

COMPLEMENTARY THERAPY IMPROVES THE PATIENT EXPERIENCE IN A GROUP RECEIVING
INTENSIVE CHEMOTHERAPY FOR HAEMATOLOGICAL MALIGNANCIES

A PILOT STUDY

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Dedication

To Joan Tarbotton who died in 2006 with acute myeloid leukaemia (AML).

She was my guiding light. I miss our talks, I miss her guidance and her wisdom even though I didn't always like what she had to say. Joan was a nurse and a midwife, a dedicated mother of five children, a loving and humorous wife to Lester and a devoted grandmother to her 13 grandchildren. Joan would no doubt be delighted to see her five great-grandchildren now roaming the earth. This special woman was my Mother and a role model of loving kindness.

At the time of her diagnosis in 1999, my parents had just retired from farming in the Mid-Canterbury foothills. They made the most of the next seven short years while Mum spent periods of time in the South Island Bone Marrow Transplant Unit where this study was conducted eleven years later. During this time she kept a diary which Dad shared with me after her death and I feel very privileged to have been able to read her thoughts about living with AML. Dad maintains an unshakeable faith in God and continues to be my role model for resilience and quiet determination.

My Mother loved life, she enjoyed hearing about nursing in today's world and I never forgot her words when I was training, "I hope you are a kind nurse that is the most important thing, it's what you do not what you say that matters most." I didn't know it then but now I understand how integrating "Healing Touch" into my nursing practice has become the greatest way to demonstrate loving kindness in action. In a world where people are starving for human touch and connection this is a free yet priceless gift.

May God bless all those who choose to walk the "Healing Touch" road and may their light never be extinguished.

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And now last but certainly not least the words I have been imaging writing as my conclusion.

To Robbie my long suffering husband, thank you so much for your love and support over the years this work has taken to come to fruition, for giving me the space to do what was necessary to complete this part of my life. You are the best husband I could imagine and a

great Dad and a loving Grandad. You have waited patiently for this time to arrive and now I shall tidy up and let's go sailing!

Abstract

The Bone Marrow Transplant Unit (BMTU) at Christchurch Hospital, New Zealand trialled a new initiative in 2017 involving “Healing Touch Therapy” (an energy-based complementary modality), using gentle nurturing touch.

Aim

To evaluate the feasibility and acceptability of delivering Healing Touch (HT) sessions to patients receiving intensive chemotherapy for haematological malignancies.

To improve patient’s health related quality of life with a “hands-on”, gentle touch intervention which requires no energy expenditure on the part of the patient.

Method

Ten patients were allocated to a HT practitioner (HTP) for the duration of their hospitalisation. HT sessions of 50-60 minutes occurred twice weekly. Pre/Post Treatment Evaluations were completed by the Healing Touch Practitioner (HTP) and a modified Functional Assessment of Cancer Therapy- Leukaemia (FACT-Leu), evaluation tool was completed by the patient after each session. Nursing Staff from the BMTU were also surveyed.

Results

The HT intervention was well received by patients and supported by the nursing staff. Patients reported; finding the sessions helpful overall, creating a state of relaxation, reduced anxiety, pain and muscle tension. A total of 59 HT sessions were delivered during the four month pilot project with 57 complete evaluation sets. Eighty two percent of patients, found the sessions very helpful” or “quite a bit helpful” and 10% found them, “somewhat” or “a

little bit” helpful. The data showed an increasing benefit over time, suggesting an accumulative effect took place.

Conclusion

The goal for this pilot study has been met by demonstrating the ability to recruit and retain participants and to receive a high rate of positive qualitative feedback from both patients and staff. This suggests a HT Programme is feasible, acceptable and positive. The results have shown that HT can be a positive contributor to wellbeing in the Bone Marrow Transplant Unit (BMTU) and that HT therapy could be offered to all patients with minor changes to delivery and funding arrangements.

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Chapter One Introduction

Australia and New Zealand have the highest rates of leukaemia in the world (Franki, 2018). No other country has a higher incidence than these neighbouring countries. The reason behind this statistic warrants investigation. Research into the cause of haematological disorders such as leukaemia is important but so too is the need to find safe, cost effective and acceptable ways to address the human element involved in delivering nursing care, technical medical treatment and supportive care to patients and their families. Leukaemia has a higher incidence in males than females and in 2012 the rate in men was estimated to be 11.3 per 100,000 and in women it was 7.2 per 100,000 (Leukaemia New Zealand, 2017). New Zealand is estimated to have 21,000 people living with a blood cancer such as leukaemia, myeloma or lymphoma at any given time (Leukaemia New Zealand, 2017). Haematological diseases strike indiscriminately and patients become acutely unwell over the course of days or weeks. This disease can occur at any age and has a sudden and dramatic impact on a person's life. It is the fifth most common form of cancer in New Zealand and the most common cancer in children. <https://www.leukaemia.org.nz/information/about-blood-cancers/> Leukaemia is a considerable burden on families and on the health system because it is the most costly cancer to treat at an average cost of \$95,000 per case (Blakely, 2015).

Thesis outline

The Introduction situates the researcher's interest in the field of holistic nursing and explains how a Master's Research Thesis evolved from a simple suggestion, to provide "Healing Touch" treatments to a group of haematology patients.

Chapter one then offers a definition of the Healing Touch modality and outlines the historical roots and possible modes of action.

Chapter two begins to discuss gaps in the literature surrounding Leukaemia and Healing Touch and presents the research questions and hypotheses to be examined throughout the rest of the thesis.

Chapter three reviews the literature and examines the way other researchers have approached the topic and added their knowledge to the growing body of literature.

Chapter four restates the research questions and describes the methods and methodology utilised to gather data and the rationale behind these decisions.

Chapter five presents the results of the data generated from three patient focused research instruments and the evaluations gathered.

Chapter six deals with the discussion generated from the findings and looks at the strengths and limitations of this study along with recommendations for future research in this developing field of science and art.

Prologue

The experience of being a twelve year old patient, in hospital for an appendectomy, ignited my desire to be a nurse. I idolised the nurses as I watched them “nursing”, showing kindness to the patients, and utilising caring skills, as they went about their work. I remember their gentle touch but I cannot remember their names. I wonder where they are today, perhaps retired, even deceased? Those nurses will never know the impact they made on my career choice and I may never know the impact I make on patients I care for during my nursing career. People may not remember a name or exactly what was said to them but they do remember how they were made to feel and that is a fundamental role of HT a “Hands-on” energy based bio-field therapy.

The second life experience that prepared me for this Research Project was my late Mother's diagnosis and treatment for acute myeloid leukaemia. She spent long periods of time in the Bone Marrow Transplant Unit (BMTU) at Christchurch Hospital between 1999 and 2006. I felt an empathetic connection towards these patients and their families. Walking through those automatic doors to enter the Unit, washing my hands, and passing the nurse's station on route to see the patient, waiting expectantly in an isolation room felt all too familiar. These patients live in a surreal bubble, divorced by necessity from the rest of the world. Here I was in this environment again after eleven years. This time my purpose was to facilitate a research project, aimed at helping someone else's Mother/Father or relative to improve their "health related quality of life" (HRQoL), using Healing Touch (HT), a hands-on bio-field therapy, delivered by trained HT practitioners at the patient's bedside.

