-822.

¹¹⁷ Guenter B. Risse and John Harley Warner, 'Reconstructing clinical activities: patient records', *Social History of Medicine*, 5 (1992) 183-205.

This feature resonated with the ‘deregulation of personal life’,¹¹⁸ characterising a more permissive era in the late 1970s. An openness to new ideas and philosophies followed. One example is the Mind Body Spirit Festival, initiated in 1977 as the first international exhibition entirely devoted to the pursuit of healthier, more creative and fulfilling lifestyles.¹¹⁹ The following year saw even greater support when 83,000 people flocked to Olympia for the Festival, which philosopher and teacher Sir George Trevelyan, a leader of the New Age movement, described as: ‘... not a religious revolution with any dogma you’ve got to believe in – it’s a spiritual awakening.’¹²⁰

The media signalled this awakening with several broadcasts on the subject of alternative medicine. For example, BBC2’s *Notes in the Margin*, which focused on the issue of ‘Natural Movements 1980-89’, claimed in its publicity for the broadcast:

In the Green 80s, nature became the basis of a new and powerful morality. The last 10 years have seen the unprecedented growth of alternative medicine. Rosalind Coward¹²¹ believes that a mythical version of nature has now acquired almost magical qualities. She talks to the people behind these natural movements: entrepreneurs like Anita Roddick and the 80s priesthood of complementary healers.¹²²

In her work *The Whole Truth: the myth of alternative health* (1989), academic and writer Rosalind Coward discusses the term ‘awareness’ and its application to alternative options in healthcare by bringing about a self-transformation – ‘meeting

¹¹⁸ Jane Lewis, ‘Providers, consumers the state and the delivery of health care services in twentieth century Britain’ in Andrew Wear, ed., *Medicine in Society* (Cambridge: Cambridge University Press, 1992).

¹¹⁹ By Graham Wilson, ‘fuelled by a desire for people to discover the spirit within and open themselves up to possibilities previously only dreamed of.’ See www.mindbodyspirit.co.uk, accessed 7 January 2015.

¹²⁰ *It’s Your New Life*, BBC 1, broadcast 1 October 1978, www.genome.ch.bbc.co.uk, accessed 7 January 2015.

¹²¹ Rosalind Coward, *The Whole Truth: the myth of alternative health* (London: Faber & Faber, 1989).

¹²² *Notes in the Margin*, BBC, broadcast on 1 February 1990, www.genome.ch.bbc.co.uk, accessed 7 January 2015.

yourself has become synonymous with meeting the possibility of health'.¹²³ Her view was that criticism of mainstream healthcare was not necessarily a reason for seeking alternative approaches, but that the sense of a need for eradicating long term disease had been taken up by movements such as Festival of Mind Body and Spirit 'as fuel to fire the need for personal change'¹²⁴ and to introduce alternative approaches.

Keith Bakx also recognised the culture of awareness: 'emergent green culture is just as concerned with the awareness of self as it is of awareness of nature,¹²⁵ and he notes that an era of openness, awareness and expressiveness was flourishing and provoking an alliance with new ways of medicine. These were reflected in the claim of astronomer, scientist and writer Carl Sagan who said more broadly that, 'Perhaps for the first time in the history of the world people are being really open, expressing their feelings without fear of being judged.'¹²⁶ This is reflected in a comment made by nurse therapist Peter Mackereth in his interview:

...in the 80s and 90s when people were, like, exploring... thinking of possibilities and thinking about making things better for people.¹²⁷

One practical expression of this objective of 'making things better for people' was a changing attitude to hospital visiting hours. In the early 1950s, a survey of 1,300 hospitals that admitted children showed that only 300 allowed daily visits by parents

¹²³ Rosalind Coward, *The Whole Truth: the myth of alternative health* (London: Faber & Faber, 1989), 100.

¹²⁴ *Ibid.*, 100.

¹²⁵ Keith Bakx, 'The 'eclipse' of folk medicine in western society', *Sociology of Health and Illness*, (1991) 31.

¹²⁶ Carl Sagan, quoted in Marilyn Ferguson, *The Aquarian Conspiracy*, (London: Routledge & Keegan, 1981), 35.

¹²⁷ Peter Mackereth, interviewed 30 January 2014.

and 150 allowed no visiting at all.¹²⁸ Robin Rohrer describes the experience of psychological isolation of hospitalisation and the significance that patient visiting contributes to wellbeing,¹²⁹ and this began to be acknowledged in the 1970s.

Interestingly, Annette Turton, when talking to me of changing attitudes in society, gave the example of how a call for an improvement in regulation on the visiting of hospitalised children illustrated the spirit of the time and how she recognised it as an expression of a holistic approach:

I think nursing and medicine reflect to a large extent what the feelings are within the society. How come parents were suddenly wanting to go into the hospital? They never did before. [...] What was ...very new and very obviously holistic was the introduction of ... parents being allowed to visit. I mean the idea that you had parents having open visiting, no! Staying on the ward? You must be joking!¹³⁰

She continued by explaining the ways in which this mood affected nursing practices and how the use of complementary therapies was becoming a part of a new empowering approach:

There was a *zeitgeist* and it was at that point quite acceptable for people to do things like Therapeutic Touch or acupuncture. And complementary, alternative, therapies were ...there was a feeling about what should we integrate into a normal curriculum and what not. And increasingly massage... You see, even things like counselling and this whole thing about empowering patients and information-giving, I think, was seamlessly part of that new approach.

This resonates with concepts described in *The New Age Movement*, by British sociologist Paul Heelas, who argues that the movement was intrinsically bound up with a sense of healing – healing the earth, healing the dis-eases of the capitalist

¹²⁸ James Robertson and Joyce Robertson, *Separation and the Very Young* (Free Association Books, 1989).

¹²⁹ Robin Rohrer, 'Visiting children with cancer: the parental experience of the Children's Hospital of Pittsburgh, 1995-2005' in Graham Moony and Jonathan Reinartz, eds, *Permeable Walls: Historical Perspective on Hospital and Asylum Visiting* (Amsterdam: Rodopi, 2009).

¹³⁰ Annette Turton, interviewed 10 April 2014.

system, healing individuals spiritually – in addition to physical healing.¹³¹ ‘The basic idea is simple’, he says, ‘...the spiritual realm is intrinsically healing. Healing comes from within, from one’s own experience of the natural order as a whole.’¹³²

This conveys the background to a time when the British public was feeling more confident to seek answers and to make choices, to think outside the conventional box, and to have open minds about healthcare options that were available. It was underpinned for many by an awareness of natural healing, which had been reflected in policy, media and social movements. And into this environment emerged a growing sense of the effectiveness of complementary and alternative therapies, as nursing academic Professor Steven Ersser summarises:

I think nationally there was a lot more awareness of the uptake of complementary therapies by the public in the media really. And I think one could track that through the media...a growing interest in finding alternatives really - or complementation... It did feel like a very exciting time. There were conferences, there was a lot more literature written about it, there was national interest...¹³³

But against this background of changes in society and developments in attitudes to healthcare, the nursing profession, too, was experiencing a time of transition, and the aim of the next section is to examine how these changes are relevant to the research.

4.3.3 Nursing

In order to provide the context and describe the environment for the development of CAM in nursing practice, it is helpful to divide the history of nursing during this

¹³¹ Paul Heelas, *The New Age Movement* (Cambridge Mass: Blackwell, 1996), 81.

¹³² *Ibid.*, 82.

¹³³ Steven Ersser, interviewed 14 July 2014.

40-year research timeframe into three periods. It may appear to be a crudely partitioned arrangement, but I believe this will help to position the important political and cultural frameworks for nursing and how they shifted, and it will give a relevant context for nurses' use of CAM.

1960–mid-1970s

This was a period of the traditional nursing model. Nursing had entered the NHS in 1948 as a fragmented system; training was not centralised and the management was under the control of individual governing bodies of a range of types of medical institutions.¹³⁴ Nursing in these early years of the NHS was traditional, conservative, bureaucratic and hierarchical.¹³⁵ By the 1960s, nursing was working more closely with medicine but was still struggling with calling itself a profession with a unique body of knowledge and skills.¹³⁶ The Platt Report of 1964, commissioned by the RCN, proposed key education reforms, including university education for nurses, but this had limited effect for some years.¹³⁷ The first nursing degree had been established in 1960 at Edinburgh¹³⁸ and Manchester followed in 1969, but in general terms, nursing remained an apprenticed occupation.

In 1967, sociologist, nursing historian and specialist in healthcare systems Brian Abel-Smith commented on current nurses' practice by suggesting that the system

¹³⁴ Rosemary White, 'Pluralism, professionalism and politics in nursing', *International Journal of Nursing Studies*, 20 (1983) 231-244.

¹³⁵ Christopher Maggs, *Nursing History; The State of the Art* (Croom Helm, 1987), 163.

¹³⁶ Anne Borsay and Billie Hunter, eds, *Nursing and Midwifery in Britain since 1700* (Basingstoke: Palgrave Macmillan, 2015), 3.

¹³⁷ *A Reform of Nursing Education: first report of a special committee on nurse education*, Royal College of Nursing.

¹³⁸ Jane Brooks, Anne Marie Rafferty, 'Degrees of ambivalence: attitudes towards pre-registration university education for nurses in Britain, 1930-1960', *Nurse Education Today*, 30 (2010) 579-583

had toughened them, but not necessarily to the benefit of patients:

Most nurses have worked all their lives in regimented institutions. Strictly disciplined themselves, some react by disciplining their staff, who in turn discipline the patients. [...] Some nurses have become hardened ...¹³⁹

This suggests that a regimented system and culture was threatening nurses' fitness to care. It perhaps explains the reasoning behind a new element in nurse training that had been agreed in 1960, determining that 'Questions shall be included on those parts of the section of the syllabus relating to human behaviour and illness which deal with the "effects of hospitalisation on the patient" and the "nurse/patient relationship"'.¹⁴⁰ The theory of caring was now required to be in the curriculum, although not implemented until 1962. By the late 1960s and early 1970s, alternative medicine was beginning to be openly debated by health professionals, supported by a holistic view and the rise in consumer knowledge about health and was being offered privately as a viable 'alternative' to mainstream biomedical practice.¹⁴¹

Although the following quote relates to American nursing, the thorny issue of autonomy applied also in the UK as 'the important decisions about what work is to be done...are made by people outside the profession ... decisions under which nurses work are made by doctors.'¹⁴² Doctors' power and supremacy was to be challenged later, but at this point, the nurse was still arguably in the handmaiden-to-medicine

¹³⁹ Brian Abel-Smith, 'Administrative Solution: A Hospital Commissioner?' in Barbara Robb, *Sans Everything: a case to answer* (London: Thomas Nelson & Sons, 1967), 128.

¹⁴⁰ National Record Office, Kew, General Nursing Council papers, Confidential memo regarding changes to preliminary and final examinations, DT38/155.

¹⁴¹ Nicky Genders, *Fundamental Aspects of Complementary Therapies for Healthcare Professionals* (London: Quay Books, 2006), introduction; Vincent di Stefano, *Holism and Complementary Medicine* (London: Allen and Unwin, 2006).

¹⁴² Lyle Saunders quoted in Christopher Maggs, *Nursing History: The state of the art* (Croom Helm, 1987), 163.

role.¹⁴³ Into this context came a series of developments in nursing, most notably resulting from the Salmon Report in 1966,¹⁴⁴ which brought changes to the senior nursing structure,¹⁴⁵ along with the change in delegated nurses' clinical responsibilities.¹⁴⁶

Salmon's reforms, which enabled the introduction of new management practices into the NHS, were not always popular, as St Bartholomew's nursing sister Mary Walker described:

I used to like to try out new things – never turn your back on them...you've got to try them...We had, what's his name? – Salmon. Well he came to talk to us about changes that were going to be implemented ... I thought, oh horror, this is not for me I am going to have to leave!¹⁴⁷

(However, after her initial shock at the proposed management changes, she did not leave and continued at Barts as a ward sister until retirement). While appearing to offer an equal role with medicine and administration, the Salmon reforms divided the nursing role between management and clinical work,¹⁴⁸ and the fundamental consequence of these changes was to take senior nurses away from the bedside and create a career structure that did not enhance the clinical aspects of nursing.

¹⁴³ Keith Soothill, Christine Henry and Kevin Kendrick, eds, *Themes and Perspectives in Nursing* (Chapman Hall, 1992), 22.

¹⁴⁴ Ministry of Health and Scottish Home and Health Department. *Report of the Committee on Senior Nursing Staff Structure*, London, 1966.

¹⁴⁵ 'The ward sisters were pretty fierce', quoted in 'Nursing in the 1960s', *NursingTimes.net*, 4 February 2008.

¹⁴⁶ Davina Allen, *The changing shape of nursing practice: the role of nurses in the hospital division of labour* (London: Routledge, 2001), 14.

¹⁴⁷ Mary Walker, interviewed 11 June 2014.

¹⁴⁸ M.C. Versluysen, 'Old Wives Tales and women healers in English History' in Celia Davies, *Rewriting Nursing History* (1980), 168.

There were no heightened opportunities for clinical nurses and the only route for upward mobility was by demonstrating good management skills.¹⁴⁹ Six years later, further changes were brought about by the 1972 Briggs Report when student nurse education and training programmes were reviewed.¹⁵⁰ The report recommended that degree preparation for nurses should be increased to 'recruit people with innovative flair and leadership qualities,' and that nursing should become a research-based profession, while safeguarding the philosophy that:

The role of the nurse must always be close to the needs of the patient. These needs are never static but vary according to the needs of the individual patient and medical and technical advances.¹⁵¹

Nursing was 'a profession with a knowledge-base, separate from, but equal to, the medical profession.'¹⁵² However, it was those technical advances, together with task-orientated approaches, that began increasingly to change the nursing role as the 1970s progressed.

Mid-1970s–mid 1980s

Geoffrey Mercer's research in the 1970s summarised the rewards of nursing at that time in two parts; the first involved extrinsic rewards (such as pay, job prospects, working conditions etc.) and the second integrated intrinsic rewards such as relational expectations (for example, relations with peers, supervisors) and level of autonomy and responsibility.¹⁵³ With that responsibility came a change in the way the

¹⁴⁹ Margaret Stacey, *The Sociology of Health and Healing* (London: Routledge, 1988),130.

¹⁵⁰ Asa Briggs, Report of the Committee on Nursing (1972).

¹⁵¹ *Ibid.*

¹⁵² Robert Dingwall, Anne Marie Rafferty and Charles Webster, *An Introduction to the Social History of Nursing* (London: Routledge, 1988).

¹⁵³ Geoffrey Mercer, *The employment of nurses: study of the National Health Service* (London: Croom Helm, 1979).

nursing tasks were organised with a marked increase in use of technology and a growth in record-keeping and processes, as described here:

The tendencies of modern medicine seek to make the patient an object tied up to instruments whose readings mean more to the attendants than feeling and sensations of the patient.¹⁵⁴

For it was not just the technology that was separating nurse from patient, but the administration demanded by the consequent record-keeping and that of the introduction of codes of practice and professional protocols governing nursing practice. For example, nursing models, which had been derived from American models of care plans, implemented organisational tasks. They were first discussed in Britain in the 1970s and publications were soon emphasising the models of assessing patients' needs, and subsequent planning, implementation and evaluation of care, with the aim of improving care quality,¹⁵⁵ although these were not considered part of the curriculum or incorporated in many areas of practice until the 1980s. The process involved the provision of care according to the patient's needs, requiring nursing staff 'to communicate more with each other in giving care.'¹⁵⁶ This was a period when British nurse educationalists Nancy Roper, Winifred Logan and Alison Tierney were collaborating and amalgamating ideas about nursing and these were later to be published as the RLT model of nursing, which included some elements of interpersonal skills.¹⁵⁷

¹⁵⁴ *Journal of Social Policy*, July 1973, 2, quoted in *Nursing Mirror*, 31 March 1977.

¹⁵⁵ Charlotte Kratz, *The Nursing Process* (London: Balliere Tindall, 1979), Robert Dingwall *et al.*, *An Introduction to the Social History of Nursing* (1988), 214.

¹⁵⁶ R. Long, *Systematic Nursing Care* (London: Faber & Faber, 1981).

¹⁵⁷ Nancy Roper, Winifred Logan and Alison Tierney, *The Elements of Nursing* (Churchill Livingstone, 1980).

Similarly, the nursing process was initiated into nursing practice at this time. It had been introduced by the University of Manchester in 1970¹⁵⁸ and was included in the 1977 pre-registration curriculum published by the General Nursing Council (GNC) but, again, it did not have great impact in clinical areas until the 1980s. It involved a problem-solving framework, using four elements: assessment, planning, implementation and evaluation, and was underpinned by an ideological emphasis on patient involvement, choice and individualised care. Its assessment model was built on checklists and it was not without critics. Nursing academic Mike Walsh claims that ‘the nursing process largely failed to deliver individualised care and has consumed large amounts of precious nursing time filling in forms.’¹⁵⁹

David Armstrong referred to it as ‘a surveillance apparatus’,¹⁶⁰ or reductionism in another form, and Carmen de la Cuesta describes the way that patient care at this time was, as a result of the nursing process, broken down into a set of tasks, which encouraged only superficial nurse-patient relationships.¹⁶¹ Mary Walker in her interview recalls one example of this:

Like the kardex system, we tried that out I remember... there was one: ‘Welcome patient to the ward’. Well, you don’t need to be told that, do you? But that is how it was, it had to be written down and ticked off – you’d done it.¹⁶²

Into this scenario was launched the Radical Nurses Group, founded in 1980, because some nurses were dissatisfied with the care that they provided and were

¹⁵⁸ Jean McFarlane and George Castledine, *A Guide to the Practice of Nursing Using the Nursing Process* (London: CV Mosby, 1982).

¹⁵⁹ Mike Walsh, *Models and critical pathways in clinical nursing: conceptual frameworks for care planning* (London: Balliere Tindall, 1997).

¹⁶⁰ David Armstrong, ‘The fabrication of nurse-patient relationships’, *Social Science of Medicine*, 17 (1983) 457-460, 459.

¹⁶¹ Carmen de la Cuesta quoted in Dingwall *et al*, *An Introduction to the Social History of Nursing* (1998), 214.

¹⁶² Mary Walker, interviewed 11 June 2014.

'feeling isolated and unsupported in their efforts to improve it.'¹⁶³ The organisation operated nationally, with its main centres in the early years in Sheffield, London and Edinburgh with other regions (Birmingham, Brighton, Cardiff, Leeds, Manchester, Southampton) subsequently establishing RNG groups. At the annual conference in 1982, nurse Ruth Schrock critically commented that:

nursing care, described in many kardexes, is the minimum nursing care level, a depersonalised uniform care which unfortunately has nothing to do with the personality and feelings of each individual patient.¹⁶⁴

This expression of unease among nurses in the early 80s reflects the earlier comments about a sense of the limitations of nursing practice and nurses seeking an enhanced relationship with the patient. Jane Salvage, who was herself a nurse activist, a founder member of the Radical Nurses Group, author of *Politics in Nursing*¹⁶⁵ and, later, editor of the *Nursing Times* (1996-2001), describes the early days of another organisation which had been formed earlier, the Politics of Health Group:

Quite early on, as I was developing my thoughts about nursing and politics and policy, I joined a group called the Politics of Health Group, which was a sort of radical leftie group that was extremely interesting and flourished in the late-70s and early 80s – still does in a different form. And that group was full of interesting people, practitioners, academics and a really widely-ranging and eclectic group. And we used to have weekend conferences on different themes and one of them was on complementary therapies – that would have been around 1980 or so.¹⁶⁶

This is one of the earliest references I have encountered to an input of CAM for nurses by any group and it is of significance that it is in the context of a marginal and

¹⁶³ RCN Archives, C304/1.

¹⁶⁴ RCN Archives, Report on conference held Sheffield May 15/16 1982, Newsletter No 6 Sheffield, C405/1/8.

¹⁶⁵ Jane Salvage, *Politics of Nursing* (London: Heinemann Medical Books, 1985).

¹⁶⁶ Jane Salvage, interviewed 11 May 2015.

politically-active organisation such as this. I will return to this point later in drawing a parallel with the marginalisation of CAM with marginal groups and marginal practices. However, by the mid-1970s, a concept of holistic support was also beginning to emerge, emphasising the heart of the nursing role and respecting the patient as having choices about his/her healthcare.¹⁶⁷ Ruth Sewell recalls her early involvement in teaching holistic principles:

It was mid-70s when I started to talk about it [holism in practice]. But it was quite a lonely experience. There were very few nurses who wanted to talk about it in that way. Before I moved out of hospital practice, I was a ward sister running a trauma unit. I started to use nursing notes and do afternoon seminars for the nursing staff on holistic practice within trauma and orthopaedics.¹⁶⁸

Although the practice of complementary therapies was not yet considered widely, in 1978, the WHO Health for All (HFA) programme was launched,¹⁶⁹ which proposed some limited complementary methods in primary care.¹⁷⁰ Yet, in spite of very occasional articles in nursing journals,¹⁷¹ there was at this stage little opportunity for a nurse to develop a role in using CAM. However, a development in nursing emerged during the mid-1980s, when apparent enlightened approaches were introduced and opened up opportunities for wider practices.

¹⁶⁷ Charlotte Searle, *Ethos of Nursing and Midwifery: a general perspective* (Durban: Butterworth Heinemann, 1987), 158.

¹⁶⁸ Ruth Sewell, interviewed 26 January 2015.

¹⁶⁹ Started by the Declaration of Alma-Ata 1978.

¹⁷⁰ Chris Brooker and Anne Waugh, *Foundations of Nursing Practice: fundamentals of Holistic Care* (London: Moshy, 2007).

¹⁷¹ For example, a series of articles published in *Nursing Mirror* in late 1970s on complementary therapies.

Mid-1980s–2000

'Treating the body as a machine', as *The Times* suggested in 1985,¹⁷² was a trend that inevitably led to the concept of its technological repair as well. Technology was making new demands on nurses, providing fresh challenges to the balance of clinical practice and the caring role. Nursing academic Geertje Boschma writes of the tension between holism and technology in needing to make a decision between developing a good nurse-patient relationship or achieving the height of efficiency and a routine based in 'disembodied specialized knowledge.'¹⁷³ History of nursing academic Christine Hallett also claims that there was a basic choice: either to be technically proficient or to meet the holistic needs of the patient,¹⁷⁴ which was so intricately bound up in the therapeutic relationship, as expressed in 1981, when the writer Marilyn Ferguson claimed:

We have oversold the benefits of technology and external manipulations, we have undersold the importance of human relationships and the complexity of nature.¹⁷⁵

On 2 April 1986, Alastair Gray reflected on this issue in the *Nursing Times*:

The job of retaining the human touch in a health care system increasingly like a fast food store will become even more demanding.¹⁷⁶

And nurse interviewee Alison Ellis developed this, describing how,

nursing has definitely become a lot more technical. It is relying much more on machinery, on beds that tip, on mattresses that blow up and down, on...things on fingers that take temperatures - so there is no

¹⁷² *The Times* leader article, 13 March 1985.

¹⁷³ Geertje Boschma, 'Ambivalence about nursing's expertise: the role of a gendered holistic ideology in nursing, 1890-1990' in Anne Marie Rafferty, Jane Robinson and Ruth Elkan, eds, *Nursing History & Politics of Welfare* (London & New York: Routledge, 1997), 165.

¹⁷⁴ Christine Hallett, 'Time Enough! Or Not Enough Time? An Oral History Investigation of Some British and Australian Community Nurses' responses to demands for 'efficiency' in Health Care, 1960-2000', *Nursing History Review*, 20 (2012) 157.

¹⁷⁵ Ferguson, *The Aquarian Conspiracy*, 246.

¹⁷⁶ 'The face of the future' in *Nursing Times*, 2 April 1986.

need to go to the patient and stick a thermometer in their mouths any more and talk to them while you were doing it.¹⁷⁷

This was the challenge that threatened the caring role and all of the themes that have been addressed above. By the 1980s, nursing was at a crossroads. Nurse researcher Lisbeth Hockey wrote at the time:

I feel very strongly that in the 80s professional nursing will either disappear or assert itself. If nursing is to assert itself, nurses as individuals and as a collectivity must use their knowledge, their sensitivity, their intelligence, their tenacity, their initiative and their political muscle.¹⁷⁸

Hockey recognised that nursing pressures were resulting in 'less time for patient contact by each nurse and the need for more nurses for each patient'.¹⁷⁹ In 1994, academic GP George Lewith of the Centre for Study of Complementary Medicine at Southampton summarised it:

Philosophically and culturally, nursing ...has been driven further and further down the technological road over the last twenty years. Nurses have difficulty caring and touching because this is somehow not seen as a useful task-orientated achievement.¹⁸⁰

In his interview with me, Stephen Wright saw this tension too, in claiming:

In contrast to the high-touch, relational, holistic nursing model ... is the high-tech nursing model.¹⁸¹

¹⁷⁷ Alison Ellis, interviewed 12 May 2014.

¹⁷⁸ RCN Archives, Lisbeth Hockey papers, Open Lecture at McGill University Oct 1979, C300/2/5/4.

¹⁷⁹ RCN Archives, from lecture reprinted in *Nursing Times*, 1980, C300/2/5/4.

¹⁸⁰ Jean Sayre-Adams and Stephen Wright, *Therapeutic Touch* (Churchill Livingstone, 2001), foreword.

¹⁸¹ Stephen Wright, *My Patient, My Nurse: practice of primary nursing* (London: Scutari Press, 1999), 25.

Two contrasting images in nursing publications illustrate this high-touch, high-tech tension.

Figure 2 Image from *Nursing at Barts*, (1970s)



Figure 3 Advertisement *Nursing Times*, November 1995



The first is a photograph from the 1970s of two nurses turning a male patient; each stands either side of his bed and it is obvious that, while they are physically moving him, they are interacting with the man, possibly chatting to him while working¹⁸² – demonstrating the ‘high-touch relational model’ where patients were turned at two-hourly intervals.¹⁸³ The second image is an advertisement for a ‘Mattress System’, designed to prevent pressure sores, and which avoids the required patient-turning routine. The nurse stands at the end of the bed. The mattress is ‘Holistic’, or so the manufacturer declares in its caption, and is an example of the ‘high-tech nursing model.’ Yet, for a modern viewer, this ironic claim of the ‘holistic approach’ contradicts not only the evident lack of physical contact but spatial distance between

¹⁸² Geoffrey Yeo, *Nursing at Barts* (Sutton Publishing Ltd, 1994), 115.

¹⁸³ Barbara Robb, *Sans Everything: a case to answer* (London: Thomas Nelson & Sons, 1967), 28.

the nurse and her patient. Somewhere on the timeline between these two images, nursing care changed and Angela Taylor describes this in her interview:

Patients were turned. Now you rely on ripple mattresses and things like that – which are good. I think that is a good development. But they are not touched. It didn't require a presence, so nursing old style was much more labour-intensive if you like and now it is a little more remote and I think ... we are human beings; we respond to touch.¹⁸⁴

Jacqui Stringer developed the contradictions between nursing the patient and attending to the technical nursing tasks by referring to 'nursing the instruments':

Somewhere along the way, nursing was turning into [...] a situation where you were actually nursing the instruments, the technology, the ... drug-giving regimes, the IVs, and there was very little touch with the patients!¹⁸⁵

Having established that some nurses were converting to holistic approaches as a result of the health and cultural climate, as argued previously, here was an added tension between those holistic principles and a technical nursing culture. The topic of touch and its significance in nursing care will be fully addressed in the following chapter, but in accepting at this point that the nurse-patient relationship was challenged by increases in technology, the data support my argument that some nurses turned to CAM as a way to return to a quality therapeutic relationship, as expressed here by Peter Mackereth:

...that to me brings back the whole idea of the journey and bringing comfort ... hospitals being a place of refuge and support and not just institutions that are technically driven... .

This was summarised in the 1998-1999 Annual Report of the RCN Complementary Therapies Forum, which gave this as the cause for the surge in membership:

¹⁸⁴ Angela Taylor, interviewed 11 February 2014.

¹⁸⁵ Jacqui Stringer, interviewed 30 January 2014.

... a reaction to the high-tech and impersonal aspects of the modern healthcare delivery system.¹⁸⁶

However, it was not just technology that affected the relationship: morale among nurses in this period in particular was low. Issues of image, and challenges surrounding pay and conditions were all amplified in the 1980s, and these tensions, together with the pressures resulting from the Griffiths Report¹⁸⁷ and Project 2000,¹⁸⁸ brought nursing to a crossroads. Sociologists Patricia Owens and Howard Glennerster claim that, in 1988, nursing experienced a 'crisis of meaning and value in society', and nurses 'were rarely out of the national newspaper for a week at a time',¹⁸⁹ with pay and conditions at the heart of their concerns. Historian Christopher Maggs, writing in the *Nursing Times*, described the average nurse of the 1980s as ...

... much more vocal in her [*sic*] criticism of nursing's long established traditions. She almost certainly belongs to one of the staff associations or unions agitating to improve her lot. Pay and conditions dominate her life.¹⁹⁰

This is reflected in a comment in a Radical Nurses Group newsletter of 1988 describing nurses' negative self-perception:

...we stand over-worked, under-paid, under-valued by our employers, often misunderstood by the public....¹⁹¹

¹⁸⁶ RCN Archives Edinburgh, RCN Complementary Therapies Forum Annual Reports.

¹⁸⁷ R. Griffiths, *NHS Management Enquiry Report* (London: DHSS, 1983).

¹⁸⁸ *Project 2000: a New Preparation for Practice* (London: UKCC, 1986).

¹⁸⁹ Patricia Owens and Howard Glennerster, *Nursing in Conflict* (Palgrave Macmillan, 1990), 19.

¹⁹⁰ *Nursing Times*, 25 November 1987.

¹⁹¹ RCN Archives, Edinburgh, A.S.Jenkins in RNG newsletter, C405/1/10.

The early 1980s saw a burst of activity, with reforms and changes provoking intense views and strong actions – in particular the 1983 Griffiths Report, which introduced general managers throughout the NHS in a value-for-money exercise which aimed to bring about economy, accountability and decentralisation. Nursing historian Stuart Wildman and policy analyst Alistair Hewison summarise the shift in management style from ‘an industrial model in the 1960s [...] [to] a business model in the 1980s.’ and make the point that changes in nursing and in nursing management have occurred as a consequence of several developments in government policy during the twentieth century.¹⁹² The new model was not warmly welcomed. Reaction to the Griffiths reforms was deeply felt, and the Royal College of Nursing energetically focused on using the media to criticise them.¹⁹³ As part of its campaign that year, the RCN purchased a full page spread in the *Sunday Times* provocatively asking whether ‘the general manager knows his coccyx from his humerus?’ Three years later, discontent was still simmering and challenging newspaper advertisements, sponsored by the RCN, were confrontational in summarising this disquiet in nursing. Two advertisements which were published in January 1986 are shown on the following page.

¹⁹² Stuart Wildman and Alistair Hewison, ‘Rediscovering a history of nursing management: from Nightingale to the modern matron’, *International Journal of Nursing Studies*, 46 (2009) 1650-1661, 1655; A. Hewison and S. Wildman, The theory-practice gap in nursing: a new dimension *Journal of Advanced Nursing*, 24 (1996) 754-761.

¹⁹³ Susan McGann, Anne Crowther and Rona Dougall, *A History of the Royal College of Nursing* (Manchester: Manchester University Press, 2009), 398-399.

Figure 4 Guardian 13 January 1986

The nurse on the left established British nursing standards. The nurse on the right is being forced to compromise them.



Over a century ago, Florence Nightingale brought to nursing a degree of professionalism, commitment and care that has been its hallmark ever since. As a result, thousands of little children grew up wanting to be nurses.

Today, many of the children who did become nurses are wishing they hadn't.

Because since the Griffiths Report, nurses are increasingly being treated like children.

The Griffiths Report recommended major changes in the way that the National Health Service is run. Chief among them is the idea that it can be made more cost-effective by employing managers from the business world.

WHO THIS?

We would agree that in many places, cost-cutting is being carried out at the patients' expense.

Because, whilst we agree that administrators can run hospitals, we don't believe that they can, run nursing.

More and more Health Authorities are appointing executives; at the same time, they are depriving nurses of any meaningful management role.

The results could be frightening.

Imagine a hospital where the nurses have no say at all in the choice of beds or other equipment. Where nursing staff can advise on patient care, but can't take any decisions. Where a matter of life and death can become a matter of pounds and pence. A hospital where the patients' spokesman has no real voice.

Now stop imagining.

Because this is what's starting to happen in Health Authorities throughout the country.

As the protector of nursing standards, the Royal College of Nursing is appalled.

THERE MUST BE A BETTER WAY.

We want to see a director of nursing appointed in every health unit in Britain.

Someone with the power and the nursing experience to make health care more effective.

Whilst the administrator concentrates on making it more cost-efficient.

We think that Miss Nightingale would agree with us. If you do too, please add your name to our petition by sending us the coupon.

And, if you're invited as we are, please write to your Member of Parliament now (the address is in the House of Commons, Westminster, London, SW1A 0AA).

Large Nursing should be run by nurses.

Name: _____
Address: _____

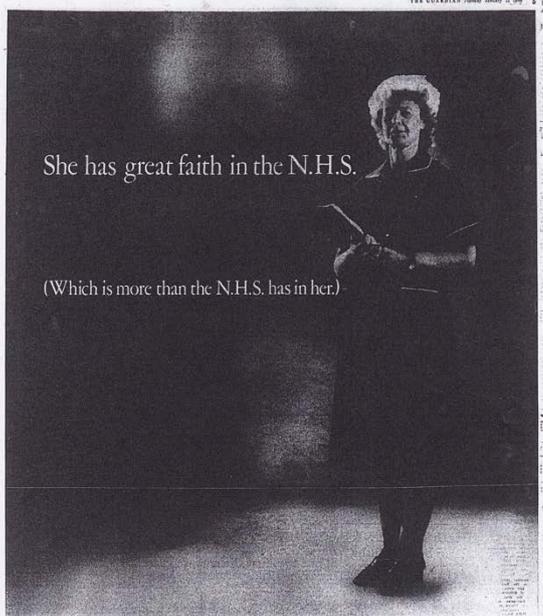
Please send to the Royal College of Nursing, 11, Bedford Way, London WC1E 6HT.

WE CARE FOR NURSES. SO THEY CAN CARE FOR YOU.

Figure 5 Guardian 21 January 1986

She has great faith in the N.H.S.

(Which is more than the N.H.S. has in her.)



This nurse is a committed, hard working professional. Without her (and thousands more like her), the NHS would collapse.

Twenty years ago, this would probably have been a nurse.

Today, thanks to unprecedented changes in NHS organisation, her voice and skills are being taken from her.

As the protector of British nursing standards (and the largest nursing trade union) the Royal College of Nursing has always believed in the NHS and worked within the system to effect change.

We've had a general pledge egg to work.

So we are more than a little alarmed at the way the NHS is running on.

The Griffiths Report suggested ways in which the NHS could be made more efficient. Among them was a recommendation that managers should be brought in from outside the NHS to make it more cost-effective.

If better managed resources meant better standards of patient care, we'd be all in favour.

But Griffiths hasn't stopped there.

In more and more health units, the professional managers have taken it upon themselves to decide that nurses cannot run nursing. Many Health Authorities now have no nurses in managerial positions at all.

So the very people who have qualified for years in looking after patients now have no say.

No say in how best to staff a general ward. No say in what best to choose for equipment matters. No say in where patients should be sent home.

NURSES WITHOUT VOICES.

And when nurses are dismissed, nurses aren't consulted.

When equipment is being bought nurses' opinions aren't sought.

When patients complain to the nurses, the trustees have someone who understands nursing to complain to.

The Royal College of Nursing believes that such developments are in the nurses' best interests. Even more important, they're usually in the patients' best interests.

What we want to see is the appointment of directors of nursing with both the experience to understand the problems of nursing and the power to make management decisions.

Administrators are qualified to run hospitals. Nurses are uniquely qualified to run nursing.

And you, as a patient, should be entitled to the best of both worlds.

If you think we have a fair point, please add your name to our petition by sending us the coupon.

And, if you're invited as we are, please write to your Member of Parliament now (the address is in the House of Commons, Westminster, London SW1A 0AA).

Large Nursing should be run by nurses.

Name: _____
Address: _____

Please send to the Royal College of Nursing, 11, Bedford Way, London WC1E 6HT.

WE CARE FOR NURSES. SO THEY CAN CARE FOR YOU.

Source: Newspaper archives, British Library

Social scientist Robert Dingwall, writing in the *Nursing Times*, summarised the reforms in a more pragmatic way:

Aspects of the Griffiths' reorganisation have clearly been grossly insensitive, but its principles reflect on an important sense of realism about the availability of resources and the need for careful evaluation of competition priorities.¹⁹⁴

Nurse Rosie Winyard, when interviewed, recalled how the Griffiths Report affected her nursing practice as:

... the pressure on efficiency savings and moving people quickly through an acute treatment system. And I would say that was even true in the 1980s with the Griffiths Report coming out and management in medicine being seen as, you know, 'we've got to be demonstrating value for money' and that means numbers in the treatment system and

¹⁹⁴ *Nursing Times*, 28 March 1986.

getting good outcomes at the end of it, moving people from hospital to home and making sure they don't go back to hospital...¹⁹⁵

But government reforms were not the only object of reproach that year. When the *Daily Express* revived the 'Nurse of the Year' contest (a competition that many hoped was dead and buried because of its sexist overtones), it was reviled by the *Nursing Times*. It condemned the RCN for supporting it, believing that the profession's status could never advance with this official sanction for 'sentimental mumbo jumbo'. The image of nurses would remain, it said, that of 'quiet and subservient, self-sacrificing angels of mercy', and the RCN was criticised for its regrettable support for a charade that flew in the face of the 'forward-looking and realistic' image of nursing that was sought.¹⁹⁶

Then came Project 2000, which added more reforms focused on education and which dominated nursing education for the rest of the century.¹⁹⁷ Some of the nurses I interviewed were very clear that they felt that these reforms took them away from their traditional roles and added to the pressures in nursing during the 1990s.

Annette Turton and Ruth Sewell recalled the strain of those times:

We were very strongly saying we don't want to go the American route where they can hypothesise and theorise but they can't catheterise!¹⁹⁸

When you look back and think about all the changes in nursing ... there was Project 2000 coming in, ...Nursing has to be degree level, diploma/degree level... there was so much starting to gush in ...¹⁹⁹

¹⁹⁵ Rose Winyard, interviewed 8 May 2014.

¹⁹⁶ *Nursing Times* editorial, 30 July 1986.

¹⁹⁷ *Project 2000: a New Preparation for Practice* (London: UKCC, 1986).

¹⁹⁸ Annette Turton, interviewed 10 April 2014.

¹⁹⁹ Ruth Sewell, interviewed 26 January 2015.

Hermione Elliott added:

I don't know when Project 2000 came in. It must have been around that time ... and again for some reason, they decided that nurses would be better trained in university and although I can understand that in terms of status, nurses had felt quite oppressed and second class and that was a completely wrong and inappropriate thing. I have always felt that to remove the training, or to put the training into a university context, is a real mistake because it is utterly about being a relationship, developing the intuitive skills, understanding and knowing people, clinical skills ...²⁰⁰

Of course, the aim of these reforms was not to unsettle the profession, nor to alienate nurses, but to achieve greater efficiency. However, the fact that new processes and systems threatened a holistic nursing approach by requiring more administrative tasks did not reassure those nurses who were seeking a more hands-on nurturing role.²⁰¹ Philip Tovey and Jon Adams' study of the changing nature of nurses' job satisfaction in the early 1990s conclude that the pressures experienced by them were caused by a combination of:

new roles, role conflict, lack of job security, 'tight' resources, new technology, a perceived lowering of standards of patient care, coping with increased amounts of paperwork and the experience of working in a rapidly and constantly changing environment.²⁰²

Some nurses opted for a change of career and sociologist Ursula Sharma's 1995 study of private complementary therapists found that nursing had been the most common previous career.²⁰³ Gavin Andrews' work reveals that 82.5% of nurses had

²⁰⁰ Hermione Elliott, interviewed 12 November 2014.

²⁰¹ Geertje Boschma, 'Ambivalence about nursing's expertise: the role of a gendered holistic ideology in nursing, 1890-1990' in Anne Marie Rafferty, Jane Robinson and Ruth Elkan, eds, *Nursing History and Politics of Welfare* (London & New York: Routledge, 1997), 171.

²⁰² Philip Tovey and Jon Adams, 'The changing nature of nurses' job satisfaction: an exploration of sources of satisfaction in the 1990s', *Journal of Advanced Nursing*, 30 (1999) 150-158.

²⁰³ Ursula Sharma, *Complementary Medicine Today: Practitioners and Patients* (London: Tavistock Routledge, 1992).

given their reason for turning to private practice as having been disillusioned with the NHS.²⁰⁴

Demonstrating that political tensions in nursing were still high in the last decade of the twentieth century, Jane Salvage, writing a review of 1996 in her editorial of the *Nursing Times*, described it frankly. It was, she said, 'a mixed bag of conflict, controversy and success.'²⁰⁵ Nursing roles remained under scrutiny and tensions arose between new bureaucratic tasks and the caring role of a nurse. Stephen Wright, writing on Project 2000 describes these tensions and the potential for fragmentation:

It focuses too much on theory and technology – now we need to explore more about the nature of healing and the drive to care – the core of nursing. Some areas of nursing are already taking this forward, such as the Holistic Nurses Association and the British Association of Therapeutic Touch. That is worrying from the RCN's point of view, as it risks the fragmentation of nursing. But it is about nurses being dissatisfied with the approach the profession is currently taking, and it goes much deeper than issues about pay; it shows that nurses are hungry to initiate a more profound meaning and understanding of their work.²⁰⁶

This 'profound meaning and understanding' was aligned to a holistic approach and the nature of healing. The subject of holistic culture and holistic healing in nursing is important, intriguing and complex and it is relevant to focus on it briefly in the context of how CAM was considered in this nursing timeframe.