Thirdly, a friend introduced me to Energy Medicine over 12 years ago, and I started attending training courses until I had completed the pre-requisites to become a Certified International Healing Touch Practitioner (CHTP) in 2008. In the same year I travelled to America on a university scholarship which enabled me to visit seven hospitals, in six States, to observe the delivery of Complementary Therapy and Integrative Care programmes. I was particularly interested in mainstream health care facilities incorporating "Healing Touch" into their model of patient care. My goal was and still is, to raise awareness within the New Zealand health care system about the untapped potential of "touch" as a vital healing force. My goal is also to provide more opportunities for patients to experience bio-field therapies. A connection needs to be made between existing and emerging scientific information in the field of complementary and alternative modalities (CAM) and complementary integrative therapies (CITs). I present this work, not as a scientist, but as a nurse, a HT practitioner and a member of a community who has a vision to see touch therapies readily available to all who wish to

receive them. Observing this field of care first hand during my four week visit to America gave me the confidence to offer “Healing Touch” sessions to a rising number of students presenting with anxiety and depression at the University where I worked as a nurse until very recently. Over ten years have passed since this overseas experience and now there is a well-established “Healing Touch Clinic” providing this hands on nursing intervention to students and staff at the University of Canterbury Health Centre. This programme has been acknowledged by the referring general practitioners, nurses and counsellors as a valuable addition to standard care. The “Healing Touch and Relaxation Therapy” sessions are offered free of charge for funded and enrolled patients at this Practice.

A Definition of Healing Touch

Healing Touch bio-field therapy is a gentle complementary energy based approach to health and healing. The goal is to restore harmony and balance to the human energy system through a heart-centred caring relationship with the use of contact and non-contact touch. The Practitioner uses his/her hands to deliver gentle touch on or just above a fully clothed body. Healing Touch influences physical, mental, emotional, and spiritual aspects of healing. Some possible effects could include the reduction of pain, anxiety, nausea and a profound sense of relaxation which is often experienced during and following treatment, see the pamphlet in Appendix A Patient Information Pack.

Healing Touch is a relaxing, nurturing energy therapy which can positively affect a person’s health and well-being. The focus is on “healing” as opposed to “curing”. Curing is seen as an event where the goal is to eliminate or control the symptoms of disease. The body is also viewed like a defective machine Healing is a process where everything is understood to be connected and synergistic. When healing takes place it may be on multiple levels and the

intention is not simply to eradicate symptoms or disease but the focus is on the patients highest good. The HT Practitioner adopts a whole person approach to health and healing that forms the basis of a healing partnership and creates an environment that supports the healing process. HT is a blending of energies between the Healer and Healee which raises the vibrational frequency of the Healee's body and places it in a better position to self-heal. According to Gerber, the Healer creates a much needed energetic boost to push the Healee's total energetic system back into homeostasis (Gerber, 2001 p.305)

“The Universe does not hear what we are saying.

It feels the vibration you are offering.” Abraham Hicks (<https://jennifer365.com/blog>)

One of the most widely used classification structures for complementary and alternative therapies (CAM) and complementary integrative therapies (CITs), was developed by The National Centre for Complementary and Alternative Medicine [NCCAM \(2000\)](#), <https://nccih.nih.gov/> now known as National Institutes of Health (NIH), it divides these modalities into five categories:

1. Alternative medical systems
2. Mind-body interventions,
3. Biologically based treatments,
4. Manipulative and body-based methods
5. Energy therapies.

As the name implies, Alternative Medical Systems is a category that refers to an entire system of theory and practice that developed separately from conventional medicine. Examples of

these systems include traditional Chinese Medicine, Ayurveda Medicine, Homeopathy, and Naturopathy.

Mind-body therapies use a variety of techniques to enhance the mind's ability to affect body functions and symptoms. Examples include; guided imagery, meditation, yoga, biofeedback, music and art therapy, journaling, humour and prayer.

Biologically based therapies are substances found in nature such as herbs and essential oils, special diets and nutritional supplements.

Manipulative and body-based therapies involve movement of one or more parts of the body and include chiropractic medicine, osteopathy, massage and bodywork such as Feldenkrais and Rolfing.

The fifth category described by NCCAM is energy therapies which include the manipulation and application of energy fields within and around the body. In addition to electromagnetic fields outside of the body, it is hypothesized that energy fields exist within the body. The existence of these bio-fields has not been experimentally proven; however, a number of therapies include them, such as Qi gong, Reiki, and Therapeutic Touch/ Healing Touch. (NCCAM, 2002)

[The History of Energy Medicine](#)

Nikola Tesla is credited with saying; if you want to understand the universe, you need to understand, energy, frequency and vibration

https://www.goodreads.com/author/quotes/278.Nikola_Tesla

It would seem there is an increasing amount of scientific research being discovered and re-discovered about the role of electricity and magnetism which surrounds and interpenetrates

all living things. (Oschman, L (2000) documents the historical background of electricity and magnetism producing bio-magnetic fields used in medical diagnosis and treatment. Familiar diagnostic tools in use today are; x-ray, gamma ray and infrared rays as well as magnetic resonance imaging (MRI), electrocardiograms (ECG) and electroencephalograms (EEG). Audiograms utilise sound wave vibrations and thermal imaging utilises infrared radiation. These are examples of pulsing waves being widely used in Western medicine. Another example is the use of sound waves to destroy kidney stones through the mechanism of harmonic resonance. Kidney stones are crystals whose atoms vibrate at a particular frequency so by directing the same harmonic frequency towards the kidney stone it absorbs the energy and vibrates until it literally explodes. This is called constructive interference (Lipton, 2005 p. 88). Early works by Harold Saxton Burr between 1916 and 1935 focused on the development of the nervous system and electrical impulses. This was the era of antibiotic discovery and the use of x-rays to diagnose illness. Burr published 93 papers and his colleagues contributed many more to this field of science. He wrote a book called "Blueprint for Immortality: the Electric Patterns of Life (Burr, 1972) cited in (Oschman, 2000 p. 17). "Burr was convinced that the fields of life were the basic blueprints for all living things."

Energy fields have been used for healing since ancient times according to Oschman, (2000). By the late 1880s, thousands of physicians in the USA and Europe were using electricity daily to treat a wide range of ailments. Despite this activity mainstream medicine rejected the idea that living matter possesses a 'life force', known as vitalism'. In 1910, science was formally established as the basis for medicine, and medical schools were overhauled. Clinical electrotherapy became illegal in the USA. Few academic scientists dared to study the therapeutic potentials of energy fields except Burr, a Yale Professor, who was convinced energy fields were the basic blueprints for all life. Burr continued to research methods that

supported his belief about every physiological process having an electrical counterpart. Burr hypothesised that diseases altered energy fields before pathological changes began (Burr & Northrop, 1935). Others who concur with this philosophy include; Eden & Feinstein, (2008), Brennan, (1987), Zimmerman, (1990), Gerber,(2001) and Becker & Gary, (1985).

In the early 1980s, the Federal Drug Administration (FDA) cautiously began to approve electrical and magnetic devices to stimulate bone repair. This was the beginning of a new era in electromagnetic medicine. According to Oschman, (2000), modern research has confirmed the observations of Burr and his colleagues.

“As a phenomenon, bioenergy fields have gone from scientific “nonsense” to an important and expanding subject of biomedical research. In later chapters we see not only that fields can be detected at a distance from the body, but also that scientists are explaining how these fields are generated, why they become distorted when pathology is present, why living systems are so extraordinarily sensitive to fields, and how fields can be used in healing.”
(Oschman, 2000 p. 23.)

Oschman makes a very interesting point at the conclusion of his book by saying,

...while scientists were determining that tissues can extract meaningful signals from much higher levels of electromagnetic ‘noise’, engineers were developing sophisticated sensing devices with similar attributes. Many of these devices have been sent, at great expense, about as far away from humans as possible, to the outer edges of the solar system, where they record the properties of interstellar wind and other distant celestial phenomena. Why have we not turned these elegant sensors toward ourselves, to explore the kinds of

energies all of us can emit? Research of this kind is of profound medical importance (Oschman, 2000 p.260).

The Founder of Healing Touch

Janet Mentgen, (RN, BSN, CHTP/I) (1938-2005) formally created Healing Touch in the early 1980's as a nursing continuing education programme. Her vision was to spread healing light worldwide. While HT is practiced by people from all walks of life and can be self-administered, it was first taught to holistic nurses. Mentgen received the American Holistic Nurse of the Year Award in 1988. The Healing Touch certificate programme developed by Janet Mentgen was administered through the American Holistic Nurses Association (AHNA) from 1989-1996. It was then transferred to Healing Touch International (HTI) Inc. and in 2013 HTI became Healing Beyond Borders (HBB), a non-profit service organisation. HBB has a code of ethics and standards of practice and scope of practice, to ensure safe and ethical practice, see (Appendix H). Students of HT are taught a standardised curriculum so classes taught anywhere in the world are similar. Completion of the five levels of the HT programme takes a minimum of two years and international certification allows the use of the title Certified Healing Touch Practitioner (CHTP). Re-certification takes place every five years after that.

Eight core concepts are expressed in Healing Touch;

1. Health and quality of life are affected by the health of the energy system.
2. All life experiences are recorded and stored in the human energy system.
3. Centring, grounding and attuning are the first steps in facilitating healing.
4. Healing is a sacred process.
5. Self-care is empowering and supports health and healing.
6. Thought is a form of energy and precedes form.

7. The human energy system is influenced by thoughts, emotions and actions.
8. The energy of love has a wisdom of its own that calms, relaxes the body and promotes its natural ability to heal.

“Love one another and help others to rise to the higher levels, simply by pouring out love. Love is infectious and the greatest healing energy.” — Sai Baba (me2yousaying.blogspot.com/p/sai-babahtml) accessed 13/4/19

Jean Watson, a nursing theorist developed, “Human Caring Science”, a theory which seeks to advance human caring in nursing. Watson is a Distinguished Professor at the University of Colorado, and her Caring Theory makes explicit the values, knowledge and practices not just of nursing but of all the healing arts. (www.watsoncaringscience.org 2018).

Jean Watson is a strong supporter of HT and has authored or co-authored 14 books on Nursing Theory and Human Caring Science. Watson wrote the foreword in the twentieth anniversary edition of the “Healing Touch Guide Book- Practicing the Art and Science of Human Caring” by Dorothea Hover-Kramer (Hover-Kramer, 2000). Jean Watson upholds Healing Touch (HT) as an example of an intentional caring-healing modality grounded in ethics, philosophy, values and consciousness consistent with her original Theory of Human Caring and Transpersonal Caring. (www.watsoncaringscience.org)

[Nursing and Healing Touch Go Hand in Hand](#)

Healing Beyond Borders (HBB) also encourages the integration of HT into mainstream medicine and supports the work in over 30 countries world-wide.

“The richness of Healing Touch is that it lends itself to flowing to and across continents and cultures and maintains its standardisation while it melds with

the flavours of the area it serves.... As its foundation is from ancient sources, Healing Touch provides a renewal of knowledge into the importance of human touch and interaction” Wardell, Kagel, & Anselme, (2014)

Evidence based research pertaining to HT and bio-field therapies is increasing rapidly and at the time of writing this chapter (December 2018) there were 583 registered clinical trials for Healing Touch recorded with the US National Institutes of Health (ClinicalTrials.gov). According to Wesa 2009, Healing Touch is not purported to directly treat cancer but may decrease side effects associated with cancer or its treatment. It is nurturing, relaxing and pleasant to receive and can provide patients with a sense of control. Complementary therapies such as Healing Touch are rational, evidence-based, safe and cost effective to deliver (Wesa K., 2009)

Martha Rogers (1914-1994) is another American nursing theorist who has shaped modern day nursing. Roger’s created the “Science of Unitary Human Beings”, a theory which viewed nursing as both a science and an art. She theorized that the purpose of nurses was to promote the health and well-being of all people wherever they are.

Perhaps the most well-known nurse in history is Florence Nightingale (1820-1910). A British nurse in the Crimean War, she is credited as the founder of modern day nursing. She provided education on hygiene, especially hand washing and created strict sanitation rules which reduced the mortality rate of wounded soldiers in the Crimean War from 42.7 percent down to two percent in a matter of months (Mancini, 2018). International Nurses Day commemorates her birthday on May 12th each year. Nursing was not a respected profession in the 1800’s and because of poor wages it was generally associated with alcoholism, low

social status and prostitution to make ends meet. Today nurses' are valued members of society and well respected healthcare professionals.

The word "nurse" is both a noun and a verb. It is derived from the word "nurture" which can be defined as educating, nourishing and raising (McKivergren, 2000) "Nursing" also stands as a metaphor for caring-healing, wholeness, and connection with inner processes beyond treating the physical body alone (Watson 2012). Florence Nightingale (1859) states, the care of the body can never be separate from care of the soul. Healing Touch is focused on helping to put the patient in the best possible condition so nature can heal. Healing can be likened to planting a garden; we don't make the flowers grow, we simply prepare the soil and plant the seeds. All healing is self-healing meaning the body has an innate ability to heal itself but various medicines or procedures can change the environment and enhance the process. No Practitioner creates healing, instead the practitioner's role is to facilitate a peaceful environment so healing can occur at whatever level is possible for the individual. This means that Practitioner's know how to use themselves as a therapeutic agent who gives unconditional love to the best of their ability (Hover-Kramer, 2000 p. 138)

Healing is a process; one that involves the recognition of wholeness, and steadfast refusal to allow ourselves to be fragmented, even when we are terrified, or broken apart by life. Ultimately, healing is a coming to terms with things as they are, rather than struggling to force them to be as they once were, or as we would like them to be to feel secure, or to have what we sometimes think as our own way (Kabat-Zinn, 2018)

The technological advancements in nursing over the last decade, have reduced the opportunity for human to human and hands-on contact, during nursing interactions. The

result is fewer caring moments between nurse and patient. There is a machine to measure and monitor almost every bodily function and the machine distracts the nurse from patient focused interaction. Nursing has always encompassed the moral ideal of human caring, and according to Watson it consists of,

Transpersonal human to human attempts to protect, enhance, and preserve humanity and human dignity and wholeness by helping a person find meaning in illness, suffering, pain and existence and to help another gain self-knowledge, self-control, self-caring and self-healing wherein a sense of inner harmony is restored regardless of the external circumstances (Watson, 2012 p. 65)

Here lies the important difference between healing and curing. It is through healing, that a person moves to “be-in-right relationship with self/other and the wider universe.

Healing Touch Practitioners are taught to set an intention or healing goal, at the beginning of each HT session, for the client’s “highest good” and then to let go of any attachment to the outcome. This allows the healing process to be whatever is most appropriate in that moment in time. Some people may experience a pleasant relaxing sensation while others may experience an emotional release, a profound insight or an improvement in mind/body/spirit health.