²⁰⁴ Gavin Andrews, 'Nurses who left the British NHS for private complementary practice. Why did they leave? Would they return?', *Journal of Advanced Nursing*, 41 (2003) 403-415, 410.

²⁰⁵ Jane Salvage, *Nursing Times*, January 1997.

²⁰⁶ *Nursing Times*, February 1997.

In the week of 4 January 1995, *Nursing Times* readers had much to say on the subject of healing and in an article, 'Healing – the way forward', a Macmillan nurse raised the subject of the very use of the word:

I am aware that to call a therapy healing can raise people's prejudices because of old-fashioned religious-based connotations and that calling such a therapy therapeutic touch helps remove those prejudices.

Why was this? I would argue that it relates to the understandable touch element of caring. It also relates to intangible elements as nurse Nicky Baker described. It is 'about energy and intention'²⁰⁷ she explained, and Peter Mackereth expressed this in the context of end of life:

I think that holistically, healing is much more than physical healing. The problem is that the public, our medical colleagues, some of our nursing colleagues would see healing as curing and that is the confusion. And I get really concerned ... people glibly saying the word healing... people could be having a healing moment even when they are dying...where they have insight, where they shift emotionally, spiritually, physically....²⁰⁸

Here, Mackereth reflects the argument of writer Jeanne Achterberg in her discussion of women as healers. She describes the separation of caring and curing as having resulted from Cartesian dualism,²⁰⁹ of viewing the body in mechanistic terms – with a consequent loss of compassion and intuition – in favour of science and medicine. Achterberg asserts that the function of caring then continued as a second-order need, principally undertaken by women under the direction of male physicians.²¹⁰ The view of the 'clockwork universe' became a common metaphor for healing, suggesting that individuals, like clocks, could be better understood if they were

²⁰⁷ Nicky Baker, interviewed 26 January 2015.

²⁰⁸ Peter Mackereth, interviewed 30 January 2014.

²⁰⁹ Reductionist, mechanistic. Roy Porter, *Flesh in the Age of Reason: how the Enlightenment transformed the way we see our bodies and souls* (London: Allen Lane, 2003).

²¹⁰ Jeanne Achterberg, *Woman as Healer* (Rider, 1990), 101.

examined and mended as individual parts (as described in 4.3.1), not healed in the holistic way that Mackereth articulated.²¹¹ Achterberg also sees that the scientific movement causes the separation of mind, body and spirit and tears 'at the very fabric of women's healing power'. The concept and significance of holistic nursing will be more fully addressed in Chapters Five and Six, but it is a central aspect in the background to this research, which is why I include it briefly here in the context of the understanding of healing. Achterberg refers to the healing power of women and it is difficult to conduct a discussion on healing or on the practice of CAM without reference to gender.

In her interview, Alison Ellis observed that it was 'mainly women' who were involved in the RCN Complementary Forum activities; this comment introduces the discussion on gender in CAM. Sociologist Sarah Cant argues that CAM's popularity in the 1980s was particularly driven by female users and practitioners and that its appeal to women was due to its 'holistic, person-centred, subjective, spiritual, egalitarian, care-orientated provision characteristics.'²¹² She concludes that CAM has the potential to 'create spaces for gender-sensitive healthcare and sees an affinity of CAM with women's health concerns and feminist agendas.'²¹³ Judith Shuval also writes of the

²¹¹ *Ibid.*, p.101.

²¹² Sarah Cant and Peter Watts, 'The knowledgeable doer' in Nicola Gale and Jean McHale, eds, *Routledge Handbook of Complementary and Alternative Medicine: perspectives from social science and law* (Routledge, 2014), 101.

²¹³ Sarah Cant and Peter Watts, 'CAM, Gender and Marginality' in Ellen Kuhlmann and Ellen Annandale, eds, *The Palgrave Handbook of Gender and Healthcare* (Basingstoke: Palgrave Macmillan, 2012), Ch.29.

affinity of CAM to the caring orientations of female-dominated nursing and midwifery,²¹⁴ and Stephen Wright describes this view too:

The use of complementary therapies in Western culture is very much associated with feminine values: caring for the whole person, giving time and attention, accepting individuals as they are, seeking to work with them rather than at or to them, and depending upon 'softer' qualities of caring, intuition and imagination.²¹⁵

This was a subject of reflection by Patrick Pietroni in his interview when talking about the masculine and feminine nature of medicine:

The masculine nature of medicine - the link with the 'battle' and the 'magic bullet' and all the medical interventions are terribly powerful ... the drugs and surgery and radiotherapy, which I see as the masculine model of medical practice.²¹⁶

However, being clear that he also did not advocate an essentialist view of gender (which would attribute feminine essence to characteristics rather than to activities involving support and empathy for example²¹⁷), he added:

And the feminine model is about nurturing, about counselling, about listening, about hands-on massage. And, although that was so much linked to the nursing profession, it wasn't, in my view anyway, linked to your gender.²¹⁸

Jane Salvage, too, had that view:

I have never been struck by any particularly gendered approach to it. I haven't seen it as something that female nurses are more likely to do

²¹⁴ Judith Shival, 'Nurses in alternative health care: Integrating medical paradigms', *Social Science and Medicine* 63 (2006), 1784-1795.

²¹⁵ Stephen Wright, 'The competence to touch: helping and healing in nursing practice', *Complementary Therapies in Medicine*, 3 (1995) 1.

²¹⁶ Patrick Pietroni, interviewed 7 July 2015.

²¹⁷ Elizabeth Grosz, *Space, time and perversion: essays on the politics of bodies* (New York: Routledge, 1995); Anne Scott, 'Homeopathy as a feminist form of medicine', *Sociology of Health and Illness*, 20 (1998) 191-214.

²¹⁸ Patrick Pietroni, interviewed 7 July 2015.

than male. I don't think so. ... loads of men are acupuncturists ... So I am not sure that it is gendered.²¹⁹

While other participants did not raise it as an issue, the theme of scientific medicine perceived as a male preserve and the separation of healing from caring has been a theme of some sociologists²²⁰, not least because usage of CAM is dominated by women and many more practitioners are women, nurses or otherwise. Psychiatric nurse and academic Chris Hart discusses how nursing was increasingly challenged by science 'and a more masculine approach' where greater importance was given to 'the biological, the visible and measurable'.²²¹ Hannah Flesch supports the view that the qualities of CAM and its appeal to women is centred on the 'caring, nurturing, holistic, person-centred and preventative focus' of complementary therapies.²²² Agnes Miles, however, describes how this stereotyping can be over-simplified but that its reality, amid the decline of medical dominance, is more complex. Moreover, the recruitment of more women to the medical profession and more men to nursing has, she says, made an aberration of this typecasting.²²³

In summary, the published literature and my supporting data have shown how the historical context of healthcare, culture and nursing was shaped during the years of the research, 1960-2000. The impact of the developments in these contexts engendered a growing conviction among some nurses that 'things aren't quite right',

²¹⁹ Jane Salvage, interviewed 11 May 2015.

²²⁰ M.C. Versluyen, 'Old wives tales? Women healers in English history', in Celia Davies, ed., *Rewriting Nursing History* (London: Croom Helm, 1980).

²²¹ Chris Hart, *Nurses and Politics: the impact of power and practice* (Basingstoke: Palgrave Macmillan, 2004).

²²² Hannah Flesch, 'Balancing Act: women and the study of CAM', *Complementary Therapies in Clinical Practice*, 16 (2010) 20-5.

²²³ Agnes Miles, *Women Health and Medicine* (Buckingham: Open University, 1991), 132.

with comments such as ‘there must be more’ and ‘we are losing each other’²²⁴ revealing a hunger for an alternative model. A loss in confidence in biomedicine, the experience of HIV/AIDS, an open-mindedness to new healthcare options, the culture of consumerism and an increase in confidence by ‘new experts’, together with a rise in public awareness of complementary therapies, led to nurses’ personal and professional use of CAM. And the pressures of procedures, politics, technology and image in nursing drew them to an emerging wish for role enhancement. By the mid-1980s, some nurses, aware of the value of complementary therapies in developing their practice, were beginning to incorporate them and by October 1995, a *Nursing Times*’ survey revealed that 58% of nurses who responded to the questionnaire were implementing CAM in their work. The survey provides valuable insight into the contemporary state of therapies in nursing practice,²²⁵ but the question of *why* they were drawn to CAM was not addressed. I suggest that it was a combination of a number of these push and pull factors, but there is also the question of how flexible was nursing practice until this point? In spite of the growing dominance of scientific medicine in the 1950s and 1960s (and increasing throughout the later period of the study), in the questioning of participants I examined whether there had been a history of freedom to use other treatments and therapies and to what extent had a pluralistic approach traditionally been acceptable in employing non-orthodox remedies alongside those of conventional medicine?

²²⁴ Quotations from interviews with Hermione Elliott, Alison Ellis, Ruth Sewell.

²²⁵ Therapies most commonly employed were massage (40%), aromatherapy (34%), reflexology (10.5%) and therapeutic touch (8%). www.internethealthlibrary.com/Surveys/surveys-uk-nursing-comp-medicine.htm

4.4 Nursing and CAM

4.4.1 Latent pluralism

'Latent pluralism', a phrase coined by Helen Sweet and Anne Digby in their work on traditional medicine in South Africa, describes the underlying use of a variety of long-established modalities,²²⁶ and I argue that it is an appropriate term for mid twentieth-century British nursing practice too. Folk medicine, including the use of maggots, honey and herbs,²²⁷ was not only an individual choice, but a hospital practice, as recalled by nurses²²⁸ and reported in medical journals.²²⁹ Retired nurse Christine Eberhardie in her interview with me explained the concoction of natural products that were used in the early days of her nursing, by vividly describing a range of treatments:

In the 1960s and 70s, we used all sorts of things for pressure sores - egg white and oxygen - to stimulate blood flow ... honey ...sugar ...maggots and even flour. In fact my Nursing Officer once said he didn't know 'whether they were curing them or baking a cake!'

²²⁶ Helen Sweet and Anne Digby, 'Nurses as Culture Brokers in 20th Century South Africa' in Waltraud Ernst, ed. *Plural Medicine in Tradition and Modernity 1800-2000* (London: Routledge, 2002).

²²⁷ R. and M. Root-Bernstein, *Honey, Mud, Maggots* (New York: Houghton Muffin, 1997), 35.

²²⁸ For example, transcription of oral history interview by Helen Sweet of Betty Reid, 1.10.96, who gives an example of early remedies used by nurses. RCN Archives Edinburgh, T/ 364.

²²⁹ E.H. Wilson, C.A. Doan and D.F. Miller, 'The Baer maggot treatment of osteomyelitis', *Journal of the American Medical Association*, 98 (1932) 1149-52; J. Bunkis, S. Gherini and R.Walton, 'Maggot therapy revisited', *Western Journal of Science*, 142 (1985) 554-556; T. Postmes, A.E. Van Den Bogaard and M. Hazen, 'Honey for wounds, ulcers, and skin graft preservation', *The Lancet*, 341 (1993) 756-757; M.H.E. Hermans, 'Results of a survey on the use of different treatment options for partial and full thickness burns', *Burns*, 24 (1998) 539-551; R.A. Cooper, P.C. Molan and K.C Harding, 'Antibacterial activity of honey against strains of *Staphylococcus aureus* from infected wounds', *Journal Of The Royal Society Of Medicine*, 92 (1999) 283-285.

The use of honey was also described by other retired nurse participants. Sybil Allen and Elizabeth Hill recalled use of it as a remedy for pressure sores,²³⁰ and Sue Myring remembered its wider uses in nursing in the 1960s:

I do also remember using honey...it was used for bedsores. It was seen as a very good healing agent for all sorts of things. We put it on leg ulcers too. The honey used to clean them nicely – it had antiseptic properties.²³¹

In her interview, Angela Taylor described her nursing training in 1963 and how it involved instruction about the use of leeches and cupping. I asked her if she continued to these in later practice and she explained:

Not immediately, but in the late 1990s, they were finding that the use of leeches was very good with plastic surgery for reducing ... and of course they left no scar, so leeches did come back - but you need to counsel your patient.[...] because leeches have a reputation in most people's minds of coming out of the jungle and being dirty. But these would have been medicinally produced leeches – with a pedigree!²³²

The use of honey for wounds continued throughout the period as demonstrated by two articles in the *Nursing Times* in 2000:

Using honey as a dressing for infected skin lesions, the anti-inflammatory action of honey and the antioxidants present decrease the number of destructive free radicals.²³³

Using honey dressings: the practical considerations: Honey is increasingly being used as a dressing for infected wounds – particularly where conventional treatments have failed.²³⁴

The way the nurses spoke of these remedies did not necessarily reflect an 'alternative' or non-mainstream attitude, but simply easily-available constituents of

²³⁰ Sybil Allen, interviewed 11 June 2014; Elizabeth Hill, interviewed 6 January 2014.

²³¹ Sue Myring, interviewed 6 January 2014.

²³² Angela Taylor, interviewed 11 February 2014.

²³³ *Nursing Times*, 6 April 2000.

²³⁴ Cheryl Dunford, R. Cooper and P. Molan, 'Using honey for infected skin lesions', *Nursing Times*, 7 December 2000.

the nursing tool-kit.²³⁵ A further typical example of this type of traditional practice outside that of the biomedical model was massage, which had long been widely incorporated by nurses as a part of their caring role. This, in some cases, was then developed in incorporating tactile therapies such as aromatherapy and reflexology and this will be discussed extensively in the following chapter.

4.4.2 Role enhancement

By the mid-1980s, some nurses were undergoing training in complementary therapies, albeit on an *ad hoc* and personal basis.²³⁶ Many had reservations about implementation, however, such as senior nursing sister, Inga Newbeck, who suggested in 1986 that trying to integrate complementary therapies into nursing practice without fundamental changes in other aspects, such as valuing the nurse-patient relationship, would be 'like trying to ice an uncooked cake'.²³⁷ This also suggests that, without a structure of training and regulation, it was often a daring choice to make and to take and I was interested in examining the motivation of those nurses who made the decision to do so. Annette Turton's reference to the renewed holistic culture of 'thinking outside the box' was one of the reasons some nurses considered the use of CAM when the opportunity arose in the last decades of the twentieth century. In 1988, journal editor, nurse and leading CAM advocate Denise Rankin-Box²³⁸ suggested that nurses were turning to CAM, having grown

²³⁵ Honey-impregnated dressings are now manufactured by multinational companies and are seen as mainstream therapies for certain types of wounds. Similarly, the use of maggots is also still a mainstream therapy, for which 'sterile' maggots are supplied.

²³⁶ Denise Rankin-Box, *Nurses Handbook of Complementary Therapies* (Edinburgh: Balliere Tindall, 1995), 60.

²³⁷ *Ibid.*, 60.

²³⁸ Chair of the Royal College of Nursing Complementary Therapy Forum, 1990 -1996 and Editor in

disillusioned with the way healthcare was being provided²³⁹ – as has been shown (although her later informal survey in 1997 to assess nurses' use of complementary therapies did not specifically address motives). Nicky Baker, the last director of the Holistic Nurses Association, however, summarised the exasperation that was expressed by some of the nurses I interviewed. In repeating my question, she said, 'How were nurses feeling? Frustrated! That's [CAM] how they wanted to help people.'²⁴⁰

Researcher Dorothy Chadwick's work on this topic in the 1990s used a survey approach to gather data. Chadwick included questions about motivation and concluded that role expansion was the greatest incentive for nurses turning to CAM.²⁴¹ Sociologist Sarah Cant agrees and argues that it was a coordinated drive by nurses to 'augment their legitimacy, credibility and autonomy of practice.'²⁴² However, I would claim that it should be differently expressed as 'role fulfillment' or 'role enhancement'. I would argue that there is a subtle distinction between the terms 'expansion' and 'enhancement', but that this is significant in the discussion of why nurses turned to using complementary therapies. Rather than expansion (that is, *increasing* the nursing role), I claim that nurses were looking for enhancement (that is, a more *effective* role). In her interview for this study, Denise Rankin-Box also stated that role enhancement was a key motivator in nurses turning to CAM, while

Chief, *Complementary Therapies in Nursing and Midwifery*.

²³⁹ Denise Rankin-Box, *Complementary Health Therapies* (Croom Helm, 1988).

²⁴⁰ Nicky Baker, interviewed 24 January 2015.

²⁴¹ Dorothy Chadwick, 'What are the reasons for nurses using complementary therapy in practice?', *Complementary Therapies in Nursing & Midwifery*, 5 (1999) 144-148.

²⁴² Sarah Cant, 'The knowledgeable doer' in Nicola Gale and Jean McHale, eds, *Routledge Handbook of CAM* (2015), 98.

also giving the example of nurse-practitioners who were able to enlarge their role by absorbing some of the work of doctors. She explained the difference by stating:

Nurses wanted to expand their role and there were two ways of expansion...to take on more of the doctor's role, which is what has happened with the nurse-practitioners, but to enhance their role with taking on more independence in terms of recognising that there were other ways of treating people and caring for people that could work in conjunction with the type of treatment they were already on.²⁴³

This means of enhancement is also described by Jane Salvage, editor of the *Nursing Times*, who wrote about healing, meaning and a 'new spirit' in an article:

Reacting to the Western world's materialism, more and more people are looking for a spiritual dimension to their lives; seeking healing and meaning in making deeper connections with others, in work and personal life... In nursing, this new spirit glows in the incredible explosion of interest in complementary therapies. You cannot get enough of them! From aromatherapy to massage, these ancient healing arts put nurses back in touch with values and experiences that are in danger of being destroyed by rapid patient throughputs, cash limits and deskilling. Indeed, in combination with the deceptively simple acts of 'basic' nursing care, they give nurses the chance to practise the interpersonal and technical skills that attracted them to nursing in the first place.²⁴⁴

Caroline Stevensen also described this enhancement in an article in the *Nursing Times* in 1992:

My training in complementary therapies alongside my role as an orthodox intensive care sister has been the most enjoyable and demanding part of my career...it has also enhanced my nursing practice as well as that of others. By the mid-1980s I was keen to introduce and develop some form of complementary care in the intensive care unit ... massage, aromatherapy, and shiatsu.²⁴⁵

These quotations summarise the motivations for nurses using CAM – a desire to be in touch again with the traditional caring values which had been threatened by

²⁴³ Denise Rankin-Box, interviewed 4 August 2015.

²⁴⁴ Jane Salvage, 'Changing Nursing, Changing Times', *Nursing Times*, 29 January 1997.

²⁴⁵ *Nursing Times*, 16 September 1992.

processes and resources. In the *Nursing Times* of March 1986, senior nurse and health visitor June Clark wrote that ‘the professionalisation of nursing over the past two decades is most clearly seen in an increasing self-awareness and self-confidence among nurses.’ She refers to nurses as practising more confidently in spite of, rather than because of, the newly imposed managerial systems and phrased their self-assurance as the ‘spirit within the straightjacket’. Part of this new confidence was demonstrated by some nurses in their determination to enhance their roles with the use of CAM. However, exactly how they became initially involved is an area of study that has not received attention.

4.4.3 CAM: prompts and motivations

In seeking to establish why some nurses had turned to CAM, I also examined *how* they had originally become involved, hoping to identify their motives more clearly. Their responses showed that they had approached it in a variety of ways: personal interest, ideology and often as a result of an ‘awakening’ experience. Angela Taylor, for example, had attended a League of Friends meeting at St George’s Hospital, where presentations had demonstrated a variety of therapies and she was attracted by the chance to train in reflexology. She seemed surprised by her own reaction:

I think I was probably of the opinion that reflexology and the like were probably a bit cranky up until that point. So it was a bit of a turnaround really!²⁴⁶

This was echoed by Stephen Wright in his account of first attending a course on Therapeutic Touch:

²⁴⁶ Angela Taylor, interviewed 11 February 2014.

I attended one of Jean's [Sayre-Adams] courses and it had quite a profound impact on me, upon my sense of self and wellbeing to a degree – a kind of *awakening*, even though I think I personally thought I had become quite a nursing high flyer ... Being in Jean's class with the meditative quality, the touch and everything ... phew... I thought, 'Stop - so what's going on here?'

Interestingly, Wright used the same word, 'awakening', later in the interview to describe how his work in CAM had developed to the extent that he made the decision to ease out of mainstream nursing:

... it was through the complementary therapies that contributed to an inner *awakening* of what it was I was really looking for, what it is my own heart was longing for...²⁴⁷

Hermione Elliott's 'conversion' was more of an ideological one, when she encountered several osteopaths who introduced her to a new way of viewing health:

So it was as if I was being exposed to a whole range of new thinking that made complete sense to me. And in the mid-70s [it] was way-out actually - really quite far from the mainstream, and way off from anything I had been taught.²⁴⁸

This was developed by Jacqui Stringer, who recognised that CAM could enhance the quality of relationship with a patient:

I made a concerted effort to look into complementary therapies as a support mechanism when I started work on the haematology unit because it just consolidated my thoughts – which were sometimes just about being there for a patient and letting them access you at whatever level they want to ...and a really good way of doing that is through touch.²⁴⁹

Alison Ellis' first encounter with CAM had been from a personal need:

Quite by chance I met a practitioner of [...] Bach flower remedies and she really spoke to me and I went and had a couple of treatments with her at a time in my life when I desperately needed support from those remedies - which of course work on the emotions. And they helped me

²⁴⁷ Stephen Wright, interviewed 16 January 2014.

²⁴⁸ Hermione Elliott, interviewed 12 November 2014.

²⁴⁹ Jacqui Stringer, interviewed 30 January 2014.

tremendously and that opened up for the first time the possibility of complementary medicine.²⁵⁰

From being a patient of CAM, she developed her interest and knowledge and, as already described, became trained and was then able to incorporate complementary therapies into her nursing practice. Peter Mackereth's descriptions of his first experiences of body psychotherapy similarly reflected a personal need:

And they recommended a therapist, so I went to see this person and I went weekly for nearly a year and it was absolutely life-changing in my view. I did a lot of work around my relationship with my father, a lot of stuff around my sexuality, about why I was a nurse, about why I was driven into helping people, starting to understand the whole concept about being 'the rescuer', you know... trauma.²⁵¹

Significantly, these nurses talked of an 'awakening', and a 'turnaround', and the detection of excitement in their personal attitudes to CAM conveys a sense of this drive in their continuing interest. Mackereth, for example, became aware of how training in CAM could enhance his own nursing role and patient care, and when I asked him why nurses in general had taken up CAM, he explained:

I think it is to do with championing quality for patients and it is that therapeutic rapport as far as nurses are interested in. I think that the champions often are in areas such as elderly care, intensive care, cancer care, palliative care, where conventional medicine didn't have all the answers and complementary therapies can offer comfort...²⁵²

This view was echoed in Gavin Andrews' 2003 study of nurses leaving the NHS to practise CAM privately.²⁵³ Andrews discusses the push and pull factors involved and the pull factors reflect Mackereth's comment here that nurses embrace the positive

²⁵⁰ Alison Ellis, interviewed 12 May 2014.

²⁵¹ Peter Mackereth, interviewed 30 January 2014.

²⁵² *Ibid.*

²⁵³ Gavin Andrews, 'Nurses who left the British NHS for private complementary medical practice: why did they leave? Would they return?', *Journal of Advanced Nursing*, 41 (2003) 403-415.

and satisfying *therapeutic approach* as well as the *results* of complementary therapies.

These examples demonstrate the range of motives and opportunities for nurses turning to CAM; from ideological searching, personal need, a conscious desire for role enhancement in patient care and, in a few cases, chance, which also played its part.

4.5 Conclusion

This chapter has provided the context for the research in exploring the historical, cultural and nursing environment of the second half of the twentieth century. I have argued why some nurses may have turned to CAM, proposing a range of reasons, which came together within a twenty-year period, some of which pushed them away from the medical model towards use of CAM and some of which attracted them to it. First, the issues of debate, doubt and distrust in medicine peaked in the 1960s and 1970s. A social movement that encouraged alternative interests and alternative choices followed and the *zeitgeist* of counter-culture, New Ageism, nature and awareness of responsibility for self provided the opportunity for exploration of complementary and alternative medicine and the 'explosion of interest',²⁵⁴ which burgeoned in the 1980s among the general public and healthcare practitioners such as nurses. I argue that conditions in nursing in the 1980s, pressures of new management reforms, nursing processes and increasing technology, which was

²⁵⁴ Rosalind Coward, *The Whole Truth: the myth of alternative health* (London: Faber & Faber, 1989), 3.

distancing nurses from patients, led them to want to enhance their role, with patient care in nursing practice having become marginalised.

The opening section of the chapter shows how the very language of CAM exemplified its marginal nature – from ‘fringe’, ‘alternative’ to ‘non-orthodox’. Sarah Cant has drawn connections between the marginality of CAM and its users and practitioners who, too, have tended to be marginalised. She gives the example of women, men with HIV, men with challenges of potency, minority ethnic groups, and those with chronic illnesses whom biomedicine has failed.²⁵⁵ I argue that there was also an affinity with the marginality of a ‘product’ – the personal patient care that was being crushed out of nursing practice. Technology and nursing processes had, as discussed, pushed nurses to the edge of being able to provide this personal care for patients, reducing occasions for time spent with them, shrinking the opportunities for touch and limiting the chances to share empathy. CAM provided a new way to claim opportunities for providing those things.

Finally, the chapter also addressed the method by which nurses became involved with CAM. Several participants had quite casually taken up an interest in complementary therapies, only later making the decision to train professionally when they understood the potential they held for role enhancement and improved patient-centred care. All of the participants had turned to CAM through self-direction and were not specifically encouraged to do so by the nursing profession. I had expected a much greater sense of continuing professional development as a reason for their

²⁵⁵ Sarah Cant, speaking at an ESRC Festival of Social Sciences workshop, ‘Complementary Medicine – What do Social Scientists Think?’, Complementary and Alternative Medicine Birmingham Research Alliance, University of Birmingham, 11.11.15.

motivation, rather than the patient-interest that was expressed. Several spoke of the important part that was played by support networks and information structures (both formal and informal) in providing information, backing and encouragement. From my interviews, it was clear how significant this support was and it will be fully examined in Chapter Six.

Having established the background and the reasons for nurses' involvement with CAM, the subsequent question is how was nurses' initial interest developed by them, what therapies were used, how were they implemented into practice – and how was this challenge to the medical model handled? This provides the next major research theme and the subject of the following chapter.

CHAPTER FIVE: INCORPORATION

5.1 Introduction

The previous chapter has explored nurses' gradual 'awakening' to CAM in the latter years of the period 1960 to 2000. I have shown this to be due to the context of the spirit of the time, both in healthcare and society, pressures in nursing and a consequent desire to enhance patient care – together with a more open-minded atmosphere in which to practise it. Nurses describe how, although they believed that some aspects of nurse-patient interaction were intrinsic to the care of patients, they were feeling increasingly threatened by the growing use of technology and mechanistic procedures. Their increasing awareness of CAM provided a way to re-engage with patients.

This chapter will examine how, in the mid-twentieth century, an awareness also increased of the importance of the nurse-patient relationship and the nature of the therapeutic effect of nursing. I will show that this was formally recognised as putting the patient at the centre of care (as opposed to nursing-centred activity) and will develop this in examining how the qualities and practices involved in putting the patient at the heart of nursing were applied, with innovations such as Nursing Development Units and 'new nursing' in the 1990s.

Enhanced empathy and its 'spiritual' elements developed from this and the importance of giving time, talk and touch to patients became increasingly

acknowledged by nurses as central qualities of the therapeutic power of the nursing relationship. As Hildegard Peplau summarised, 'There is a significant difference between taking responsibility for the care of patients, and being therapeutically responsive to each patient.'¹ The understanding of the importance of touch opened awareness to the potential of touch therapies and some nurses were drawn to the use of massage for patients in order to offer reassurance and pain relief. For some, this developed into the particular use of aromatherapy and reflexology and interest in other modalities. This leads to the central discussion of the practice of CAM, which became, for some nurses, an instinctive extension of these therapeutic approaches.

Finally, the practical issues of how nurses integrated therapies and the level of support from managers and healthcare colleagues will be addressed. It is an area of work that adds important value to the wider field of the history of nursing, as well as to the history of CAM within nursing because it is an example of clinical practice that has not received full attention. Empirical data is drawn from interviews with nurses who were active from the 1960s to 1990s, together with nursing journals from that period.

The chapter opens with examination of the nurse-patient relationship which is shown to have an impact on healing² and is an underlying quality in a holistic approach. This, in turn, may have had an influence on the use of CAM by nurses.

¹ Hildegard Peplau, 'Psychiatric mental health nursing: challenge and change.' *Journal of Psychiatric and Mental Health Nursing*, 1 (1994) 5.

² Janet Quinn *et al*, 'Research guidelines for assessing the impact of the healing relationship in clinical nursing', *Alternative Therapies in Health and Medicine*, 9 (2003) 65-79.

5.2 The nurse-patient relationship

In 1983, sociologist David Armstrong stated that 'it might fairly be claimed that until recently the British nursing profession denied the patient even had emotions (and, by implication, neither did the nurse).'³ He argues that the caring role of the nurse had been restricted primarily to the biological functioning of the patient⁴ – until, that is, when the relationship between nurse and patient and its therapeutic impact became particularly highlighted in the 1980s. Works such as Alan Pearson and Barbara Vaughan's *Nursing Models for Practice*⁵ and Richard McMahon and Alan Pearson's *Nursing as Therapy*,⁶ Stephen Wright's *My Patient, My Nurse*,⁷ Bill Fulford, Steven Ersser and Tony Hope's *Essential Practice in Patient-Centred Care*,⁸ and Steven Ersser's *Nursing as a Therapeutic Activity*,⁹ all promoted a holistic approach and centred on the quality and value of the nurse-patient rapport.

This was reflected in a changing model of the doctor-patient relationship, too, which had become a focus of attention in the 1950s and 1960s as a neglected area,¹⁰ and it would be negligent not to include mention of it here. Although this topic has not

³ David Armstrong, 'The fabrication of nurse-patient relationships', *Social Science of Medicine*, 17 (1983) 457-460, 457.

⁴ *Ibid.*

⁵ Alan Pearson, Barbara Vaughan and Mary Fitzgerald, *Nursing Models for Practice* (Oxford: Butterworth Heinemann, 1986).

⁶ Richard McMahon and Alan Pearson, eds, *Nursing as Therapy* (London: Chapman and Hall, 1991).

⁷ Stephen Wright, *My Patient, My Nurse* (London: Scutari Press, 1990).

⁸ Bill Fulford, Steve Ersser and Tony Hope, eds, *Essential Practice in Patient-Centred Care* (Oxford: Blackwell, 1996).

⁹ Steve Ersser, *Nursing as a Therapeutic Activity* (Aldershot: Ashgate Publishing Company, 1997).

¹⁰ David Armstrong, 'The doctor-patient relationship, 1930-1980' in P. Wright and A. Treacher, *The Problem of Medical Knowledge: towards a social constructivist view of medicine* (Edinburgh: Edinburgh University Press, 1982).

attracted extensive study,¹¹ the important work that was undertaken by the psychologist Michael Balint in seminars with GPs at this time is relevant in highlighting a new interest in therapeutic relationships. It culminated in Balint's 1953 work, promoting the value of an improved therapeutic connection, and emphasising the essential quality of listening to patients.¹² I examined transcripts of some of the seminars,¹³ which showed how value was added to the medical encounter in encouraging GPs to look beyond the complaint presented by the patient and to recognise the importance of the doctor-patient relationship.¹⁴ Paula Dunleavy, a dentist and now acupuncturist, explained to me these challenges, as she had perceived them from her experience:

Some patients don't have the time to talk to their medical practitioner and also I think some people aren't particularly articulate or good history-givers and so by the time their 10 minutes is up, they may not have got to the thing that is really bothering them - or the thing that is really bothering them is actually something else. They haven't actually prioritised that because they say something to the doctor and the doctor picks it up and runs with it and they disappear down that particular track and the opportunity is gone.¹⁵

Balint described the power of the good listening relationship as the doctor being part of the treatment: 'the doctor as the drug.'¹⁶ Retired GP John Walton described to me how his discovery of Balint's work in the 1960s was an inspiring catalyst that persuaded him of the value of general practice and how he understood the potency

¹¹ Fay Bound Alberti, ed., *Medicine, Emotion and Disease, 1700-1950* (Basingstoke: Palgrave Macmillan, 2006) xiv.

¹² 'The ability to listen is a new skill, necessitating a considerable though limited change in the doctor's personality.' *The doctor his patient and the illness*, 121. Balint continued to be an important influence on therapeutic relationships until the end of the century - and Balint Groups have continued to exist since then, examining and working to improve the quality of the doctor-patient relationship. The Balint Society, www.balint.co.uk (accessed 25 November 2014).

¹³ Seminars No. 72 and No. 73, 5 & 12 January 1966, Wellcome Archives.

¹⁴ Margaret Stacey, *The Sociology of Health and Healing* (London: Routledge, 1988), 166.

¹⁵ Paula Dunleavy, interviewed 27 August 2014.

¹⁶ Michael Balint, *The doctor, his patient and the illness* (London: Pitman, 1957).

of the doctor-patient relationship when it worked well, and the key part that a listening doctor played:

It was a fairly new concept ... getting the doctors to listen, without interruption necessarily ... and let the *patient* do the talking.¹⁷

This approach seemed innovative to practitioners at the time, but Dr Patrick Pietroni argues that Balint's work was further evidence of a revival of the tradition of 'whole-person medicine',¹⁸ and in his interview he reiterated the value of a holistic approach by a medical practitioner who knows how to use:

...a set of communication skills which would allow the client/patient to feel safe and be listened to and to take part in the decision-making process.¹⁹

Medical education clinical communication modules increasingly focused on this quality of compassion and empathy,²⁰ supported by the General Medical Council.²¹ Nursing academic Stephen Wright alluded to the strength of this relationship in nursing too, claiming 'The power of nursing to promote healing lies ...in this therapeutic relationship ... a purposeful, supportive and healing association between two persons that is holistic.'²² Nursing sisters Inga Newbeck and Denise Rowe, writing in the February 1986 *Nursing Times*, reiterated this: 'The sharing of decision-making, realistic goal-setting and working together in therapy are implicit in the idea of holistic nursing.'²³

¹⁷ John Walton, interviewed 20 May 2015.

¹⁸ 'Would Balint have joined the British Holistic Medical Association?', *Journal of the Royal College of General Practitioners*, 36 (1986) 171-173.

¹⁹ Patrick Pietroni, interviewed 7 July 2015.

²⁰ Victoria Bates, Jonathan Reinartz and Connie Wiskin, 'The History of Clinical Communication Teaching' in J Brown *et al*, eds, *Clinical Communication in Medicine* (John Wiley, 2016).

²¹ *Tomorrow's Doctors* (General Medical Council, 1993).

²² Stephen Wright, interviewed 16 January 2014.

²³ *Nursing Times*, 19 February, 1986.

But there is another element to holistic nursing, which several participants referred to – that of empathy. Here, I will return to Florence Nightingale briefly and reinforce the point that it was her emphasis on holistic qualities that had such a major influence on nursing. Nightingale's most recent biographer, Mark Bostridge, summarised her approach:

Above all, the book [*Notes on Nursing*] encourages the notion that good nursing stems from an ability to engage in imaginative sympathy with someone else's feelings, feelings that by definition you yourself can never have felt.²⁴

This quality of empathy is not just valued as in kindness and emotional sensitivity but something more. Nurse Rosie Winyard reflects this in speaking of rapport, which was central to her nursing practice:

... rapport ... comes from listening and responding in an appropriate way to a question. It is just fundamental to every engagement with a service user ...²⁵

When discussing therapeutic relationships in his interview, psychiatric nurse Dan Jones went further than this: 'Everything is about relationships', he stated, '...it entirely makes sense for me that it is relationships that heal.'²⁶ And Hermione Elliott, Director of the Holistic Nurses Association, echoed this, writing in 1997: 'When we get the relationship right, everything else falls into place.'²⁷ In her interview, she expanded on this comment saying, 'It is really possible to influence another by my state of being...'²⁸ This theme of relationality is a point that has been made by

²⁴ Mark Bostridge, *Florence Nightingale: the woman and her legend* (London: Viking, 2008) 357.

²⁵ Rosie Winyard, interviewed 8 May 2014.

²⁶ Dan Jones, interviewed 30 May 2014.

²⁷ Hermione Elliott, 'Holistic nursing and the therapeutic use of self', *Complementary Therapies in Nursing and Midwifery*, 3 (1997) 81-82.

²⁸ Hermione Elliott, interviewed 12 November 2014.

health services researcher Carole Estabrooks, too, who compares the ‘super nurse’, using touch in a caring way, with the ‘mechanical nurse.’²⁹ In 1975, this had been expressed by nurse Lori Zefron writing in *Nursing Forum* by stating simply, ‘We as nurses are committed to a healing art. That art is caring, and caring is loving.’³⁰

In his interview, nursing academic Stephen Wright stressed the importance of the quality of the relationship with the patient, extending the concept of spirituality in nursing.³¹ Although a supporter and practitioner of CAM, his view is that applying a complementary therapy is still about an *intervention*, rather than developing a *relationship*, and he explained this in terms of the relationship between practitioner and patient:

... there was a growing realisation that it was not about putting something into somebody, there was a growing realisation of a deeper understanding of human consciousness, of how the quality of relationships in health care, about how relationality aspects could be as powerful as any therapy.³²

Peter Mackereth also describes the power of this relationship:

As a nurse, I am much more interested in how do we engage with people meaningfully, how do we ease people’s situation, how do we bring comfort how do we support the family ... how do we value each other, how do we make that connection?³³

Nurse academic P.A. Meutzal similarly analysed the therapeutic relationship between nurse and patient as ‘being there’ or ‘presencing oneself’,³⁴ and Wright illustrates this by use of his emotive metaphor of ‘the glassy-eyed nurse’ and ‘the clear-eyed nurse.’

²⁹ Carole Estabrooks, ‘Touch: a nursing strategy in the intensive care unit’, *Heart and Lung*, 18 (1989) 329-401.

³⁰ Lori Zefron, ‘The history of laying on of hands in nursing’, *Nursing Forum*, xiv (1975) 4.

³¹ Stephen Wright, interviewed 16 January 2014.

³² Stephen Wright, interviewed 16 January 2014.

³³ Peter Mackereth, interviewed 30 January 2014.

³⁴ P.A. Meutzal, ‘Therapeutic nursing’, in Alan Pearson, ed., *Primary Nursing: Nursing in the Burford and Oxford Nursing Development Unit* (London: Chapman & Hall, 1988).

He explained it to me when discussing a friend who first observed the different ways in which nurses engaged with him as a hospital patient. I quote it in full, as it is an important explanation of Wright's – and others'³⁵ – belief in the importance of empathy, or the therapeutic use of self, and the effect it has, not only on the nurse-patient relationship, but on the potential of healing:

There were some people there when you were with them, you knew that they weren't really there for you; they had this glassy-eyed look, you knew they were thinking about the next patient or what they did the night before, or the stresses of the job... that there was some quality in their presence or in their conversation and you knew they weren't with me. And some people would come into the room ... and I knew by the way they looked at me, the clear-eyed look, and I knew they were absolutely there for me. In spiritual terms, in Buddhist terms, that is being in the moment. You are absolutely there, dealing with what is before you, you're fully attentive, in the moment, your consciousness is not all over the place, thinking about other things, so on and so forth, but fully present there for that patient.³⁶

Wright recollected teaching nurses how to reach their potential, to be conscious of who they were and how they could be 'fully present, compassionately, with the patient.' This was reinforced by nurse therapist Jean Sayre-Adams who stated, 'Every time we walk up to touch someone with love and intention and presence, there is something that happens there.'³⁷

Hermione Elliott echoed this explanation of nursing empathy in reflecting on the HeartMath³⁸ research, which proposes that 'the heart is the powerhouse' in

³⁵ Carl Rogers (1962), Hildegard Peplau (1952), Joyce Travelbee (1971), Anne Altschul (1972), Steve Ersser (1997).

³⁶ Stephen Wright, interviewed 16 January 2014.

³⁷ Jean Sayre-Adams, interviewed 15 January 2014.

³⁸ www.heartmath.com accessed 28 November 2014.

therapeutic relationships.³⁹ The part that the heart plays in this way has been discussed by others too. The history of emotions is experiencing a growing academic focus,⁴⁰ and Fay Bound Alberti, in her work on the heart, writes about how less attention has been paid to this emotional, empathetic aspect of the patient relationship, compared with a focus on power and profession.⁴¹

The notion of the 'empathetic healer' or the 'empathetic practitioner' has evolved simultaneously, as has a range of critical writings concerned with narratives of illness and the emotional impact of physical illness on the mental wellbeing of patients.⁴²

Wright summarises this holistic style in saying: 'If nursing is anything, it is an expression of heartfelt compassion for the wellbeing of another human being. It is heart-centred work.'⁴³ This heart-centred work is expressed in patient comfort-care. Nursing academics Marie Evans' and Christine Hallett's phenomenological study of comfort-care concluded that it is comprised of three aspects: 'comfort and relief', 'peace and ease' and 'spirituality and meaning',⁴⁴ and my argument is progressing towards exploring this 'spiritual' element of the nurse-patient relationship.