Animals, plants and biological substances are also purported to have energy fields and have been shown to respond to bio-field Energy Healing techniques (Jana, 2018).

Experiments in this field, are not included in this pilot study, except to say some have been shown to rule out the placebo effect (Jana, 2018). The science of Epigenetics also demonstrates ways that every cell in the body has the potential to be affected by thoughts

and those thoughts create biochemical changes in the brain which explains how the mind and body link is created. Healing Touch raises awareness about the mind/body/spirit responses to thought which precedes reality (Lipton, 2005).

The Relaxation Response

There are many different healing practices and breathing techniques which elicit the body's relaxation response. The relaxation response can be observed occurring in a person during a HT session. It is often noticed as a deep sigh or a change in breathing pattern. Breathing awareness and rhythm is the gateway to many relaxation techniques such as; Focused Breathing, Meditation, Guided Imagery, Hypnosis, Yoga and Tai Chi. According to (Zelano, 2016) inhalation synchronizes brain oscillations across the limbic system which is responsible for emotion, memory and behaviour.

Scientists first discovered these differences in brain activity while studying seven patients with epilepsy who were scheduled for brain surgery. A week prior to surgery, an electrode was implanted into patients' brains to identify the origin of their seizures. Scientists acquired electro-physiological data directly from their brains. The recorded electrical signals showed brain activity fluctuated with breathing. This activity occurred in areas of the brain where emotions, memory and smell are processed (Zelano, 2016).

When the Practitioner notices this relaxation response, they are aware the client/patient has entered into an alpha brain wave pattern of 8-12 Hertz (Hz) which relates to being deeply relaxed in a state between wake and sleep. Brainwave speed is measured in Hertz (cycles per second) and is divided into bands of slow, moderate, and fast waves. Alpha brainwaves are dominant during quiet flowing thoughts and meditative states. Alpha is 'the power of now' and being in the present moment. Alpha is the state sought by those practicing the technique of "mindfulness". Alpha is a resting state for the brain and allows mental coordination,

calmness, clarity and alertness. This assists mind/body integration and the ability to learn. <https://www.brainworksneurotherapy.com/contacts>'. This state is most beneficial to support the body to self-heal.

Just as there is a relaxation response, there is also a stress response (Oschman, 2005). Psychological stress such as was documented in a recent study by (Shah et al., 2019) in patients with Sickle Cell Disease could cause the same stress as having a chronic, life threatening illness such as leukaemia. The impact on the autonomic nervous system reduces blood flow due to vasoconstriction.

Slow breathing with attention on the heart is a potent activator of the parasympathetic branch of the autonomic nervous system (ANS) which counteracts the stress response. This is taught as a quick coherence technique by the Heartmath programme (HeartMath Institute, n.d.). A slow breathing technique deactivates the release of stress hormones such as epinephrine and norepinephrine and interrupts the fight or flight response to activate the rest and digest response instead. Clearing stress hormones creates a mental shift and brings about a sense of calmness. HT utilises this body state by teaching practitioner preparation and the delivery of standardised techniques which induce relaxation or quiet the ANS. HT can be easily taught to anybody who is interested to learn. HT is not restricted to delivery by nurses. One of the barriers nurses trained in Healing Touch report, is the demands on their time does not allow them to spend as much "hands-on" quality time with patients as they would like (Frisch, 2016).

Engebretson (2002) writes about the metaphor of "hands-on" which has been used throughout the history of nursing, and reflects on the concept of patient-centred care. Some nurses have moved from holistic care of the patient to holistic use of self as healer. Unifying

the heart, head and hands; and working in harmony with nature is exemplified in healers using therapies such as HT, Therapeutic Touch (TT) and Reiki. Head and heart unite with the action of the hands with the intent to heal. (Engebretson, 2002 p.23)

Other ways HT may influence health and wellbeing.

Modern science now teaches the concept of the heart being much more than a muscle pumping blood around the body. Eastern philosophies have long held a wider view of the heart's role in the body. In the 1960's and 1970's, researchers' John and Beatrice Lacey found the heart was able to "talk" to the brain and this was the beginning of two decades of work which formed the basis of a new understanding about the role of the heart and how people perceive and react to the world they live in. In the last twenty years new discoveries by researchers such as Shaffer, McCraty, and Zerr (2014) and also Lipton (2005), have been referred to as the "new biology". These key discoveries relate to the field of HT and show how the heart communicates with the brain and the body in four unique ways.

- Firstly a pulse wave ripples throughout the body with each heartbeat, causing a tiny vibration in every cell of the body and this is referred to as biophysical communication.
- Secondly, a sophisticated nervous system containing a network of about 40,000 neurons, gives the heart an ability to sense and process information from the environment, facilitating neurological communication.
- Thirdly, the heart processes a biochemical communication pathway secreting hormones. In 1983 the heart was reclassified as an endocrine

gland when it was discovered to produce a hormone called atrial natriuretic factor (ANF).

- Fourthly, the heart communicates energetically, it possesses an electromagnetic field that can be measured on the body and 2-3 metres away. An electrocardiogram (ECG), measures the heart's electromagnetic field and an electroencephalogram (EEG) measures the brain's electromagnetic field. This shows measurable activity taking place in real time and a synchronization takes place between the brain and the heart when the body is brought into a state of coherence. When the heart and the brain are in full coherence, the body responds in amazing ways according to literature from the HeartMath Institute. (HeartMath Institute, n.d.)

In summary, the heart communicates with the body in four ways: neurological communication (nervous system), biochemical communication (hormones), biophysical communication (pulse waves) and energetic communication (electromagnetic fields) (McCraty, 2015 p.3)

This finding supports one of the ways in which Healing Touch could influence the state of the body through contact and non-contact touch between practitioner and client. Rollin McCraty, Ph.D., director of research at the "HeartMath Institute", demonstrated how the heart and the brain possess an ability to communicate within the body but even more significant is the fact that they communicate between people and between animals and people (McCraty et al., 1999). His research showed, when two people hold hands there is a synchronization that takes place called "entrainment" and this is seen when the brain wave pattern from one

person shows up in the heart rate recording of the other person which was seen in “real time”. (McCraty, Atkinson, & Tiller, 1999) Giving HT is a form of communication, in which the hands do the talking. Presuming the heart communicates with the body in the four ways mentioned above, and the brain communicates with the body via the heart (and the senses), it seems logical to assume the human hand would also possess the ability to connect energetically and physically to modulate cellular activity in and around the body.

Touch

The pioneering work of Dr Tiffany Field began in the 1980's and found simple touch could stimulate the growth and development of pre-term infants. In 1986 Field established the Touch Research Institute and carried out many studies demonstrating strong evidence in support of the positive effects of touch throughout the human lifespan. Dr Tiffany Field focused her early research on the benefit of touch with premature babies who were gently stroked three times a day. The results showed these babies gained more weight and left hospital sooner than their counterparts receiving standard care and therefore less touch. (Scafidi & Field, 1990). This touch therapy for babies involves direct skin to skin contact so it is important not to confuse HT with massage. The recipient of HT is fully clothed but may receive techniques that involve massage to both hands and feet. Generally HT is performed over top of clothes and a blanket covering the client or patient.

Touch stimulates changes in the body, physically, emotionally and spiritually. Previous studies in the area of energy healing suggest healing modalities have efficacy in reducing anxiety; improving muscle relaxation; aiding in stress reduction, relaxation, and creating a sense of well-being; promoting wound healing; and reducing pain. (Engebretson & Wardell, 2007) "Touch seems to have analgesic potential without the risk of side-effects."

Slater (2018) found the optimal pain-reducing stroking speed was about three centimetres per second. Observations suggest parents intuitively stroke their babies at this rate and that speed of stroking activates a class of sensory neurons in the skin called C-tactile afferents (nerve cells), which are known to reduce pain in adults.

Eco psychology

Eco psychology is a new field of Western Science which studies the relationship between man and the natural world. Warren Grossman is an orthopaedic surgeon who attributes some of our daily stress to the disconnection from the earth <https://warrengrossman.com> the mental and physical benefits of being in natural environments are being recommended by doctors around the world. Man's electromagnetic link with the earth through his feet is verifiable (Stevens, 2014). This earth connection is referred to as "grounding". In HT it is taught as an important first step in healer preparation preceding each HT session.

Healing Presence

Osterman (2002) talks about two dimensions of presence: the physical state of "being there" and the psychological state of "being present with" which relates to a mind to mind connection.

Presence is "being there" but the quality of "being there" is explained by the "Presence Framework" of Osterman and Schwartz-Barcotti (Osterman, 2002)

"Authentic presence in a given moment between persons captures the human to human spirit to spirit connection, which is experientially felt but may not be detected by an outside objective observer." Jean Watson

Support for a Multidimensional and Integrative Model of Healing Worldwide

The Quantum University curriculum encompasses a reinvention of Integrative Medicine to introduce the name, Pro-Consciousness Medicine. It states, “The knowledge of the subtle energy body and its effect on the human body must be added to the current model and teachings of human anatomy.” <https://quantumuniversity.com>

Quantum University teaches medical professionals to reinvent the client practitioner relationship and realize how each patient can participate in their own healing. The intention here is to broaden the use of healing modalities that are based on these new scientific discoveries that understand quantum entanglement and the field of consciousness. This will restore the balance between the doctor and patient, empowering the patient to understand the role they play in their own healing instead of focusing on treatment for the symptoms they are experiencing. “Pro-Consciousness Medicine will implement an integrative vision that transforms medicine into something better and greater through a deeper understanding of the role human consciousness plays in the human body and overall health and well-being.” (<https://quantumuniversity.com>)

Body mind and spirit come into balance and harmony when consciousness and emotions serve as the door into the physical being. How a person perceives and responds in a given situation depends on past experience and emotions which are attached to that experience.

A pre-summit policy roundtable report by the European Congress for Integrative Medicine (ECIM) 2015 Global Summit on Integrative Medicine and Healthcare held in September 2015 in Copenhagen, called for strategic policies in support of integrated health care that would include a vision for setting up “an integrative medicine (IM) department in at least one hospital in every European country. Globally there is a strong need to tackle issues related to

health systems, efficiency of health care and the rising cost of health care delivery throughout the world. The constant increase of health system expenditure is not synchronized with the quality of health care. Also, there is a rich data base of knowledge and research; positive results are available but little of it is in use. Cooperation is required, among all stakeholders for each country, in order to establish policies implement changes towards better efficiency, coverage and costs Ostojić & Saxer, (2016).

Conclusion

Chapter one explains how this research project evolved and the relevance of the researcher's life experience as a nurse and HT Practitioner. It also provides a definition of HT and credits Janet Mentgen as the founder of this modern day healing modality. A frequently used framework from the NIH showed where HT fits in comparison with other complementary and alternative therapies. Chapter one also talks about the scientific basis for energy medicine and research by Harold Saxton Burr from as far back as 1916 and how the growing body of scientific knowledge may explain possible mechanisms of action for HT. Chapter one finishes by suggesting there is global support for Integrative and Complementary Medicine in an effort to provide safe, cost effective supportive care for patients.

The research questions and hypothesis follow, to give some context to the information presented in Chapter Two and then the literature review in Chapter Three.

Research questions (RQ) and hypotheses (HY)

RQ 1: Is HT feasible to deliver and acceptable to receive by patients hospitalised with haematological disorders?

HY 1: Supportive care in the form of a hands-on complementary modality improves the patient's subjective well-being measures.

RQ 2: Is the patient experience of receiving HT measurable, pleasurable and positive?

HY 2: Certain patient conditions or patient groups respond in a positive way to HT therapy.

RQ 3: What is the optimal effect of repeated HT treatments on patients improved sense of well-being?

HY 3: There is sustained and accumulative effects from repeated HT treatments that persist into the next day

Chapter Two

Chapter two will talk about a diagnosis of leukaemia, a haematological disorder and the prevalence in New Zealand and world-wide. The Bone Marrow Transplant Unit (BMTU) will be described and the rationale for patient placement and management here. An explanation of the HT intervention and the research questions being asked are also presented in this chapter.

Leukaemia

Leukaemia is the name given to a group of cancers that develop in the bone marrow. According to the Leukaemia & Blood Cancer NZ website, (Leukaemia New Zealand, 2017) six children and adults in NZ are diagnosed every day with a blood cancer such as leukaemia, lymphoma or myeloma and 10,000 people in NZ are living with the condition. It is the most common childhood cancer and fifth most common cancer in New Zealand. Cases worldwide are increasing (Miladinia, (2016)). A diagnosis of blood cancer can have far-reaching consequences. It can strike anyone, at any age without warning and immediate medical treatment is necessary and may go on for months or even years. Such a diagnosis can change a person's life overnight and have a significant impact on every aspect of life affecting family, friends, income, career or school as well as mental and spiritual well-being.

Leukaemia is a chronic disease involving the bone marrow that increases the number of abnormal blood cells and decreases the number of normal blood cells. There are two categories; myeloblastic and lymphoblastic and these may be acute or chronic.

One of the most common problems patients experience due to leukocyte infiltration in the tissues is anaemia, which reduces the oxygen carrying capacity of the blood and causes

extreme fatigue. Other symptoms patients experience from various haematological disorders which includes leukaemia are; pain, bruising, mucositis, nutritional deficiencies, weight loss, nausea, vomiting, digestive upsets, sleep disturbance, impaired body image, anxiety and depression. These symptoms reduce quality of life even before a person undergoes chemotherapy, radiotherapy or bone marrow transplantation. The patients' condition may be acute or chronic and newly diagnosed or relapsed. Even when the medical decision is to adopt a wait and watch approach, the level of anxiety may be very high and life constantly stressful. The opportunity for patients to experience a calming, relaxing therapy that requires no energy expenditure on the part of the patient is a worthwhile adjunct to treatment options and a source of supportive therapy. Healing Touch is safe for all ages and stages of disease it offers a relaxing and nurturing experience that is therapeutic and able to improve patient quality of life (Slater, 1996).

Current management of patients experiencing unwanted side effects from the illness and treatment of leukaemia relies predominantly on pharmacology which in itself can create adverse effects. Anti-nausea medication for example has the potential to cause sleepiness, dizziness, headaches, dry mouth, constipation or diarrhoea, anxiety and mood changes.