Nursing academic Chris Hart writes that: 'The efficacy of the care being given, rather than the treatment, is diminished as soon as either party, patient or nurse loses

³⁹ Hermione Elliott, interviewed 12 November 2014.

⁴⁰ For example, The Centre for the History of Emotions at Queen Mary's, University of London.

⁴¹ Fay Bound Alberti, *Medicine, Emotion and Disease* (Basingstone: Palgrave Macmillan, 2006) p.xiii; Fay Bound Alberti, *Matters of the Heart* (Oxford: OUP, 2010).

⁴² Alberti footnotes: Michael J. Bennett (2001), *The Empathetic Healer: an Endangered Species?* (2001), Ellen Singer More and Maureen A. Milligan, eds, *The Empathetic Practitioner: Empathy, Gender and Medicine* (1994); Howard M. Spiro, Mary G McCrea Curnon, Enid Peschel and Deborah St James, eds, *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel* (1993); Bernard Lowen, *The Lost Art of Healing: Practising Compassion in Healing* (1996).

⁴³ Interview in *Nursing Standard*, March 2011.

⁴⁴ Marie Evans and Christine Hallett, 'Living with dying: hermeneutic phenomenological study of the work of hospice nurses', *Journal of Clinical Nursing*, 16 (2007) 742-751.

faith,⁴⁵ suggesting that the sense of trust between nurse and patient is delicately poised. Caroline Hoffman also describes it as a sensitive encounter:

It is our duty as health care providers to really listen to the person deeply, and understand – not only intellectually, but understand intuitively – what might be the thing that that person might need? Medicine is an art and a science and for all of us, it is keeping that balance. And when we have somebody in front of us, having enough understanding about what would really be helpful for that person...⁴⁶

Hermione Elliott develops this further in talking about the potency and power (not in a hierarchical sense) that exists in this type of engagement:

If I can be in my compassionate heart, it has a direct effect on somebody who may be in distress. It can quieten things down or help people feel safe, so for me that is a really sort of, very subtle or esoteric kind of practice of the therapeutic use of self.⁴⁷

Receiving emotional support from nurses is an expectation by patients, comments sociologist Ann Oakley, who asserts that nurses are naturally perceived as warm, kind and sympathetic.⁴⁸ However, for some, the quality of the caring encounter is expressed even more intensely as a 'spiritual' element, and several of my participants referred to this. In 1964, Canadian psychologist Sidney Jourard wrote of this aspect of the nurse-patient relationship and how it was a significant feature in a patient's recovery. He used the term 'inspiring', thereby avoiding the religious connotations,⁴⁹ which was a discomfort for some, as nursing academics P.J. Barker, W. Reynolds and T. Ward discuss in their work.⁵⁰ They examine what they call the 'spiritual enlightenment of new caring' in western healthcare, derived from 'third-force

⁴⁵ Chris Hart, *Nurses and Politics, the impact of power and practice* (Basingstoke: Palgrave Macmillan, 2002), 97.

⁴⁶ Caroline Hoffman (*née* Stevensen), interviewed 10 June 2015.

⁴⁷ Hermone Elliott, interviewed 12 November 2014.

⁴⁸ Ann Oakley, *Essays on Women, Medicine and Health* (Edinburgh: Edinburgh University Press, 1993), 46.

⁴⁹ Quoted in Lori Zefron, 'The history of laying-on of hands', *Nursing Forum*, xiv (1975) 4.

⁵⁰ P.J. Barker, W. Reynolds and T. Ward, 'The proper focus of nursing: a critique of the 'caring' ideology', *International Journal of Nursing Studies*, 32 (1995) 386-397.

psychology.⁵¹ While sharing sympathy for humanistic psychotherapy, they cautiously write of their concern about possible hidden religious agendas that might lie in the undercurrents of caring and ‘the waters of academic discourse.’ Reflecting this, some interviewees in my study used other terms, which included ‘relationality’,⁵² ‘intention’,⁵³ ‘rapport’,⁵⁴ intuition⁵⁵ and ‘intuitive understanding’.⁵⁶ It was noteworthy that a number of interviewees, when talking about the spiritual element in holistic nursing, were keen to add that they had no particular religious affiliations, even though they used the word ‘spiritual’ in the absence of an alternative. Others made excuses for the word (for example, ‘I use the word very tentatively’ (Jane Salvage), ‘I keep using ‘spiritual’, but it might not be the right term. (Denise Rankin-Box)). Nevertheless, a type of spiritual dimension of nursing care – quite unrelated to faith healing – found a new focus in the last decades of the twentieth century. Peter Mackereth highlighted this in stating,

There was a lot of interest in spirituality in the 80s and 90s ... that has definitely gone off [...] maybe we live in a much wider community where spirituality is not addressed in the way it has been.

Having established the existence of a change in consciousness with a renewed holistic approach in nursing and its demonstration in a quality relationship with the patient – in comfort-care, in empathy, and in a ‘spiritual’ sense – I now turn to how this was borne out in practice.

⁵¹ *Ibid.*

⁵² Stephen Wright, interviewed 16 January 2014.

⁵³ Jean Sayre-Adams, interviewed 15 January 2014.

⁵⁴ Rosie Winyard, interviewed 8 May 2014.

⁵⁵ Nicky Baker, interviewed 16 July 2015.

⁵⁶ Caroline Hoffman (*née* Stevensen), interviewed 10 June 2015.

In 1992, the RCN asked members to contribute to a study on 'The value of nursing' and one of the responding comments refers to the importance of helping patients to find new hope or comfort in distress, and adds how this could be achieved through 'touch, massage and gentle encouragement.'⁵⁷ This leads to my next argument – that of the nature and extent of the therapeutic relationship in the nurse-patient encounter. Healthcare academic Alan Pearson summarises this in saying:

To be therapeutic is to be remedial, in either a curative or healing sense. It has long been my conviction that high-quality nursing (the generalistic caring acts which are embodied in everyday practice) has a healing effect or an effect which results in movement towards recovery.⁵⁸

Steven Ersser also describes the importance of the nurse's therapeutic repertoire and how it could be extended in the quality of the interaction with a patient: 'nursing is a therapeutic activity in its own right.'⁵⁹

Physician and academic David Reilly, on observing the themes of the images in nursing advertisements, noted how many were of nurses busying with syringes, monitors and blood pressure machines and he commented that 'everything was busy, competent, professional, technical and inter-ventive, and legitimised by the stamp of what is seen as science.' They gave, he said, a sense that the caring aspects of nursing were now not good enough, not 'real science', not 'real medicine', not powerful enough, and he added: 'what emerges time after time is a picture of a patient who has felt rushed, unlistened to.'⁶⁰ The increasing focus on technology was pushing nurses away from patient contact, yet many recognised the therapeutic

⁵⁷ *The Value of Nursing*, Royal College of Nursing (1992).

⁵⁸ Richard McMahon and Alan Pearson, eds, *Nursing as Therapy* (London: Chapman & Hall, 1999).

⁵⁹ Steven Ersser, interviewed 14 July 2014.

⁶⁰ David Reilly, 'Nursing care – who cares?', *Complementary Therapies in Nursing & Midwifery* 3 (1997) 121-122.

value of touch, time and talk – activities that were being eased out of nursing practice.

5.2.1 The nurse-patient relationship: touch

It is not by chance that the title of the journal published for members of the RCN Complementary Therapies Forum was entitled *In Touch*. Its first issue was published in autumn 1995. None of my participants could recall debate or decision about its christening, but I learned that they believed that, along with time and talking, the value of touch was recognised as a crucial element in their nursing practice. From this starting point, I explored historical, social and cultural concepts of touch in order to consider and analyse their responses.

Massage and touch have historically been fundamental to nursing, evidenced by the range of published textbooks,⁶¹ and the teaching of ‘friction’ in early nurse education.⁶² However, in his book *Massage as a Mode of Treatment* (1886), the English physician William Murrell wrote of his frustration that massage was underrated and misunderstood by nurses:

Applicants are often anything but pleased when they are told that it takes at least two years to learn...I constantly see nurses and others

⁶¹ e.g. Herbert Tibbits, *Electrical and anatomical demonstrations delivered at the School of Massage and Electricity – a handbook for trained nurses and masseuses* (London: J&A Churchill, 1887); William Murrell, *Massage as a mode of treatment* (London: H.K. Lewis, 1886); Samuel Hyde, *Nurses’ Guide to Massage* (Manchester: J. Heywood, 1890); Lucy Fitch, *Massage for beginners, Massage Movements*, (1891); Thomas Davey Luke, *Textbook of massage and Swedish gymnastics for masseuses and nurses* (London: Scientific Press, 1913); Maude Rawlins, *A Textbook of Massage for Nurses and Beginners* (London: Henry Kimpton, 1933).

⁶² Florence Nightingale Museum, Memorandum of Instructions by Matron to Ward Sisters; On Duties to Probationers, page 4 (Easter 1879), Object 0788.

who think they are thoroughly competent to undertake Massage, but who have not the dimmest idea even of the meaning of the word.⁶³

The Society of Trained Masseuses, later to become the Chartered Society of Physiotherapists, was founded in 1894 by four nurses aiming to regularise the practice of massage following 'massage scandals' addressed in medical journals, which had involved brothels masquerading as massage parlours.⁶⁴ In their article about massage in this period, CAM historians David Nicholls and Julianne Cheek make two interesting arguments for the rise of massage in the 1880s among nurses:

Firstly, it was closely allied to the development of professional roles for women that challenged medicine's domination of therapeutic modalities; secondly, it gave women a degree of professional autonomy and self-determination that had not been seen before.⁶⁵

As noted in the previous chapter, these were two of the motivations for the rise in use of CAM among nurses a hundred years later too. It is noteworthy that, in each case, this introduction of a therapy treatment into the practice of nursing was perceived to give increased professional autonomy and status, arguably through enhancing the interventionist role by demonstrating a competency. This shifting between care and treatment and the perception of the crossing of professional boundaries⁶⁶ is worthy of fuller attention and could give opportunity for further study.

⁶³ William Murrell, *Massage as a Mode of Treatment* (London: H.K. Lewis, 1886), 2.

⁶⁴ *BMJ* 1894(b), 88.

⁶⁵ David Nicholls and Julianne Cheek, 'Physiotherapists and the Shadow of Prostitution: The Society of Masseuses and the massage scandals of 1894', *Social Science and Medicine*, 62 (2004) 2336-2348.

⁶⁶ Sylvia Walby and June Greenwell, eds, *Medicine and Nursing: professions in a changing health service* (London: Sage, 1994) 40.

The history of touch in a clinical context is relevant. Carole Estabrooks claims that in the USA from 1900 to 1920, nurses rarely wrote about using touch.⁶⁷ Only instrumental touch was occasionally referred to, but it was not until the 1970s, she states, that touch was viewed as expressive and non-procedural. British nursing journal articles also reflect a similar lack of interest in nursing touch during the early decades of the twentieth century.

Cultural historian Constance Classen claims that 'therapeutic touch has two strands. One concerns touch as a medium of supernatural influences – as in the Royal Touch – and the other deals with the natural healing powers of touch, as in physiotherapy.'⁶⁸ To this, I would add 'nursing', and this second category is the one I have focused on here. This research does not address supernatural characteristics of touch – with one exception, however, that of 'Therapeutic Touch', or TT. This is a very specific type of healing therapy and is included at this stage in order to clarify its position. Although it is often mentioned in the same context as touch and massage (as indeed it was sometimes by my interviewees), it should not be categorised with physical touch for it is a non-contact modality based on the concept of manipulating energy flowing around the body in order to alleviate illness. In 1971, its originator,¹ Dolores Krieger, a professor of nursing at New York University, demonstrated a physical result in proving evidence of changes in haemoglobin values in patients,⁶⁹ and, in

⁶⁷ Carole Estabrooks, 'Touch in nursing practice: a historical perspective', *Journal of Nursing History*, 2 (1987) 33-49.

⁶⁸ Constance Classen, *The Book of Touch* (Oxford: Berg, 2005) 35.

⁶⁹ Using an experimental group and a control group consisting of comparable individuals. The experimental group received 'laying-on of hands' healings while the control group did not. Dr Krieger measured haemoglobin levels in both groups both before and after a series of healing treatments. There was a significant increase in haemoglobin levels in those the healer treated. Dolores Krieger

1975, Lori Zefron wrote in *Nursing Forum* that nurses using this type of healing touch experienced vibrations, and that these 'vibes' were intrinsic in the natural model of this style of caring-healing-nursing.⁷⁰ This modality should be included in Classen's 'supernatural strand of touch',⁷¹ and is the therapy closest in practice to the laying on of hands or spiritual healing.⁷²

Categorising the different types of touch is challenging. A wide range of possible forms and purposes exist, but it is important to explore them here before looking at the data. Nursing academics Madeline Gleeson and Fiona Timmins summarise a range of researchers' conceptualisations and definitions of touch used within nursing.⁷³ They itemise the following terms which have been employed by a range of researchers: 'instrumental touch', 'expressive touch',⁷⁴ 'task touch', 'caring touch', 'protective touch',⁷⁵ 'therapeutic' touch, 'affectional' touch,⁷⁶ 'functional touch', and 'non-physical' touch.⁷⁷ For the purposes of this research, I will use only two of the terms that they use for touch: instrumental (associated with tasks) and expressive (associated with caring), which I believe are sufficiently clear to imply the division of touching styles in nursing. Other studies have demonstrated in detail the interaction

'The response of in-vivo human haemoglobin to an active healing therapy by direct laying-on of hands', *Human Dimensions*, 1 (1972) 15.

⁷⁰ Lori Zefron, 'The History of the laying-on of hands in nursing', *Nursing Forum*, XIV (1975) 350-363.

⁷¹ Classen, *The Book of Touch*, 35.

⁷² Lori Zefron, 'The history of the laying-on of hands in nursing', *Nursing Forum*, XIV (1975) 350-363.

⁷³ Madeline Gleeson and Fiona Timmins, 'A review of the use and clinical effectiveness of touch as a nursing intervention', *Clinical Effectiveness in Nursing*, 9 (2005) 69-77.

⁷⁴ Kathleen McCann and Hugh McKenna, 'An examination of touch between nurses and elderly patients in a continuing care setting in Northern Ireland', *Journal of Advanced Nursing*, 18 (1993) 838-846.

⁷⁵ Carole Estabrooks, 'Touch: a nursing strategy in the intensive care unit', *Heart and Lung*, 18 (1989) 329-401.

⁷⁶ S. Schoenofer, 'Affectional touch in critical care nursing: a descriptive study', *Heart and Lung*, 18, (1989) 146-54.

⁷⁷ Ruth Vortherms, 'Clinically improving communications through touch', *Journal of Gerontological Nursing*, 17 (1991) 6-10.

of touch and nursing,⁷⁸ but I know of none that address the issue of how touch impacted on some nurses' decisions to use CAM in their practice, which is what I am exploring in this chapter. An important statement was made by American nursing academic Mary Johnson, however, in claiming that 'more than any other word, the term 'touch' seems to symbolise the shift toward a holistic perspective.'⁷⁹

Instrumental touch was acknowledged by the nurse participants in this study as being part of a daily natural routine in its use in necessary and unavoidable nursing processes. How this changed due to technological developments will be addressed later but even this practical, instrumental type of nursing touch was perceived as an important element and nurses' responses in interviews demonstrate a sense of its value, as nurse Sue Myring expressed:

We used to do one-hourly back rounds – rubbing people's bottoms, elbows and heels – and I think, looking back, this was an absolutely vital bit of the caring. This was the touching...⁸⁰

It was, they suggest, a natural action as a result of a practical procedure: 'Patients were washed...and when you wash, you are touching', said nurse Angela Taylor.⁸¹

Nurse academic Annette Turton developed this idea further by suggesting that instrumental touch could naturally evolve into expressive touch without intention:

⁷⁸ Ruth Vortherms, *Ibid.*; A. Carter and H. Sanderson, 'The use of touch in nursing practice', *Nursing Standard*, 9 (1995) 31-35; P. Routasalo and A. Isola, 'Physical touch in nursing studies: a literature review', *Journal of Advanced Nursing*, 30 (1996) 843-850; S.C. Edwards. 'An anthropological interpretation of nurses' and patients' perceptions of the use of space and touch', *Journal of Advanced Nursing*, 28 (1998) 809-817; S.O. Chang 'The conceptual structure of physical touch in caring', *Journal of Advanced Nursing*, 33 (2001) 820-837.

⁷⁹ Mary Johnson, 'The Holistic Paradigm in Nursing: the diffusion of an innovation', *Research in Nursing & Health*, 13 (1990) 129-139.

⁸⁰ Sue Myring, interviewed 6 January 2014.

⁸¹ Angela Taylor, interviewed 11 February 2014.

...within nursing, we are becoming more specialist and more – ironically – task-orientated. The tasks we think we should be doing are the high-tech things and not the very tasks that are fundamental to holistic care...feeding, watering, touching. I don't think, 'I'll go over and give Christine a touch.' No, it should be 'I'll go over and help Christine wash.'⁸²

In other words, it felt second nature for the nurses to express their connection with patients literally through their hands-on nursing activities – not necessarily in applying a specific therapy. Nursing sister Elizabeth Hill commented, 'you knew that touching and stroking was a big part of their healing process',⁸³ and Rosie Winyard highlighted a means of combining both the instrumental and the expressive nature of touch in providing support for a patient:

If you were going to deliver a painful procedure to a patient who wasn't anaesthetised, you would have one nurse to hold their hand – and that sense of holding their hand was seen as a way of helping the person to overcome their pain.⁸⁴

The expressive, reassuring touch here was a natural action of a supporting type.

The physical closeness required by many nursing procedures was commented on by several participants, describing it as a nurturing concept, and there was greater detail from some who developed the idea further, claiming that touch in this expressive way demonstrated an instinctive parenting role.

When asked whether the touch was taught or was intuitive, theatre nurse Ruth

Message replied:

Oh it was intuitive. I don't remember that being mentioned, it was just a natural thing to do. Like a mother holding a child's hand. Patients are

⁸² Annette Turton, interviewed 10 April 2014. .

⁸³ Elizabeth Hill, interviewed 6 January 2014.

⁸⁴ Rosie Winyard, interviewed 8 May 2014.

very much in that sort of category in a way. When they come in, they are handing themselves over to you. So it was intuitive.⁸⁵

Nurse therapist Jacqui Stringer confirmed that she used this parenting style of gesture:

I think it [touch] helps them [patients] to feel secure, safe, somehow. I think it is instinctive. For example, as a mother...if you are protecting, you put your arms around someone, they feel safe...so it's allowing that sort of feeling of security...⁸⁶

This concept of 'nurturing' was developed further by some participants in their reflections on the significance of touch, as nursing sister Alison Ellis describes:

We are a naturally gregarious sort of herd creature and I have noticed in widows and widowers, divorcees....I'm sure that a lot of their depression is that they have lost someone who gives them a hug, holds their hand when they are out shopping and just generally nurtures them. And I think that this is what early nursing was - nurturing. So often there wasn't a lot that could be done, to be honest, by Florence Nightingale and her ladies in the Crimea...but if they could go and sit and hold somebody's hand and promise to write home for them or something, that *had* to reduce the anxiety of that patient and I think it is an anxiety-reducing thing to do which is so simple and so free.⁸⁷

Nursing is frequently regarded as an extended role of a mother surrogate claim A. Montagu⁸⁸ and S. Schulman⁸⁹ and this critique of the gendered view of the caring role (as opposed to the healing role) is upheld by sociologist Agnes Miles, who makes the point that, 'In the course of separation of healing from caring, powerful scientific medicine became a male preserve.'⁹⁰ American psychologist Jeanne Achterberg

⁸⁵ Ruth Message, interviewed 7 January 2014.

⁸⁶ Jacqui Stringer, interviewed 30 January 2014.

⁸⁷ Alison Ellis, interviewed 12 May 2014.

⁸⁸ A. Montagu, *Touching the human significance of the skin* (London: Harper and Row, 1978).

⁸⁹ S. Schulman, 'Basic Functional Roles in Nursing: mother, surrogate and healer', in G. Jaco, ed. *Patients, Physicians and Illness: Sourcebook in Behavioural Science and Medicine* (New York, London: Free Press Collier Macmillan, 1972).

⁹⁰ Agnes Miles, *Women Health and Medicine* (Milton Keynes: Open University Press, 1991), 132.

also maintains that, 'The function of caring continued to be recognized in the healing arts, but as a nonscientific necessity, a second-order need largely performed by women under the direction of male physicians.'⁹¹ These parenting/nurturing images suggest a protective model of expressive touch. On reflection, I realised that it could also hint at another issue – that of dominance in the nurse-patient relationship.

Constance Classen suggests that touch in a medical context is limited not only to a therapeutic procedure but is involved in the confirmation and challenge of power, status and social order,⁹² as sociologists Beverly Willison and Robert Masson write: 'Touch has power implications of which the counselor must be aware.'⁹³ As a result, I examined the participants' responses for evidence of this challenging claim. Possibly my questioning did not provide enough opportunity for this viewpoint to be explored, but absence of comment suggests that interviewees had not encountered this position. Journals that I subsequently examined for the period did not discuss this issue either and I conclude that this is a significant absence, suggesting that it was not an issue that was considered in nursing at that time.

Two interviewees emphasised that some patients did not always welcome touch (although it was not clear that it was because of any perception of social order).

Nurse Julia Ayres said:

You could tell who liked it and who didn't, and you didn't touch people who felt wouldn't like that [...] Some patients would perhaps welcome someone holding their hand, other patients would not like it at all.⁹⁴

⁹¹ Jeanne Achterberg, *Woman as Healer* (London: Rider, 1990), 101.

⁹² Classen, *The Book of Touch*, 349; Peter Northouse and Laurel Northouse, *Health Communication Strategies for Health Professionals* 3rd ed. (Stamford, Conn.: Appleton & Lange ; London : Prentice Hall International, 1998).

⁹³ Beverly Willison and Robert Masson, 'The Role of Touch in Therapy: an adjunct to communication', *Journal of Counseling and Development*, 63 (1986) 497-500.

⁹⁴ Julia Ayres, interviewed 1 February 2014.

And nurse Chris Eberhardie commented:

Some people don't like being touched. If they don't mind being touched, I think you have to respect the rules of intimacy.⁹⁵

The subject was specifically addressed in the *Nursing Times* in November and December 1986, when a series of articles about touch was featured. The first article by Andree le May importantly identified the need to respect patients' privacy and space:

Nurses should recognise patients' needs for privacy and personal space and consider individual differences in the need for and acceptance of touch.⁹⁶

As far as the official training for nurses and touch are concerned, I examined the curriculum for the period of the study on the subject of personal communication for details of what was instructed on the subject of touch and massage. Copies of curricula are held at the National Archives Kew and some also were available to read at the Bachelor of Nursing Office at Birmingham University.⁹⁷ Nothing was noted and it is striking that no direction is given, in view of the importance given to it by nurses who saw it as central to the expression of caring and the background of use of CAM.

Returning to Alison Ellis' opinion of touch as being anxiety-reducing, another aligned issue was raised by two participants: that of single people's experience of not being

⁹⁵ Christine Eberhardie, interviewed 3 September 2014.

⁹⁶ Andree le May, 'The human connection', *Nursing Times*, 19 November 1986.

⁹⁷ GNC archives at the National Archives Kew and in a collection of curricula and examination papers of Dr Alison Coates, University of Birmingham, for which I thank her.

touched regularly and how that heightened their awareness and appreciation of touch as a nursing therapy. This was discussed by nurses Pat Turton and Rosie Winyard:

You can be very touch-deprived when you are older ... because if you don't have relations any more because your partner has died or whatever and you don't have grandchildren ... you know ... nobody touches you.⁹⁸

I think the power of touch is amazing and I don't think as a young nurse you realise how much it means, particularly for old people or people who have lived on their own for a long time and maybe don't have much family, they haven't experienced touch in a therapeutic sense, a healing sense.⁹⁹

Elderly people were emotively described by retired American surgeon and writer Bernie Siegal, who, in his work on the patient/healing process relationship, describes them as being 'skin starved'.¹⁰⁰ In an article in *Nursing Forum*, Lynne Goodykoontz writes, 'We should understand that when there is no more that technology can offer the elderly, we can offer ourselves as well as our hands.'¹⁰¹ This is, indeed, what was obtainable at the Marylebone Health Centre, as Patrick Pietroni explained:

Many of the isolated lonely ladies and gentlemen, widows and widowers, who no longer had anybody to hug would come in and would be depressed and lonely. And I would say, 'What did the GP do?' And they had been given antidepressants – it was crazy. They used to come in and have a massage once every two weeks. They loved it.¹⁰²

These examples of instrumental touch developing into a therapeutic activity by nurses are supported by articles in the contemporary journal literature and they reinforce the fact that the decades of the 1980s and 1990s were periods of

⁹⁸ Pat Turton, interviewed 9 June 2014.

⁹⁹ Rosie Winyard, interviewed 8 May 2014.

¹⁰⁰ Cited in Michael Dixon and Kieron Sweeney, *The Human Effect in Medicine: theory, research and practice* (Abingdon: Radcliffe Medical, 2000), 126.

¹⁰¹ Lynne Goodykoontz, 'Touch: attitudes and practice', *Nursing Forum*, xviii (1979).

¹⁰² Patrick Pietroni, interviewed 7 July 2015.

increasing awareness of issues around touch. In a *Nursing Times* article in 1986, for example, Alison Berry wrote of how nurses should consciously use touch as a therapeutic tool, rather than 'a gesture made spontaneously or haphazardly.'¹⁰³

In 1992, a major piece of research was undertaken by the Nuffield Institute for Health Services Studies, which systematically collected data from the observation of nursing and patient activity, using 'Criteria for Care'¹⁰⁴ and 'Monitor'¹⁰⁵ research instruments to gather data on patient dependency, nursing activity and nursing quality. The database was split into two – 1984-1988 and 1989-1992 – based on developments in nursing management, education and practice such as the Griffiths Report¹⁰⁶ and introduction of Project 2000¹⁰⁷ in the mid-1980s. Six thousand hours of nursing activity were analysed and the result showed that the most remarkable change between the two time periods was an 8% reduction (from 51% to 43%) in hands-on care by nurses.¹⁰⁸ This evidence of a developing technological profession was not welcomed by all, and Hermione Elliott in the Holistic Nurses Association newsletter of January 1995 wrote of 'the longing in many nurses to reconnect with the human touch which is at the heart of nursing.'¹⁰⁹ Annette Turton, writing in the *Nursing Times* that year, also wrote about touch and Therapeutic Touch as part of a three-part series, entitled 'The Human Connection', which also included a contribution from

¹⁰³ Alison Berry, *Nursing Times*, 3 December 1986

¹⁰⁴ J. Ball, L. Goldstone and M. Collier, *Criteria Care* (Newcastle upon Tyne: Newcastle upon Tyne Polytechnic Publications, 1983).

¹⁰⁵ L. Goldstone, J. Ball, and M. Collier, *Monitor* (Newcastle upon Tyne: Newcastle upon Tyne Polytechnic Publications, 1983).

¹⁰⁶ R. Griffiths, *NHS Management Enquiry Report* (London: DHSS, 1983).

¹⁰⁷ *Project 2000: a New Preparation for Practice* (London: UKCC, 1986).

¹⁰⁸ *Nursing Times*, 18 March 1992.

¹⁰⁹ Personal archive, Annual Report, HNA newsletter, 1995.

Andree le May, who gave an overview of touch¹¹⁰ and Sally Sims who discussed her research on massage with cancer patients. In that same *Nursing Times* article, Alison Berry claimed that little research had been undertaken on the effect on rehabilitation of touching a patient where a major change of body image had taken place, due to surgery, injury, disability or psychological damage.¹¹¹ This was a topic that was addressed by two of my participants, Pat Turton and Rosie Winyard, who demonstrate in their comments their sensitivity and powerful belief in the value and effect of nursing touch:

When I was at the Cancer Help Centre, one of the massage therapists said to a patient who was having massage, 'Shall I massage your scar?' and she said, 'Oh nobody has ever touched it – and I don't look at it.' And she said, 'Let me just touch it because it will help the scar tissue.' And it just caused a huge emotional release for her. Because it kind of overcame that sort of trauma....¹¹²

One of the most difficult things is to enable people who have been abused to experience healing touch; they are very frightened of being touched.¹¹³

Retired nurse, Alice Temple-Bruce developed this to explain the importance of touch in feeling 'touchable':

Most of us feel that if somebody touches us, we must be *touchable* and that goes a long way to trust and to be feeling good about yourself or feeling something – and even feeling loved...¹¹⁴

These examples of delicate situations with patients highlight the significance of touch and the part it plays, not just in physical, but in psychological wellbeing too. Many nurses recognised this, and I argue that touch in all its applications was becoming increasingly understood as intrinsic to care during the period of my study. Moreover,

¹¹⁰ 19 November 1986.

¹¹¹ Alison Berry, 'Knowledge at one's fingertips', *Nursing Times*, 3 December 1986.

¹¹² Pat Turton, interviewed 9 June 2014.

¹¹³ Rosie Winyard, interviewed 8 May 2014.

¹¹⁴ Alice Temple-Bruce, interviewed 8 June 2015.

it provided the natural background for some nurses to develop their instincts in taking up complementary therapies, particularly those such as massage, aromatherapy and reflexology, as an extension of expressive touch. A 1993 *Nursing Times* article put this very simply in saying that as back rubs went out, massage and CAM came in, as a means for nurses to remain in touch.¹¹⁵ This was described by GP and complementary medicine academic George Lewith as a 'synonym':

I felt as far as nurses were concerned, with cancer and long term chronic illnesses, complementary medicine became an acceptable synonym for them to put their hands on people and reassure them – something that we were driving out of the system with evidence based medicine.¹¹⁶

Peter Mackereth similarly summarised how he was pleased to be able to develop his use of massage in the 1980s:

I used to do simple back rubs and neck rubs and things like that. ...so when I was, say, doing a bed bath, I would be soaking their feet and massaging their feet... ... I was exploring what things stressed patients out, what things calmed patients down ... I was reading literature about gentle touch, about using things like creative imagery, visualisation to relax people... Sometimes you can't do stuff with words and it always surprises me that ... a simple hand massage or a foot massage may be of value.¹¹⁷

Mackereth went on to complete an aromatherapy and massage course and later, a two-year body-psychotherapy/biodynamic massage course, and has been a high-profile advocate and spokesman on CAM in nursing since the 1990s. His work demonstrates the progress that was made in the latter decades of the twentieth century in nurses' incorporation of CAM in their practice and the way that

¹¹⁵ L. Smith, 'The art and science of nursing', *Nursing Times*, 89 (1993) 42-43.

¹¹⁶ George Lewith, interviewed 8 February 2016.

¹¹⁷ Peter Mackereth, interviewed 30 January 2014.

opportunities were presented to them. This had often begun with developing relationship skills and incorporating touch therapies.

But it was not just touch that was recognised as being valued by nurses, but also time spent with patients and the chance of talking with them. These were considered to be central components of comfort-care in academic methodologist Janice Morse's research in 1983.¹¹⁸ Inga Newbeck, writing in the *Nursing Times* in 1986, endorsed this by saying, 'Perhaps one thing which conventional medicine fails to give patients is time. No one has it. No one gives it. No one receives it.'¹¹⁹ This was a shockingly stark summary of medical care and ten years later, questions about the value of time with a patient were being seriously addressed.

5.2.2 The nurse-patient relationship: time and talk

In March 1996, The *Nursing Times* undertook a survey, entitled 'Do you have time to talk?' The introduction to the survey quoted a ward manager's view: 'Talking to patients is a clinical intervention. It is not a luxury.' Two hundred and forty-two nurses responded to the survey and the results expose a picture of nurses who longed to talk with patients and meet personal and emotional as well as physical care needs. However, they describe the constraints: one in five said they were too busy with administration. A ward sister wrote: 'It is one of the tragedies of nursing: the greater one's clinical experience the less time one has to use it.' Many respondents

¹¹⁸ J.M. Morse, 'An ethnoscientific analysis of comfort: a preliminary investigation', *Nursing Papers*, 15 (1983) 6-19.

¹¹⁹ *Nursing Times*, 19 February 1986.

even recalled how they had been castigated for talking to patients (one reported, curiously: ‘I was told not to sit on beds and talk to patients as I’d get a urinary tract infection’). The survey report concluded: ‘Nurses want to talk to patients because it helps them identify needs, assess and meet them’,¹²⁰ and this became an increasingly important element in nurse training, as the following chapter will discuss.

In my interviewing of nursing participants, I included a question about spending time with patients, asking about the pressures, the challenges and perceived importance of giving a patient time and the opportunity to talk. Some participants expressed frustration at not being able to spend more time doing so as part of their work and they commented on how the opportunity had changed during their careers. Several referred to talking to the patient as an important opening in order to explore his/her mood and wellbeing, as Annette Turton said:

You are engaging with people, you are talking to people. You are not actually *going* to them to talk to them. It is part of a normal daily routine but you are nonetheless taking in, how is this person? How are they feeling?¹²¹

Alison Ellis expanded on this:

When we were still going round and doing the ubiquitous ‘back round’ ... when four times a day, a patient got the time and the conversation and the opportunity to talk to - usually - two nurses and they were rubbed, they were smoothed, they were lifted up the bed, their pillows were plumped, there was a bit of a joke, there was attention as well as touch. ... I think that that is to me one of the essentials of nursing.¹²²

Both these nurses had trained in the 1960s, which is relevant.

¹²⁰ D. Carlisle, ‘Careful talk saves lives’, *Nursing Times*, April 24 1996.

¹²¹ Annette Turton, interviewed 10 April 2014.

¹²² Alison Ellis, interviewed 12 May 2014.

Evidence from a confidential minute of the General Nursing Council (GNC) Education and Examinations Committee reveals that a proposed change in the syllabus for nurse training was made in 1961 (effective February 1962), which introduced an element on applied psychology. The committee discussed examples of questions on topics such as 'the effects of hospitalisation on the patient' and the 'nurse/patient relationship'.¹²³ This new subject area in the nurse training syllabus in the 1960s was not, however, reflected in the competencies that are listed in the 'Record of Practical Instruction and Experience for the Certificate of General Nursing' produced by the GNC.¹²⁴ Six pages of procedures and technical competencies 'on which the student nurse must have received instruction before entry to the Final Examination' omit mention of any psycho-social aspect of hospitalisation or the nurse/patient relationship. Nursing academics, Carol Kirby and Oliver Slevin argued that the nursing curriculum lacked a sense of true caring.¹²⁵

However, talking to patients seems to be a quality that was intrinsic to some of the older nurses I interviewed, suggesting that it was, for them, implicit in nursing care. One of these was Sheila Forrest, who was sensitive to the relationship with a patient, describing it as a two-sided experience, which had had the additional benefit of enhancing her personal nursing role:

I always felt that people in hospital were terribly lonely and isolated and frightened and I think that was the thing I picked up on, so I was always very happy just to talk to people and let them tell me about what they

¹²³ National Archives, Kew, London, General Nursing Council papers, confidential minute, Education and Examination Committee (7 September 1960), DT38/155.

¹²⁴ University of Birmingham Bachelor of Nursing degree curricula. Thanks to Dr Alison Coates.

¹²⁵ Carol Kirby and Oliver Slevin, 'A new curriculum for care' in Oliver Slevin and Mike Buckenham, eds, *Project 2000 The Teachers Speak* (Campion, 1992), 57.

were feeling and thinking. I was intrigued by what people did feel and think so it suited me well to listen...¹²⁶

This comment reflects another issue, that of restricted visiting in hospitals, where it was common for patients to feel isolated and to be more reliant on staff contact, and deprived of the emotional and practical support of family and friends,¹²⁷ which has been briefly discussed in the previous chapter. This changed in the 70s and 80s, when patient groups expressed their disquiet about care and services¹²⁸ and the work of the National Association for the Welfare of Children in Hospital (NAWCH), for example, had pressured for, and finally succeeded in, the beginning of de-restricting by hospitals of visiting children,¹²⁹ following the work of psychiatric sociologist James Robertson, who had formed a theory of phases of response of small children when staying in hospital without their mothers.¹³⁰ Hospital visiting became more relaxed in the 1970s,¹³¹ and Annette Turton perceives this as a development in the holistic approach to care, describing how open visiting on a children's ward finally became approved: 'That was very slowly coming in, and certainly our ward was one of the first to have open visiting and then having patients' parents staying over.'¹³²

¹²⁶ Sheila Forrest, interviewed 7 January 2014.

¹²⁷ Graham Mooney and Jonathan Reinartz, eds, *Permeable Walls: Historical Perspective on Hospital and Asylum Visiting* (Amsterdam: Rodopi, 2009).

¹²⁸ Alex Mold, 'Repositioning the Patient: patient organisations, consumerism and autonomy in Britain during the 1960s and 1970s', *Bulletin of History of Medicine* (2013), 225-249.

¹²⁹ *Ibid.*, 235. In 1964, only 75% of hospitals allowed unrestricted visiting of children – this figure increased until the 1970s.

¹³⁰ Linda Alsopshields and Heather Mohay, 'John Bowlby and James Robertson: theorists, scientists and crusaders for improvements in the care of children in hospital', *Journal of Advanced Nursing*, 35, 2001, 50-58.

¹³¹ S. Bradley, 'Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards, 1940-1970', *International History of Nursing Journal*, (February 2001).

¹³² Annette Turton, interviewed 10 April 2014.

Talking was an integral part of the therapeutic relationship between nurse and patient and both were restricted when shorter hospital stays became the practice. Health policy academics Anthony Harrison and Sally Prentice even provocatively claimed that, by 1998, ‘the nature of the acute hospital is being transformed and the typical currency for describing a hospital – the staffed bed – is outmoded.’¹³³ Their work on hospital length of stay (LOS), based on OECD data, demonstrated a significant international decrease in LOS between 1988 and 1993.¹³⁴ Aileen Clarke and Rebecca Rosen argued that by the year 2000,

As the acute hospital becomes more busy, and geared to high-technology diagnostic and interventionist care, it may be becoming increasingly inappropriate as a place for offering bed rest, aftercare or any sort of convalescent care. Since responsibilities, caring and care plans can travel with the patient outside the hospital walls, LOS is likely to become both a less meaningful measure of the amount of care received by an individual and a less meaningful measure of the performance or efficiency of a hospital.¹³⁵

Reasons given for aiming to reduce hospital LOS include the fact that patients would rather be cared for in their own home if appropriate care is available, being able to plan and manage healthcare resources for an individual, and to reduce overall spending.¹³⁶ Another example is the reduction of LOS involved in cataract surgery. Up until the 1990s this had required a week’s stay in hospital following surgery, but from the 1990s, the procedure was improved and could take place in an outpatient clinic.¹³⁷ Mary Walker, who started her training in 1948 at St Bartholomew’s Hospital, where she then worked as a ward sister for over 30 years, believed that these types

¹³³ Anthony Harrison and Sally Prentice, *Hospital policy in the United Kingdom: its development, its future* (New Brunswick: Transaction Publishers, 1998).

¹³⁴ See Appendix G.

¹³⁵ Aileen Clarke and Rebecca Rosen, ‘Length of stay: how short should hospital care be?’, *European Journal of Public Health*, 11 (2011) 166-170, 169.

¹³⁶ *Ibid.*, 168.

¹³⁷ Worcester Royal Infirmary display on disused Ophthalmology Ward, November 2014.

of examples of the reduction in LOS had a vital impact on patient care. She described her early nursing days when ‘Our patients stayed in much longer; we got to know them, we got to know the family.’¹³⁸ And Fiona Mantle confirmed, ‘We did more hands-on because the patient was in the hospital for longer.’¹³⁹ This argument about a change in discharge policies and time spent with patients becoming an increasingly precious commodity in the hospital environment was supported by others. For example, Elizabeth Hill commented on the extent to which it impacted on how patients were perceived, with more of a focus on biological functioning, rather than the individual:

Nowadays it is very much more of a business – in and out as fast as you can go. We are looking at the illness, we are not looking at the whole person.¹⁴⁰

Mary Walker, retired nursing sister, spoke of her experience on the ward. She recalled the challenge that faced some junior nurses when they started nursing. They understood the value of interacting and talking to patients, she said, but they sometimes lacked the confidence to understand its practice:

I always remember a nurse saying to me ... ‘Can't you teach us how to talk to patients?’ ‘Well’, I said, ‘I can't actually teach you how to do that, but you will see, hopefully, how I do it.’¹⁴¹

Communication in the practitioner-patient relationship was first regarded as significant when psychologist William Halse Rivers Rivers (1864-1922) pioneered a ‘Talking Cure’ at Liverpool’s Maghull Hospital in 1915. He was working with war survivors suffering from shell shock and his approach was based on what was then a new, and apparently basic, principle – that patients needed to be treated and listened

¹³⁸ Mary Walker, interviewed 11 June 2014

¹³⁹ Fiona Mantle, interviewed 3 April 2014.

¹⁴⁰ Elizabeth Hill, interviewed 6 January 2014.

¹⁴¹ Mary Walker, interviewed 11 June 2014

to as individuals.¹⁴² But it was not until the 1950s when – as was examined in Section 5.2 – the concept became recognised as an important element in doctor-patient relationships and then developed during the twentieth century as a number of psychotherapeutic approaches were introduced into healing practice. For many nurses, the therapeutic value of talking and, more importantly, listening, seemed a natural intuition for them, as Pat Turton and Alison Ellis explained:

You would go up and down the Nightingale wards and clean the lockers and put a clean rubbish bag and...freshen up the water and when you did that, you talked to people and so it facilitated the kind of relaxed conversations....¹⁴³

Talking to people ...most people like to talk about themselves and to give somebody an opportunity to do that – it has got to lift their spirits and reduce anxiety and we know that if you can reduce anxiety, then you can also reduce things such as pain.¹⁴⁴

Ellis demonstrates here that the listening was not just a kindness; it generated confidence and trust of the patient and this was repeated in interviews with nurses

Julia Ayres and Jacqui Stringer:

And I think they think that if you are doing that little bit extra, then you are interested in them and what is wrong with them, they hopefully have more confidence in you and more confidence in the outcome.¹⁴⁵

It stands to reason that you will get a closer relationship with patients the more time you spend with them. It's logical. And you get to know that person and you build up a level of trust.¹⁴⁶

'Confidence' and 'trust' are core values in any relationship, but were a perceived necessity in the therapeutic rapport between nurse and patient.

¹⁴² Aisling O'Neil, 'We will remember', *Johnian News*, 35 (University of Cambridge, 2014).

¹⁴³ Pat Turton, interviewed 9 June 2014.

¹⁴⁴ Alison Ellis, interviewed 12 May 2014.

¹⁴⁵ Julia Ayres, interviewed 1 February 2014.

¹⁴⁶ Jacqui Stringer, interviewed 30 January 2014.

Guidance notes to the nurse training syllabus relating to the 1960 examination for registration of nurses makes this point about the need to include:

a discussion on what is involved in 'loyalty to the patient' and how important for the welfare of the sick person is the feeling of security derived from confidence in the hospital staff. Many other examples will come readily to mind that will evoke valuable discussion not only on ethical matters but also the closely related subject of 'personal relations'.¹⁴⁷

This is important evidence of the growing awareness of these relationship elements in nursing practice. Nurses who were interviewed quite unequivocally expressed their belief in the importance of this therapeutic relationship and its effect on patient wellbeing and therefore the healing process, as described here by Pat Turton:

It comes out quite clearly in some of the surveys of patient experiences; they report, 'If it hadn't been for such and such a nurse, I wouldn't be where I am now' sort of thing. So there is definitely something there, which I think is very important and it helps people psychologically to keep going and that sense of support and efficacy and caring and unconditional love and support makes a big difference to patients, particularly at very difficult times of their lives.¹⁴⁸

In summary, this examination of touch, talk, therapeutic relationships, and a holistic approach to nursing care illustrates an important shift within nursing practice. It was initiated in the 1960s, gathered momentum in the late 1970s and was at its peak in the 1980s and 1990s, when patient-centred care was introduced. How this was played out in practical terms can be demonstrated by the emerging movement of 'new nursing' and Nursing Development Units, which introduced innovative models of nursing and care delivery in the 1980s.

¹⁴⁷ National Archives, Kew London, General Nursing Council papers, Preliminary Examination Guides to Syllabuses, DT38/155.

¹⁴⁸ Pat Turton, interviewed 9 June 2014.

5.3. CAM in nursing practice

5.3.1 Nursing Development Units (NDUs)

Putting the patient at the centre of care was a new development in healthcare in the last decades of the twentieth century, as has been demonstrated by the breadth of literature on the subject in Chapter Two. A conference on Patient-Centred Health Care at Green College in Oxford in 1996 (which involved nurses as well as doctors), challenged the prevailing model and, in the resulting edited book of conference papers *Essential Practice in Patient-Centred Care*,¹⁴⁹ nurse academics such as Ann Bradshaw, Steven Ersser and Stephen Wright called for putting the patient at the centre stage, rather than providing only task-orientated care.

Another key campaigner was Jane Salvage, editor of the *Nursing Times* (1996-2001), who championed the cause of prioritising the patient as the focus of care. Even more significantly, she supported the introduction of appropriate complementary therapies.¹⁵⁰ In her role at the King's Fund, Salvage was involved in the establishment of Nursing Development Units (NDUs), which incorporated this new methodology in primary nursing and, moreover, enabled the use of CAM to be integrated in NDU nursing practice. Steven Ersser described the practical arrangements:

The idea of the NDU was there were nursing beds where people would come to a nursing unit for intensive nursing, either post-operative or for medical care, and basically [...] this unit was a regular ward at the Radcliffe Infirmary [...] and we used things like massage.

¹⁴⁹ Bill Fulford, Steven Ersser and Tony Hope, eds, *Essential Practice in Patient-Centred Care* (Oxford: Blackwell, 1996).

¹⁵⁰ Jane Salvage, interviewed 15 May 2015.

The term 'Nursing Development Unit' had been first adopted in 1981 by nurses working in a small cottage hospital in Burford, Oxfordshire,¹⁵¹ which was formed under Alan Pearson's management. The core concept was a shift to patient-centred care and the introduction of a new model of nursing, as described by nursing academic Jane Robinson:

We listen to what the patient has to say and through ... communication, we help him [*sic*] to become clear on his concerns around [his] particular treatment plan ... he will clarify his own motivations....The nurses will aim to work in such a way that the patient becomes a partner who is actively encouraged to become an equal voice in decision-making about his nursing and other therapies.¹⁵²

In a *Nursing Times* article challengingly entitled 'The Steady Advance of a Revolution' in April 1991, Mary Finch charts the development of primary nursing and places Pearson as its instigator.¹⁵³ He, however, suggests that this therapeutic nursing concept, encapsulated in NDUs, had evolved from earlier work by others,¹⁵⁴ but that it had not been realised in a practical project until this point. Another NDU was set up at Tameside General Hospital in 1986 under Stephen Wright, who summarised the innovative methodology as 'encapsulated in the concepts of fellowship and companionship.'¹⁵⁵ In his interview, he described the advances that were incorporated there:

¹⁵¹ Stephen Wright and Jane Salvage, *Nursing Development Units: A Force for Change* (London: Scutari Press, 1995).

¹⁵² Jane Robinson, A. Gray and R. Elkan eds, *Policy Issues in Nursing* (Open University Press, 1992).

¹⁵³ *Nursing Times*, 24 April 1991.

¹⁵⁴ Richard McMahon and Alan Pearson, eds, *Nursing as Therapy*, (Cheltenham: Nelson Thomas, 1991) 192. Earlier proponents had been Lydia Hall 'Another view of nursing care and quality', in M. Straub and K. Parker, eds, *Continuity of Patient Care: the role of nurses* (Washington DC: Catholic University of American Press, 1966); D.H. Tiffany, 'Nursing organizational structure and the real goals of hospitals', unpublished PhD thesis, Indiana University, 1977; G.J. Alfano, 'A professional approach to nursing practice', *Nursing Clinics of North America*, 3 (1969) 487.

¹⁵⁵ Stephen Wright, *My Patient, my Nurse* (London: Scutari, 1990) xi.

Alan Pearson, ed., *Primary nursing: nursing in the Burford and Oxford Nursing Development Units* (London: Croom Helm, 1988).

There was a programme of innovation over 5 years, pet therapy, opening visiting hours, sharing meals with staff, radically different discharge programmes, self-medication, all stuff that was very, very innovative in elderly care at the time.¹⁵⁶

At that time, Jane Salvage was working as director of an innovative national nursing programme at the King's Fund, and was in a position to collaborate with Stephen Wright, Alan Pearson and others who were the leaders of this revived approach to nursing. In 1988, the NDUs became the centrepiece of the programme run by Salvage and, by 1995, there were several hundred units throughout the UK, having had a dramatic boost from government in 1991, with £3.2 million for their development.¹⁵⁷ This was part of the 'new nursing' model, coined by Salvage, and summarised by nurse educator Matthew Aldridge as 'an emphasis on developing a close, holistic relationship between nurse and patient.'¹⁵⁸ Importantly for this study, for some nurses it led to a surge of interest in the use of CAM therapies, as Jane Salvage describes:

It was all about putting the patient back as the focus of care. Part of what a lot of the nurses in the NDUs and similar practice settings were doing was actually introducing different approaches to care, different approaches to healing, offering other kinds of therapies. There was a real growth, a surge of interest among nurses – not just because of the NDUs – but it was similar things that were going on at the time with a lot of nurses realising that things like massage, maybe aromatherapy... all kinds of other therapies that weren't normally available on the NHS any more could be of comfort and value and have healing power.¹⁵⁹

Stephen Wright claimed that, by the late 1980s, this had brought about an end to task-based nursing and that, by then, 80% of nurses had moved to the concept of

¹⁵⁶ Stephen Wright, interviewed 16 January 2014.

¹⁵⁷ *Nursing Times*, 5 June 1991, 87.

¹⁵⁸ Matthew Aldridge, 'Unlimited liability? Emotional labour in nursing and social work', *Journal of Advanced Nursing*, 20 (1994) 722-8.

¹⁵⁹ Jane Salvage, interviewed 11 May 2015.

nursing as a therapeutic act.¹⁶⁰ (This claim is, however, contested by those who maintain that task-orientation is still a part of nursing practice, such as in the ritualised activity of 'intentional rounding'.¹⁶¹) Nursing academic Steven Ersser developed this in my interview with him, referring to the Oxford NDU and confirming that the concepts of nursing as a therapy in itself which supported an enhanced relationship between nurse and patient had been a radical idea, stating:

Oxford was very open minded at the time about giving nurses more opportunities to develop more of a therapeutic role...¹⁶²

In their work on NDUs, Salvage and Wright¹⁶³ described the historical and social background, and in his review of that publication, nursing academic Brendon McCormack discusses the innovative nature of these ideas, applauding the individuals who had been prepared to 'put their heads above the parapet and turn their nursing visions into reality' in order to introduce this *avant-garde* model of nursing.¹⁶⁴

Importantly, in the context of this research, the model of nursing practised in NDUs increasingly made use of CAM, which was seen by Wright and Salvage as a part of nurses' empowerment.¹⁶⁵ At the Oxford NDU, for example, all nurses were skilled in massage and aromatherapy, incorporating it into daily practice,¹⁶⁶ and it was noted, in

¹⁶⁰ Stephen Wright and Jane Salvage, *Nursing Development Units: A Force for Change* (London: Scutari Press, 1995) 2.

¹⁶¹ 'Intentional Rounding' is a formal structured system, introduced in 2011, of nurses' checks on patients to assess care needs, with the aim to improve care in the NHS. Marie Hutchinson and Debra Jackson, 'Editorial: rounding: unpacking the ritual, routine and evidence impasse', *Journal of Clinical Nursing*, 25 (2016) 5-7, 5.

¹⁶² Steven Ersser, interviewed 14 July 2014.

¹⁶³ Stephen Wright and Jane Salvage, *Nursing Development Units* (London: Scutari Press, 1995).

¹⁶⁴ *Nursing Times*, 6 September 1995.

¹⁶⁵ Wright and Salvage, *Nursing Development Units*, 13.

¹⁶⁶ *Ibid.*, 35.

the *Nursing Times* in 1991, that Tameside NDU was awarded a £1000 grant from the King's Fund for workshops on therapeutic massage.¹⁶⁷ But, ultimately, what had been the impact of NDUs and these practices on patient care? Nurse educator Kate Gerrish claimed that, in 2000, when she was evaluating the service, there was little indication of improved patient wellbeing, although evidence was found of greater patient satisfaction with nursing care, a reduced length of patient stay, increased patient compliance with care and enhanced patient independence.¹⁶⁸ Surprisingly, her work makes no mention of the CAM therapies that were incorporated in the therapeutic practice. A later King's Fund document, published in 2002, included results of a study of NHS patient-centred care, with an appraisal of the success of its integration. It concluded that, despite the rhetoric, there was confusion about the concept and that, generally, patient-centred care had failed to penetrate the understanding of health practitioners.¹⁶⁹ Nurse educators John Costello and Monica Haggart have studied the history of the teaching of care to nurses in the context of therapeutic nursing and NDUs in the 1980s¹⁷⁰ and they suggest that it was an area that was set to evolve but that, due to political pressure, it did not develop in nursing across the UK. This is a contentious view because when I asked Jane Salvage about the manner of the ending of the NDU movement, her response reflected a different position:

It didn't really come to an end. There still are projects of that sort around the country. So I think what happened was that a lot of the

¹⁶⁷ *Nursing Times*, 27 Feb 1991, 87.

¹⁶⁸ Kate Gerrish, 'A pluralistic evaluation of nursing/practice development units', *Journal of Clinical Nursing*, 10 (2001) 109-118.

¹⁶⁹ R. Gillespie, D. Florin and S. Gillam, *Changing Relationships: Findings of the Patient Involvement Project* (London: King's Fund, 2002).

¹⁷⁰ John Costello and Monica Haggart, 'The nature of nursing: can we teach students how to care?' *CARE*, 2 (2008) 41-55. And at www.healthquest.org/care/show.php?contentid=69 Accessed on 23 May 2015.

ideas got mainstreamed. When you read a modern nursing textbook, they at least pay lip service to these notions, which certainly were not there when I was trained in the late 70s.¹⁷¹

New nursing and the NDU projects undoubtedly reinforced the concept of the ideal of the patient's place being at the centre of care and highlighted the value of intense therapeutic nursing care. However, there is little evidence of whether it encouraged a greater integration of complementary therapies into general nursing practice, in spite of their having been employed in the units.

The value of the therapeutic relationship was an area much examined in the 1980s and an experimental project launched in 1984 embodies this and, with it, a whole new approach to healthcare provision – the Marylebone Model. I include it here as a case study for the implementation of CAM in healthcare in the period; a model that is held by many as an example of the development of what was considered an integrated system.¹⁷²

5.3.2 Case study - the Marylebone Model

The innovative model of the integration of complementary therapies into general practice was introduced by Dr Patrick Pietroni in 1984 and became known as the Marylebone Model, based on the Marylebone Health Centre and Marylebone Centre Trust. Its objective was to 'explore and evaluate ways in which primary healthcare can be delivered to a deprived area in addition to the General Practice component.

The approach is to include a holistic component comprising an education self-help

¹⁷¹ Jane Salvage, interviewed 11 May 2015.

¹⁷² Mike Saks, *Alternative Medicine in Britain* (Oxford: OUP, 1992), 245; Susan Budd and Ursula Sharma, *The Healing Bond* (London: Routledge, 1994); *The Sixth Report on Complementary and Alternative Medicine*, House of Lords Select Committee of Science and Technology, 21 November 2000.

model and a complementary healthcare model.’ Pietroni’s aim was to provide this model in a primary care setting under one roof,¹⁷³ and he described it as ‘a new map in old territory.’¹⁷⁴ He explained how the idea was first mooted when he and the rector of Marylebone Church saw the opportunity offered by the empty church crypt and Pietroni related the discussion:

‘We’ll set up something quite new that no one else has done. Why don’t we set up a primary health centre, general practice in the NHS and come alongside it? Bring together both GPs, doctors, nurses, counsellors, the spiritual work in the church and a group of alternative therapies to see what would happen if you brought this group of folk together?’ And I began to offer a much wider range of interventions...¹⁷⁵

Following a pilot project in Paddington in 1984/85, the Marylebone Health Centre clinic was opened in the crypt of St Marylebone Church in 1987, housing four units (a pastoral centre, NHS general practice, music therapy unit and magnetic resonance imaging centre). Therapists worked alongside GPs and nurses in a multidisciplinary clinic, providing a holistic health service.¹⁷⁶ It was a remarkable model of practice, which attracted a wide range of patients who registered in the usual way, but who were offered CAM services such as osteopathy, homeopathy and herbalism.¹⁷⁷ Nurse Rosie Winyard, working at the Westminster Hospital in London, recalls how powerful this model was for her at the time:

I can remember reading some of the evidence about complementary therapy and questioning it in my own mind and that is where Pietroni was very interesting to me...when I read some of the research about

¹⁷³ Patrick Pietroni, *Innovation in Community Care and Primary Health* (Edinburgh: Churchill Livingstone, 1996).

¹⁷⁴ Patrick Pietroni, ‘Holistic Medicine – new map, old territory’, *British Journal of Holistic Medicine*, 1 (1984) 1-13.

¹⁷⁵ Patrick Pietroni, interviewed 7 July 2015.

¹⁷⁶ Catherine Zollman and Andrew Vickers, ‘Complementary medicine in conventional practice’, *BMJ*, 319 (1999) 1422.

¹⁷⁷ Patrick Pietroni, *The Greening of Medicine* (London: Gollanz, 1990), 190-193.

the Marylebone Institute [*sic*], I liked the idea of complementary therapy. It seemed safe the way it was practised there - where people who had wanted it had also been assessed by a doctor in the NHS first.¹⁷⁸

This prototype challenged contemporary medicine and yet asserted the authority of the doctor. However, the initial consultation was carried out by a practice nurse, and one patient recalls the process of how his treatment proceeded:

... the practice nurse discovered that I was suffering from hypertension and this was duly reported to the doctor. After a series of questions...I was asked if instead of being prescribed powerful drugs, I would be prepared to embark on a programme of relaxation and diaphragmatic breathing exercises....The benefits have transformed my life....¹⁷⁹

Pietroni describes how this type of practice was not only popular with patients, but with practitioners too, because of its positive budgetary implications:

With a lot of the different therapies, our prescribing rate in Marylebone was about 30%-40% below average so we saved so much money on our prescribing bill, it was more than enough to pay for these therapists. And I felt I had demonstrated holism in action.¹⁸⁰

The integrated healthcare model at Marylebone was unique and effective, although, at a workshop at the Wellcome Trust in March 2000, David Peters described the challenges too:

We began to realise some knotty issues about what happens when you bring practitioners together – dynamics were difficult.¹⁸¹

These tensions are further discussed in the following chapter.

¹⁷⁸ Rosie Winyard, interviewed 8 May 2014.

¹⁷⁹ Quoted in information leaflet (No.1), (Marylebone Centre Trust, 1988).

¹⁸⁰ Patrick Pietroni, interviewed 7 July 2015.

¹⁸¹ Wellcome Collection Archives, audio recording, 'Advancing Research in Complementary Medicine' workshop at Wellcome Trust, 10 March 2000,152A. This workshop hosted by the Trust explored the issues facing CAM research. The aim of the workshop was to inform future Trust policy and to stimulate discussion amongst CAM practitioners, researchers and policy makers. The participants comprised an international audience and CAM and orthodox practitioners, covering a wide spectrum of therapies and organisations, were represented.

The Marylebone Centre focused on dealing with the psychological, spiritual, and emotional needs of the individual, in relation to all patterns of living and Pietroni explained how the model at Marylebone involved more than just medical care in describing how his approach to holism affected the whole community:

Why don't we go up to the three big schools in Westminster and the kids who are doing sixth form in Serbian, or French or Arabic? Get them come and interpret for us so they can practise the language?' It didn't cost us anything but it is about making connections at a community level, developing community engagement – and you start getting resilience in a community. You don't get rid of the problems but you provide the framing where the problems are not so dumped on an individual and they are shared. Now that is to me as much a holistic approach as deciding where the chi is.¹⁸²

The Marylebone model has never been replicated elsewhere as far as I am aware although there was limited implementation with the introduction of GP fundholding in the early 1990s and Pat Turton described how this affected the introduction of complementary therapies in primary care:

There were some [GP] practices that used that opportunity to use complementary approaches and one in Somerset I remember ... he did an amazing job with his complementary therapies ...and they were really, really beneficial for people with anxiety or problems that are what they call psychosomatic problems, things that are causing physical symptoms but not for any obvious reason. And [he] saved money because they weren't prescribing these people drugs. And as they learned techniques like relaxation, they would actually do quite well...and not require medication and use the health service so much.¹⁸³

For nurses wanting to use CAM, these opportunities were not always accessible, however, and the next section will examine those who were successful in incorporating complementary therapies in their practice.

¹⁸² Patrick Pietroni, interviewed 7 July 2015.

¹⁸³ Pat Turton, interviewed 9 June 2014.

5.3.3 Incorporating CAM

The previous chapter has discussed how, for a variety of reasons, nurses were developing and expanding their interest in holistic practices, and turning to CAM.

The nurse academic, Lisbeth Hockey, gave a paper to the first British Conference on 'Therapeutic Nursing' in Oxford in March 1989, which provided the impetus for a serious study of the term and its origin.

She first raised a basic question:

The question which must now be addressed is: Do these procedures constitute nursing or not? It seems to be that the guarded answer must be: it depends. If they are undertaken as part of nursing they are, but if they are administered independent from nursing they are probably not.¹⁸⁴

Before discussing how complementary therapies fitted with this new model of nursing, she continued with a statement of support for nurses wanting to use them:

...I believe that they [nurses] may and probably should acquaint themselves with at least some of these more recent procedures in order to widen their available repertoire.¹⁸⁵

It is important to clarify at this point which CAM therapies were being incorporated.

My data show that one genre of therapy dominated – that of touch - and Hockey identified that the principle modality being used by nurses was aromatherapy, remarking, 'Here we have a new practice, aromatherapy, but used to enhance rather than replace conventional nursing practice.' Other practices, highlighted in the literature included massage, meditation, imagery and acupuncture. Therapeutic

¹⁸⁴ RCN Archives Edinburgh, Lisbeth Hockey papers, C300/2/6/2.

¹⁸⁵ *Ibid.*

touch receives frequent mention.¹⁸⁶ These therapies were the most popular, most easily incorporated and most readily accepted by medical staff. In the *Nursing Standard* in 1992, Caroline Hoffman,¹⁸⁷ who was then an intensive care sister at the Middlesex Hospital, itemised appropriate therapies for nurses to practise. These were arranged in three sections: 'complete systems', therapeutic modalities' and 'diagnostic methods':

1. Complete systems – acupuncture, shiatsu, osteopathy, chiropractic, homeopathy, herbal, Bach remedies, gem remedies, reflexology, Australian bush remedies.
2. Therapeutic modalities – massage, Therapeutic Touch, spiritual healing, Alexander technique, hydrotherapy, aromatherapy.
3. Diagnostic methods, self-help, tactile, energetic, administrative.¹⁸⁸

The comprehensive list demonstrates the confidence that was experienced at the time, although in reality, many were not incorporated widely. In 1995, Denise Rankin-Box published *The Nurses' Handbook of Complementary Therapies*, a 'guide, which gives you immediate access to concise answers and information ... and helps you plan towards competent practice.'¹⁸⁹ It contained chapters on acupuncture, aromatherapy, autogenic training, biofeedback, counselling, healing, herbalism, homeopathy, humour, hypnosis, massage, reflexology, relaxation, shiatsu, Therapeutic Touch.¹⁹⁰

Denise Rankin-Box explained that the therapies were selected for the handbook only if there was convincing evidence for their use:

¹⁸⁶ RCN Archive, Lisbeth Hockey papers, Lisbeth Hockey conference paper, 'Therapeutic Nursing', Oxford, March 1989, C/300/2/1-6.

¹⁸⁷ née Stevensen

¹⁸⁸ Caroline Stevensen, 'Appropriate therapies for nurses to practice', *Nursing Standard*, 6 (1992) 51-2.

¹⁸⁹ Denise Rankin-Box, *The Nurses Handbook of Complementary Therapies* (Edinburgh: Balliere Tindell, 1995).

¹⁹⁰ Appendix A provides definitions of therapies.

When I did the first book, I was looking at how to find out what evidence there was behind certain therapies. So clearly, the ideal is that there is some evidence, rather than saying 'Oh, this is wonderful, it works' but there is no evidence behind it, so you haven't got any credibility.¹⁹¹

By the early 1990s, evidence-based medicine was being highlighted in healthcare as a means of integrating clinical expertise with best research evidence, and had soon gained a foothold in nursing – although not without controversy¹⁹² – and nurses were encouraged in their awareness of it in their practice, as Annie Hallett describes:

The message very much was, 'It needs to be tightened up so that it is more evidence-based.' Which was a really good message becauseit is good in respect that it gave permission to ... it guided and separated nursing...How can I put it? It meant that the people who were involved in nursing and complementary therapies realised, I think, that it had to be more than just complementary therapy and feel-good.¹⁹³

Steven Ersser added how 'there was quite a lot of evidence-based work developing really, but we went through this phase of starting to collate the evidence, do systematic reviews, technical reviews as evidence.'¹⁹⁴ The RCN defined evidence-based practice as 'doing the right thing in the right way at the right time for the right patient',¹⁹⁵ and nursing academic George Castledine wrote that 'the integration of the best knowledge with the practitioner's best clinical judgement' made for best nursing practice,¹⁹⁶ but that if there was no research-based evidence, nurses should use their best judgement, based on what information was available. This was the guidance of the RCN Complementary Therapies Forum, too, in their 1994 statement of beliefs,

¹⁹¹ Denise Rankin-Box, interviewed 4 August 2015.

¹⁹² G. Rolfe, 'Insufficient evidence: the problems of evidence-based nursing', *Nurse Education Today*, 19 (1999) 433-442; P. French, 'The development of evidence-based nursing', *Journal of Advanced Nursing*, 29 (1999) 72-78.

¹⁹³ Annie Hallett, interviewed 18 May 2015.

¹⁹⁴ Steven Ersser, interviewed 14 July 2014.

¹⁹⁵ *Clinical Effectiveness* (London: RCN, 1996).

¹⁹⁶ George Castledine 'Evidence-based nursing: where is the evidence?' *British Journal of Nursing*, 6 (1997) 290.

which stated: 'We believe that where possible, research based complementary therapy practices should be used. Where this is not possible then, as an accountable professional, the nurse using a complementary therapy must be able to justify their actions.'¹⁹⁷

In the monograph she wrote as part of a series for the *Nursing Times*, Fiona Mantle details the studies that had been undertaken on a range of therapies but acknowledged that there were often shortcomings in the standards of the research. She urged, 'practitioners should evaluate critically the research described and decide for themselves the evidential strength with which they feel comfortable.'¹⁹⁸ By 2000, the RCN Complementary Therapies Forum acknowledged the need for a more coherent system of recording research on CAM and, in its submission to the House of Lords, stated that 'The forum supports the concept of establishing some kind of database to collect and collate all levels and types of evidence.'¹⁹⁹

My interviews reveal the extent to which nurses respected this EBM approach,²⁰⁰ which is also supported by the fact that by 1994, one in three enquiries to the Research Council for Complementary Medicine database was from a nurse wanting information about research.²⁰¹ Nursing journals show that several CAM research studies were undertaken, which were principally on massage (for example, a 1992 study by staff nurse Dawn Hewitt on the effect of massage with lavender oil on

¹⁹⁷ Figure 7 in the following chapter.

¹⁹⁸ Fiona Mantle, *Complementary Therapies: is there an evidence base?* (London: Nursing Times, 1999), 11.

¹⁹⁹ See Appendix I.

²⁰⁰ For example, interviews with Jacqui Stringer, Rosie Winyard, Fiona Mantle, Pat Turton.

²⁰¹ *Nursing Times*, 27 July 1994.

lowering tension,²⁰² Jane Buckle's 1993 research on massage for reduction of stress²⁰³) and healing (four nurses claimed in doctoral dissertations that TT healing was effective.²⁰⁴) As an example of the type of research that was underway, Caroline Stevensen described her research in an article in the *Nursing Times*:

I am writing up research done at Middlesex Hospital ICU 1991-1992 to demonstrate the benefits of aromatherapy massage on the day one post-surgical cardiac ICU patients. This has shown statistically significant results about the psychological benefits to patients from foot massage with and without aromatherapy oils, the effects of which they perceived to last over several days in some cases.²⁰⁵

Stevensen also researched mindfulness-based stress reduction in cancer patients, as described here by Steven Ersser, who collaborated with her on the project:

Caroline Hoffman did a very important study on the use of mindfulness-based stress reduction, MBSR, looking at a trial of using it with cancer patients. And we went on to publish that in the *Journal of Clinical Oncology*, which is a very prestigious journal...this is how far it had come, that the establishment medical journal [published] the paper by Hoffman, Ersser *et al.* [...] We have come a long way really.²⁰⁶

Jacqui Stringer described how she had been working with a consultant in his outpatients clinic and 'he allowed me to use massage and work with essential oils. His only issue at that point was that, "You need to prove to me that using the oils is not going to cause infection; that they don't harbour fungal spores for example."' Jacqui Stringer had worked with a micro-biologist at the University of Manchester, and was able to reassure that 'far from causing infections, these things are phenomenally anti-microbial agents in their own right.'²⁰⁷ Ersser similarly recalled

²⁰² *Nursing Times*, 17 June 1992.

²⁰³ *Nursing Times*, 21 September 1994.

²⁰⁴ Heidt (1979), Quinn (1982), Ferguson (1986), Fedoruk (1984). Quoted by Daniel Benor in 'Spiritual Healing in Clinical Practice', *Nursing Times*, 30 October 1991. (No further details found).

²⁰⁵ Caroline Stevensen, *Nursing Times*, September 1992.

²⁰⁶ Steven Ersser interviewed 14 July 2014.

²⁰⁷ Jacqui Stringer, interviewed 30 January 2014.

how he defended the use of essential oils to the Oxfordshire Health Committee when he was participating in a project: 'Essential Oils in Nursing'. He explained:

My basic point to them (Oxfordshire Health Committee) is the fact that essential oils are made up of pharmacologically active substances. And I said that, as a nurse with scientific training, I could not ignore the fact that if I gave somebody tea tree, that tea tree had a known antimicrobial effect, or that peppermint had an effect on the gut or that lavender which was pleasant and comforting for elderly people might have a slight calmative or relaxing effect on the brain and it seemed a very rational thing to me. ...Because as a nurse who had had a reasonable education, I felt it was our duty under the NMC Code of Conduct that we had to obviously consider the evidence base of what we were doing, we had to only do things that promoted a patient's welfare, not to do the patients any harm, to protect them from harm.²⁰⁸

While efficacy and safety were the practical issues of implementing therapies into practice, what were the principle purposes for which they were actually being used?

Joanna Trevelyan noted that therapies were principally employed by nurses for relaxation, stress reduction, pain relief, insomnia and palliative care.²⁰⁹ This is also supported by my data.

By the mid-1990s, there was an increasing thirst from the readers of nursing journals for support in their interest in complementary therapies, and appeals to the editor were received in the form of *cris des coeurs* letters. Typical examples are found in 1995 issues of *Nursing Times*. In May 1995, for example, a letter was published from Jennifer Dick of the Lindisfarne Assessment Unit in Morpeth:

I am involved in setting up a system of nursing guidelines, policies and procedures on the use of complementary therapies in my trust. I would

²⁰⁸ Steven Ersser, interviewed 14 July 2014.

²⁰⁹ Joanna Trevelyan, A true complement? *Nursing Times*, 92 (1996) 42-43.

be grateful for any information, policy or procedural documents on complementary therapies used in other hospitals or organisations.²¹⁰

The following month, an appeal came from a nurse in Christchurch Dorset requesting advice on 'Aromatherapy – I would welcome guidelines for use in a palliative care unit.'²¹¹ And on 2 August, a nurse from Gledfield General Hospital wrote 'Help wanted – advice on aromatherapy for pain control and cardiac care...'²¹² Two weeks later, a request from a nurse in a Scottish nursing home on how to incorporate aromatherapy into her work was published,²¹³ and on the 29 August an appeal from a nurse in Braintree stated: 'Help wanted on reflexology – I am a nurse in an orthopaedic ward and would like to use reflexology in my nursing care ... '²¹⁴

These typical examples from the *Nursing Times* demonstrate the eagerness for information about complementary therapies at this time, which is reflected in the survey undertaken by The *Nursing Times* in December 1995 on the use of CAM by nurses. Allegedly the largest survey of its kind (393 respondents), the results revealed that 58% of nurses who responded to the questionnaire were using complementary therapies in their work, and the journal asserted:

This survey suggests the complementary therapies are now an important part of nursing, midwifery and health visiting practice but that there is work to be done in ensuring that the value of the therapies being used is properly evaluated, and that employers develop appropriate policies for their use within the NHS.²¹⁵

²¹⁰ *Nursing Times*, 17 May 1995.

²¹¹ *Nursing Times*, 14 June 1995.

²¹² *Nursing Times*, 2 August 1995.

²¹³ *Nursing Times*, 16 August 1995.

²¹⁴ *Nursing Times*, 29 August 1995.

²¹⁵ *Nursing Times*, 31 January 1996.

The principal therapies were based on touch, such as massage, aromatherapy and reflexology, but Therapeutic Touch, homeopathy and acupuncture were also employed. Two years later, a snapshot survey of the RCN Complementary Therapies Forum members reported that the therapies used in order of preference were massage, aromatherapy, reflexology, relaxation, visualisation and acupuncture.²¹⁶ In the interviews I conducted, other therapies such as hypnotherapy were also quoted as being implemented by nurses at this time.

How nurses actually incorporated these therapies into their work is a story of gradual application. For example, Fiona Mantle, Chris Eberhardie, Dan Jones and Julia Ayres described the routine, and sometimes mundane, circumstances in which these touch therapies were incorporated:

We used to massage the patients in terms of if they had dry skin, we massaged cream in. Nobody called it 'massage' - it was foot care, or it was what you did after the patient's blanket bath and they had flaking skin. And nobody said, 'Oh, you've got to have a certificate in that. You can't do that.'²¹⁷

I've also seen in intensive care units that people spiked at very, very high pressure because somebody has done a chest physio or something. And to try to get that pressure down, they've given him a foot massage. And it worked.²¹⁸

I can remember that one of my colleagues ... was trained in massage and would do aromatherapy things with some of the long-stay clients. And those things to me seemed very obviously sensibly benign.²¹⁹

I have a friend who was a physiotherapist and she did a lot of massage and she taught me very basic massage, which I used to do when I did usually ulcer dressings for legs, which generally got the circulation going and patients actually liked it.²²⁰

²¹⁶ RCN Archives.

²¹⁷ Fiona Mantle, interviewed 3 April 2014.

²¹⁸ Christine Eberhardie, interviewed 3 September 2014.

²¹⁹ Dan Jones, interviewed 30 May 2014.

²²⁰ Julia Ayres, interviewed 1 February 2014.

As for visualisation and hypnotherapy, Fiona Mantle explained how it was a natural extension of something that was instinctive for her:

But when I was at Moorfields, we had a rather awful procedure for patients - a lacrimal washout. The lacrimal gland is just on the inside [of the eye]... and it involved putting a needle in - not a needle, a bore in - and gently squeezing in water and flushing it out. Well, you can imagine this was traumatic for the patient. So I used to have them lying down of course and said 'Shut your eyes' and was trying to get them relaxed I thought what I was doing was relaxing the eye muscles and I said, 'Right, what I would like you to do is to imagine that you are lying on a lovely grassy hill, looking across the valley and there is a hill on the other side of the valley and on the hill is a church. And on top of the church is a weather vane and it's glinting in the light. Now watch it, keep watching that weather vane going backwards and forwards. Don't take your eyes off it.' Well, I thought I was relaxing their eye muscles. I wasn't - I was hypnotising them... And it was years before I realised what I had been doing. But you know, you do it naturally; these odd things you can do naturally...²²¹

This instinctive and intuitive approach to using CAM in nursing emphasises the sense that it was a natural progression for these nurses. Some of these therapies are even described as 'little ways' by Steven Ersser here:

I got interested in a project in aromatherapy really and it was called 'Essential Oils in Nursing Project' and it was essentially about looking at the ways in which we might be able to integrate essential oils within everyday care. So, simple things like a foot massage, possibly using lavender to help people sleep rather than using a sleeping tablet, to possibly putting some peppermint oil in a mouth wash for people before surgery – just little ways in which we could use oils.²²²

However, nursing academic Kevin Kendrick highlights the difficulty of being able to incorporate CAM without the agreement of medical colleagues because of the threat to biomedical dominance and a lack of nursing autonomy,²²³ and Fiona Mantle

²²¹ Fiona Mantle, interviewed 3 April 2014.

²²² Steven Ersser, interviewed 14 July 2014.

²²³ Kevin Kendrick, 'Challenging power, autonomy and politics in complementary therapies: a contentious view', *Complementary Therapies in Nursing and Midwifery*, 5 (1999) 77-81.

describes the closed mind attitude:

You must remember that by this time, we were looking at evidence-based medicine. And as a result, there were a lot of people who were very closed. They said, 'There's no evidence...' But, particularly with hypnosis, there was a lot of evidence, a lot of clinical evidence.²²⁴

And then there was pure suspicion, as described by an oncologist nurse writing in the *Nursing Times*:

I watched in admiration as my colleague took the time to perform reflexology on a patient. It provided a wonderful opportunity to talk to the patient and develop a relationship. I felt her dismay when the ward sister said it was not an important feature and implied she should be doing 'proper work'.²²⁵

Alienation within the system due to the use of complementary therapies was described more strongly by Inga Newbeck when describing how her head of school of nursing was remarkably supportive amid, what she suggested was a critical environment: 'As you've probably found out by now, trying to support complementary therapies within the system was asking to walk around with knife handles sticking out of your back.'²²⁶ This sense of alienation was reflected in an item in the submission to the House of Lords Review (2000) by the RCN Complementary Therapies Forum which cited an example of a study into the use of aromatherapy in the John Radcliffe Hospital where the investigators who were undergoing the research 'felt marginalised and several left their jobs because the results of the study were perceived as threatening to medical colleagues.'²²⁷

²²⁴ Fiona Mantle, interviewed 3 April 2014.

²²⁵ D. Carlisle, 'Careful talk saves lives', *Nursing Times*, 24 April 1996.

²²⁶ Inga Newbeck, interviewed 30 March 2015.

²²⁷ Submission by RCN for House of Lords Committee of Science and Technology, page 2. See Appendix I.

Nurse practitioner Janet Richardson, who led CAM services at Lewisham Hospital from 1994, highlighted the challenges of implementation and the considerations that had to be confronted ('the steepest learning curve I have ever met'), especially those of practical administrative support, resources and the fact that demand developed such that it exceeded funding.²²⁸ The outpatient unit was established following work with general practitioners, complementary practitioners and professional bodies and was nurse-led by a senior staff nurse and qualified massage practitioner. The unit was initially funded on a block funding one-year basis by the local authority and a robust auditing system was established, including plans for RCTs. In its first year it treated 883 NHS patients with, as a health survey questionnaire concluded, 'significant positive effects.'²²⁹ There were hopes for further development but limited resources caused its disappointing early closure when the local authority was forced to reduce its overspend.²³⁰

There may have been challenges, but for many there was tacit support for CAM too, as this example from nurse Christine Eberhardie shows:

We had one patient who was a young man who had had a severe head injury and he couldn't sleep. He was walking the ward, you know ... he was distressed with the staff, the patients, his parents – because he was so restless. And one of the girls had done a complementary therapy course in the Faculty ... and she said, 'You know', she said to the doctor, 'this is the last resort here. How about we try lavender oil?' And the doctor said, 'He's not going to drink it, is he?' 'No, put it on his pillow'. He said, 'Well it'll smell like a tart's boudoir but ... if it helps,

²²⁸ Janet Richardson and Ann-Marie Brennan, 'Complementary Therapy in the NHS: service development in a local district general hospital', *Complementary Therapies in Nursing and Midwifery*, 1 (1995) 89-92.; Janet Richardson, *Complementary Therapy in the NHS: a service evaluation of the first year of an outpatient service in a local district general hospital* (Lewisham Hospital NHS Trust, Health Services Research and Evaluation Unit, 1995).

²²⁹ *Ibid.*

²³⁰ Catherine Zollman and Andrew Vickers, 'Complementary medicine in conventional practice', *BMJ* 319 (1999).

whatever – just try it.’ And they did and it worked! And that wasn’t a conscious decision of the young man - that was the nurse and yet it worked. He didn’t believe in it, he probably didn’t know why she was doing it, but it worked!²³¹

There are examples of more constructive endorsement from medical staff as experienced by nurses Caroline Stevensen and Nicky Baker, who respectively recall the support from consultants with whom they worked:

[The consultant] essentially gave me permission to do whatever I liked. Professionally he trusted me to do what was right for the patient in intensive care – he was very forward-thinking. When I was there - I was in that setting in that hospital from end-1986 to about spring 1993/1994 - he trusted me to do things there. So when I was doing

shiatsu, he allowed me to do that and he was really open to the possibility of us helping people in different ways.²³²

It was very one to one. I was the only person doing it at that time and when the work increased and increased and my job changed to being the support nurse, I was really almost being validated for what I wanted to do. Because the consultant was saying 'What would you like to be?' and I was saying 'I would like to be the support nurse for these patients.'²³³

The Calman-Hine report of 1995, which examined cancer services in the UK, proposed an improvement of outcomes and equitable access to NHS care²³⁴ and it also had an impact on the practice of holistic nursing and the use of CAM, as described by nurse therapist Annie Hallett:

The Calman-Hine report on cancer nursing [...] was hugely important in the whole direction that cancer care, not just cancer nursing, took. But it actually talked about the need to give psychological support. It was the first proper report from the Department of Health that gave direction about the direction that cancer care should take. And it certainly

²³¹ Christine Eberhardie, interviewed 3 September 2014.

²³² Caroline Hoffman (*née* Stevensen), interviewed 10 June 2015.

²³³ Nicky Baker, interviewed 16 July 2015.