Psychological distress has often been the domain of the clinical psychologist and spiritual issues have been referred to the hospital chaplaincy team or the appropriate cultural or religious ministers such as Kaumatua for Māori but positive human touch could be the one thing that is common to all peoples yet lacking in today's high tech medical environments (Pohl et al., 2007). For all medicines technological strides, it can't afford to lose touch with the caring side of patient care (Dossey, 2003)

The Bone Marrow Transplant Unit in Christchurch Hospital in 2017

In Christchurch people being treated for leukaemia are cared for by the haematology team and may be in the Bone Marrow Transplant Unit (BMTU). The physical location of the hospital haematology department and the BMTU is close to the Avon River consequently the water and willow trees harbour the aspergillus fungus species. The potential of contracting aspergillosis is a serious risk to patients with blood cancers, a low white blood count, who are on immunosuppressive drugs or undergoing chemotherapy or organ transplant. Some patients being nursed in protective isolation in Christchurch may not require this in other geographical locations. A 2019 prospective study of patients with oncological-haematological malignancies was conducted in 10 Italian centres examining factors affecting patient's perception of protective isolation. Factors associated with negative isolation experiences were; male sex, low education, double room, low satisfaction with visiting times and poor emotional support from nurses (Biagioli V, Piredda M, & Annibali O, 2019).

The haematology team recognised a potential benefit to the patients of providing supportive complementary therapy to improve their health related quality of life at a time when patients are facing a life threatening illness. According to the Clinical Nurse Specialist at the BMTU, there is a gap in what is currently available for hospitalised patients in the form of relaxation therapies so this Pilot Project was designed as an Experimental, Interventional Study, using Qualitative and Quantitative methods to evaluate the effect of delivering a "hands-on" complementary therapy, as supportive care to hospitalised patients with blood cancers.

The BMTU in Christchurch has 15 beds therefore 15 patients would have been the maximum number available to treat if everyone was eligible and willing to participate in this pilot project. There was no minimum patient recruitment requirement as this was a feasibility/pilot study

and as such, all eligible patients were invited to participate and those recruited over the course of the intervention period became the study sample. Sufficient numbers were recruited to enable power calculations to be undertaken for a more definitive comparativeness trial at a later date. The patients who opted to receive the treatment sessions on a twice weekly basis, served as their own controls as it was not possible to have a control group during this experimental stage.

The Clinical Nurse Specialist CNS provided pertinent education to the Certified Healing Touch Practitioners CHTP's prior to the commencement of the research project. She arranged a familiarisation visit to the Unit and discussed any concerns the practitioners held. The CNS educated the HT providers about the patients who were hospitalised with leukaemia's and the particular issues they were facing. The significant psychological impact on patients and their families was discussed. The diagnosis was always a huge shock and generally created a feeling of disbelief for all involved. On top of this was the social and physical impact caused by long hospital stays time being nursed in isolation units.

Patients could expect to be in and out of the BMTU for a period of six months or longer during which time they would probably not be well enough to work. This could result in serious financial pressures on top of those already mentioned. Chemotherapy treatment is divided into three to four cycles of four to six weeks in duration. By the time patients have recovered from a cycle of chemotherapy it is time to start the next round. The aim for people who are newly diagnosed is remission and the long term goal is for a cure, however the five year survival rate of people diagnosed with acute leukaemia is 50-60%. Approximately 50% of patients are expected to respond to medical treatment for leukaemia while some will die, others will go into remission and relapse only to return months or years later (W Jar, personal

communication, Jan 27, 2017). Treatment depends on age, co-morbidities, type of haematological disease and the stage of the disease.

Gaps in research knowledge about Healing Touch bio-field therapy

The National Centre for Complementary and Integrative Health (NCCIH) 2016 Strategic Plan emphasizes fundamental research to advance understanding of the mechanisms through which mind and body approaches affect health, resiliency, and well-being.

“Large clinical studies are an essential component of the evidence base regarding clinical efficacy or effectiveness. To implement such studies, the magnitude and nature of treatment effects must be estimated in preliminary studies, treatment algorithms must be developed and validated, and feasibility of accrual must be established. Methods need to be in place to measure consistency and fidelity of protocol implementation, practitioner variability, and adherence of participants to the regimens being studied. In addition, well-characterized and meaningful clinical and laboratory outcome measures are needed to fully determine safety, and to definitively measure benefit or lack thereof.” <https://nccih.nih.gov/grants/mindbody>

The field of energy healing modalities such as Healing Touch, does not readily lend itself to traditional scientific analysis because paradoxical findings often co-exist (Wardell & Weymouth, 2004). What is reported to have been missing in many studies is information about practitioner experience, confounding variables and the specific HT techniques used.

The Research Committee of Healing Beyond Borders, educates and certifies Healing Touch Practitioners worldwide and it has identified certain areas of research that are lacking or have not yet been explored. There are five areas needing to be addressed;

- 1) To determine the effect of “dose” of Healing Touch, including frequency and duration of sessions and techniques used, in general and for persons with a particular clinical condition or diagnosis.
- 2) Engage in bidirectional, translational research between clinical and preclinical studies (basic science) and settings to provide a more complete picture of health, illness and treatment related to Healing Touch.
- 3) Explore how Healing Touch might work at the physiological level, particularly looking at stress related immunological, or other independent pathways.
- 4) Determine the contributions of practitioner training, intention, treatment expectation, meaning and context in Healing Touch using a mixed methods approach.
- 5) Present and publish research in peer-reviewed journals whenever possible to build the evidence base. (Anderson, Der-Fa, Strybol, Hess, & Mangione, 2015) (www.healingbeyondborders.org)

Summary

In summary, Leukaemia is a disease that has sudden onset and causes major psychological, emotional, social, physical, mental and spiritual turmoil, leading to high levels of chronic, unrelieved stress.

Healing Touch is a complementary bio-field therapy grounded in the art and science of nursing. It sits comfortably with nursing theorists both ancient and modern from Florence Nightingale to Martha Rogers and Jean Watson.

It is a safe, cost effective and nurturing way to provide individualised care and support for patients of all ages experiencing a wide range of dis-eases. In the context of this research the focus will be on treatments provided to a homogenous group of ten inpatients with haematological disorders in 2017. The results of this study focus on the patient experience of receiving HT sessions for 50-60minutes twice a week. The Practitioners choice of technique will be of interest to future researchers designing methods to study HT while still retaining the true essence of a heart-centred modality.

Chapter Three Literature Review

In this chapter the purpose of the literature review is explained and will give context to my research. The search terms and criteria are defined before going on to discuss the “hierarchical levels of evidence” used to grade and evaluate the relevant literature. Two systems will be presented and specific examples given of where Healing Touch (HT) studies sit in relation to these criterion. Only studies where HT is the key intervention have been chosen for this review. Research from the last decade (2008 – 2018) will be grouped under the conditions for which HT was utilised. Some earlier works pertinent to this study are included and so are some relevant new studies published after 2018. The literature relevant to this research project will be examined and credited for the way it has influenced the design and methodology of this study. Lastly I will discuss the limitations, the gaps and the ambiguities before finishing this chapter by looking into what the literature has to say about the future of complementary and alternative medicine (CAM) therapies, and integrative medicine (IM).

Methods

The literature search was conducted during 2018. Databases searched; Cumulative Index to Nursing and Allied Health Literature (CINAHL), EMBASE, Cochrane Library, Clinical Trials Database, Scopus, Medline, PsycINFO, PubMed, Science Direct, Web of Science. Google Scholar was also searched using the key words “Healing Touch” bio field therapies, energy healing, energy medicine and complementary nursing intervention. Many sources use the term “healing touch” in a general way which retrieved 1,200 references to appraise in an effort to identify those sources that were relevant to the specific nursing intervention of HT. Since 2018 there have been a further 72 results using the same search criteria and 21 results up until June 2019. Bibliographies on the websites of two organisations; Healing Beyond

Borders (HBB) and Healing Touch Program (HTP) were also used in the literature search.