²³⁴ Calman-Hine Report, *A Report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales. A Policy Framework for Commissioning Cancer Services*. Department of Health, 1995.

promoted a holistic perspective and ... I can't remember the exact wording ... but it certainly meant that counselling, psychological support had to be provided and I think it included complementary therapies. And that of course gave people, not just permission, but ideas.²³⁵

Pain relief was one area in which CAM was used by nurses and the RCN Forum for Complementary Therapies (which is examined in the following chapter) worked internally with the RCN Pain Forum in order to develop guidelines for nurses using complementary therapies in the management of pain.²³⁶ These examples illustrate how nurses incorporated CAM in their work, albeit in a limited way, by gradually introducing massage or oils and receiving the support and trust from medical colleagues to make decisions about incorporating other appropriate therapies for patients. Support also came from the RCN, as demonstrated by this comment by Christine Hancock, the General Secretary of the College in 1995:

In recent years there has been growing pressure on nurses to prove their value in terms of cost effectiveness and their contribution to patient well-being ... nurses everywhere are pushing at the boundaries of care to find innovative ways of solving long standing problems. The increased use and greater understanding of complementary therapies provides a good example of this.²³⁷

Before leaving the subject of CAM practiced by nurses, there is one therapy that has not been included in discussion to this point. Therapeutic Touch, an energy healing therapy, stands apart from others. The *Nursing Times* of 4 January 1995 includes references in several letters to the editor about Therapeutic Touch and how it related to other forms of healing touch. The writer of one letter maintained that, while 'healing is being practised increasingly by doctors and nurses within the health-care setting ... many authorities are beginning to think that they are two quite different

²³⁵ Annie Hallett, interviewed 18 May 2015.

²³⁶ *Ibid.*

²³⁷ Christine Hancock in Denise Rankin-Box ed., *The Nurses' Handbook of Complementary Therapies* (Edinburgh: Balliere Tindell, 1995), Introduction.

therapies.’²³⁸ In another letter, Jean Sayre Adams stressed that in the USA, TT was considered, not as a complementary or alternative therapy, but ‘mainstream nursing practice’ – although, judging from the interviews I carried out, it seems never to have flourished in the UK to the same extent.²³⁹ The *Nursing Times* in November 1986, claimed that there were 20,000 healers in the UK at that time, courses were regularly advertised in nursing journals and in the *Nursing Times* of 26 April 1995, Adam Jackson’s ‘Alternative Update’ monthly report claimed of Therapeutic Touch that it ‘has become an accepted practice in the UK.’ Although two of my nurse interviewees had been trained by Delores Krieger²⁴⁰ and others had undertaken courses, either in the UK or US, it was not widely recognised by most participants. However, those who had embraced it were enthusiastic and evangelical about its benefits.

Stephen Wright, when professor of nursing and holistic studies at St Martin’s College, Lancaster, wrote in the *Nursing Times* in March 1999:

When the jokes are over and the ridicule forgotten, we are left with the need to take a serious professional look at something that seems to work for many people and ask how best we can integrate it into our own work.’²⁴¹

(In his interview with me, Wright additionally claimed benefits for the practitioner, too, saying that ‘Therapeutic Touch practitioners tend to be healthier than those who don’t practise TT, because their white cell count is better, their blood pressure is lower.’)²⁴²

²³⁸ Rosemary Hays, *Nursing Times*, 4 January 1995.

²³⁹ ‘It didn’t catch on as much here.’ Jean Sayre-Adams, interviewed 15 January 2014.

‘Therapeutic Touch hasn’t really taken off in the same way that it seemed to take off in America.’ Peter Mackereth, interviewed 30 January 2014.

²⁴⁰ Annette Turton, Jean Sayre-Adams.

²⁴¹ *Nursing Times*, March 10 1999, 95, 10.

²⁴² Stephen Wright, interviewed 16 January 2014.

Ironically, there were claims that TT was one therapy for which there was clear evidence of its therapeutic efficacy, as Daniel Benor wrote in October 1991:

There is more research evidence to support the efficacy of healing than there is for all the other complementary therapies combined, with the exception of hypnosis.²⁴³

5.4. Conclusion

This chapter has addressed questions and themes that support the practice of CAM by nurses. How 'kindness' developed into 'caring' and 'caring' evolved into 'empathy' provide the background to holism in nursing and I have attempted to situate the additional element of 'spirituality' (and its several aliases), which, for the many nurses who were practising holistically, was a major tenet of their ideology. This is an area that has not received wide previous study and this discussion will contribute to the understanding of motivation of holistic nursing and its impact on CAM practice.

That the nurse-patient therapeutic relationship was perceived to grow in importance during the period is evidence of a variety of causes: patient-centred nursing, the 'new nursing' movement, a turning away for some from the progressively technological approaches, the influence of Balint's work on the therapeutic relationship of doctor-patient and nurse-patient, and the increasing interest and attention to the practices of touch and the time spent talking with the patient – and their effect on the quality of the nurse-patient relationship. This formed a significant section of the chapter and the 'touch' section, in particular, was substantial. However, the theme of touch is an

²⁴³ Daniel Benor, 'Spiritual Healing in Clinical Practice', *Nursing Times*, 87 (1991).

area that was so widely discussed in my oral history interviews that I believe it is a central element in explaining the increasing interest in, and incorporation of, CAM by nurses in the 1980s-1990s, especially in practising the tactile modalities that employ it, such as massage, aromatherapy and reflexology. How nurses undertook CAM practice in their work, the support they had from medical colleagues and the type of therapies they introduced concluded the chapter.

The following chapter will focus on the support that nurses sought for their practice of CAM. It will introduce groups and networks and will discuss policy, especially that concerned with training and regulation. The data presented in the chapters so far have concentrated on the reasons nurses turned to CAM and what practices were incorporated. The final data chapter will explore the question of how this was achieved.

CHAPTER SIX: ENDORSEMENT AND AUTHENTICATION

6.1. Introduction

In the last chapters, I explored the reasons why some nurses turned to CAM in the 1980s and 1990s and examined the therapies and modalities that they employed. This included background discussion of the issues of debate, doubt and distrust in medicine stemming from the 1960s and 1970s, which preceded a cultural movement encouraging alternativism, consumer choice and self care. I argue that the appetite for a less reductionist model and increased focus on 'nature' and 'natural' things ushered in a more holistic approach to healthcare as a change in consciousness, leading to an awakening of nurses' interest in CAM. I investigated empathy and ways in which nurses regarded touch and communication and the influence of these holistic approaches on the nurse-patient relationship, and how this, in turn, impacted on CAM and its implementation in nursing practice.

The principal question of this chapter aims to explore how those nurses interested in using complementary therapies went about incorporating them into their practice. Where did they turn for support, for example? From where did the training, the information and the inspiration come? While the published literature generally claims that nurses' use of CAM developed as an isolated and haphazard activity,¹ I will show that it was more coherent, with key people driving developments – many of whom I

¹ Sarah Cant and Peter Watts, 'The Rise and Fall of Complementary Medicine in NHS Hospitals in England, *Complementary Therapies in Clinical Practice*, 18 (2012) 135-139.

approached to contribute to this research with oral history interviews. In addition to interviewing nurses, I undertook fifteen face-to-face interviews with principal individuals involved in organisations and networks, in order to corroborate the events outlined in journals and archives and to enrich understanding of their development.

Writing in 1998, Joanna Trevelyan, the deputy editor of the *Nursing Times*, described the evolving scene:

The picture that emerges is one in which complementary medicine remains a marginal activity in the NHS, even though it can be found everywhere. ... On the one hand, it has been allowed to take its first steps in the health service but, on the other, it has been prevented from being developed properly.²

She blamed inertia and lack of resources for preventing greater implementation, and a third constraint – that of duplication of effort. I will examine this statement in the light of groups and associations that were founded during this time, focusing on their interconnectedness, tensions (where they existed) and overlapping agendas. In the last two decades of the twentieth century, a number of these ‘CAM in nursing’ and holistic nursing organisations and networks were founded, such as the British Association for Holistic Health (BAHH, founded in 1984), the Holistic Nurses Association (HNA, founded in 1993) and the RCN Complementary Therapies Forum in Nursing (formed in 1994). These particular associations had not been thoroughly explored prior to this study. Furthermore, organisational archives in two cases (HNA, BAHH) were not previously available. This final data chapter thus provides a significant new contribution to the field, in examining the professional structures – as well as the informal support networks – that encouraged nurses in their practice.

² Joanne Trevelyan, ‘Complementary Options’, *Nursing Times*, 1 April 1998.

The chapter comprises five sections: policy, networks, journals, patronage and the legislature. Two other issues are examined: discussion of CAM as a 'movement' and the relationship between holism and complementary therapies. I could have chosen to examine these topics earlier in the thesis (and they have been referred to), but they are intentionally woven here into the accounts of the organisations as part of their story, for the data show that they were issues that fiercely challenged the protagonists then, just as much as they are debated retrospectively.

The chapter opens with background of evidence of the emerging interest by nurses in complementary therapies, followed by an analysis of nurse education, training and regulation issues and how they related to nurse-patient relationships and CAM practice. It leads into an examination of the principal relevant organisations, networks and journals of the late-twentieth century, ending – as the century did – with examination of the House of Lords Select Committee report in 2000,³ in which nurses were involved by submitting evidence, and which provides an endpoint to the study timeframe.

6.2. Background

6.2.1 The first evidence of interest in CAM by nurses

Changes in healthcare attitudes were evident by the mid-1980s, as has been shown. But how were these reflected in nursing practice? In January 1984, the first *Nursing Times* editorial of the year looked ahead and predicted its effect:

³ *The Sixth Report on Complementary and Alternative Medicine*, House of Lords Select Committee of Science and Technology, 21 November 2000.

Alternative approaches to medicine will come to play an increasingly large part in any future health service, one suspects...⁴

Indeed, in June that year, The *Nursing Times* organised its first one-day conference in Manchester on holistic nursing and complementary therapies. Pam Holmes, Features Editor, described the environment of the new healthcare model in encouraging nurses' attendance:

This conference will give nurses the chance to make up their own minds about something which is occupying the public – a new approach to health.⁵

The conference title was 'Holistic Nursing: Complementary Concepts and Theories' and the event included presentations on holistic health, self-awareness and the role of alternative therapists, with workshops on Therapeutic Touch, massage, shiatsu, aromatherapy, biofeedback and Kirlean photography.⁶ There was irony in the promotional advertising with reference to 'new-fangled ideas', but a challenge was added: 'are they relevant for nursing care today?'⁷ The level of interest in response to the conference suggests that they were. The event was a significant success and was greatly oversubscribed, as recorded by Annette Turton in an article in the *Nursing Times* afterwards, claiming that support for it had surpassed all expectations:

Over 100 applicants, more than for any other *Nursing Times* conference, had to be turned away because of lack of space. The 300-strong audience, far from being predominantly students or newly qualified staff, were, in the main, experienced nurses, tutors and managers.⁸

This observation reveals the important fact that the topic was of interest to senior staff, who would be in the strongest position to implement practices.

⁴ *Nursing Times*, 4 January 1984.

⁵ *Nursing Times*, 19 June 1984.

⁶ See Appendix A for definition of therapies and Appendix H for the conference details.

⁷ *Nursing Times*, 4 April 1984.

⁸ *Nursing Times*, 11 July 1984.

Reflecting the success, a further holistic nursing conference was organised at Islington Town Hall and the one-day programme (see Appendix H) again incorporated practical therapy workshops, as well as talks and discussions, with the promise that 'participants will learn enough to take their new skills back into clinical practice.'⁹ These mid-1980s conferences provide the first evidence of endorsement and practical help for nurses wanting to incorporate CAM in their work.

I reflected on how the nurses who may have been inspired and motivated by these conferences, would have felt about implementing some of the techniques that had been presented and where they would have turned for further information on research or training and issues of regulation. These policy issues are basic to the understanding of twentieth-century CAM in nursing and the following section examines their complexities.

6.3 Policy

6.3.1 Training and education

In the first phase of research in this area, I examined training curricula for evidence of nurse education, both on the therapeutic relationship between nurse and patient (including psycho-social communication) and also on training in CAM. Prior to 1989, almost all of nursing education was undertaken in hospitals in an apprenticeship system, until Project 2000 brought about the integration of nursing education into

⁹ *Nursing Times*, 26 March 1986.

higher education institutions. Examination of the curricula in the early period¹⁰ shows little indication that the nursing training programmes were especially patient-centred,¹¹ even though in 1960, a recommendation had been made to introduce nursing examination questions which included applied psychology and the nurse/patient relationship.¹²

Nursing academic Ann Bradshaw's work on the history of competence and British nursing analyses statutory syllabi and nursing textbooks from 1874 to 1977.¹³ An examination of the 1938 textbook *Aids to Practical Nursing* and its later editions illustrates the required attitude of the nurse to patients:

The nurse should be loyal to her [*sic*] patients by giving ungrudging loyalty, respecting confidentiality, being trustworthy and reliable.¹⁴

There is no mention of empathy or psycho-social skills.

In 1982, the final nursing examination paper includes one question based on an 80-year old patient being admitted to hospital for a transurethral resection of prostate under a spinal anaesthetic, asking:

How can the nurse help him to settle into the ward and provide specific psychological and physical preparation for surgery?¹⁵

¹⁰ National Archives of the United Kingdom, Kew, London (hereafter TNA), General Nursing Council (GNC) for England and Wales archives, DT16/579.

¹¹ Peter French, 'The quality of nurse education in the 1980s', *Journal of Advanced Nursing*, 17, 1992, 619-31.

¹² TNA, GNC Preliminary Examination Guides to Syllabuses, 1960, DT38/155.

¹³ Ann Bradshaw, 'Competence and British nursing: a view from history', *Journal of Clinical Nursing*, 9, 2000, 321-329.

¹⁴ Subsequently 10 editions until 1965, revised in 1971 by Margaret Clarke and retitled *Practical Nursing*.

¹⁵ TNA, GNC final state exam for general part of the register, 4 October 1982, DT16/744.

This is the only reference on the paper to psycho-social contact between nurse and patient. During the 1970s and 1980s, great emphasis was placed on teaching communication skills, but there was concern that results were not apparently 'effective' – presumably in terms of producing high quality care.¹⁶ Evidence of a heightened focus on these skills emerges in curricula in the 1990s, and the following requirements were noted in the student learning outcomes of the 1990 curriculum of the University of Birmingham Bachelor of Nursing (Hons), (Children Branch component):

- j. The ideal of physical, psychological, social and spiritual needs of the patient or client.
- f. The use of appropriate communication skills to enable the development of helpful and caring relationships with patients and clients and family and friends and to initiate and conduct therapeutic relationships with patient and clients.

In 1994, the Department of Nursing Studies at Birmingham directed that 'students will learn to talk to people, to listen, to be aware of body contact, eye contact and good kinetic response', which was to be achieved through lectures and role play sessions.¹⁷ However, this area of nurse training was still criticised, and communication training in nurse education was recognised as a neglected area – as healthcare academics Paul Crawford, Brian Brown and Peter Nolan acknowledge, suggesting that nurses should improve their skills by usefully examining tape-recorded samples of their conversations with patients and listening critically to what was said.¹⁸ In 2000, writer Simon Chant and colleagues undertook a literature search on the topic of communication and interpersonal skills in nursing. Over 200

¹⁶ S. Wilkinson, 'Confusions and Challenges', *Nursing Times*, 26 August 1992.

¹⁷ University of Birmingham Bachelor of Nursing degree curricula archives of Dr Alison Coates, for which I thank her. 1994 curriculum.

¹⁸ Paul Crawford, Brian Brown and Peter Nolan, *Communicating Care: the language of nursing* (Cheltenham: Stanley Thornes Publishers, 1998), 158.

articles were found, but he concluded that problems continued to exist in these areas and that an emphasis on training was required to improve both patient and staff satisfaction.¹⁹

Of education in CAM, there is even less evidence. In 1989, a European Commission initiative was developed to monitor the impact of complementary medicine on healthcare delivery and to consider its integration within mainstream health care.²⁰ And complementary therapies were tentatively discussed as an element in nurse training when, in attempting to standardise CAM education, the European Commission recommended a minimum of three-year training in complementary medicine for therapists wanting to practise.²¹ The RCN special interest group (pre-Forum) investigated this for nurses, but with no evident further action.²² This step to introduce training was endorsed by the BMA report in 1993,²³ which stated that an awareness of CAM should be part of training and education of all health professionals, not only of doctors. However, education in CAM for nurses was never standardised in any official capacity and the available training opportunities were piecemeal. I categorise them as originating from four principal sources. Training was either obtained by nurses with participation in private courses, from quasi-official courses (such as those arranged in hospitals or by RCN-Institute of Complementary Medicine initiatives²⁴), by training from specialist groups who promoted holistic

¹⁹ Simon Chant *et al*, *Journal of Clinical Nursing* 11 (2002) 12-21.

²⁰ D. Aldridge, 'Complementary medicine in the European Community', *Comp Medical Research*, 4, (1990) 1-3.

²¹ European Commission, Council Directive 89/48/X, no L19: 16-23.

²² Denise Rankin-Box, 'Innovation in practice: complementary therapies in nursing', *Complementary Therapies in Medicine*, 1 (1993) 30-33.

²³ *Complementary Medicine, new approaches to good practice* (London: BMA, 1993).

²⁴ *Nursing Times*, 6 October 1993.

methods and CAM practice (such as the BAHH, BHMA), or, finally, from courses via nursing institutions. Most nurses wanting to practise CAM took advantage of training opportunities from multiple sources.

Some nurse participants in the study expressed their frustration and disappointment at not being able to gain formal training. Nurse Alison Ellis, for example, described how she felt when she first became interested in CAM and wanted to pursue it:

They didn't offer qualifications so I couldn't say to the RCN, 'That's fine, I'll enrol on one of your ENB – English National Board – courses and I will get this accredited course from you to practise.' That wasn't available then.²⁵

Instead, Alison went to an evening class to learn massage and qualify so that she could practise it. Similarly, Hermione Elliott and Nicky Baker describe how they took advantage of private courses for their own interest and development:

I had done a lot of self-study with Bach flower remedies, Gestalt, transactional analysis. You know, I had been doing all kinds of little courses for my own interest really.²⁶

It just came into my view and if it fitted and I felt like I wanted to do it [...] I saw that as making me the person that I was becoming, and hopefully being more skilled in what I could offer patients.²⁷

Courses at specialist colleges for specific therapies were regularly advertised in nursing journals; for example, one sample issue of the *Nursing Times* on 16 September 1998 featured classified adverts for acupuncture, hypnosis and herbal medicine courses, all aimed at nurses.

²⁵ Alison Ellis, interviewed 12 May 2014.

²⁶ Hermione Elliott, interviewed 12 November 2014.

²⁷ Nicky Baker, interviewed 16 July 2015.

Nursing sister Fiona Mantle described how she came to be trained:

There was a lecturer at Birkbeck, a psychologist, who used hypnosis in an experimental way and he introduced me to what was then the British Society for Clinical and Experimental Hypnosis. ... He took me along to one of their training weekends and he said I could go on this training weekend because as a nurse I had a code of conduct and the rules of this learned society, academic society, were that they would train people to use hypnosis but they had to use it only in relation to their professional organisation. There was myself and later another nurse

²⁸

However, Mantle could see that there was a need for a more structured approach to training nurses in CAM.²⁹ In 1995, she introduced the first introductory two-week course for complementary therapies for nurses at St George's Hospital, which covered a number of therapies including herbalism, Alexander Technique and massage. She acknowledges that, at that time, there was still a 'fringe' label to complementary therapies and she appreciated that she had been fortunate that her Director of Nurse Education allowed her to develop and launch the course.³⁰ She described how the training team was formed:

We found we had enough expertise within the college to teach the hands-on therapies and transcultural nursing... We decided to buy in outside speakers to cover the teaching of herbalism, homeopathy, acupuncture and Alexander Technique. The RCN assured us that their indemnity insurance covered complementary therapies used within a nursing context.³¹

I asked her if the course had encouraged implementation of any of the therapies and she described the challenges:

I did hear that on one of the wards, they were dishing out camomile tea to the patients ... anyway, it opened their minds. I think that some went on to do training. But there was a difficulty. You see, the trouble we

²⁸ Fiona Mantle, interviewed 3 April 2014.

²⁹ Fiona Mantle, 'Safe practices', *Nursing Times*, 92 (1996) 36-38.

³⁰ Fiona Mantle, *In Touch*, 2004.

³¹ *Nursing Times*, 29 April 1992.

had with trying to integrate was that the seniors did not understand the therapy and therefore were reluctant to allow it. There weren't enough senior people doing it, that was the problem. It was difficult to integrate from that point of view.³²

This sort of *ad hoc* hospital training in CAM was noted in *The Nursing Times* in September 1989:

The London College of Massage and Shiatsu is pioneering the training of nursing staff in massage at St Thomas' Hospital. Up to 16 nurses and nursing auxiliaries from three acute wards for the elderly will be able to take a short massage course specially designed for them ... to develop nurses' sense of touch...³³

Nurse Peter Mackereth described how he similarly profited from a course at his hospital:

They were offering some nurses and teachers this massage course and I thought 'Wow, I could get a professional qualification in massage; it goes beyond what I learnt as a student nurse.' So I did a formal course at the hospital, learning about aromatherapy and massage.³⁴

Nurse practitioner Rosie Winyard independently incorporated complementary therapies into her teaching when she was lecturing at a college attached to the University of Leeds:

I lectured in health studies and that is when I included complementary therapy in the education programme for the nurses ...³⁵

Nursing academic Annette Turton told me that she introduced healing, massage, meditation and relaxation into the curriculum when she was teaching nursing at the University of Manchester.³⁶ And nursing sister Caroline Hoffman³⁷ described how she and a colleague started a massage course for nurses:

³² Fiona Mantle, interviewed 3 April 2014.

³³ *Nursing Times*, 27 September 1989.

³⁴ Peter Mackereth, interviewed 30 January 2014.

³⁵ Rosie Winyard, interviewed 8 May 2014.

³⁶ Annette Turton, interviewed 10 April 2014.

She and I ended up teaming up - she was in oncology, a lecturer in the school of health care – and started to teach nurses some very basic massage that they could safely do with their patients on the ward. That is how it all started. I can't remember how long we did it for. We took the safe elements out of a whole body massage, so it might have been neck and shoulders, or feet, or back, or hands – elements that could easily be applied to patients on a ward who were feeling distressed and needing a bit of touch and connection with someone to support, and put these things together.³⁸

The British Holistic Medical Association (BHMA) and the British Association for Holistic Health (BAHH) collaborated in arranging joint meetings at the Royal Free Hospital, London, at which demonstrations, talks and training sessions were presented. Nurse Inga Newbeck described a four-week BAHH course in meditation for example,³⁹ and Denise Rankin-Box (editor of *Complementary Therapies in Nursing and Midwifery* and a key individual in nursing in CAM) recalls attending similar courses run by the BHMA.⁴⁰

Limited training provision was organised by nursing institutions too. In 1994, Joanna Trevelyn and Brian Booth published *Complementary Medicine for Nurses, Midwives and Health Visitors*, giving advice on offering a complementary therapy to a patient and discussing training. They noted that massage was included in some Project 2000 courses and nursing degree and diploma courses. The first of these was at Oxford Brookes in 1992 (where massage had been taught to student nurses since 1985), where an undergraduate course in the School of Health and Social Care was offered and taken in conjunction with the external International Therapy Examinations

³⁷ née Stevensen.

³⁸ Caroline Hoffman, née Stevensen, interviewed 10 June 2015.

³⁹ *Nursing Times*, 23 July 1986.

⁴⁰ Denise Rankin-Box, interviewed 4 August 2015.

Council (ITEC) examination.⁴¹ In 1997, the BMA undertook a survey of those faculties of nursing and organisations approved for nurse education and reported that by this stage, the majority at least provided some awareness education in CAM. Fifty-two responses were received from the 80 (65%) faculties/colleges of Nursing listed by the four UK Nursing Boards which demonstrated that 38 (73%) institutions were providing a total of 68 courses/modules, which included some education on CAM; seven courses/modules were 'specialist' CAM courses which covered one or more therapies in complementary or alternative medicine in some detail usually involving practical or clinical experience.⁴² However, few were validated by a CAM professional body.⁴³

In 2000, nurse educators Pauline Stuttard and Elizabeth Walker wrote of the lack of a co-ordinated approach in nurse education in CAM and stressed the need to meet changes in healthcare by acknowledging the value of education in complementary therapies. They outlined the steps that had been taken since 1995 by their own institution, the Faculty of Health at the University of Central Lancashire, by running complementary therapy workshops within the branch programmes – at that stage for a total of 16 workshops and 350 students, stressing the importance of the philosophy and values of complementary therapies. Evaluation sheets from the courses provided valuable feedback, which revealed a call for more training and

⁴¹ Private archive of Theresa Bentley, nurse teacher and counsellor, Oxford Brookes University, for which I thank her.

⁴² D. Morgan, H. Glanville, S. Mars and V. Nathanson, British Medical Association (1997). Published as 'Education and training in CAM: a postal survey of UK universities, medical schools and faculties of nurse education', *Complementary Therapies in Nursing and Midwifery*, 6 (1997) 64-70.

⁴³ Julie Stone, 'Using complementary therapies within nursing: some ethical and legal considerations', *Complementary Therapies in Nursing and Midwifery*, 5 (1999) 46-50.

'demonstrated an overwhelming desire by students to seek more information about complementary therapies and their development within nursing.'⁴⁴

However, as has been universally recognised and as these examples demonstrate, training in CAM was unstructured and amorphous.⁴⁵ Ethics and legal healthcare academic Julie Stone describes the system's arcane and fragmented nature and the resulting frustration for nurses:

A nurse who sets out with all good intention to pursue an appropriate training leading to membership of a credible register may have considerable difficulty in identifying which professional body has genuinely high standards.⁴⁶

This was an issue that the RCN Complementary Therapies Forum recognised and worked hard to address and, in November 1999, they proposed an agenda item to Congress:

That this meeting of the RCN Congress urges Council to support the Complementary Therapies Forum in taking the lead in defining education standards and corresponding levels of competence and practice for nurses using complementary therapies within clinical practice.

However, the proposal was turned down⁴⁷ and, in spite of the pressure for a more coordinated structure of education, no specific training or qualification was ever required for nurses within the period of my study. The forum's chair, Angela Avis, summarised the unsatisfactory and disappointing situation:

⁴⁴ Pauline Stuttard and Elizabeth Walker, 'Integrating complementary medicine into the nursing curriculum', *Complementary Therapies in Nursing and Midwifery*, 6 (2000) 87-90.

⁴⁵ Sarah Cant and Ursula Sharma, *A new medical pluralism?* (London: UCL Press Ltd, 1999), 103.

⁴⁶ Julie Stone, 'Using complementary therapies within nursing: some ethical and legal considerations', *Complementary Therapies in Nursing and Midwifery*, 5 (1999) 46-50.

⁴⁷ RCN Archives, RCN/15/15/COM.

Higher education courses are often of questionable validity [...] not courses that would provide nurses with the knowledge to use the therapies in clinical practice.⁴⁸

Indeed, this was one of the principal criticisms of the House of Lords Select Committee, which reported on the 'RCN's passive approach to CAM' and the fact that there was 'almost no guidance for nurses who are trained, or want to train in CAM'.⁴⁹ The report concludes:

We were concerned to hear that, unlike the medical schools, there seems to be little or no evidence of a trend within nursing schools to ensure that student nurses come into contact with the main issues connected to the practice of CAM therapies. This is despite the fact that nurses are probably the most likely of all conventional health practitioners to use CAM techniques in their day-to-day practice....

The Royal College of Nursing were unable to give a clear picture of how common this is because they have not achieved any systematic monitoring of the teaching of CAM within the nursing curriculum.⁵⁰

We are concerned about their passive approach to CAM and the lack of work being undertaken by these bodies in relation to nurses' use of CAM and their training in the awareness of CAM practices. There is a concern that nurses may be exposed to inferior or superficial training programmes and may practise without adequate supervision of this component of their work.⁵¹

However, the committee did not state who should pay for training, it was noted, which was 'a major stumbling block,' said Celia Manson, RCN adviser on complementary therapies.⁵² But it was not just the scarcity and fragmented nature of training that was lacking. Together with these issues of education and training were those

⁴⁸ *Nursing Times*, 7 December 2000.

⁴⁹ House of Lords Select Committee on Science and Technology (2000), 6.103.

However, the report did acknowledge the Forum guidance that had been in existence since 1995, discussed later in chapter.

⁵⁰ *Ibid.*, 6.97.

⁵¹ *Ibid.*, 6.101.

⁵² *Nursing Times*, 7 December 2000.

surrounding the audit, evaluation and regulation of nurses practising CAM. These similarly raised concerns and confusion.

6.3.2 Regulation

An interview conducted with retired school nurse Alison Ellis revealed the lack of understanding, even within the profession, when her actions in using essential oils for students were reported by colleagues, unhappy with the apparent lack of regulation:

I was working with colleagues who didn't believe in any form of complementary medicine at all and were actually making threats stopping me from using things like arnica cream on bruises.⁵³

However, Ellis was officially supported in her work because the necessary requirement of 'competency' for nurses was achieved by a self-evaluated exercise, as established in the Code of Conduct of the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC).⁵⁴ The UKCC had been set up in 1983 as a body to set standards and provide quality assurance for nurse education, and it immediately published its code of conduct, which established ethics and standards to which nurses should adhere. On the matter of nurse practice, it required only that a nurse should take his/her own responsibility for the appropriate level of competency:

2. Be accountable for her [*sic*] practice and take every reasonable opportunity to sustain and improve her knowledge and professional competence.⁵⁵

In 1992, an enlarged and enhanced code was published and included a clause concerning acknowledging limitations of competence:

⁵³ Alison Ellis, interviewed 18 August 2011.

⁵⁴ UKCC Code of Conduct (1983), Joanna Treveylan, 'Complementary therapies on the NHS: current practice, future developments' (Pt 1), *Complementary Therapies in Nursing and Midwifery*, 4 (1998) 82-84.

⁵⁵ UKCC Code of Conduct, 1983, para. 2.

...you are personally accountable for your practice and, in the exercise of your professional accountability, must ...

3. Maintain and improve your professional knowledge and competence.

4. Acknowledge **any limitations** in your knowledge and competence and decline any duties or responsibilities unless able to perform the in a safe and skilled manner.⁵⁶

Two years later, the guidance on competence became rather more specific with the inclusion of 'instruction':

You must:

4. Acknowledge any limitations of competence and refuse in such cases to accept delegated functions **without first having received instruction** in regard to those functions and having been assessed as competent.⁵⁷

This was the first UKCC Code reference to training. Competence and its definition was a controversial issue, and the RCN Complementary Therapies Forum was concerned at the lack of guidance for nurses and made the following recommendation to the RCN Council in 1995:

It is the responsibility of the individual practitioner to judge whether the qualification in a complementary therapy undertaken has brought him or her to a level of competence to use that skill in patient or client care. Where a practitioner is working independently, self-evaluation of competence and accountability are particularly vital.⁵⁸

The RCN Complementary Therapies Forum did much, both then and afterwards, to support the nurse's position with complementary therapies, most especially in producing practice guidelines, which are outlined later in this chapter. These guidelines augmented the policy statements that had been produced by some

⁵⁶ UKCC (1992), Code of Conduct, paras 3 and 4.

⁵⁷ UKCC (1994), Code of Conduct, para. 4.

⁵⁸ Royal College of Nursing (RCN) Archives, Edinburgh, Position Statement of RCN Council, 31 Jan 1994, 3/38/1.

regional health authorities that stipulated forms and standards of practice.⁵⁹

However, an unpublished survey by the National Association of Health Authorities and Trusts (NAHAT) revealed that, of the 96 (of 124) health authorities and boards, only just over half had agreed - or were in the process of agreeing at that time - a policy with regard to CAM.⁶⁰ (Hospital NHS trusts were established by the National Health Service and Community Care Act (1990), but no policy has been found that covered CAM in the ensuing 10 years until the end of this study). In the absence of legislation in this area, some hospitals pushed ahead with their own policies, as seen in Bath with additional practice criteria.⁶¹ 'Where policies or protocols do not exist it would be worthwhile [for nurses] to press for the development of them,' proposed Mark Darley, Professional Officer, Policy Development and Research UKCC.⁶²

Two years later, steps were taken to tighten up procedures:

Nurses are to be urged in a document expected shortly from the RCN to audit and evaluate the use of complementary therapies at their places of work. The college is preparing a statement of principles to follow the BMA report.⁶³

It is not clear, however, that this auditing measure was implemented and no further steps were taken to formalise regulation. Indeed, sociologists Sylvia Walby and June Greenwell believed that the nursing profession at this stage was increasingly moving 'nearer to the medical concept of an autonomous individual' – that is, nurses taking

⁵⁹ For example, Bath (1991), West Berkshire (1992), St Bartholomew's (1993), West Yorkshire Health Authority (1995).

⁶⁰ Joanna Trevelyan, 'Complementary therapies on the NHS: current practice, future developments', *Complementary Therapies in Nursing and Midwifery*, 4 (1998) 82-84.

⁶¹ F. Armstrong and R. Waldron, *Nursing Times*, 87 (1991) 34-35.

⁶² Mark Darley, 'Complementary therapies, the position of the UKCC', *Complementary Therapies in Nursing and Midwifery*, 1 (1995) 106-109.

⁶³ Joanna Trevelyan, *Nursing Times*, 30 June 1993.

responsibility for deciding their practice in line with UKCC guidance.⁶⁴ In 1997, Caroline Stevensen and Mike Wall, both key individuals in the RCN Complementary Therapies Forum, succeeded in a matter for discussion being accepted at RCN Congress. They proposed:

That this meeting of the RCN Congress discusses issues relating to the safe practice of complementary therapies with specific reference to the administration of essential oils, homeopathy and herbal medicines.

Their particular concerns were the lack of understanding of potential hazards and a need for training (again).⁶⁵

Another development arose in 1993, when CAM in nursing practice emerged as a political topic and the Labour Party became involved in the issues. Perhaps there were expectations that the impasse in regulation and training issues would change when the Labour Party declared its support for nurse training in complementary therapies. Shadow health minister Dawn Primarolo spearheaded the campaign and announced that the Labour Party had judged that nurses

could play an important part in providing alternative treatment in the NHS by training in areas such as aromatherapy, reflexology and counselling which ... would enhance any health centre or hospital ward. Nurses should be given training in complementary therapies so they can play an important part in providing alternative treatment on the NHS.⁶⁶

However, there is no evidence of further political action; Labour remained in opposition for a further four years and CAM training and tighter regulation for nurses continued only as talking points. But lack of information was a potential risk, as

⁶⁴ Sylvia Walby and June Greenwell, *Medicine and Nursing: professions in a changing health service*, (London: Sage, 1994), 52.

⁶⁵ *In Touch* (Forum newsletter), 1997.

⁶⁶ Interview with Dawn Primarolo, *Nursing Times*, 14 July 1993.

noted by academic Steven Ersser, who acknowledged that there were potential limits in how nurses could account for their actions if information on safety and effectiveness were inaccessible,⁶⁷ and this theme of a lack of knowledge of research was also addressed by nursing academic Bob Gates, who expressed his serious concerns.⁶⁸ Practitioners, providers and purchasers, he said, needed to agree a position regarding use of complementary therapies in healthcare, given the conflicting evidence and lack of knowledge of research.

It would appear prudent of this group to agree those therapies that are and those therapies that are not acceptable in nursing practice. Such an agreement should also identify which therapies may be practised by which profession. Lastly such a group must determine the minimum training requirements before a practitioner may engage in their use. Failure to agree such a covenant within all health districts will leave practitioner, provider and purchaser alike vulnerable to potential claims of malpractice.⁶⁹

In 1996, senior nursing sister Maxine McVey categorised the key areas that needed to be explored in order to tighten the principles of practice. They were identified as professional autonomy, accountability and responsibility, competency to practise, consent, consultation and collaboration, general management issues, documentation and insurance.⁷⁰ She outlined the steps that should be taken to set up a working party to establish policy and promote principles of practice and augment the UKCC Code of Conduct and set a strategy to establish links with the already-formed RCN Complementary Therapies Forum. Codes of practice and guidelines were being

⁶⁷ Steven Ersser, 'Complementary therapies and nursing research: issues and practicalities', *Complementary Therapies in Nursing and Midwifery*, 1 (1995) 44-50.

⁶⁸ Bob Gates, 'The use of complementary and alternative therapies in health care: a selective review of the literature and discussion of the implications for nurse practitioners and health-care managers', *Journal of Clinical Nursing*, 3 (1994) 43-47.

⁶⁹ *Ibid*, 46.

⁷⁰ *Complementary Therapies in Nursing and Midwifery* (1996) 41-46.

⁷⁰ Denise Rankin, *The Nurses Handbook on Complementary Therapy* (1995).

debated by all. In her book, (1995), Denise Rankin-Box, who was the Forum's first chair, describes how the guidelines were compiled as a result of the 'constant requests' for more information.⁷¹ These guidelines stressed the importance of accreditation and validation by an examining body, but clarified again that, in terms of practice, a nurse was expected to evaluate her/his own competency as a 'knowledgeable doer', in accordance with the UKCC and, in fact, a transition from self-regulation to more formal oversight never materialised for health professionals.⁷²

In Chapter Four, I discussed the issue of a shift in healthcare consciousness from the medical model to a holistic approach and how much this contributed to the emerging use of complementary and alternative medicine. The 1984 RCN conference which, I claim, signalled the beginning of the main period of CAM in nursing was entitled 'Holistic Nursing: Complementary Concepts and Theories'. It demonstrates how closely the concept of holism was linked to the practice of CAM, and further evidence of this is shown in the founding in 1984 of the British Association for Holistic Health, which encouraged nurses and other non-medical practitioners to network and increase their knowledge of holistic practice - and CAM therapies.

⁷² Nicola Gale and Jean McHale, eds, *Routledge Handbook of Complementary and Alternative Medicine: perspectives from social science and law* (Routledge, 2015) Conclusion.

6.4. Organisations, groups and networks

6.4.1 The British Association for Holistic Health (BAHH), 1984 – 1987

In November 1984, The *Nursing Times* announced that ‘health workers had united to form a holistic body’.⁷³ This body was the newly-created British Association of Holistic Health (BAHH) for therapists, nurses and physiotherapists – those health workers who had been denied membership of the British Holistic Medical Association (BHMA), founded the previous year for doctors.⁷⁴ Although not clear from its title, the purpose of the BAHH was not only to encourage holism, but holistic health practices – interpreted as CAM – and in its early publicity, the BAHH clearly set out its aims ‘to educate, to support, to create links and to give a voice to holistic health practitioners.’⁷⁵ I collected data for the history of the Association from archives in the Wellcome Library, from oral histories of founding members and from a private archive of early records, minutes and notes that had been personally filed by one of its first management committee members.⁷⁶

The founding BAHH working conference took place on 3 and 4 November 1984, and 12% of attendees were nurses,⁷⁷ although acupuncturist David Mayor, one of the convenors of the conference, recalled little of the nurse element in membership at this point:

⁷³ *Nursing Times*, 14 November 1984, 11.

⁷⁴ Wellcome Library, London, Special Collections, Papers of the BAHH, SA/BHH/A5 Box 1.

⁷⁵ Wellcome Collection Archives, Papers of the BAHH, BAHH promotional leaflet, SA/BHH/A4 Box 1.

⁷⁶ Roger Beeching.

⁷⁷ Wellcome Collection Archives, Papers of the BAHH. Of the 110 attendees, 14 were nurses. Others were CAM practitioners, physiotherapists and other health workers, SA/BHH/A5 Box 1.

Nurses might or might not have been part of that but they certainly weren't kind of at the forefront of the picture for me....⁷⁸

One nurse-tutor, however, who was instrumental in organising the early committee meetings of the Association, Inga Newbeck, described the practicalities (and frustrations) in doing so and reflects the support from colleagues and management:

Cynthia Gilling became Head of the School of Nursing [Royal Free Hospital] and she turned out to be a remarkable person - she actually allowed us to hold meetings after hours in the School of Nursing, which was really quite brave of her. ...It was not easy ... trying to get it going, holding meetings and talking to people and it was just hard work. Of course we were also fully employed!⁷⁹

Records confirm that the Central Committee continued to meet at the Royal Free Hospital throughout 1985.⁸⁰

The BAHH aimed to work in partnership with the BHMA, to share events and co-operate in exchanging 'thoughts and hopes,'⁸¹ and their powerful collaboration was recognised to have been important:

The BHMA/BAHH must not be just another voice adding to the splintering. Linking is important.⁸²

However, it would appear that the relationship was not always harmonious.

Acupuncturist and dentist Roger Beeching, one of its early management committee members, recalls:

We weren't working together. There was a sort of, 'Do we trust them?', 'Do they trust us?' attitude going on. Our particular group was much more broadminded and much less scientific and much less rigid, whereas the BHMA, although they were doctors, they were much more scientific...⁸³

⁷⁸ David Mayor, interviewed 25 October 2014.

⁷⁹ Inga Newbeck, interviewed 30 March 2015.

⁸⁰ Wellcome Collection Archives, BAHH papers, SA/BHH/A5.

⁸¹ Inga Newbeck, *Nursing Times*, 23 July 1986.

⁸² *Ibid.*

⁸³ Roger Beeching, interviewed 14 January 2015.

According to minutes of a BAHH meeting in March 1984, there was concern about a 'confusion of voices, and all this jockeying for power positions.'⁸⁴ Inga Newbeck is also quoted in meeting minutes with an honestly frustrated comment, suggesting occasional disharmony between the associations:

Inga stated that every meeting and conference we hold seems to degenerate into discussions and complaints about conflicts between the BHMA and the BAHH. She felt it was time that we got going and did something instead of talking all the time.⁸⁵

However, in her interview, she remembered more collaboration than tension:

There was a whole lot more sharing than might appear on paper and we had conferences together - and held each others' hands.⁸⁶

Patrick Pietroni, then chair of the BHMA, also recalls the relationship between the two organisations and the importance of the joint conferences:

Looking back on it, I feel it was a mistake really that there were two separate organisations, but we were linked together. We had very good conferences.⁸⁷

It seems that once the tensions were smoothed, the BAHH effectively reflected its aims in urging a holistic model – not just in theory, but in practice, as this item in the minutes summarises:

The climate of the 1980s challenges us to rediscover this truth [holism] in our person and working lives. And, indeed, there seems to be a certain urgency about pursuing this task in real and practical ways.⁸⁸

Roger Beeching recalled the position of the BAHH as 'a movement that was starting up, that was bringing [together] various bits and pieces that had been going on.' It interested me that he used the word 'movement', and I questioned whether others

⁸⁴ Private archive, BAHH minutes of '2nd meeting with Patrick Pietroni' 16 March 1984.

⁸⁵ Wellcome Archives, BAHH papers, meeting minutes of 11.4.86. SA/BHH/A5 Box 1.

⁸⁶ Inga Newbeck, interviewed 30 March 2015.

⁸⁷ Patrick Pietroni, interviewed 7 July 2015.

⁸⁸ Wellcome Archives, BAHH Papers, draft leaflet. SA/BHH/A5 Box 1.

saw it as such in this ‘heyday of innovation and exploration’ - which is how Steven Ersser described it.⁸⁹ I identify a movement having a sense of crusade, encompassing positive and potentially improving qualities. Public policy academic Marshall Ganz highlights that a movement involves ‘purposeful individuals’⁹⁰, and a powerful issue in this research is the sense of the territory of CAM being dominated by the same key individuals supporting and encouraging others in the formation of these links and groups, which, in some cases, competed and overlapped. Ersser explained: ‘There were more pioneers in the 80s and 90s. There are always pioneering people, but I think there was more of a movement in this time because [...] you can track the social movement of CAM in this country and its interest because it was on the ascendency at the time.’⁹¹ Annie Hallett described the personalities involved as ‘all very strong drivers’⁹² and, examining the directors of the organisations, the authors of works on CAM, the speakers at conferences, many of the same names reoccur. Patrick Pietroni spoke of high profile ‘heady days’ on ‘the circuit’, when he was trying to influence the medical profession with holistic approaches:

Satish Kumar, Jonathan Porritt and myself for a while we did a trio on the conference circuit. You could spend all your life going from conference to conference and being adulated by everybody. Because you were saying things that people wanted to hear. But I wasn't sure back home when you were actually trying to put it into practice.⁹³

⁸⁹ Steven Ersser, interviewed 14 July 2014.

⁹⁰ Marshall Ganz, *Supporting a Movement for Health and Health Equity: Lessons from Social Movements: Workshop Summary* (Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities). Board on Population Health and Public Health Practice; Institute of Medicine. Washington (DC): National Academies Press (US): 3 Dec 2014. Accessed 1 April 2016; Jan Willem Stutje, ‘Charismatic leadership and social movements: the revolutionary power of ordinary men and women’, *International Studies in Social History*, 19, 2012.

⁹¹ Steven Ersser, interviewed 14 July 2014.

⁹² Annie Hallett, interviewed 18 May 2015.

⁹³ Patrick Pietroni, interviewed 7 July 2015.

Stephen Wright also referred to the height of his involvement in the CAM scene:

I was on a roll, and got the eye of government, advising the Secretary of State, writing speeches for them, seconded to the Department, giving advisory work, swanning all around the world, doing conferences and writing books.⁹⁴

This added to a sense of a movement and several of my interviewees agreed with this term.⁹⁵ Ganz argues that another element of movement building is building relationships among people and building capacity by mobilising and organising people,⁹⁶ which were certainly components of the CAM in nursing activity, evidenced by the organisations and networks that were established. Caroline Stevensen also described this, although was honest about how the activity dissipated – or was absorbed:

I don't know whether there has been a cumulative, expanding movement.... whether it had a normal distribution, went up and came down again. But there were people who were following on. I am wondering whether we started to raise interest in the area where a lot of people were interested, and maybe some of that work has been quietly absorbed into different areas so we are not hearing so much about it.⁹⁷

Some interviewees referred to the reality that, when deeply involved in something, an individual is not able to be aware of its impact, as Caroline Stevensen and Inga Newbeck expressed:

It did certainly feel groundbreaking, that is certainly so. At the time ... when you are at the forefront of something,...you just do what you are doing. You maybe don't realise the impact of what is happening...it is just part of what interests you.⁹⁸

⁹⁴ Stephen Wright, interviewed 16 January 2014.

⁹⁵ e.g. Annie Hallett, Nicky Baker, Inga Newbeck,

⁹⁶ Marshall Ganz, *Supporting a Movement for Health and Health Equity: Lessons from Social Movements: Workshop Summary* (Roundtable on Population Health Improvement; Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities; Board on Population Health and Public Health Practice; Institute of Medicine.

Washington (DC): National Academies Press (US); 2014 Dec 3. Accessed 1 April 2016.

⁹⁷ Caroline Hoffman (*née* Stevensen), interviewed 10 June 2015.

⁹⁸ Caroline Hoffman (*née* Stevensen), interviewed 10 June 2015.

I think I was probably too involved to be able to make a comment on that. I mean it is very hard to see what is happening when you are in it.⁹⁹

However, others – even advocates – referred to what was happening as a fashion and the suggestion of a holistic and CAM-practising bandwagon is one that I also examined, asking interviewees what they thought of this suggestion. Fiona Mantle agreed that:

There were nurses who jumped on the bandwagon who knew very little ... and some who had no qualification whatsoever in complementary therapies but who pronounced what they thought and what they felt ought to happen and what nurses ought to do - without any background knowledge or understanding!¹⁰⁰

Ruth Sewell, founder and first chair of the Holistic Nurses Association, confirmed that it was sometimes viewed as an organisation that could offer a certain *cachet*, and she explained why:

Oh yes, we had people asking to join our committee - I won't name names - but they thought it was something to be seen to be doing... ..because it was a new movement, because they would be a big fish in a little pond.¹⁰¹

The new holistic wave was perceived by some to have an effect beyond healthcare, and this point had not missed the attention of *Telegraph* journalist John Morrish, in describing the apparent fashion of holism:

'Holism' kicked around the world of philosophy for decades before being rediscovered in medical schools in the 1960s. They used it for a therapeutic approach that attempts to treat the whole person, rather than just the disease which is why conscientious doctors sometimes remember to ask, 'Anything else?' before handing over your prescription. 'Alternative' and 'complementary' therapists borrowed the

⁹⁹ Inga Newbeck, interviewed 30 March 2015.

¹⁰⁰ Fiona Mantle, interviewed 3 April 2014.

¹⁰¹ Ruth Sewell, interviewed 26 January 2015.

expression, as did other experts claiming, however rashly, to know ‘the whole you’ and to see ‘the big picture’. These days, you can adopt ‘holistic management’, visit a ‘holistic priest’, and take ‘holistic financial advice’ or a ‘holistic massage’. You can even go ‘holistic shopping’, a discipline that requires you to ponder the fate of the earth’s resources even as you are loading them into your trolley. As Jerry Lee Lewis might have said, there’s a whole lot of holism going on.¹⁰²

The fashion of holism was pervasive, but Alison Ellis commented that integrating complementary medicine into nursing practice was a much more serious challenge than following fashion:

I wouldn’t have seen it as a bandwagon. I was at that time seeing it as fundamentally changing parts of nursing practice. I would have liked to have seen it really introduced into the training from the word go.¹⁰³

The literature considers the wider CAM activity as a health social movement (HSM)¹⁰⁴ and Nicola Gale terms it an ‘embedded form of activism’¹⁰⁵, arguing that there are links between use of CAM and participation in social movements. In my research it emerged that CAM in nursing was part of a wider awakening, as has been discussed in Chapter Four, and its use reflects a diversity of experience – for some nurses transformative, but for others, a passing phase, as recognised here by Steven Ersser. He acknowledges elements of faddism in observing how sometimes more extreme therapies had been considered, ‘You get a lot of people who jump on the bandwagon and think about more obscure things like crystals and things ...’¹⁰⁶ This introduces the question of exactly which therapies were involved in practices and the

¹⁰² John Morrish, *Frantic Semantics* (London: Macmillan, 1999). Jerry Lee Lewis was an American singer-songwriter, whose *There’s a whole lotta shakin’ goin’ on* was a hit in 1957.

¹⁰³ Alison Ellis, interviewed 12 May 2014.

¹⁰⁴ Melinda Goldner, ‘The dynamic interplay between Western medicine and complementary and alternative movement: how activists perceive a range of responses from physicians and hospitals’, *Sociology of Health & Illness*, 26 (2004) 710-736.

¹⁰⁵ Nicola Gale, ‘The sociology of traditional, complementary and alternative medicine’, *Sociology Compass*, 8 (2014) 805-822.

¹⁰⁶ Steven Ersser, interviewed 14 July 2014.

question of the taxonomy of CAM. Ruth Sewell implies that the hierarchy of therapies included undercurrents of what was acceptable in general perception, and what was not.

When they [practitioners] talk about auras, when they talk about chakras, when they talk about energy fields ...in those early days, they [the medical profession] would run for the hills and just see it as some...New Age stuff.¹⁰⁷

Evidently, the perception of a grading of therapies did not escape even those who were supposedly promoting them and a classification of therapies is referred to in the BAHH minutes of 16 March 1984, in which a hierarchy of therapies is mentioned (regrettably, without a note of how the issue was resolved):

Should we invite to the conference only practitioners of ‘major’ therapies, or of fringe therapies too?¹⁰⁸

While collecting the oral histories, I explored how this differentiation was justified and on what basis. Denise Rankin-Box – although not involved in that particular discussion – explained that it was the evidence, or lack of it, that made the distinction. For example, in her first book, *The Nurses’ Handbook of Complementary Therapies* (1995), she examined the evidence behind a variety of therapies ‘to see if it is *strong* evidence or the odd case study.’¹⁰⁹ She explained that in an earlier version of her book, aromatherapy was not included because it had lacked sufficient evidence, giving an example: ‘Three drops – well, how big is a “drop”?! And what is the concentration of a “drop”?!’¹¹⁰ These points demonstrate that, as much as they

¹⁰⁷ Ruth Sewell, interviewed 26 January 2015.

¹⁰⁸ Private archives.

¹⁰⁹ Denise Rankin-Box, interviewed 4 August 2015.

¹¹⁰ Denise Rankin-Box, interviewed 4 August 2015.

were urging for implementing CAM, advocates were showing discernment and caution too.

Roger Beeching had described the BAHH as part of a movement, but although the movement was apparently gathering momentum, the organisation ceased in 1987 for reasons that are not obvious. Members were encouraged to transfer to the BHMA and, by October that year, 57 members of the BAHH had done so.¹¹¹ The arrangement was not totally welcomed by BAHH members, some of whom, it was noted, 'disagree with the course... but the majority feel that the way forward for Holistic Health is in co-operation, not separation; in team-work not in individual power.'¹¹² This comment suggests a tension at this point among those wishing to form networks to further the practice of CAM and reflects a warning given by the Institute for Complementary Medicine in June 1987 whose director, healer Anthony Baird, warned that natural therapies could disappear in Britain within four years 'unless the profession forgets its differences and pulls together.'¹¹³ I questioned what these differences were and whether they were caused by rivalry, duplication of effort or a clash of ideologies and asked Denise Rankin-Box, the editor of *Complementary Therapies in Nursing and Midwifery* and first chairman of the RCN Complementary Therapies Forum for her view. She spoke generally about tensions among CAM groups in describing the wider 'political' tensions:

It's politics. Once you get organisations together, you start to get people vying for a pecking order. Everybody wants to be at the top. People say, 'Our organisation is better than yours' or 'Our way of perceiving this therapy is the more appropriate way. As with anything, you get

¹¹¹ Private archive, letter from Sarah Wade to Roger Beeching.

¹¹² Private archive, 8.9.87, Report by Pan Wade copied to Roger Beeching, 8 September 1987.

¹¹³ *Journal of Alternative and Complementary Medicine* 1987, 5.

different schools of thoughtAnd you start to get dissonance and factions occurring and it can be quite difficult and very time-consuming to get those people together because by definition, each thinks they're right. So you get this polarity occurring again. I think that is what he [Baird] was referring to – at that point there were different organisations emerging. They claim that theirs perhaps is the best way.¹¹⁴

Complementary medicine academic George Lewith has a similar view:

What I was seeing in complementary medicine was the emergence of the guru. There would be lots of gurus – there would be the guru who said 'Traditional Chinese medicine is best', and the guru who said 'Western approaches are better' and the guru who said 'My homeopathic approach is better' and there would be the guru who said 'Classical homeopathic approaches are best.'¹¹⁵

This was also illustrated by midwife and complementary practitioner Denise Tiran's example of the number of types of practice within a modality, offering reflexology as an example:

The problem is that reflexology is not just one thing; it is lots of different styles of therapies, you've got Chinese reflexology or reflex zone therapy or the Ingham method of reflexology - they are all slightly different, so even getting an opinion within an individual therapy profession is really difficult.¹¹⁶

These are examples of the tensions caused by competition and conflicting agendas referred to by Joanna Trevelyan, who believed these were impeding further development in CAM. The BAHH had a short life, but Roger Beeching was positive about its effect. In answer to my question about whether it had achieved what it set out to achieve, he confidently agreed, stating 'Yes, yes. Very much so! Yes. Very definitely.'¹¹⁷

¹¹⁴ Denise Rankin-Box, interviewed 4 August 2015.

¹¹⁵ George Lewith, interviewed 8 February 2016.

¹¹⁶ Denise Tiran, interviewed 18 June 2014.

¹¹⁷ Roger Beeching, interviewed 14 January 2015.

A more targeted focus for holistic nursing practice came six years later when the Holistic Nurses Association was founded, providing a core support for those nurses who wanted to embrace the holistic model, but not necessarily one involving CAM. This section introduces the nuance of the difference between them.

6.4.2 The Holistic Nurses Association, 1993-1997

Nurse Hermione Elliot, a founder member of the HNA, describes the exhilaration of the moment when she met Rita Benor (now Ruth Sewell) and she recounts the first stirrings of the Association in 1992:

Rita and I immediately, whoosh, got on like a house on fire...completely passionate about nursing, totally in despair about nursing with this very absolutely, clear sense of the holistic approach and how there was such a huge gap. And she was just thinking about setting up the HNA and I said, 'Well, I'm in!' And there were a couple of other people. We had an inaugural meeting very early on at the Marsden, where she was working...¹¹⁸

The first HNA newsletter was produced in October 1993 and states the aims of the Association as providing 'a forum in which to promote research and education amongst nurses wishing to practise holistically. To encourage and support nurses in their professional and personal development.' It included a letter of support from the BHMA's then chair, David Peters, and his assurance of 'our continuing interest in and support for the work of the HNA'.¹¹⁹ In fact, there had been a call for a holistic nursing association a decade earlier when, in July 1984, Annette Turton, writing in *Nursing Times*, issued a challenge: 'What about forming an Holistic Nursing Association to carry the idea [of holistic nursing] further?'

¹¹⁸ Hermione Elliott, interviewed 12 November 2014.

¹¹⁹ Private archives, letter to HNA newsletter, October 1993.

A year later, a comment by Inga Newbeck is noted in minutes of the BAHH that she thought such an association was about to be created,¹²⁰ but there is no evidence that a group was established at that point. So what were the motivations for the founding of the association? There was clearly a pull factor in wanting to harness the enthusiasm for holism in nurses – but there was also motivation for pushing *against* the biomedical model to create a change, as Hermione Elliott described:

It feels like a kind of juggernaut of technological revolution - or a particular model that has supremacy really - and that feels like a juggernaut. And then these, you know, oh, sweet little people popping up, saying 'Hang on a minute! You know, it doesn't have to be like this.'

We were just tapping in somewhat to the essence of nursing ... It felt really ... not revolutionary at all. It wasn't like revolutionary zeal, it was like 'this is something really important' and it felt exciting and it felt like a privilege to be a part of it and there was a lot of hopefulness that this might somehow create a change...¹²¹

Here, Elliot seems to be suggesting that there was an alternative community with an identity, which, while not necessarily being 'revolutionary', was anti-establishment.

Other evidence of describing the organisation as a sanctuary, outside the mainstream, supports this. For example, Ruth Sewell portrayed the HNA as a bolt-hole, 'a refuge for people who desperately wanted to practise holistically.' A nurse in Windsor, writing in the HNA newsletter, emotionally described her relief on discovering the Association: [it was] 'like finding water in the desert...I no longer feel alone in this strange medical model world of the NHS...'¹²² This illustrates the important element of marginalisation and its relationship to CAM, as already discussed.¹²³

¹²⁰ Wellcome Collection Archives, BAHH Papers, meeting minutes, 19 July 1985. SA/BHH/A5/1, Box 1.

¹²¹ Hermione Elliott, interviewed 12 November 2014.

¹²² Lesley Richards, letter to HNA journal, 15 October 1994.

¹²³ Chapter Six, Section 4.5.

The first challenge for the Association was to communicate the holistic model for which its members sought support. In March 1996, an article in the *Nursing Times* describing HNA's aim acknowledged a dilemma for nurses:

Their quest is for spiritual meaning as well as, both for their patients and themselves... [which] is hard to get over to others without falling into New Age jargon of which many are suspicious.¹²⁴

The quote raises the theme of healing. Both of the previous chapters have discussed the difference between physical healing and a wider, psychological sense of healing power, and the HNA often addressed this issue in their newsletter, summarised in a comment by Penny Brohn, founder of the Bristol Cancer Help Centre – ‘healing need not be synonymous with curing.’¹²⁵ The difference is well-defined:

Alternative therapies are often advertised as ‘healing’ and this word can be interpreted as referring to personal, subjective and psychological benefits [...]. By contrast, orthodox medicine is focused upon curing disease in which the disease and the cure tend to be defined as objectively and scientifically as possible.¹²⁶

This discussion is reminiscent of terms used in nineteenth-century hospital reports in using ‘cured’ or ‘relieved’, to assure the subscribers that their money was well spent.¹²⁷

¹²⁴ *Nursing Times*, 27 March 1996.

¹²⁵ Quoted in Ruth Benor, ‘Reaching into the Foundations of Society’, HNA newsletter, September 1994, 9.

¹²⁶ Bruce Charlton, in ‘Healing but not curing’ in Edzard Ernst, ed., *Healing, Hype or Harm* (Andrews UK Ltd, 2013).

¹²⁷ Ruth E. Taylor, ‘Death of neurasthenia and its psychological reincarnation: a study of neurasthenia at the National Hospital for the Relief and Cure of the Paralysed and Epileptic, Queen Square, London, 1870-1932’, *The British Journal of Psychiatry*, 179 (2001) 550-557.

More importantly for this research is the challenge of how holistic nursing corresponded to CAM. This has never been a straightforward issue, judging by the many articles on the subject. The first conference on Holistic Nursing had even been subtitled 'Complementary Concepts and Theories'.¹²⁸ A two-day conference organised by the *Nursing Times* in October 1995 featured a debate, entitled 'Are complementary therapies holistic?', between sociologist Mike Saks (for) and Patrick Pietroni (against). There is no record of the outcome, although two years later they both wrote articles in the *Complementary Therapies in Nursing and Midwifery* journal to clarify their perspectives. Mike Saks argued, for example, that osteopathy and chiropractic manipulation were closer to biomedical practices, rather than holistic ones. On the other hand, he said, a doctor who treats patients with 'integrity' and heightened communication skills is practicing holistically.¹²⁹ Patrick Pietroni supported this view, while describing his 'conceptual definition, which allows me to encompass reductionism and the scientific method within the concept of holism.' He stressed that holism was not confined only to CAM practice and contended: 'the alternative and complementary therapies have hijacked the word holism and misused and abused it so that it has lost its meaning.'¹³⁰ In his interview, he also expressed this clearly:

I thought there could be doctors and nurses practicing orthodox medicine who could be holistic... what I hoped we would achieve [in BHMA] was to bring whole person medicine back into medicine – body, mind, spirit, psycho-social approach – which was very much a part of the Royal College of Physicians approach but hadn't been given sufficient attention. My concept of holistic medicine wasn't about what

¹²⁸ Announcement of conference, *Nursing Times*, 4 April 1984.

¹²⁹ Mike Saks, 'Alternative therapies: are they holistic?', *Complementary Therapies in Nursing & Midwifery*, 3 (1997) 4-8.

¹³⁰ Patrick Pietroni, 'Is complementary medicine holistic?', *Complementary Therapies in Nursing and Midwifery*, 3 (1997) 9-11.

therapy you give – you can be a holistic brain surgeon as far as I was concerned!¹³¹

The HNA newsletters themselves do not easily clarify the issue. An article by nurse therapist Jane Buckle on ‘When is holism not complementary’ returns to the point that holism involves spiritual aspects as well as practical ones, and concludes that ‘we may be practising complementary therapies but without spirituality we are not practicing holism.’¹³² An article in the January 1995 newsletter seems to encourage the transferring of that spirituality to physical touch, encouraging the use of CAM in holistic nursing:

I know that many of our members have a keen interest in the complementary therapies....I see complementary therapies as an increasingly acceptable way of ‘getting in touch’ with the real person. Your hands and your body language, the atmosphere you create, is your communication....¹³³

However, another article, while acknowledging the ‘relationship between CAM and holism’, appears to contradict this, suggesting that CAM is just another ‘methodology of separateness’:

The shift towards complementary therapies appeared to be synonymous with holism...Complementary therapies have much to teach towards the holistic approach, but in themselves can be as isolating as conventional treatment. Unless we identify the limitations of either conventional or complementary approaches, we will still fall

¹³¹ Patrick Pietroni, interviewed 7 July 2015.

¹³² HNA newsletter, April 1994, p.6. Jane Buckle was Director of Research Co-ordination, Research Council for Complementary Medicine.

¹³³ R. Hays, ‘*Creating the Reality – holism and clinical practice*’, HNA newsletter Jan 1995, 7.

short of achieving holism and may just take on another methodology of relating which creates separateness.¹³⁴

This very much echoes the view of Stephen Wright describing CAM as another intervention, as discussed in Chapter Five.¹³⁵ Wright believed that complementary therapies were being used as alternative ways of applying a *treatment*. He believed that a deeper understanding of human consciousness was the most important feature, and that relationality qualities were as powerful as any therapy.¹³⁶ In 1986, Dr E. S. Farmer spoke of this when giving a paper at the HNA annual conference, which addressed the dangers of nurses turning to practice of CAM without an understanding of holism:

Nursing has been trapped in a scientific paradigm that denies wholeness in every sense. There is a great temptation for many nurses simply to add the therapies to the tools and techniques of nursing and to neglect the philosophy underpinning these therapies....¹³⁷

I asked Inga Newbeck (not a member of the association, but her view is relevant here) whether all practitioners of complementary therapies have holistic approaches. Her view was, 'No, absolutely not....that's not a given ...'¹³⁸

Later in the interview, I probed further,

I know that in 1986 you took part in a conference – possibly the one you talked about earlier – in Islington. And you talked about 'how holistic therapies can be used in nursing' – that was the title of your presentation.

I don't know how I would have said it... However, certainly what I might have said was that they can be intertwined as long as they are safe and appropriate. I am sorry if I said 'holistic therapy'. What I should have

¹³⁴ Hermione Elliott, HNA newsletter, January 1996.

¹³⁵ See Section 5.2.

¹³⁶ Stephen Wright, interviewed 16 January 2014.

¹³⁷ No reference given as to who s/he was, or his/her full name, other than being a speaker at Conference, November 1986.

¹³⁸ Inga Newbeck, interviewed 3 March 2015.

said is 'a variety of therapies' which make some sort of holistic care-plan. I think there is so much gobbledegook in terms of making sure that what you are saying is what you mean and not interchanging those terms, without giving good thought to what the audience might pick up. Because you have already asked me about whether one was necessarily the other and the answer is no. I think holism is a way of looking at the world, people, and that would include the best possible health.¹³⁹

At the end of its first year, the HNA confronted the issue of holism and CAM head-on and summarised their interdependent relationship in its annual report, stating that there was 'an increasing awareness of the benefits of complementary therapies as well as the growing understanding of interconnection between mind, body and soul and how this can affect health.'¹⁴⁰ But it continued to be a much-debated issue throughout the life of the Association. HNA members appear to have been calling for a return to an understanding of holistic approaches rather more than focusing on therapies – in other words, for the whole person to be treated, irrespective of the modality used.

Ruth Sewell confirmed this point in her interview and clarified the position of holistic nursing:

We weren't about complementary medicine – that was an important point. We didn't want to slide into that. It is too easy to assume that complementary medicine is holistic. It isn't necessarily. And we were petitioning for the whole person to be seen, irrespective of what modality was treating them.¹⁴¹

¹³⁹ *Ibid.*

¹⁴⁰ Hermione Elliott, Annual Report 1993-1994, HNA Newsletter, January 1995.

¹⁴¹ Ruth Sewell, interviewed 26 January 2015.

American psychologist Lawrence Le Shan summarised this in asserting: 'There is no such thing as a holistic technique or modality. There is only holistic *attitude*.¹⁴² [...] Holistic medicine is a set of concepts, not a precise set of techniques.'¹⁴³ Considering the issue of whether the holistic approach was controversial within mainstream nursing, I examined the HNA's relationship with the RCN by questioning interviewees on the topic. There was no clear conclusion, but the impression is that there was no significant interaction between the HNA and the College, as Ruth Sewell recalled, 'I don't remember any particular interest from them towards us...[HNA]'¹⁴⁴ Similarly, Inga Newbeck did not recollect any particular interest by the RCN in the BAHH.

In practical terms, the HNA grew quickly and extended the means of practical support to nurses and by April 1995, it was running workshops throughout the UK on 'Developing Holistic Nursing'.¹⁴⁵ In 1997, a board of patrons for the HNA was established who represented the key influential individuals of the time,¹⁴⁶ and it seemed that the Association was set for further growth. However, it did not endure.

Hermione Elliott explained that it just ran out of steam:

You have a few people who were willing to put in the effort, but then sustaining it further down the line, getting people involved, is not so easy. So I think in the end we kind of ran out of steam...¹⁴⁷

¹⁴² Author's italics.

¹⁴³ Lawrence LeShan, *Holistic Health: how to understand and use the revolution in medicine* (Harper Collins, 1984), 126 and 205.

¹⁴⁴ Ruth Sewell, interviewed 26 January 2015.

¹⁴⁵ HNA newsletter, July 1995.

¹⁴⁶ Patrick Pietroni, David Reilly, Penny Brohn, Claire Rayner, Robert Holden and Barbara Dossey. Stephen Wright and Jean Sayre-Adams joined as Directors.

¹⁴⁷ Hermione Elliott, interviewed 12 November 2014.

Nicky Baker confirmed that the lack of willing leaders led to its closure and members were encouraged to join the BHMA, which had opened its doors to non-medics by this time.

No one is sure now of the HNA's membership numbers, and it is hard to evaluate the impact of the organisation. Had it achieved what its founders set out to accomplish?

Ruth Sewell remarked on its potential, but at the same time, suggested that it could have done more:

It should have been much more of a shaker and a mover. It was a very exciting time! It had so much potential, so much hope and very talented people got involved in those early days, very committed people. ...¹⁴⁸

Nicky Baker reflected on their early expectations. She claimed, 'We thought we were going to open up a stream of awareness,'¹⁴⁹ and Hermione Elliott used the same word ('awareness') in claiming that it *had* successfully raised this in changing attitudes: 'It may be that the HNA didn't continue but I think it was definitely part of a shifting, changing awareness.'¹⁵⁰

Awareness to changing approaches to healthcare was developed further in 1994, when the RCN established a specialist forum for complementary therapies. This was a significant step in demonstrating approval and endorsement of CAM in nursing and it had an important practical impact too.

¹⁴⁸ Ruth Sewell, interviewed 26 January 2015.

¹⁴⁹ Nicky Baker, interviewed 26 January 2015.

¹⁵⁰ Hermione Elliott, interviewed 12 November 2014.

6.4.3 RCN Complementary Therapies in Nursing Forum, 1994 - 2007

The RCN had long provided forums, or special interest groups, within its structure, covering all nursing specialities and providing networks to focus on particular aspects of nursing. Examples are the Diabetes Nursing Forum, Defence Nursing Forum, Fertility Nursing Forum, Public Health Forum, Mental Health Forum, and the Older People Forum, the object of all of which was the sharing of knowledge and influencing nursing practice. The special interest group for complementary therapies within the RCN was established in June 1991 and its inaugural meeting had attracted 80 RCN members. The purpose was to focus on setting standards, promoting research and development and provide information on training.¹⁵¹ It quickly organised a national conference, 'Complementary Therapies: The Way Forward for Health-Care Professionals', five months later at Stockport College of Further and Higher Education, and Denise Rankin-Box spoke of its success: 'I remember we weren't sure if anybody would come to it and we were sold out within, I'd say, about three days!'¹⁵²

One of the driving forces for the group was Stephen Wright, who spoke of the effort in establishing it:

I used all my influence – I was an RCN Council member at the time – to make sure that this group got set up because there were nurses interested in it ...

¹⁵¹ Report in *Complementary Therapies in Nursing & Midwifery*, 1 (1995) 122-123, *Nursing Times*, July 1991.

¹⁵² Denise Rankin-Box, interviewed 4 August 2015.

It was granted Forum status in April 1994, which gave it formal entitlements to a definable budget, larger committee and voting rights at RCN Congress. Jean Sayre Adams recalled its early days, and I asked her about how the RCN viewed the proposal and how the forum's support gradually intensified:

There was resistance of course but within a couple of years it became the largest forum. Nurses spoke with their feet....¹⁵³

The forum flourished under the chairmanship of Denise Rankin-Box, with local groups gradually being formed throughout the UK. Its official aim was 'To support the safe and effective integration of appropriate complementary therapies into nursing care with the aim of enhancing care.' Steven Ersser described some of the issues that it addressed:

What is legitimate for nurses to use in clinical practice? And then, who should use them? And what level and expectation of training should they have? And a myriad of questions [...] and we weren't just promoting the issues, but trying to make a response – a professional approach – to it and acknowledging the regulatory, educational and research issues.¹⁵⁴

A year later, the forum was comprised of 1,100 members and the network spread nationally, with groups throughout England, Scotland and Wales.

Denise Rankin-Box spoke of its aim to make nurses:

aware of the different therapies and how they could possibly integrate those into nursing practice... to enhance [a] sense of transparency and put it on a legitimate footing and meet with the RCN Council and talk to them about it and how guidelines could be amended for nursing so they could incorporate certain therapies.¹⁵⁵

¹⁵³ Jean Sayre-Adams, interviewed 15 January 2014.

¹⁵⁴ Steven Ersser, interviewed 14 July 2014.

¹⁵⁵ Denise Rankin-Box, interviewed 4 August 2015.

Their statement of beliefs was formulated and issued, which effectively formed a code of practice, enhancing the regulatory UKCC code (1992).

Figure 6 RCN Complementary Therapies Forum, Statement of Beliefs (1994)

1.	We believe that nurses using complementary therapies as part of their care should know and understand their responsibilities to the patient/clinic and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. Further we believe that the UKCC code sets the professional requirement to be met by all registered nurses using complementary therapies.
2.	We believe that all patients and clients have the right to be offered and to receive complementary therapies either exclusively or as part of orthodox nursing practice.
3.	We believe that all patients have the right to expect that their religious, cultural and spiritual beliefs will be observed by nurses practising complementary therapies.
4.	We believe that all complementary therapies available to patients must have the support of the collaborative care team.
5.	We believe that a registered nurse who is appropriately qualified to carry out a complementary therapy must agree and work to locally agreed protocols for practice and standards of care.
6.	We believe that the patient/client, in partnership with the nurse using complementary therapies should determine the suitability of any proposed complimentary [sic] therapy. Informed consent will be obtained and records kept with the patients/clients care record.
7.	We believe that where possible research based complementary therapy practices should be used. Where this is not possible then, as an accountable professional, the nurse using a complementary therapy must be able to justify their actions.
8.	We believe that nurses using complementary therapies should seek to develop their self awareness and interpersonal skills and also enhance their role as reflective practitioners.
9.	We believe that nurses using complementary therapies should when appropriate, be prepared to instruct significant individuals in the patients/clients life (including the patient/client) so that they can learn basic complementary therapy skills for self care.
10.	We believe that nurses using complementary therapies have a responsibility to evaluate the outcomes of therapy on the patient/client. These should include measurement of treatment outcome whenever possible. This outcome evaluation should be documented in the clients/patients care plan.
11.	We believe that the practice of complementary therapies by nurses should be the subject of at least an annual review through clinical audit. This audit should take into account patient measures of satisfaction, benefit and clinical effectiveness.
<p><i>This statement of beliefs will be revised as necessary and on the advice and suggestion of members and other interested parties following discussion by the Forum.</i></p> <p><i>Revised: October 1994 – esigrps/statofbe195</i></p>	

Source: RCN Archives Edinburgh, 3/38/1, RCN Complementary Therapies Forum papers

As a result of requests by nurses for information about training in CAM, a training guide was also produced by the forum, with details of courses at five levels: certificate, diploma, degree, masters degree and doctorate. The same document gave reassurance that the UKCC Code of Practice (1992) covered the issue of competence, and that the RCN would provide professional indemnity insurance for

nurses practising a particular therapy.¹⁵⁶ Insurance was an issue that was reviewed regularly. (The minutes of the forum steering group meeting held on 12 December 1995 record that discussion took place on this issue when 'Howard Richmond, Assistant Director of the RCN Legal Department joined the meeting to discuss the legal viewpoint on complementary therapies in relation to insurance').¹⁵⁷

While debates had simmered in the HNA about the concepts of holism *without* CAM and holism *with* CAM, the forum was a group whose clear purpose was to support nurses wanting to use complementary therapies as an intervention, as HNA's Hermione Elliott pointed out when explaining the difference between the two organisations:

The Holistic Nurses Association wasn't about people who do complementary therapies ... We could see that with the RCN Complementary Therapies Forum it was almost as though there was a kind of replication of the model that in nursing we 'do' things to people to help them to get better.¹⁵⁸

In its first year, the forum declared that it aimed to liaise with both internal and external groups in order to collaborate. The annual report for 1994-1995 stated that close links with external organisations such as UKCC, BMA, parliamentary bodies, national complementary therapy associations, and the Institute of Advanced Nursing were being developed and:

The group are pleased to report widespread support for the development of complementary therapies in nursing through the RCN.¹⁵⁹

¹⁵⁶ *A guide to the levels of training available in complementary therapy courses which nurses may wish to undertake* (1996), Complementary Therapies Form, RCN. At Appendix J.

¹⁵⁷ Minutes, RCN Archives, 3/38/1.

¹⁵⁸ Hermione Elliott, interviewed 12 November 2014.

¹⁵⁹ RCN Archives, RCN Forum for Complementary Therapy Annual Report, 1994-1995, 3/38/1.

This is supported by Peter Mackereth's remark about the sense of RCN backing for the forum once it was thriving:

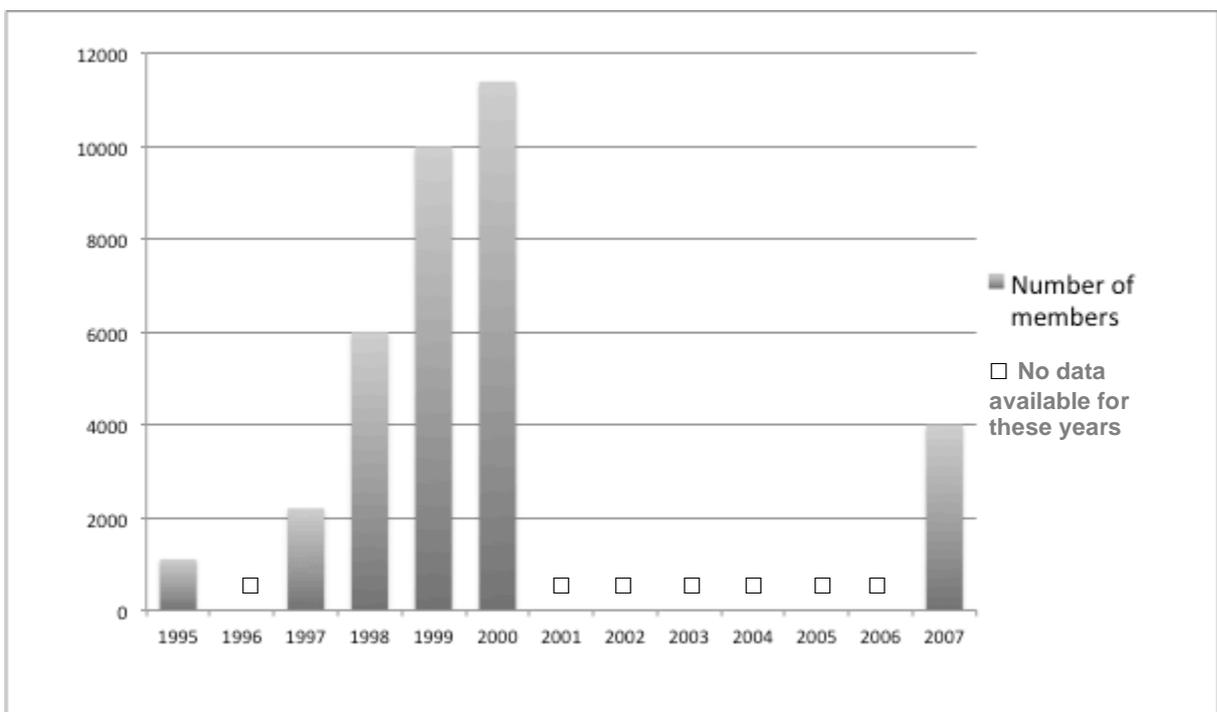
I really felt that there [were] ... a lot of people in the RCN who were very supportive and ... the interest group really flourished...¹⁶⁰

Denise Rankin-Box expressed her surprise at this early success and in speaking about the first forum conference, she recalled her delight that it was so well attended:

It was absolutely amazing that the interest was there but not only that, but people were sufficiently motivated to want to come to a conference to hear more about it and to network.¹⁶¹

Membership of the forum grew rapidly. By the end of its first year, there were 1,336 members, and it became the seventh largest RCN forum (of 41).¹⁶² Between 1997 and 1999, the Forum increased its membership by 4,000 nurses each year,¹⁶³ which was hailed as a 'dramatic rise,'¹⁶⁴ and by 2000, there were 11,424 members. No records exist to compare this figure with other forums in that year, but examination of a confidential record of all membership statistics from five years earlier indicates that it was likely to have had, as Jean Sayre-Adams claimed in her interview, the largest membership.¹⁶⁵

Figure 7 RCN Complementary Therapies Forum Membership 1995-2007 (no data for 1996 or 2001-2006)



For nurse Alison Ellis, membership was a positive encouragement in integrating therapies and she described the important impact of the forum for her:

I was a member of the forum for complementary therapies and I went to more than one of their conferences and met up with some of the women who were really pushing forward and making strides... The most interesting thing about it was that there you were at last with perhaps a group of 80, mainly women, who thought the same...who were having the same problems. And who were trying to move some complementary therapies that nurses could easily incorporate into their practice, into the mainstream.¹⁶⁶

As support continued to grow for CAM and for membership of the forum, their conferences continued to be well supported. In May 1998, a conference, entitled 'A Complementary Approach to Evidence Based Nursing Practice', was held in York, and was recorded as being 'oversubscribed and well evaluated'.¹⁶⁷ A revealing comment about members' enthusiastic support in that year's annual report speaks of their 'willingness to take an active part in professional issues'.¹⁶⁸ That year, as part of its support for members, the forum produced guidelines for the development of proposals for the integration of complementary therapies into clinical nursing practice. By then, the forum chairman was massage therapist Angela Avis, who was also working closely with the Prince of Wales' Foundation for Integrated Health, together with Denise Rankin-Box, Steven Ersser and Caroline Stevensen.

Angela's considerable contribution to promoting CAM in nursing was recognised in 2000, when she was awarded an MBE for services to complementary therapies in nursing. On receiving this accolade, she summarised the path that CAM in nursing

¹⁶⁶ Alison Ellis, interviewed 12 May 2014.

¹⁶⁷ RCN Archives, RCN Forum records, 3/38/1.

¹⁶⁸ *Ibid.*

had taken. It is relevant to quote her statement in full, for it demonstrates the impact of not only her work, but of all those who had been involved in this dynamic period:

I am delighted to receive this award. I see it as validation of the work that has been done by nurses all over the country who have shown determination and imagination in exploring ways to enhance patient care. This is a significant event in the process of integrating complementary therapies into mainstream health care and recognition that nursing practice is dynamic and has the potential to shape health care trends. It follows the positive stance taken in the House of Lords' report on complementary and alternative medicine on the issue of complementary therapies by nurses, which was endorsed on the Government's response. However, it is not a signal or a stamp to use therapies. One of the reasons there has been successful integration is the systematic and necessarily slow process that has identified the therapeutic outcomes nurses want to achieve and set these within the boundaries of nursing practice. However, developments are not exclusive to nursing and close collaboration across the professional health care spectrum can only serve to promote therapies that will enhance patient choice and care.¹⁶⁹

Angela's statement authenticates CAM in nursing very powerfully and describes the key proponents they had been striving for, even suggesting that her MBE, as an event, was integral to the process of integration itself. Taking a critical stance, it is also evidence of the royal patronage of CAM, which will be addressed more fully later in the chapter. Was CAM being manipulated away from its position as the outsider/alternative/fringe element in healthcare, to be integrated into the mainstream by coercion from the establishment ('The Royal push'¹⁷⁰)?

The founding of these organisations and groups gives a sense of a gathering momentum for CAM in nursing in the last decade of the twentieth century. How this was fuelled and inspired by the increase in articles in nursing journals provides

¹⁶⁹ RCN Archives Edinburgh, Complementary Therapies Forum papers, 15/15/COM.