Healing Beyond Borders (HBB) is an international organisation that trains and certifies HT Practitioners worldwide. It holds a repository for bio-field therapy research and offers guidance for future research strategies. Healing Touch Program (HTP) could be described as a sister organisation with a similar role. Both organisations are based in the USA which is home to the HT modality www.healingbeyondborders.org,

www.healingtouchprogram.com

A second search string in the same databases looked at supportive care in cancer and non-communicable diseases (NCD), health related quality of life (HRQOL), complementary and alternative medicine (CAM) and integrative medicine (IM).

A third search thread looked specifically for the term “Healing Touch” in relation to haematological disorders, such as Leukaemia. The HT modality was of interest when it was being delivered in a clinical setting, as an intervention for human subjects. Studies using Healing Touch on animals, plants and biological substances have not been included nor have those that were specifically looking at other similar therapies such as Reiki and Therapeutic Touch. The search limitations were; English language, and no other complementary therapies, although these may be referred to in this literature review if they feature as a comparator in a HT study.

The search encompassed the grey literature which gave rise to eighteen unpublished master’s theses or doctoral dissertations which were discovered by ancestral searching using the reference lists (Wicking, 2012).

The Clinical Trails website was also searched. This website is a registry and results database administered by the US National Institutes of Health (NIH), as a resource provided by the U.S. National Library of Medicine. <https://clinicaltrials.gov> Researchers from any country can register a trial and update the trial as it progresses onto completion. Australia and New Zealand also have a registry for trials conducted within these two countries and a search revealed no trails on this site www.anzctr.org.au Under the search term “Healing Touch Therapy”, there were eighteen completed studies registered and two of these involved patients with a haematological disorder but not all research is required to be registered so it is not an accurate reflection on what is currently being researched or has already been undertaken in the field of HT.

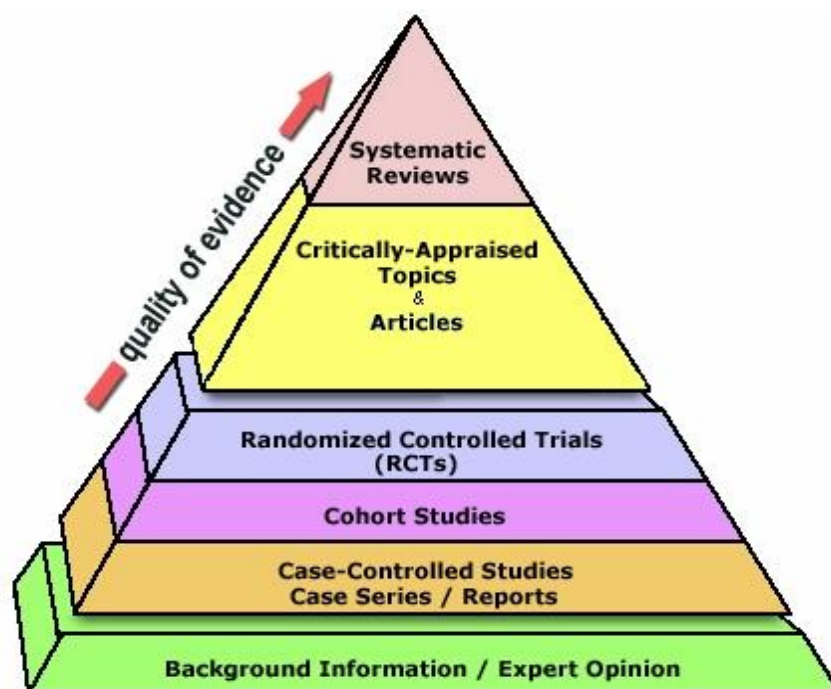


Figure 1. The seven hierarchical levels of evidence

Levels of Evidence

All the research literature examined, spanned the seven hierarchical levels of evidence, (Ingham-Broomfield, 2016) cited in (Glover 2006) based on the nursing research pyramid.

(See Figure 1)

This hierarchical system can be pictured as a triangle or pyramid containing the relevant research categories. The least rigorous research makes up the majority of the literature which fits at the base of the pyramid model. The most reputable studies sit at the apex of this model. At the apex of this research pyramid model, sits meta-analyses, of which there appear to be no studies relating to HT, followed by Systematic Reviews, of which there is one by Anderson, Der-Fa, et al. (2015). At level three there are more than twenty two, randomised controlled trials identified. These studies are recognised as having the highest standards in evidence-based practice and must be of sound design, scientific and reproducible to fit this criteria.

“The field of energy healing does not readily lend itself to traditional scientific analysis because paradoxical findings often co-exist” (Wardell & Weymouth, 2004).

What is missing from many studies is detailed information about the practitioner’s experience, techniques they used, the duration of the session (dose) and frequency of the treatment. An example of the level of scrutiny given to each study identified for a systematic review is seen in Anderson, Der-Fa, et al. (2015). This search result identified three hundred and thirty two (332) potential studies and three hundred and twenty seven (327) were excluded as they did not meet the criteria. That left five RCT’s eligible to be included by Anderson (2015).

Another simple way used to assess the literature, has been presented by the Research Committee of Healing Beyond Borders (HBB). In their publication “Healing Touch Research Brief”, 2015, (p. 5) the research grading appears as;

“A”, strong evidence,

”B”, good evidence

“C”, conflicting evidence.

Strong means “findings from three or more rigorous clinical studies, including randomized controlled trials, showing statistically significant evidence of benefit.” Good, means “findings from one or two strong clinical studies showing statistically significant evidence of benefit” and Conflicting Evidence forms category “C”, meaning findings from clinical studies showing conflicting results to some benefit, or results from basic science research. Studies here are grouped under populations and conditions rather than the evidence based hierarchy of the research.

Conditions and Populations

There are many conditions and populations for which HT has been used, as the following list will show. These include, but are not limited to; cardiovascular disease, coronary artery bypass surgery, anxiety, stress reduction, depression, pain, fatigue, bi-lateral total knee arthroplasty, bariatric surgery, breast cancer, bowel cancer, cervical cancer, ovarian cancer, children with cancer, cancer related fatigue, spinal cord injury, PTSD, elderly, HIV, sickle cell disease, hepatitis C, palliative care, spirituality and leukaemia.

In some of these conditions, such as Sickle Cell Disease and Hepatitis C, only one or two studies have been published, conversely for other broad fields such as cancer, there have been at least twenty seven studies published since 2002.

The earliest Therapeutic Touch studies were conducted by Delores Kreiger (Krieger, 1975) and Janet Mentgen created Healing Touch as a continuing education programme in the 1980's (Mentgen, 1996). The most recent research published at the time of writing the literature review, identified Gentile D et al. (2018) and the condition addressed was cancer pain. This study avoids some of the criticisms made in systematic reviews of earlier HT studies specifically in Wardell and Weymouth (2004) and Anderson and Taylor (2011) which noted small sample sizes and failure to include important details such as; practitioner training, techniques used, statistical analysis and lack of a control group or suitable comparator. These deficiencies reflected negatively on the field of CAM research, at this time. Gentile D et al. (2018), sought to establish and compare the effectiveness of HT and Oncology Massage (OM) in achieving clinically significant improvement in cancer related pain, after one therapy session. This is thought to be the largest study to date, examining a retrospective review of 1,644 HT patient's data and 1,504 OM patients' data. Ultimately, a cohort of 572 patients with cancer pain was analysed. The study design was an observational, retrospective, pre-test/post-test study of a single HT or OM therapy session. The length of session was documented as were the credentials of the practitioners and the techniques they adopted. This study used a non-experimentally manipulated clinical environment (a strength of the study) and it allowed patients to self-select to either HT or OM. It notes some limitations, confounding variables and suggestions for future research. Most importantly the need to assess the longevity of pain improvement and the optimal number of treatment sessions or dose required to achieve this.