¹⁷⁰ Collette Clifford, private communication.

another area for examination. In 1992, Joanna Trevelyan (*Nursing Times* deputy editor) and Brian Booth (*Nursing Times* clinical editor) noted:

It is a rare week in which *The Nursing Times* does not receive at least one paper on aromatherapy, massage, therapeutic touch, reflexology...all submitted by nurses seeking publication. There is no doubt that these 'alternative' therapies are being afforded serious consideration by growing numbers of nurses, at all levels of the profession.¹⁷¹

More than this, the launch of a specialist journal, *Complementary Therapies in Nursing and Midwifery*, in 1995 took CAM in nursing practice to a new level. Its deputy editor, Caroline Stevensen, describes the effectiveness of combined power in this new journal and the RCN Forum as 'a really solid platform for this work.'¹⁷²

6.5 Nursing Journals

6.5.1 *Complementary Therapies in Nursing and Midwifery*, 1995 - current¹⁷³

New medical specialisms and health social movements have tended to create their own communities – marked by particular developments, such as the first academic chair and first journal.¹⁷⁴ The introduction of *Complementary Therapies in Nursing and Midwifery* in 1995 had been heralded by the special interest group, then the RCN Complementary Therapies Forum, and there was involvement by several of the same individuals, including Denise Rankin-Box, Peter Mackereth, Caroline Stevensen,

¹⁷¹ Brian Booth, 'Fringe Benefits', *Nursing Times*, 89 (28 April 1992).

¹⁷² Caroline Hoffman (*née* Stevensen), interviewed 10 June 2015.

¹⁷³ The title changed to *Complementary Therapies in Clinical Practice* in February 2005.

¹⁷⁴ For example, *Palliative Medicine* (1987), first University Chair in Palliative Medicine in Europe (1991), *European Journal of Palliative Care* (1994), RCN Palliative Care Forum (1995).

Stephen Wright and Jean Sayre-Adams. It was the first international, refereed journal published to meet the specific needs of the nursing profession in the integration of complementary therapies into practice, cementing the structure of support for CAM in nursing, and describing itself as ‘The new professional journal that enables you to explore, understand and employ complementary therapies in order to enhance patient care.’¹⁷⁵ The previous year, *Complementary Therapies in Medicine* had been launched, with George Lewith as editor. This had originally been aimed at:

those whose background is in traditional health practices and who are seeking objective and critical guidance and information about complementary therapies, eg GPs, nurses and allied health professionals....

But, clearly, it was not focused enough for nurses, and *Complementary Therapies in Nursing and Midwifery* (now *Complementary Therapies in Clinical Practice*) was launched as the only journal specifically designed for nurses and midwives. It has flourished since its first issue in February 1995, with Denise Rankin-Box as its first (and only) editor and Caroline Stevensen and Peter Mackereth as deputy editors. In her first editorial, Rankin-Box acknowledged that the introduction of this specialist journal ‘recognised an unprecedented shift in the formal recognition of the use of complementary therapy in the nursing profession,’¹⁷⁶ and is further evidence of what Mackereth describes as a ‘very, very exciting time.’¹⁷⁷

¹⁷⁵ Churchill Livingstone’s marketing leaflet, 1995.

¹⁷⁶ Denise Rankin-Box, Editor’s letter, *Complementary Therapies in Nursing and Midwifery*,

¹⁷⁷ Peter Mackereth, interviewed 30 January 2014.

The journal's content has been varied: from research reports, policy discussions, international input, and clinical discussions. The first issue of the journal featured two significant articles, one by Stephen Wright on 'bringing the heart back into nursing'¹⁷⁸ and one by Bridgit Dimond on 'CAM and legal issues for nurses.'¹⁷⁹ These topics focus on two important current concerns – one philosophical and one practical – about CAM in nursing, but, as Denise Rankin-Box describes, the regulatory and legal issues were the priorities at that stage:

With anything you start to develop or initiate, you very quickly get involved in the medico-legal side of things if you want it to go as smoothly as possible. [...] One of the first articles I wrote in the journal was about European directives and European regulations about what you can and can't do.¹⁸⁰

The fact that this journal was founded (and has continued to flourish) bears evidence to nurses' and midwives' use of complementary therapies in their everyday practice,¹⁸¹ and fourteen years later, its editor reflected on what had been achieved:

Nurses are using so many therapies at the moment, and [...] we just have to remember how far we have come ...¹⁸²

6.5.2 Other Nursing Journals

Until the point of the birth of *Complementary Therapies in Nursing and Midwifery*, general nursing journals had increasingly reflected the expansion of interest in CAM

¹⁷⁸ Stephen Wright, 'Bringing the heart back into nursing', *Complementary Therapies in Nursing and Midwifery*, 1 (1995) 15-20.

¹⁷⁹ *Ibid.*, 21-23.

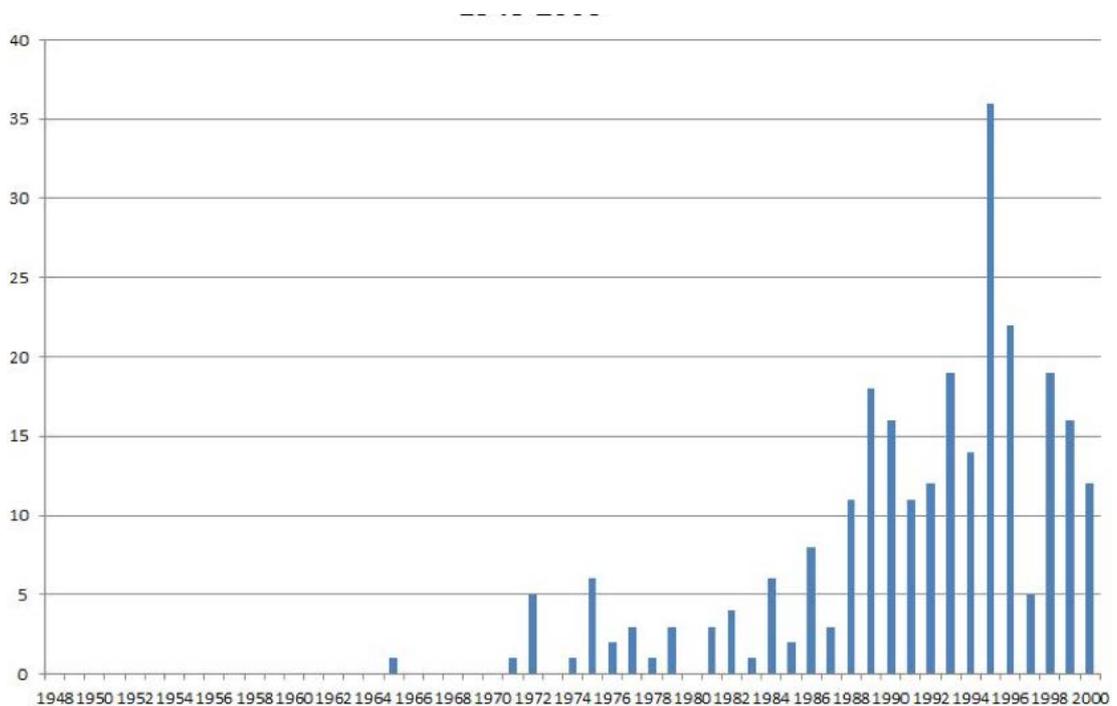
¹⁸⁰ Denise Rankin-Box, interviewed 4 August 2015.

¹⁸¹ Kevin Kendrick, 'Challenging Power, autonomy and politics in complementary therapies: a contentious view', 1999, *Complementary Therapies in Nursing & Midwifery*.

¹⁸² Denise Rankin-Box, *Nursing Times*, 6 May 1998.

by nurses,¹⁸³ although Jon Adams and Philip Tovey rightly draw attention to the fact that this does not necessarily reflect consensus.¹⁸⁴ Their work to show the limitations of the significance of the perception that ‘there is a general, deeply engrained affinity between nursing and CAM practice’ is based on analysis of four nursing journals published in the years 1995-2000,¹⁸⁵ identifying 278 papers (which did not include any on the subject of specific therapies). I based my own analysis on a search of references to complementary therapies in *Nursing Times* in a wider range of years, 1960-2000 and a total of 2132 issues were examined, 884 by hand in hard copy. Figure 8 illustrates the increase in interest towards the end of the decade (I am not aware of any explanation for the peak in 1995, or the trough in 1997).

Figure 8 *Nursing Times*: CAM articles, 1948-2000



¹⁸³ See Figure 9.

¹⁸⁴ Jon Adams and Philip Tovey, ‘The authentication of CAM in Nursing’ in *CAM in Nursing & Midwifery: towards a critical social science* (London: Routledge, 2008).

¹⁸⁵ *Complementary Therapies in Nursing and Midwifery, Journal of Advanced Nursing, Nursing Standard and Nursing Times.*

The resulting examination of articles on the subject of the therapies themselves was the least significant – although very necessary – element of my methodology. What was far more revealing was the discovery of nurses requesting support, the promotion of available literature, surveys, advertisements for holistic and/or CAM conferences and events, book reviews – even cartoons¹⁸⁶ – which reflect the mood of a new approach in healthcare. These items represented a small percentage of the topics covered in the journals, but demonstrate a growing theme that was interwoven among other articles on clinical topics, political issues and international nursing practices.

This is summarised by Jane Salvage's 1997 enthusiastic new year *Nursing Times* editorial, which supports the sense of a movement in CAM for nurses:

From aromatherapy to massage, these ancient healing arts put nurses back in touch with values and experiences that are in danger of being destroyed by rapid patient throughputs, cash limits and deskilling.¹⁸⁷

But towards the end of the period of the study, another powerful influence played a part in nurses' involvement in CAM – that of The Prince of Wales.

In the history of medicine, royal and aristocratic patronage has been a feature of innovations such as water therapies and spas¹⁸⁸, electrical therapies¹⁸⁹, anaesthesia¹⁹⁰ and, most significantly, homeopathy.¹⁹¹ Royal attention has tended to

¹⁸⁶ See Appendix E.

¹⁸⁷ Jane Salvage, *Nursing Times*, 29 Jan 1997.

¹⁸⁸ Phyllis May Hembry, Leonard W. Cowie and Evelyn Elizabeth Cowie, *British Spas from 1815 to the Present: A Social History* (London: Athlone, 1997), 148.

¹⁸⁹ Lydia Syson, *Doctor of Love, James Graham and his celestial bed* (Alma Books, 2008).

¹⁹⁰ H. Connor, 'Did the use of chloroform by Queen Victoria influence its acceptance in obstetric practice?', *Anaesthesia*, 51 (1996) 955-957.

give public and professional confidence in these medical innovations, or in some cases, just making them more fashionable. The founding of the Prince of Wales' Foundation for Integrated Medicine has not yet been judged by time as to whether it falls in the first or second category.

6.6 Royal patronage and The Prince of Wales' Foundation for Integrated Health (later 'Medicine'), 1993 – 2010.

However controversial the involvement of the Prince of Wales has been in the story of CAM in the twentieth century, by having raised issues, he has opened up debate about its implementation in healthcare. The catalyst for this occurred very publicly in December 1982, when the Prince, who had been invited to be President of the British Medical Association for its 150th-anniversary year, was the speaker at their anniversary dinner. He provocatively spoke of his concern about patients' dependency on prescribed drugs and asked that the medical profession re-examine its values and end their 'hostility to the unorthodox' and accept the possibility of alternative approaches to 'statistical, computerised healing'. The Prince then suggested that 'the whole imposing edifice of modern medicine, for all its breathtaking successes is, like the celebrated tower of Pisa, slightly off balance,' and he introduced a reference to the failure in orthodox healing by adding:

Modern medicine perhaps loses sight of the patient as a whole human being, and by reducing health to mechanical functioning it is no longer able to deal with the phenomenon of healing.¹⁹²

¹⁹¹ Roberta Bivins, *Alternative Medicine? A History* (Oxford: OUP, 2007).

¹⁹² Prince of Wales' speech to BMA, December 1982, Jacqueline Foukas and Sally Watson, *The History of the BMA Volume III, 1982-2012* (BMA, 2013), Introduction.

Unsurprisingly, his comments shocked the medical establishment. However, the BMA responded by setting up a working party to assess the value of the unconventional therapies and clarify the BMA's policy. Its remit was 'To consider the feasibility and possible methods of assessing the value of alternative therapies, whether used alone or to complement other treatments.' Surprisingly, the working party contained no person familiar with the subject and no general practitioner.¹⁹³ More than 600 written submissions were received on more than 60 different therapies and the committee also heard oral evidence. Four years later ('the resulting working party took longer than most to reach its somewhat obfuscatory conclusions.'¹⁹⁴), their report was published – which rejected CAM as 'a passing fashion'.¹⁹⁵ Reaction from the CAM community to this dismissive report was understandably strong. Penny Brohn, founder of the Bristol Cancer Help Centre, retorted, 'Not worth the paper it's written on,'¹⁹⁶ and the British Holistic Medical Association in its press release exclaimed:

The report is inaccurate, incomplete and indicates a misunderstanding of the clinical practice of medicine, let alone the value or otherwise of the complementary therapies.

Annette Turton writing in *The Nursing Times*, cynically suggested that the BMA had reached its conclusions before even starting work on the report.¹⁹⁷ The ideological rift was not only widened at this point, but positions were increasingly polarised.

Meanwhile, the Prince's BMA speech challenging medical orthodoxy had also

¹⁹³ Patrick Pietroni, *Innovation in Complementary Care and Primary Health* (Churchill Livingstone, 1996), 109.

¹⁹⁴ *Ibid.*

¹⁹⁵ *Alternative therapy*, report of the Board of Science and Education (British Medical Association, 1986), 90.

¹⁹⁶ Quoted in 'Is there no alternative?', *Nursing Times*, 3 December 1986.

¹⁹⁷ Annette Turton (writing as Pat Turton), *Nursing Times*, 9 July 1986.

encouraged wide support and interest too. Meeting minutes from the BAHH noted that:

PC has been flooded with requests since his BMA speech, and has got a group together with representatives of doctors, acupuncturists, homeopaths, osteopaths... Royal Society of Medicine (RSM) sees itself as 'honest broker' and is setting up a seminar (attended by PC) on traditional/alternative meetings. 'P' is concerned that, like the College of Health, the emphasis will be divisive rather than on holism.¹⁹⁸

The Prince of Wales had long been an advocate of complementary approaches and had been supportive of the work of the BHMA and BAHH in the 1980s.

Roger Beeching spoke in detail of a visit made by him to a joint meeting of the organisations in February 1985:

It was very informal, it was like meeting somebody who was a like-spirit and you could talk to him very easily and very openly about what you were doing. And he understood and appeared to agree.¹⁹⁹

Roger described how important the visit had felt at the time and how he believed that this support from 'the establishment' had enormously boosted the progress of complementary medicine, which was further supported by a recommendation in 1988 by the Royal Society of Medicine who proposed 'bridge-building' between orthodox and alternative medicine.²⁰⁰

In developing his concern to try to bring about medical integration, The Prince of Wales established the Foundation for Integrated Medicine (FIM) in 1993. In general terms, the Foundation 'informed the public and gave a broad-minded attitude to

¹⁹⁸ Private archive, BAHH minutes, 16 March 1984.

¹⁹⁹ Roger Beeching, interviewed 14 January 2014.

²⁰⁰ Roy Porter, *The Greatest Benefit to Mankind* (London: Harper Collins, 1999), 690.

CAM²⁰¹ and its specific purpose was to encourage 'close working together of orthodox and complementary medical practitioners, with mutual respect and understanding, to widen the choice of integrated treatments available and make preventive health care the norm.'²⁰² The Foundation sought collaboration with nurses and established working groups to discuss the current positions of conventional and complementary medicine in the UK, for which members were drawn from a wide range of backgrounds.

Nursing academic Steven Ersser described his involvement:

This was a very important development because it brought together the leaders from across the country into various working groups. I think my working group was on the delivery and implementation, looking at models of effective integration of care. We use the word 'integrated care' today in the current health service language to mean the integration much more of primary and secondary care, community and hospital care. But at the time we were using it as really looking at integration of complementary therapies within the NHS to broaden the access, to improve access to complementary therapies but in a way in which fitted with regulations, high standards, safety, effective education, research.²⁰³

He explained that although nurses were being caught up in the CAM trend, training was fragmented, and the strength of the Foundation lay in attempting to regularise the system:

... there were sometimes nurses practising using oils and things where they might not be so conscientious or have awareness of regulation or awareness of the need for preparation. ... [but] out of The Prince of Wales' working group, I felt it brought together a lot of similar voices ... people who were wanting to give this area a chance but at the same

²⁰¹ Michael Dixon, medical director FIM, conversation 18 November 2014.

²⁰² Wellcome Collection Archives, Foundation of Integrated Medicine booklet, WB900 1997F771.

²⁰³ Steven Ersser, interviewed 14 July 2014.

time were quite rational about it... You know, it wasn't like 'anything goes.'²⁰⁴

Denise Rankin-Box, also involved in the Foundation, was very positive about its ability to establish co-operation and homogenise practices in nursing:

It brought people together, helped to identify differences and resolve certain differences that certain organisations might have. It helped standardise certain practices and put forward central tenets that should be basic standards for the type of care that an organisation should adhere to, or individuals should adhere to. So it wasn't being prescriptive, but it was setting up a set of principles – guiding principles – for what should be seen as good care, good integrated care within health. So from that point of view, I think it did an awful lot of good.²⁰⁵

A draft report of their findings was circulated to 125 interested organisations and individuals and, in October 1997, the Foundation published *Integrated health care: a way forward for the next five years*,²⁰⁶ concluding that there was still too little quality research on safety, efficacy and effectiveness and that training and regulation were found to be of varied quality.²⁰⁷ Importantly, it called for better training of nurses in

CAM:

Nurses may have training in particular complementary therapies which they use alongside their mainstream qualifications, but there appears to be insufficient information on the level of training received and the competence achieved.²⁰⁸

The report assured continuing dialogues and the enabling of new developments with practical and financial help. In its editorial of 29 October 1997, the *Nursing Times* responded favourably to 'the interesting and provocative report ...which deserves a

²⁰⁴ *Ibid.*

²⁰⁵ Denise Rankin-Box, interviewed 4 August 2015.

²⁰⁶ FIM (1997).

²⁰⁷ *Nursing Times*, 6 May 1998.

²⁰⁸ *Integrated Healthcare: a way forward for the next five years* (1997).

Proceedings of a conference sponsored by the Foundation for Integrated Medicine and held at the QEII Conference Centre on 28 May 1998, Royal Society of Medicine Press.

wide airing', and applauded the Foundation's work in highlighting dissatisfaction with orthodox medicine:

Many nurses, midwives and health visitors share that dissatisfaction. The way they are forced to work today usually deprives them of warm and caring relationships. More and more nurses deplore the fact that they have to leave their heart and soul outside the door of the hospital or clinic as it is not welcome inside. Practising therapies such as aromatherapy, reflexology, or massage restores that caring relationship.²⁰⁹

Pat Turton also highly rated the influence of the Foundation on her nursing education work at the Bristol Cancer Help Centre:

It was fantastic support at the time. Because they were producing resources and providing funding for conferences sometimes and, yes, they were helpful to us and I was helpful to them. I did quite a lot of work with them at the time... because we were always looking at ways of getting safe integration... It was about how to get a holistic model into the NHS, but how to do that safely.²¹⁰

This endorsement of the work of the FIM from nurses was important: it provided welcome encouragement for those in the nursing profession wanting to integrate CAM, and several other nurses I interviewed spoke enthusiastically about the practical, as well as moral, support they had received from the Prince and from the Foundation.²¹¹ By now, the BMA's second report had been published. Following the 1986 report, *Alternative Medicine*, and the division that it created, the Board of Science had set up a working party in 1990 to consider CAM developments. Major therapies were represented and members' views were sought on training, qualifications, practice, organisation and research. The report was published in

²⁰⁹ *Nursing Times*, 29 October 1997.

²¹⁰ Pat Turton, interviewed 9 June 2014.

²¹¹ Peter Mackereth and Denise Tiran, in addition to those quoted above.

June 1993,²¹² and reaction from nurses was far more favourable than to the first. Many CAM organisations supported its findings,²¹³ and even the report title indicated its more conciliatory perspective: *Complementary Medicine: new approaches to good practice*. Further BMA involvement in CAM came with their participation in the review undertaken by the House of Lords in 2000 in submitting oral and written evidence, along with involvement by nurses. I regard this review and report as a critical step in authenticating CAM in nursing, standing as the apogee in this study, as well as the final significant event in the period under research.

6.7. The Legislature: *The Sixth Report on Complementary and Alternative Medicine*, House of Lords Select Committee of Science and Technology, 2000.

The Royal College of Nursing was approached in July 1999 with a request for written evidence on the use of complementary therapies in medicine for the review being undertaken by the Science and Technology Committee of the House of Lords in preparation for its review and report on CAM. A general increasing use of CAM had raised concerns about the level of regulation to protect public safety and prompted the review.²¹⁴ In response to this, Steven Ersser, Angela Avis, Pat Owen and Celia Manson gave evidence to the Select Committee on 21 February 2000. (A summary of their evidence is in Appendix I). Ersser described how he had explained the limited

²¹² *Complementary Medicine: new approaches to good practice* (Oxford: Oxford University Press, 1993).

²¹³ Jacqueline Foukas and Sally Watson, *History of the BMA*, Vol III, 1982-2012 (British Medical Association, 2014), 268.

²¹⁴ Chris Brooker and Anne Waugh, *Foundations of Nursing Practice: fundamentals of holistic care*, (Elsevier, 2013), 233.

scale of a nurse's use of CAM and clarified how the UKCC code of conduct already regulated that use:

I said of course I did believe that it needed to be regulated and I also felt that nurses and their code of conduct permitted them to go through a process by which they could account for what they are doing. ... But we needed to keep this thing in perspective on the scale on which nurses were using it really... the principles by which our regulatory body, the NMC,²¹⁵ were operating - even the way we were trying to run the Forum - to enhance this level of regulation, or at least the training and preparation of nurses in this area. It wasn't 'do your own thing', it wasn't an anarchic, laissez-faire approach, it was quite a conscientious one ...²¹⁶

The Select Committee was chaired by Lord Walton of Detchant and Lord Baldwin of Bewdley, who served on the committee and commented on the success of the report:

That report, and other work we did in the 90s, helped therapies to come to fruition and get sorted out...The nurses came along and were involved in it and it was a good exercise, a thoroughly good one.²¹⁷

He felt it had been well-handled and was 'a good report', coming at the end of a period of much parliamentary work on CAM – as the HNA newsletter described in its account of an earlier visit by him to them:

Earl Baldwin of Bewdley spoke after coffee and gave us an interesting insight into the workings of the Parliamentary Group for Alternative and Complementary Medicine. Much is being done in parliament, albeit quietly, to support the development of complementary therapies including legislation, debates, statements from Ministers and parliamentary questions which all raises the profile of complementary therapies.²¹⁸

The recommendations for the use of CAM by nurses gave clear recommendations for the priority in improving regulation and CAM training.

²¹⁵ At the time, it was named UKCC, which changed its title to Nursing and Midwifery Council (NMC) in 2002.

²¹⁶ Steven Ersser, interviewed 14 July 2014.

²¹⁷ Lord Baldwin, interviewed 12 September 2014.

²¹⁸ HNA newsletter April 1995, *Working towards Quality*, report on the RCN Complementary Therapies in Nursing Forum.

There was, however, also a particular and significant encouragement in the report's conclusion:

There is increasing evidence that the public wants access to complementary therapies via the NHS. This trend must be addressed by nurses, who are in a unique position to support people in healthcare choices.

This final phrase is an appropriately positive one to leave ringing in the air at the end of this study. It echoes the *Nursing Times* editorial of 1984 claiming that 'Alternative approaches to medicine will come to play an increasingly large part in any future health service.'²¹⁹ It is evident that, sixteen years later, they were indeed and, moreover, that nurses had an important role in that.

6.8 Conclusion

The year 2000 saw a focus on CAM in nursing. By then, membership of the RCN Complementary Therapies in Nursing Forum was at an all-time high, the specialist journal was thriving, and, for good or ill, the establishment had recognised services to CAM in nursing by the award of an MBE. Later that year in November, the House of Lords published its report following the review on CAM, asserting that there was increasing evidence that the public wanted access to complementary therapies via the NHS and that nurses were in the 'unique position' to support this, authenticating the nurses' potential role in CAM. However, not all nurses were interested in becoming involved; some challenged its evidence base and some simply did not understand it.

²¹⁹ *Nursing Times*, 4 January 1984.

What has emerged from a study of the years leading to this is a clear picture of momentum – momentum that originated from members of the nursing profession, who seized the initiative to create support systems. I have unpicked the development of a range of these groups and networks initiated by them and which supported fellow nurses in this capacity. Their histories were not always without internal tensions and were not always long-lived, but they were generally effective and inspiring while they functioned. There were undoubtedly overlapping agendas between the groups and a certain duplication of effort in this new field in nursing. But from them, and from the RCN Complementary Therapies Forum, nurses gleaned information, training, support, encouragement and reassurance for their use of CAM. In their interviews, key informants have demonstrated their passion and energy in establishing these networks and providing support mechanisms. Evidence from codes of practice, guidelines, conferences, meetings and training courses supports this argument. In 1993, a *Nursing Times* article claimed that ‘the growth of interest in complementary therapies has outstripped all the other areas of nursing,²²⁰ and this has been recognised time and time again. Yet, what was also acknowledged repeatedly was the neglect from official sources in the provision of official CAM education. There was a wide variation in the level and quality of training opportunities for nurses, and participation depended entirely on their own initiative (and sometimes the ability to pay) and on support by managers. The Foundation for Integrated Medicine commented on this unsatisfactory situation, and the House of Lords’ report was clear in its criticism of the ‘passive role’ taken by the Royal College of Nursing in this respect. In March 2000, when the Wellcome Trust organised a

²²⁰ P. Sofroniou, ‘Complementary therapy’, *Nursing Times*, 1993.

high-profile workshop on how to develop complementary therapies and practice, these issues were yet again summarised as the key areas necessary for further development.²²¹

Underlying the increasing use by nurses of CAM ran a recurring debate – that of holism and its relationship to complementary therapies. Evidence of the debates and disagreements has prevailed throughout this study, but the issue is of such a nuanced nature, that it is impossible to summarise and it persists as contentious and unresolvable.

The following concluding chapter of the thesis moves on from these discussions to summarise the data chapters and encapsulate my contributions to the area of study.

²²¹ Wellcome Library, 'Advancing Research in Complementary Medicine' workshop at Wellcome Trust, 10 March 2000: recording of proceedings, 152A.

CHAPTER SEVEN: CONCLUSION

In the field of nursing history, it is recognised that the principal focus in the published literature has been politics, identity and development of the profession, rather than the practice of nursing.¹ The thesis has addressed one important and neglected aspect of nursing practice – that of CAM use by nurses between 1960 and 2000. This final chapter will draw together conclusions from this empirical study, justifying the methodological approach used for the work and describing its theoretical implications. It will also briefly summarise the situation of CAM in nursing immediately beyond the formal endpoint of the study in order to consider recent trends and consider past and present challenges in this area. Some of my findings anticipated the post-2000 downturn in practice by nurses, due to concerns over regulation, increase in focus on evidence-based practice and apprehension about lack of resources.

The research has sought to address three questions: what was the attitude of nurses to CAM during this period, why did some nurses use CAM in their work and how were they organised and supported? The thesis has examined these questions and demonstrated that a combination of push and pull factors awakened some nurses to the potential of CAM and their implementation of it provided the opportunity to enhance the therapeutic relationship that gained focus from the mid-1980s onwards. From this point, a range of groups, organisations, journals and networks was organised to support nurses and, although I argue that the apogee of CAM in nursing

¹ Gerald Fealy, Christine Hallett and Susanne Dietz, eds, *Histories of nursing practice* (Manchester: Manchester University Press, 2015), Introduction.

practice was in the year 2000, progress subsequently slowed and optimism about further development in the following century began to appear premature.

One of the most important findings of my research was evidence of a much more coherent movement of CAM in nursing than I had anticipated at the start of the project from my reading of the literature. My chosen methodological approach enabled a robust examination of evidence, both oral and documentary, which led to these novel findings. My analysis of late twentieth-century nursing journals has revealed themes that have not been articulated by previous research and even items such as readers' letters demonstrate the interest and requests for knowledge about complementary therapies, principally the touch therapies, and how they could be incorporated. Private archives of documents, which had been stored or forgotten, have enabled me to gain a fuller picture of key people who were involved and the activities they instigated and supported. These, together with the oral testimonies of individuals who provided empirical data by sharing their personal history of the use of CAM in the NHS, have allowed me to triangulate different data sources to reach more decisive findings. Examples of this include the founding of the BAHH and the RCN Complementary Therapies Forum, where personal accounts and memories of events are corroborated and clarified by archival material such as committee minutes. Another example is the discussion about opportunities for training in CAM by nurses. Personal experiences of *ad hoc* training have been supported by documentary evidence of the range and variety (and limitations) of available training courses. I summarise my principal findings here, in relation to the three research questions.

What was the attitude of nurses to CAM during this period?

The thesis introduction (Chapter One) stressed how important an understanding of 'caring' is in interpreting nurses' motivation to use CAM. A heightened awareness of this value in nursing in the 1960s (for example in its inclusion in nursing curricula) appeared to drive a need to improve wellbeing in patients. Approximately twenty years later, this provoked an awakening in some nurses of the potential of CAM and they developed their skills, mainly through self-motivation, to extend their role in this way to offer enhanced patient-centred care. Of course, not all nurses had an interest or wish to be involved in complementary therapies and some expressed a reluctance to allow it, especially older and more senior staff who did not understand the therapies.²

This period was one of challenge to the hegemonic model of biomedicine, as has been outlined in many previous works of a historical and sociological nature.

Generally, these convey the sense that the British public displayed distrust and doubt in the efficacy of orthodox medicine and academic debate augmented wider critiques of medicine. What simultaneously emerged was society's openness to alternative health cultures, fuelled by consumerism and a sense of choice and self-help and the *zeitgeist* of counter-culture, New-Ageism, and nature which provided the opportunity to explore CAM. I have argued that nurses were becoming distanced from their patients due to conditions in nursing in the 1980s, such as the pressures of new management reforms, nursing processes and increasing technology. A change of consciousness brought about an awakening to holism, to concepts about health and

² Fiona Mantle, interviewed 3 April 2014.

healing not being limited to symptoms, disease and health but to wellbeing, and a multi-dimensional approach. I argue that holism was not the same as CAM (although they are often conflated in the literature) in that holism involves an outlook, not necessarily a practice, and the data from interviews of nurses concluded that the expectation that one always leads to another is false. There is, however, an affinity between the marginality of personal care that was being squeezed out of nursing, with the marginality of CAM – whose very language suggests its position at the edge (for example, fringe, alternative and non-orthodox).

Why did some nurses use CAM in their work?

Technology and nursing processes had pressured nurses in their provision of personal care for patients, reducing the opportunities for touch and this was a major theme of Chapter Five, entitled 'Incorporation'. This chapter addressed the question of how 'kindness' evolved to become 'caring', and 'caring' eventually developed into 'empathy'. This formed the background to holism in nursing. The additional element of 'spirituality' (and its several aliases) is the central tenet of the ideology of holistic nursing and its impact on CAM practice. The nurse-patient therapeutic relationship became increasingly important during the period, as demonstrated by the 'new nursing' movement, a turning away for some from the progressively technological approaches and an increasing interest in the practices of touch and time with the patient. This formed a major discussion with my participants during interviews and I argue that it explained the increasing interest in, and incorporation of, CAM by nurses in the 1980s and 1990s, especially in practising the modalities that used touch, such as massage, aromatherapy and reflexology. For many nurses, CAM provided an

opportunity to regain that ground and to recapture a therapeutic quality in the relationship.

Nurses grasped the opportunities for education in CAM – albeit in an unstructured and inconsistent way, undertaking courses of varying quality – and the support of some managers enabled its practice, together with a self-regulating professional code of practice, which did not demand further directives. These added to the push-pull factors in the rationale for some nurses turning to CAM.

How were they organised and how were they supported?

My examination of archives and interviews with past practitioners and CAM scholars established that by the mid-1980s, nurses were beginning to be supported by a variety of structures and networks in this field, which increased until the end of the century. Interviews with some of the key individuals in nursing at this time revealed a group of energetic, enthusiastic and influential individuals who were passionate about holistic nursing values or about complementary therapies (in some cases, one led to another) and who organised themselves in order to develop their skills and practice. Chapter Six, 'Endorsement and Authentication', focuses on these groups and the resulting networks and codes of practice and guidelines which were created. The RCN Forum was instrumental in developing these, and the specialist journal *Complementary Therapies in Nursing and Midwifery*, enabled the dissemination of information and support. The Foundation for Integrated Medicine also involved nurses in its working groups, which were formed to discuss the positions of conventional and complementary medicine in the UK.

The range and quality of training opportunities, however, were variable. The century ended with the House of Lords Select Committee of Science and Technology's report on CAM, for which nurses provided evidence.³ In its submission, the RCN concluded that it believed that:

NHS trusts should provide services that are equitable, appropriate, effective and safe and that such services should include the integration of complementary therapies within mainstream healthcare.⁴

The House of Lords committee responded in its review that nurses offered important potential for enabling integration of CAM into health provision and were in a 'unique position' to promote this, authenticating the nurses' role in CAM. However, in spite of the structures and guidelines that had been established, the report criticised the limited formal training for those who wanted to develop their practice and the 'passive role' taken by the Royal College of Nursing. This added to the conclusion of the Prince of Wales' Foundation of Integrated Medicine, which had earlier criticised the lack of official education for nurses in complementary therapies.

The very last word and the very last image on the subject of CAM in the *Nursing Times* during the period of my study convey a confidence and demonstrate an assured expectation.⁵ They both appear in the issue of 7 December 2000. The image is a cartoon and I argue that it demonstrates that the nursing profession showed enough confidence in the practice of complementary therapies to make a satirical point to entertain the reading audience.

³ *The Sixth Report on Complementary and Alternative Medicine*, House of Lords Select Committee of Science and Technology, 21 November 2000.

⁴ Submission for House of Lords Scientific Technology Committee from RCN, page 4. See Appendix I.

⁵ *Nursing Times*, 7 December 2000.

Figure 9 *Nursing Times*, 7 December 2000

Reproduced with kind permission of *Nursing Times*, nursingtimes.net

The last written comment was an observation made by nursing academic Mark Radcliffe in his column – most aptly named ‘Last Word’ – in the same issue in December 2000. In this thesis, I have built the argument for nurses using CAM, not so much around a desire to build their professional persona by expansion of their role, but around the attraction of a closer therapeutic relationship with the patient. Mark Radcliffe alludes to the same point. While critical of complementary therapies in his article, he proposes that the humanity of caring that is implicated in CAM practice be retained in nursing practice – if not the therapies themselves:

It is not difficult to understand the appeal of complementary therapies to overstretched nurses. They give comfort and meaning and in terms of health care delivery they offer warmth and individualised care, even though a lot of them appear ridiculous. Wouldn't it be good to take the humanity of complementary therapies and reapply it to nursing?⁶

⁶ Mark Radcliffe, ‘Last Word’, *Nursing Times*, 7 December 2000.

Although there was an expectation that greater integration would follow, the early years of the twenty-first century saw disappointment in this respect, as the editor of the faltering RCN Complementary Therapies Forum's newsletter wrote in her editorial in 2006, 'In the climate of widespread financial crisis in the NHS, the vision to enhance patient care with the integration of complementary therapies is in danger of fading'.⁷ She added that:

There are nurses working in well-established complementary therapy services who are finding their jobs and the provision of therapies under threat [...] It is vital now that we stick together to prevent the integration agenda drowning in a tide of overspends. Those of you who are fortunate enough to have flourishing services need to tell the world about your successes. Write about what you do, and submit to complementary therapy and mainstream nursing journals. Get patients to shout about their positive experience and get political [...] Integration has come a long way in the last ten years and we must make sure that progress is maintained and advanced.

Progress, however, was not maintained and in this discouraging climate, many nurses left the NHS to take up private practice in CAM. Sociologist Ursula Sharma's research identified that the main reasons for therapists choosing their work was to heal and help and a desire to work independently away from bureaucratic constraints,⁸ which explains the appeal for some nurses to move outside the health service to become complementary therapists. Health geographer Gavin Andrews studied this trend and his findings conclude that the motivation for nurse therapists who had left the profession was largely connected to care issues and wanting to 'help

⁷ RCN Archives, Edinburgh, RCN Complementary Therapies Forum papers, Julia Fearson, *In Touch*, 2006, 3/38/1.

⁸ Geraldine Lee-Treweek *et al*, eds, *Perspectives on Complementary and Alternative Medicine*, K221 (Buckingham: Open University, 2005), 345.

people to empower themselves...take responsibility for their own health.’⁹ It assumes that this need was not being met within the NHS. There is irony, however, in the fact that, while the hope of developing nurses’ use of CAM in their practice diminished at the start of the twenty-first century, there is evidence of a growth in interest of it in medical training at that time – at least at a familiarisation level where medical students were informed of how CAM related to medical practice.¹⁰ A further study of medical students shows the introduction of CAM teaching and learning into the education of health professionals at this time in the United Kingdom, as well as in Canada, and the United States.¹¹

Annie Hallett summarised what she believed were the challenges to CAM in the early years of the twenty-first century:

Everything was ripe for it to develop although it was always a battle. I think the culture changed, the individuals - life and careers took them on different pathways, finances in the NHS changed so there was less money to be free with. And I think again as one generation moved on, the whole culture of nursing and medicine has changed. As Steve Wright famously said, a lot of us felt that complementary therapies were ‘vehicles to bring back the heart into nursing’. But actually politics, the computer, the digital revolution ... have changed nursing and medicine. The target culture has changed the priorities.¹²

Archived records of the RCN Complementary Therapies Forum reveal the history of the ending of its existence. From its peak in 2000, with nearly 11,500 members, membership declined. In the 2007 annual report, the forum’s chair Janet Woolmer wrote with evident anxiety:

⁹ Gavin Andrews, ‘Nurses who left the British NHS for private complementary medical practice: why did they leave? Would they return?’, *Journal of Advanced Nursing*, 41 (2003) 403-15.

¹⁰ Sheila Greenfield, Michael Innes, Teresa Allan and Andrew Wearn, ‘First year medical students’ perceptions and use of complementary and alternative medicine’, *Complementary Therapies in Medicine*, 10 (2002) 27-32, 27.

¹¹ Katja Schmidt, Charlotte Rees, Sheila Greenfield *et al*, ‘Multischool International Survey of Medical Students’ Attitudes towards Holism’, *Academic Medicine*, 80 (2005) 955-963.

¹² Annie Hallett, interviewed 18 May 2015.

...our situation has changed dramatically and we are desperately in need of either new committee members – or else we must consider new ways of working together, supporting each other and promoting the acceptance and integration of therapies into health care.¹³

Total membership had fallen to approximately 4,000 by this time, and Janet Woolmer declared, 'It is crunch time for this forum.'¹⁴ Annie Hallett recalled:

It folded really sadly. But I think it was also indicative that the membership was beginning to fall and the whole movement had peaked and I think that the culture of nursing was changing. [...] I think what happened was that the generation of nurses then grew, life took people on different pathways.¹⁵

There are no further archived records, and it is assumed that the forum was discontinued completely or amalgamated with another group, and the exact date of its cessation is uncertain.

These early years of the twenty-first century, rather than seeing an acceleration in use of CAM and development in its integration, became a period of its deceleration which, according to interview data, is attributed to diminishing resources and lack of progress on regulation.¹⁶ This raises the question as to whether the movement of CAM in nursing in the late twentieth century can be judged as a successful one or not in meeting the aspirations of its members to bring about change. Although I consider it too early to use the benefit of enough hindsight to offer a clear judgement, data from my research suggests that modified attitudes amongst nurses were evident. Nursing has continually adapted in response to social, cultural and political changes¹⁷ and the practice of CAM in a holistic atmosphere in the last decades of the twentieth

¹³ RCN Archives, Edinburgh, RCN Complementary Therapies Forum Annual Report, 2007.

¹⁴ *Ibid.*, 3/38/1.

¹⁵ Annie Hallett, interviewed 18 May 2015.

¹⁶ Interviews: Annie Hallett, interviewed 18 May 2015; Nicky Baker, interviewed 16 July 2015.

¹⁷ Annie Holmes, *Why History Matters to Nursing*, 35 (2015), 637.

century had its influence in 'a shifting, changing awareness'.¹⁸ Annie Hallett's comment that the culture of nursing changed around the end of the century also leads me to conclude that, although CAM use may not have increased, it contributed to this developing culture, a point that Angela Avis also made in her MBE statement: 'nursing practice is dynamic and has the potential to shape health care trends.'¹⁹ Perhaps, as nursing practice developed in a wider sense, complementary therapies themselves were no longer so much in demand and this could be the topic of a valuable further study.

Turning away from the findings from empirical data, I consider the theoretical implications of this research and reflect on what may be applicable to other fields. Experience of the possible effect of emotional nostalgia on the quality of data from my oral history interviews (which I discuss in Chapter Three) has methodological implications. While appreciating that evaluating one's personal history in an interview gives meaning and a sense of identity, I considered whether, because of this, an enthusiastic and positive response about whether an individual or an organisation achieved its aims may have been influenced by nostalgic reflection? Although I believe I resolved my question in the case of this particular data collection, it is an issue that has implications in all oral history work. Most importantly, it demonstrated that supplementing oral history data with archival work provided a major strength for this research. Archives sometimes functioned as prompts in the interviews, and the interviews acted as stimulants for themes for archival searches.

¹⁸ Hermione Elliott, 12 November 2014.

¹⁹ RCN Archives Edinburgh, Complementary Therapies Forum papers, 15/15/COM.

In discussing the nursing history element of the work, I have examined how political pressures raised expectations of the nursing profession in the 1980s; nurse practitioners were introduced and specialist nursing roles were created, so that taking on an autonomous, interventionist role in practising CAM appeared to have a practical appeal. Some of my findings indeed support this approach. However, as already summarised, they also strongly suggest a different motivation – that some nurses were also seeking to recapture the carative values of nursing by using therapies that involved touch, enabling an enhanced and enriched therapeutic relationship with patients. A large section of Chapter Five discussed this development in practice and the importance of the action of touch in nursing was argued to be central to the motivation for CAM use. Although tentative, this offers an important potential wider perspective to nursing practice and, in an even broader context, may give insight into resistance during the transition period of a profession.

The concept of holism and discussion of its relationship with CAM is a thread that has been woven through this research. It is recognised that the term was applied historically (and often inappropriately) to a range of activities, but it has been especially used in connection with complementary therapies – frequently in an optional phrase, ‘holistic therapies’. This has caused contention and confusion, as was discussed in Chapter Six. This teasing out of ‘holism’ as a theoretical approach – rather than holism when conflated with practical therapies – also has inferences that are relevant to its use in other fields.

The concept of healing has arisen in all of the data chapters. Medical historians have queried what historical records imply by the terms 'cured' or 'relieved' in hospital histories,²⁰ and medical sociologists and anthropologists debate the social and cultural components of the healing process.²¹ Although 'healing' is a term often used lightly during the period and geography of this study, it is of a more subtle nature in the context of holistic approaches than in biomedical interventions, which are perceived as operating in a narrow physiological framework. This was particularly discussed in Chapters One and Four in the context of a reductionist model of healing as curing, that is, 'fixing'. As an example of a more spiritual sense of healing, Peter Mackereth described how a healing moment may be experienced in a dying person,²² where healing in this sense involves insight and an emotional and spiritual shift. Chapter Five includes discussion of the psychological aspect of healing where the quality of nursing empathy itself is perceived as having healing power. The understanding of healing in this way is key in a discussion of holism, which is examined in Chapter Six, and has a theoretical implication that is widely applicable outside this particular study.

This is a timely piece of research in the context of increasing discussions on the meaning of care and understanding of compassion in nursing in the wake of the Francis Report.²³ I claim that it is relevant to examine how awareness of these concepts in nursing first arose, why they are so apparently valued and why they are

²⁰ Roy Porter, *The Greatest Benefit to Mankind* (London: Harper Collins, 1998), 33-35.

²¹ Arthur Kleinman, *Patients and Healers in the Context of Culture* (Berkeley: University of California Press, 1980).

²² Peter Mackereth, interviewed 30 January 2014.

²³ Robert Francis, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (London: The Stationery Office, 2013).

now so frequently regarded as neglected.²⁴ The thesis has included these discussions, particularly in Chapter Five, and illustrates how kindness is demonstrated as empathy and how integral to caring this is. The timescale of this study covers an era of major developments in nursing care and presents a particularly important period for the study of changes in the therapeutic relationship between nurse and patient, in which care and compassion – and the desirability of time in which to practise them – are considered to be so central, with implications beyond this thesis.

In considering the strengths and limitations of the research, I reflected on the stimulating atmosphere of many of the interviews, which demonstrated the passion and commitment that was involved in the ‘new spirit’ in nursing, as it was described.²⁵ Participants discussed their awareness of stirrings of a new medical model as they illustrated from their own experiences how it developed and grew during the latter decades of the twentieth century. This confirmed to me how important it had been to capture these oral histories to reflect the spirit of the time. Initial interviews with retired nurses provided an introduction to relevant themes, and examination of nursing journals reinforced these. My decision to examine hard copies of journals, rather than to rely on digital references, was an unquestionable strength in the research methodology. Although it was laborious and time-consuming, using this method revealed a number of significant details that would not otherwise have registered on databases. It was valuable, too, from the point of view of providing nursing and cultural context for the data that I extracted, revealing in other articles

²⁴ Katherine Curtis, ‘Compassion is an essential component in good nursing care and can be conveyed through the smallest actions’, *Evidence Based Nursing*, 18 (2015) 95.

²⁵ Jane Salvage, *Nursing Times*, 29 January 1997.

the tensions, both political and professional, that were prevalent at the time. From references in journals, I became familiar with key individuals at the forefront of CAM in nursing and through contacts and internet searches, I was able to trace and interview them. Two of them had retained documentation from their organisations, which augmented the material I had found in archives. These three methodological sources have enabled triangulation and provided a rich supply of data, illuminating the subject area.

The relevance of these discoveries is that they reflect not only a new spirit in nursing, but a development in the history of healthcare. The dominant scientific model of medicine began to be challenged in the 1960s and 1970s and this research provides evidence of how many nurses regarded their work, demonstrating their aspiration for an enhanced role in the therapeutic relationship with the patient. However, there was limited opportunity for this role. By the early twenty-first century, financial constraints on resources and a concern over a lack of policies and coordinated nurse training in CAM restricted their practice and this small window of opportunity started to close.

Concluding remarks

I challenged myself on how valuable the implications of these findings are, and I claim that there are three arguments that support the merit of this research and suggest that it makes a fresh contribution. The first is that it has been positioned in the context of the history of nursing. It is immensely important to have done so because I argue that CAM was not an isolated activity that occurred randomly to some nurses, brought about by a social trend and contemporary interest in

complementary therapies, although, of course, this was very relevant. It was part of a change of consciousness in nursing that incorporated a new approach and even a new language. 'New nursing', 'nursing development units', 'patient-centred care' and 'therapeutic nursing' were all elements of a period in nursing practice at this time,²⁶ which – in addition to an increasing holistic culture – provided the background to CAM practice. The study of CAM in nursing has often been given a sociological focus,²⁷ but I argue that it has sometimes been devoid of a nursing historical context. The culture of patient-centredness of the late twentieth century has not always been woven into references in the literature and it is particularly important to do so in order fully to interpret the story of CAM in nursing.

The second point is that this research identifies a particular discrete span of time for this movement, and makes the argument for an identifiable beginning and high point, which preceded a decrease in the use of CAM by nurses. The year 1960 saw agreement reached for a new strand in the nursing curricula – that of education on the nurse-patient relationship (which I show had a bearing on the use of CAM) and, in 2000, the House of Lords singled out nurses as being unique in their potential role to increase the use of CAM in healthcare. The period ends on a high note of optimism for CAM in nursing. These are the distinct markers of the timeframe.

²⁶ Steven Ersser, *Nursing as a Therapeutic Activity* (Aldershot: Ashgate Publishing Company, 1997); Stephen Wright, *My Patient, My Nurse: the practice of primary nursing* (London: Scutari Press, 1990); Alison Binnie and Angie Titchen, *Freedom to Practise: the development of patient-centred nursing* (Oxford: Butterworth Heinemann, 1999).

²⁷ For example, Philip Tovey, Gary Easthope and Jon Adams, eds, *The Mainstreaming of Complementary and Alternative Medicine* (London: Routledge, 2004); Sarah Cant, Peter Watts and Annemarie Ruston, 'Negotiating competency, professionalism and risk: The integration of complementary and alternative medicine by nurses and midwives in NHS hospitals', *Social Science and Medicine*, 72 (2011) 529-536.

The third reason for the significance of the research is that it has offered a new insight into the support mechanisms in exposing the variety of CAM/nursing organisations that have not been examined before. Rather than piecemeal and haphazard support for nurses and CAM, which is often suggested, these were effective networks and groups that were organised by nurses and for nurses.

I believe I have pushed my analysis far enough, and I recognise that this thesis has boundaries. There were areas that I had hoped to develop, but which would have been diversions from the main research questions. In particular, I would have liked to explore more international semblances and differences in CAM use among nurses globally. The influence of other Anglophone cultures, especially those of Australia, Canada and USA (where the role of 'nurse therapist' is comparatively well organised to include CAM practices) would be of especial interest, but, perhaps even more so, the comparisons with continental European practice, particularly that in France and Germany, would be valuable topics. As a result of my study, further research could be undertaken in this area to explore, identify and compare the influences within a closer geographical range. Similarly, undertaking a regional study of differences in CAM use by nurses within Britain would be of worth, in order to reflect possible varying attitudes. It is possible that migrant communities in some areas may reflect these variations, or that distinctions of class and affluence may have had an effect on both patient attitudes or nursing interest in CAM.

The history of regulation in healthcare, and CAM in particular, is an area that warrants greater study. In the period of this research, regulation for nurses using CAM was an ambiguous area where self-judgement of competency governed CAM use, with little statutory policy and, by 2001, there was still concern that NHS trust policies were not regulating nurses' use of CAM.²⁸ My study has focused on touch therapies, but there is scope to do further work on the history of a whole field of non-tactile therapies, such as healing, and the extent to which regulation has developed in this field. For example, in an article on spiritual healing in the *Nursing Times*, a comment reflects concern about lack of government policy in hospitals, where it was noted that 235 NHS hospitals had 'experience of spiritual healing.'

Every opportunity should be taken to clarify any confusion as to whether it is the policy of the Minister of Health to admit to our hospitals 'healers' ...²⁹

Although this was likely to refer to external individuals, rather than to NHS nurses, it is notable that neither the Ministry of Health in 1960, nor hospital trusts in 2001, had robust policies in place for the application of non-orthodox practices within the NHS. The hopes and expectation for regulation in CAM increased towards the end of the century, but progress in the struggle for policies faltered and 'the climate towards CAM has cooled considerably over the last twenty years.'³⁰

²⁸ RCN Archives, RCN Complementary Therapies Forum newsletter, 2001, 3/38/1.

²⁹ *Nursing Times*, 27 May 1960.

³⁰ Julie Stone, 'Aspirations, regulation and the politics of regulation in the UK, past and future' in Nicola Gale and Jean McHale, eds, *Routledge Handbook of Complementary and Alternative Medicine* (London: Routledge, 2015), 266.

Herbalist and chair of the European Herbal and Traditional Medicine Practitioners Association Michael McIntyre describes the anticipation of regulation progress in the 1980s, when 'people were open-minded':

In the early 1980s the Royal College of Physicians were interested in herbalism and acupuncture regulation – they were in favour of it. I thought it was a stepping stone, but it all came to nothing.³¹

He added, 'The door is now firmly shut.' How this transition occurred would be valuable to investigate.

The purpose of the research was to remedy a gap in the knowledge about twentieth-century nursing practice in Britain in respect of CAM. The thesis contributes an examination of therapeutic relationships in nursing, as well as insight into the practical aspects of the implementation of complementary therapies. But there is an additional output from the research. The recordings of my interviews and the accompanying transcripts have created an archive of CAM and nursing practice which will be deposited in the RCN archives in Edinburgh, generating a secondary product from my findings. The themes covered in the interviews include wellbeing, understanding of a therapeutic relationship, historical attitudes to health, developments in nursing and developments in CAM. These may provide a potentially useful source for the future study of the history of nursing and of the history of medicine.

³¹ Michael McIntyre, personal communication, March 2013.

The conclusion of the thesis is that it offers an important contribution to the history of nursing practice by examining nurses' use of complementary therapies in the late-twentieth century in Britain. It provides a comprehensive context – historically, culturally and politically – and it explores the reasons why some nurses were attracted to CAM and examines how they incorporated complementary therapies in their work. Moreover, it discusses the way in which nurses were organised in their practice of CAM and describes the networks and organisations that they created and which supported them.

By examining the relationship between CAM and biomedicine in this context, the research also contributes to the broader understanding of the history of healthcare and of healing, and of its practitioners, in the second half of the twentieth century.

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www.le.ac.uk/emoha/training/no2.pdf - accessed 5 December 2013

www.nursingtimes.net - accessed 11 October 2014

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www.who.int/bulletin/archives - accessed 24 January 2013.

www.youtube.com/watch?v=voPIGiv3sIQ, - accessed 29 Nov 2013

APPENDICES

- A Definition of therapies referred to in thesis
- B Oral history interviews: nursing practice timeframe
- C Participant interview information sheet
- D Schedule of interview questions
- E Sample cartoons from *Nursing Times*, 1991-1997
- F Ngram chart of terminology use
- G Length of hospital stay (LOS) for fractured necks of femurs, 1988-1993
- H Holistic Nursing Conferences: 1984 and 1986.
- I Submission for House of Lords Science and Technology Committee for review of CAM, from the RCN, 2000.
- J A guide to CAM training for nurses, RCN Complementary Therapies in Nursing Forum January 1996.

THERAPIES

Definitions of therapies referred to in this study¹

Acupuncture	A Chinese medical system which aims to diagnose illness and promote health by stimulating the body's self-healing powers.
Alexander Technique	Psycho-physical postural re-education to enhance physical and psychological wellbeing.
Aromatherapy	A form of treatment using essential oils extracted from plants for therapeutic effect.
Autogenic training	A psychophysiologic form of psychotherapy, which the patient carried out himself by using passive concentration upon certain combinations of psychophysiologically adapted verbal stimuli – Luthe 1963.
Bach flower remedies	The use of distilled essences of wild flowers taken diluted in water or as a lotion. The therapy is based on the premise that disease is directly related to temperament.
Biofeedback	A method of training which enables a person, mostly with the help of electronic equipment to learn to control otherwise involuntary bodily functions – 'learning to play the internal organs' – Lang, 1979.
Chiropractic	Diagnosis, treatment and prevention of mechanical disorders of the joints and their effects on the nervous system. Not for treating symptoms but to identify subluxation and treat it.
Counselling	A repertoire of learnt behaviours, both verbal and non-verbal, which enable a rapport to be established between nurse and client and facilitate communication.
Gems	The use of crystals and gems with belief that they possess therapeutic forms of energy that resonate with energies of the body.
Healing	The practice of a conscious intentionality to improve health and well-being.
Herbalism	The use of a whole plant material by trained practitioners to promote recovery from disease and to enable healing to take place.
Homeopathy	A system of medicine based on the Law of Similars (let like be cured by like). Medicines are produced from natural sources. Original substances are diluted many times in a water and alcohol base.

¹ Definitions from: Denise Rankin-Box, ed., *The Nurses' Handbook of Complementary Therapies* (Edinburgh: Churchill Livingstone, 1995), with exception of therapies marked * (*Which? Guide to Complementary Medicine* (1997)).

Hypnosis	The deliberate use of a trance state to enhance the sense of health and well-being.
Kirlean photography²	A collection of photographic techniques used to capture the phenomenon of electrical coronal discharges. It is named after Semyon Kirlian, who in 1939 accidentally discovered that if an object on a photographic plate is connected to a high-voltage source, an image is produced on the photographic plate.
Massage	A conscious, deliberate, and often formalized use of the instinctive response to comfort another person using touch.
Osteopathy	A diagnostic and manipulation treatment to resolve mechanical problems.
Reflexology	A treatment which applies varying degrees of pressure to different parts of the body, usually the hands or feet, in order to promote health and well-being.
Relaxation	A state of consciousness characterized by feelings of peace and release from tension, anxiety and fear.
Shiatsu	A hands-on therapy which works on energetic pathways to balance and strengthen the body.
Spiritual healing	Laying on of hands or healing by prayer/meditation, closely linked to a belief or faith system.
T'ai Chi*/ Chi gong	Chinese traditional medicine. Series of postures designed to bring health and wellbeing by restoring the natural flow of energy within the body.
Therapeutic Touch	An energy field interaction between two or more people, aimed at rebalancing or repatterning the energy field to promote relaxation and pain relief and activate self-healing.
Visualisation	Technique of using the imagination to create any desired changes in an individual's life.
Yoga*	Spiritual and mental discipline combining posture exercises with breath control and meditation to help achieve mental clarity, spiritual awareness and inner peace.

² Kirlean photography (referred to in 6.2.1) - definition from Julie McCarron-Benson in *Skeptical - a Handbook of Pseudoscience and the Paranormal*, ed. Donald Laycock, David Vernon, Colin Groves, Simon Brown (Canberra: Imagecraft, 1989).

ORAL HISTORY INTERVIEWS NURSING PRACTICE TIMEFRAME

Appendix B

1960s	1970s	1980s	1990s
Julia Ayres	Julia Ayres	Julia Ayres	Julia Ayres
Sybil Allen	Sybil Allen	Sybil Allen	Sybil Allen
Nicky Baker	Nicky Baker	Nicky Baker	Nicky Baker
Elizabeth Cranham	Christine Eberhardie	Elizabeth Cranham	Hermione Elliott
Christine Eberhardie	Hermione Elliott	Christine Eberhardie	Steven Ersser
Alison Ellis	Alison Ellis	Hermione Elliott	Annie Hallett
Sheila Forrest	Steven Ersser	Alison Ellis	Elizabeth Hill
Ruth Message	Elizabeth Hill	Elizabeth Hill	Caroline Hoffman
Sue Myring	Ruth Message	Steven Ersser	Dan Jones
Jean Sayre-Adams	Peter Mackereth	Annie Hallett	Peter Mackereth
Angela Taylor	Fiona Mantle	Caroline Hoffman	Fiona Mantle
Alice Temple-Bruce	Denise Rankin-Box	Dan Jones	Ruth Message
Annette Turton	Jane Salvage	Peter Mackereth	Denise Rankin-Box
Pat Turton	Jean Sayre-Adams	Fiona Mantle	Jacqui Stringer
Ruth Sewell	Ruth Sewell	Ruth Message	Pat Turton
Mary Walker	Jacqui Stringer	Inge Newbeck	Mary Walker
Stephen Wright	Alice Temple-Bruce	Denise Rankin-Box	Rosie Winyard
	Denise Tiran	Ruth Sewell	Stephen Wright
	Annette Turton	Jacqui Stringer	
	Pat Turton	Angela Taylor	
	Mary Walker,	Annette Turton	
	Rosie Winyard,	Pat Turton	
	Stephen Wright	Denise Tiran	
		Mary Walker	
		Rosie Winyard	
		Stephen Wright	

INTERVIEW INFORMATION SHEET

Christine Gowing
Medicine, Ethics, Society and History Unit
Institute of Allied Health Research
University of Birmingham
Edgbaston B15 2TT

Tel: xxx Email: 

COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) IN BRITISH NURSING PRACTICE 1960 – 2000

This research will examine forty years (1960-2000) of complementary therapies from a nursing perspective. It will question the extent to which attitudes of nurses to CAM changed and whether and/or how they developed their use of CAM to enhance care of their patients in nursing practice. The value of this research project is to further the knowledge and understanding of healthcare provision by nurses in the second half of the twentieth century. By examining the relationship between CAM and biomedicine in this context, it will contribute to the understanding of the history of medicine in the twentieth century.

I shall be collecting memories of former nurses and key informants and you are invited to participate in this study by consenting to be interviewed about the topic. I believe that your contribution will be very helpful. In order to be able to locate your perspective properly within the historical context and to be able to generate a useable archive (see below), participants will not be anonymous,

The interview process

The interview meeting may take about 60 minutes, including prior discussion, and will cover subjects such as your professional life, your attitudes to health and CAM, and your experience of CAM - especially in practice, if relevant. The place and time of interview will be arranged for your convenience. The interview will be recorded digitally and it will be transcribed afterwards; a copy of this transcription will be supplied to you. If you have any photographs or other documentary items which you think would be relevant, I would be very grateful for the opportunity to view them. Follow-up contact will be made to ensure that you are happy about the interview and to discuss any points that are not clear.

Copyright, use of the data and deposit of the recording

Copyright of the recordings will be assigned to me and the recordings themselves will be deposited in the Royal College of Nursing Archives. Your recording may be accessed by researchers at the discretion of the archive staff but will not be reproduced or published in any part without permission.

Data resulting from your interview will form part of the research and be included in my PhD thesis. It may also be used in other publications such as journal articles. I would be very grateful if you would complete and sign the accompanying consent form under the University of Birmingham's ethical research Code of Practice.

Risks in taking part

I very much hope that you will feel it important to tell the story of your experience and contribute to the record of this period in nursing history. However, if, at any stage, you are not comfortable with taking part, you may withdraw your agreement to participate in the research until the data collection is complete. Analysis is an ongoing process in this kind of research, so some of the themes related to your interview may have influenced my analysis already, but you can be assured that, if you withdraw, your audio recording and the transcript will be destroyed and no examples or direct quotes from your interview will be used for the research.

The interviewer and supervision

The interviewer will be myself. I studied for an MA at Oxford Brookes in the History of Medicine and, now retired from full time employment, am working for a PhD at the University of Birmingham under the supervision of Professor Jonathan Reinartz, (Director of the History of Medicine) and Dr Nicola Gale (Lecturer in the Sociology of Health Care). Dr Stuart Wildman, Honorary Research Fellow in the History of Medicine Unit, is advising on the History of Nursing.

They can be reached at:

Professor Jonathan Reinartz, Director, History of Medicine Unit, University of Birmingham, Edgbaston, Birmingham, B15 2TT.

Dr Nicola Gale, Health Services Management Centre, Park House, 40 Edgbaston Park Road, Birmingham, B15 2RT.

Ethical approval

The study has been reviewed and approved by the Science, Technology, Engineering and Mathematics Ethical Review Committee, University of Birmingham. The University of Birmingham expects all research carried out at the University or in its name to be conducted to the highest standards of integrity. The Code of Practice for Research requires all those undertaking and/or contributing to research to adhere to the highest standards of performance and ethical conduct, and embed good practice in all aspects of their work.

If you would like further clarification about anything to do with this study, please do not hesitate to contact me by email or telephone (details at the top of this leaflet). Thanking you very much in anticipation for your assistance with this research project.

Christine Gowing

SEMI-STRUCTURED INTERVIEW FRAMEWORK

COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) IN BRITISH NURSING PRACTICE 1960 – 2000

Introduction

Explain the purpose of the research

- *what it is*
- *what I will do with the information gathered*
- *what the process will be like & how long I will take*

Reassure that there are no right or wrong answers.

Take permission to record the interview; complete consent form.

*Primary interview questions are numbered and appear in **bold** text. They are aimed at getting the discussion going. By the end of the interview, all the topics and key themes will be covered.*

Probing topics are indicated with a bullet and will be used to encourage further discussion.

Thank you very much for agreeing to participate in this study. I think it is an exciting opportunity to explore the issues in the history of the use of CAM by nurses.

Nursing background

1. Can we start at wherever your beginning is – your story of why you chose to work as a nurse?

- Did you ever consider another career?

Family life, attitudes to health in the family

2. Going back in time a bit, can you describe your family?

3. Looking back, can you remember any experience of herbs, folk medicine or natural therapies in the family?

- Did anyone in your family practise non-biomedical medicine, even in a simple way, eg home remedies? Describe...
- What was your personal view of these therapies when you were growing up?
- Has this view changed? In what way?

Hospital/nursing life

4 Thinking back, what do you make of your experience when you were training as a nurse?

- Where did you study nursing?
- Can you describe your nursing experience in your first hospital?
- What wards did you work on?
- What about nursing processes and nursing models? What did they mean to you?
- What was your feeling about them as an approach?

6. To get a bigger picture, what other sorts of nursing have you done? When was this?

7. In your nursing experience, can you describe whether the attitude to touching a patient has changed?

CAM background

(having first discussed pre-interview what is meant by a complementary therapy, eg. massage etc.)

8. Can we spend some time now talking about wellbeing and any experience you have had with complementary and alternative medicine? Could you describe to me what you understand by the 'wellbeing of patients'?

- Can you describe any training you had for enhancing the wellbeing of patients?
- How do you believe this can be brought about for a patient?
- What part do you believe wellbeing plays in the healing process?
- How do you feel about the concept of self-healing?
- What do you understand by a holistic approach to health?
- How do you feel about this as an approach? Or do you have another view?

9. Can you describe how you became aware of CAM?

- Did you know of any particular groups that supported a holistic view of health? (British Assn for Holistic Health, for example?)
- Can you tell me about whether you read about CAM in any nursing literature when you were nursing?
- Were you aware of the RCN's view on CAM at any time? Details ...

10. Can you talk to me about what you understand by 'placebo effect'?

- Can you describe any change in your views of the placebo effect over the period of your working life?

11. Would you describe to me what you understand by a therapeutic relationship?

- How important do you believe this is to healing?

The Practice of CAM

12. Can you tell me about giving a complementary therapy to a patient?

- When would this have been? (Date)
- Was this a one-off or a regular activity?
- Where were you at the time?
- How well do/did you consider yourself to be trained in complementary therapies?
- Why did you decide to offer a complementary therapy?
- On what level was your rapport with the patient before the treatment?
- What were the outcomes: do you consider that there was any improvement in the patient's condition? Can you describe it?

13. For what conditions have you used complementary therapies?

- Can you describe your approach to offering a complementary therapy to a patient?
- Can you remember if a patient ever made the first suggestion to receive a complementary therapy?
- If you gave a patient a complementary therapy, did you discuss it first with her/him? Was there an element of informed consent?
- Did you consider what the health care team had already tried for the patient?
- How did risk management feature in this assessment process?
- How aware were your colleagues of your intentions?
- What was the reaction of colleagues to your giving complementary therapies?
- Did you feel any personal benefit to yourself, having given the treatments?

14. How would you describe the relationship between CAM and mainstream medicine during the time you practiced nursing?

- Can you describe how this relationship has changed over your lifetime?
-

Post interview

- *Ask interviewee if s/he is happy about what has been talked about.*
- *Outline what happens next.*
- *Type up transcript of interview, send to interviewee with copy of consent form.*
- *Confirm interviewee still happy.*
- *Offer that interviewee can contact at any time to discuss what has been shared or if there are any questions about the research.*

CARTOONS

NURSING TIMES 1991-1997

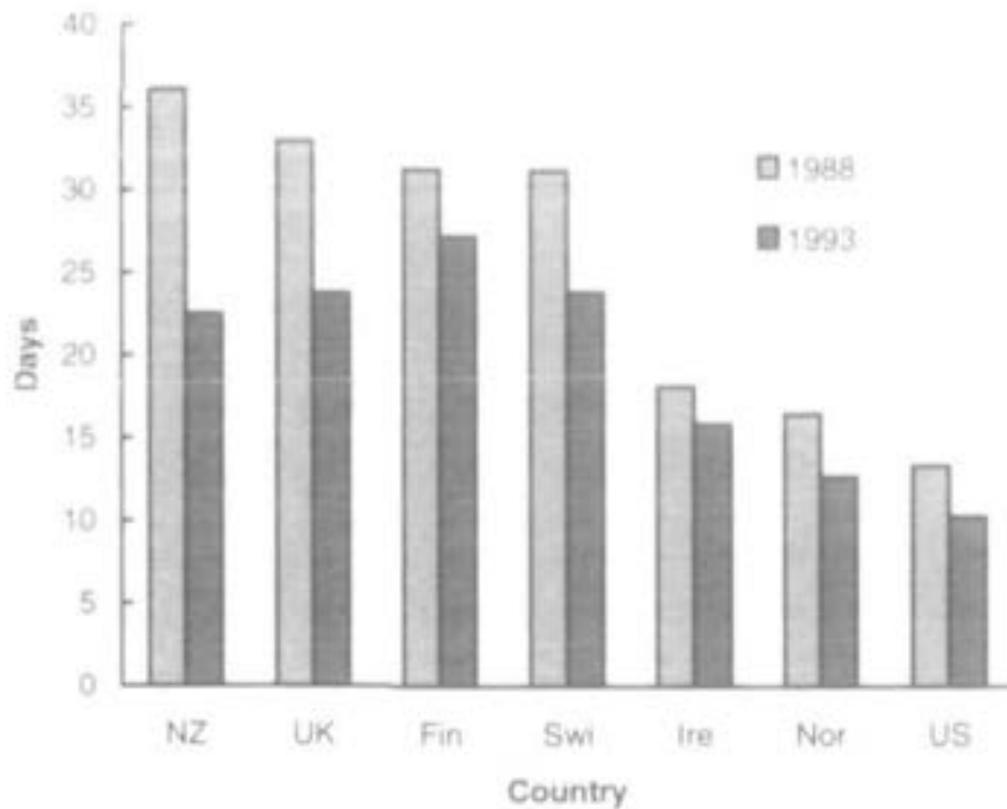


1. 27 March 1996
2. 13 November 1991
3. 10 June 1992
4. 29 November 1995
5. 10 April 1996
6. 22 January 1997

TERMINOLOGY

Ngram graph of use of terms 'alternative medicine', 'complementary medicine' and 'complementary and alternative medicine', 1960-2000.



LENGTH OF HOSPITAL STAYS**Comparison of LOS for fractured necks of femurs
1988-1993**

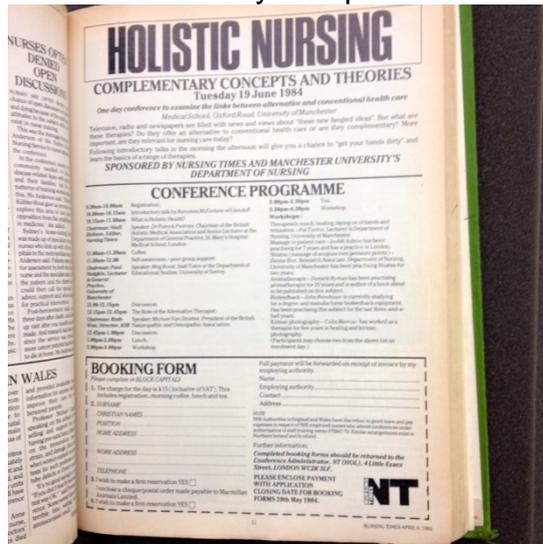
Source: OECD data, 1996

Aileen Clarke and Rebecca Rosen, 'Length of stay: how short should hospital care be?', *European Journal of Public Health*, 2011, 11, 166-170, 169.

HOLISTIC NURSING CONFERENCES 1984, 1986

Complementary Concepts and Theories 19 June 1984

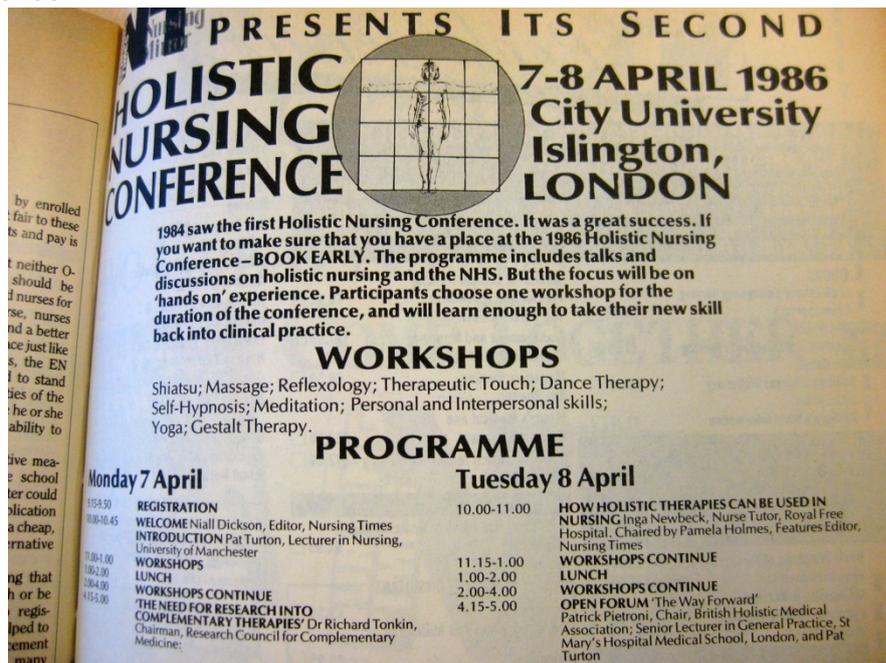
A one-day conference to examine the links between alternative and conventional health care, held at the Medical School, University of Manchester, sponsored by *Nursing Times* and Manchester University's Department of Nursing



Source: *Nursing Times*, 4 April 1984

City University, Islington London, 7-8 April 1986

'A focus on 'hands on' experience. Participants choose one workshop for the duration of the conference and will learn enough to take their new skill back into clinical practice.'



Source: *Nursing Times*, February 1986

RCN EVIDENCE TO THE HOUSE OF LORDS REVIEW OF CAM, 2000

Submission from the Royal College of Nursing (RCN)

Introduction

The RCN Complementary Therapies and Nursing Forum was established in 1994 and currently has a membership of over 10,000. This is made up of RCN members who incorporate one or more complementary therapies as an integral part of their practice or who have a particular interest in complementary therapy.

The RCN Complementary Therapies and Nursing Forum uses the term complementary rather than alternative as the RCN and its forum believe that this is both preferable and more relevant to the work of its members. Similarly, the RCN believes that its members who are involved in such work are practising complementary therapies rather than complementary medicine.

The RCN Complementary Therapies and Nursing Forum campaigns for access, choice and safety in the provision of quality complementary therapies within healthcare services in the UK. (Information sheets from and about the RCN Complementary Therapies and Nursing Forum are attached as appendix 1).

1. Evidence

The RCN believes that

Patient satisfaction is an important factor which [sic] evaluating the effectiveness of complementary therapies. Patient satisfaction may well play a key role in compliance and therefore in the effectiveness of the resources used, both human, fiscal and physical for a particular therapeutic intervention. However patient satisfaction does not necessarily mean that because patients are satisfied with a therapy that it is beneficial to them

many patients are satisfied with cigarettes and alcohol with a detrimental effect their health [*sic*].

The RCN accepts the requirement for evidence of the effectiveness of any and healthcare interventions [*sic*]. Guidance on the development of evidence-based healthcare suggests that a hierarchy of evidence exists. The RCN Complementary Therapies and Nursing Forum believes that it is sensible to encourage practitioners to contribute to professional knowledge and to evidence of effectiveness by emphasising the range of methods of which such evidence may be collected. The RCN Complementary Therapies and Nursing Forum believes that randomised controlled trials (RCTs) should not be the sole level of evidence used to demonstrate effectiveness. The RCN forum believes that measures such as RCTs are sometimes inappropriately used to try to evaluate CTs, and that qualitative as well as quantitative measures may prove more useful. Such methods may include observation case studies, interviews, focus groups, surveys, audit and quality measurement tools as well as the seemingly more rigorous scientific trials testing hypotheses which form “the gold standard” in mainstream healthcare. The RCN Complementary Therapies and Nursing Forum believes that it is important to create a culture where comprehensive pieces of research are valued, leading to a true integration of healthcare. The study of midwives at the John Radcliffe Hospital into the use of aromatherapy for the alleviation of labour pain in 8,000 cases over eight years (Burn et al 1999) serves as an example. Sadly in this instance, investigators felt marginalised and several left their jobs because the results of the study were perceived as threatening to medical colleagues.

2. Information

The RCN believes that the quality of information available to the public and to doctors should be comprehensive, reliable and consistent. It should be

easily accessible. The RCN considers that it is important that the information provided is relevant to the recipient.

The RCN Complementary Therapies and Nursing Forum consider that there is a need for unbiased and independent information about CTs. Organisations such as the Research Council for Complementary Medicine or the Consumers Association clearly have a role in partly meeting this need. The emerging professional bodies may, as progress continues in terms of regulation, be in the best position to develop quality information. The RCN Complementary Therapies and Nursing Forum believe that it is both politically unethical and unrealistic to attempt to control information for the public. In October 1993, the RCN Complementary Therapies and Nursing Forum published "Complementary Therapies – a consumer checklist". This leaflet is attached as Appendix 3. Demand for this publication has been consistent and high over the last six years. There have been several reprints.

3. Research

The RCN Complementary Therapies and Nursing Forum believe that there is a need for increased funding for research into complementary therapies. The RCN considers that it might be useful for such funding to be "ring fenced" for a specific period. The RCN believes that research funding should be rationalised so that priority is given to areas, which explore the use of CTs, or conditions that are not effectively treated by orthodox medicine. Consideration should also be given to funding specific projects with a view to reducing costs in areas of conventional therapy for example yoga for stress management. Further, the RCN believes that research in clinical areas where CTs are most likely to enhance current practice (palliative care, learning disabilities and mental health) should be encouraged and supported.

Funding sources for research should include charitable foundations, CT professional bodies, institutes of further and higher education and government departments. An example of funding from the Continuing Vocational Education sector of higher and further education is attached at Appendix 4.

4. Training

The RCN believes that public safety is best served by acknowledgement of the different model of delivery of CTs, which require different approaches and levels of training. The RCN Complementary Therapies and Nursing Forum consider that it is evident that the integration of such therapies as massage, aromatherapy and reflexology into clinical nursing practice requires more complex and comprehensive education and training than that required by therapists who offer services to the “worried well” who may seek life style enhancement. The RCN Complementary Therapies and Nursing Forum believe that there is a requirement for a formal monitoring of education and training standards in CTs before any blanket incorporation to educate and train orthodox health care professionals in CTs. However, the RCN forum also believe that there is an immediate requirement to develop awareness raising programmes about the availability of CTs and their potential use with patients and clients for all healthcare professionals. Further, the RCN Forum considers that orthodox healthcare are [*sic*] professionals should be informed and confident in referring patients to complementary therapy practitioners rather than sometimes attempting to offer CT themselves.

5. Regulation and risk

Nurses registered with the UK Central Council for Nursing, Midwifery and Health Visiting are required to work within the Code of Professional Conducting [*sic*] and other guidance issued by the Council (attached at

Appendix 5). Those nurses who integrate complementary therapies into clinical practice continue to work within this guidance. However, the RCN Complementary Therapies and Nursing Forum believe that such guidance places a large degree of responsibility on individual nurses to determine appropriate levels of preparation in particular complementary therapies. The RCN Forum considers that there is a requirement for nurses, working collaboratively with other CT practitioners to develop core curricula. The RCN Forum believe that this would then enable nurses to make informed choices, when exploring education and training opportunities.

The RCN Forum considers that there is a spectrum of regulation, which runs between some form of state registration through to voluntary self-regulation by practitioners of individual therapies. The RCN forum believes that it may be desirable to organise regulation through a single independent “umbrella” body for CTs. The forum perceive that a position of balance is required where public safety is maintained but that patient choice is not infringed; and that such a position requires that high quality information is available to all nurses who are members of the Royal College of Nursing and who incorporate one or more Complementary Therapies as an integral part of their practice are covered under the RCN’s professional indemnity insurance scheme. The RCN requires that the member has undergone some form of training or preparation for the therapies that they wish to practise, that they are competent to practice these particular therapies and that, if employed, they practice [*sic*] these therapies with the knowledge and approval of their employer. The RCN Indemnity Insurance Scheme covers members 24 hours a day, is world-wide and applies in any setting. Its cover is up to £3 million (£500,000 for members working in Canada/USA).

6. NHS Provision

The RCN Complementary Therapies and Nursing Forum believe that NHS trusts should provide services that are equitable, appropriate, effective and safe and that such services should include the integration of complementary therapies within mainstream healthcare. The RCN forum considers that NHS trusts should be encouraged to be pro-active in such initiatives and to and to develop. [sic] Supportive policies that facilitate integration. At present, the RCN forum perceive that the use of complementary therapies within the NHS occurs in piecemeal fashion, but that this is gathering on [sic] increasing momentum mainly in response to the increasing interest and demand from the general public. Contact with RCN members who incorporate or more [sic] complementary therapies into their practice, and who are usually employed within the NHS further confirms this view.

The RCN forum believe that linking access through the NHS to complementary therapies that have both an established evidence base and formal regulatory systems would be an unacceptable constraint on patient choice and would also stifle the development and integration of complementary therapies within mainstream healthcare. However, the RCN Complementary Therapies and Nursing Forum recognise that there is a requirement to develop evidence based therapies. The forum supports the concept of establishing some kind of database to collect and collate all levels and types of evidence.

(RCN Archives RCN/15/15/COM – Complementary Therapies in Nursing Forum)
Re-typed from poor copy.

INTRODUCTION TO THE RCN COMPLEMENTARY THERAPIES FORUM GUIDE TO TRAINING IN CAM FOR NURSES, 1996

**A guide to the levels of training available in complementary therapy courses
which nurses may wish to undertake**

Purpose

There has been a request by nurses to clarify the current position of complementary therapies training available. This guide only includes courses with university accreditation known to us at present. Other courses without university accreditation are not listed but may be located through the professional organisations for the individual therapy. We apologise for any omissions and would be grateful if you could let us know of other courses not included in the list, so that we can regularly update it.

Please send these to RCN Complementary Therapies Forum, C/O Anne Synnott, RCN headquarters in London.

Rationale

For the practice of complementary therapies within nursing, midwifery and health visiting, nurses are guided professionally by the UKCC (1992) documents the Code of Professional Conduct and the Scope of Professional Practice as with any other aspect of professional practice. The only complementary therapies which have statutory regulation are osteopathy from 1993 and chiropractic from 1994. There are no statutory bodies which regulate other therapies at present. This is currently in private hands. For the future other therapies are working towards statutory regulation including aromatherapy, acupuncture and shiatsu. Nurses qualified in a particular therapy are under no obligation to join the professional bodies belonging to individual therapies and this is a matter of personal choice. Nursing bodies such as the Royal College of Nursing offer professional indemnity insurance for nurses competent in a therapy and wishing to use it in nursing practice.

Academic levels associated with these courses are referenced in the text as follows:

Level 1	Certificate
Level 2	Diploma
Level 3	Degree
Level 4	Masters degree
Level 5	Doctorate

CATS points refers to the credit accumulation and transfer scheme by which academic credits may be transferred for the purposes of gaining points towards a certificate, diploma or degree.