Cardiovascular Disease

The strongest evidence for HT has been seen in the field of cardiovascular disease and well-being measures such as improvement in anxiety, mood, quality of life, attitudes and beliefs.

There are at least nine studies in this section showing some benefit to patient well-being and the most notable result is a statistically significant decrease in length of hospital stay after coronary artery bypass surgery (MacIntyre et al., 2008). This randomized controlled trial comprised 237 patients undergoing coronary artery bypass surgery in a hospital setting. Patients were randomised into three groups; “no intervention, “partial intervention comprising a visitor” and the HT intervention, which comprised of one HT session the day before surgery, immediately prior to surgery and the day after surgery. The study measured six items for comparison between groups; length of hospital stay, use of anti-nausea medication, use of pain relief medication, incidence of post-operative atrial fibrillation, functional ability and anxiety. Results showed no reduction in pain or anti-nausea medication between the groups but results did show a significant decrease in anxiety and length of hospital stay compared with the visitor group and the standard care group. This outcome lends support for the use of HT as a cost saving measure for hospitals.

Noetic Therapies and Cardiovascular Disease

Three other studies on the theme of cardiovascular conditions are; M. W. Krucoff et al. (2001), Krucoff et al. (2005), Seskevich, Crater, Lane, and Krucoff (2004). Krucoff is an interventional cardiologist at Duke University Medical Centre in Durham, North Carolina and lead author of the MANTRA studies. He researched the use of “Noetic Therapies” – music, imagery, touch therapy and prayer, in what is referred to as the MANTRA I, feasibility pilot study in 2001 and the MANTRA 2 follow up study in 2005. MANTRA refers to Monitoring and Actualization of Noetic Trainings. Noetic therapies is a generic term referring to non-drug

and non-device interventions for a medical condition. Examples are; distant intercessory prayer, music, guided imagery and touch/bio-field therapies. Music, imagery, touch equals the abbreviation in this study (MIT). Healing Touch was one of the noetic therapies delivered.

“While these are ancient healing modalities in all of the world’s cultures, the scientific literature and understanding of the role of intangible human capacities in our world of high tech medical care is very, very young” said Krucoff. “The MANTRA 2 study shows that we can do good science in this arena, and that we can disseminate what we learn in high-level peer-reviewed publications. <https://corporate.dukehealth.org>.

Krucoff’s research was the first multicentre, prospective, randomized trial of distant intercessory prayer, bedside music, imagery and touch therapy. A total of 748 patients experiencing coronary artery disease and undergoing interventional heart procedures, were enrolled in the study between May 1999 and December 2002. The prayer portion of the randomization was double-blinded. Nine locations randomised four patient groups into; off-site intercessory prayer and music, imagery, touch (MIT) 189 patients, another group of 182 patients received off-site intercessory prayer only, a third group received MIT alone and the fourth group (192 patients) acted as the control group and received no intercessory prayer or MIT. MIT was performed by a certified practitioner for forty minute sessions at the patient’s bedside prior to the cardiac intervention. The practitioner applied twenty one healing touch hand positions, each held for forty five seconds. The patient was also taught relaxation breathing, choose music to listen to through headphones and selected an image of a beautiful nature scene to focus on. No significant differences were found between the treatment groups in the primary outcome measures but there was a reduction in pre-

procedural distress in the MIT group. This group showed changes in self-rated emotional distress. However in the six-monthly follow up the mortality rate was lower in patients assigned MIT and lower still in patients receiving both prayer and MIT when compared to the control group receiving standard care with no interventions. The strengths of this study include; the number of participants giving statistical weight, the nine medical centres contributing participants giving wide applicability, the reproducibility of interventions by using specific guidelines and documented experience of the practitioner delivering interventions. Six month post intervention follow up was yet another strength of this study.

Beneficial effects of noetic therapies on mood before a medical intervention for unstable coronary syndromes was examined in Seskevich et al. (2004). These studies covered more than one condition and involved using HT for stress reduction, for anxiety and depressed mood to enhance recovery from cardiac surgery. Hence the difficulty of researching the role of HT for a particular condition or a particular symptom. HT practitioners adhere to the belief that body, mind and spirit are interconnected and cannot be treated as separate parts. Integrative therapies are just that; they integrate, connect and enhance the whole human energy structure by creating a coherent state of being.

Stress, Anxiety and Depressed Mood

Depression and heart disease have been shown to be strongly connected Lin, Lin, Lin, Huang (2011) and Jackson, Cathie, and Sudlow (2018). In fact loneliness and dying of a “broken heart” (acute stress cardiomyopathy) have also been recognised as causes of death (Marshall, 2016). This information is being studied and disseminated by a variety of people and organisations including the “Heart Math Institute.” <https://www.heartmath.org/>. Since 1991, the Heart Math Institute has researched and developed reliable, scientifically based

tools to help people understand and measure the connection that exists between the heart and the mind. Thoughts and emotions are able to produce biological changes in the body. Negative emotions such as frustration, irritation, anger, sadness and trauma get the body wound up and when these emotions are chronically present they can be responsible for the development of hypertension, cardiovascular disease, gastrointestinal problems and substance abuse. Conversely, positive emotions such as gratitude, satisfaction, compassion and joy produce beneficial effects on the nervous system. (<https://www.ijhc.org/wholistic-healing>)

“Much illness is unhappiness sailing under a physiologic flag.” - Rudolf Virchow

MacIntyre et al. (2008), showed patients experiencing stress due to coronary artery bypass surgery or invasive medical procedures exhibited decreased feelings of worry after exposure to HT, compared to a visitor only group or a control group receiving care as usual.

Cancer Care

A randomised placebo controlled trial was carried out by Cook, Guerrerio, and Slater (2004) using a two parallel arm design on sixty two women undergoing radiation treatment for gynaecological or breast cancer. The participants received either six HT sessions or the same number of placebo treatments for a duration of thirty minutes weekly over a four to six week period. Those who received HT showed improved health related quality of life (HRQoL) scores in the areas of vitality, pain and physical functioning. The HT arm reported less fatigue but not enough to reach statistical significance. The mock/sham HT sessions and the authentic HT treatments were delivered behind a large opaque screen situated at the patient's neckline as they lay on a massage bed. The practitioners were instructed not to touch the participants or speak to them. Cook et al. (2004) has been cited as an example of

a well-designed clinical trial utilising a placebo treatment in comparison to HT. Despite the scientific rigour of these results in Cook et al. (2004). The potential HT treatment effect may have been very diluted by this design protocol. A trial of this nature would not resemble a “real life” clinical setting, where HT is delivered as a nurturing, comforting gentle touch therapy that utilises both hands-on and hands-off the body and would involve some verbal communication before and after the session. A two parallel arm design with a placebo was used by the following three researchers. Schnepfer (2009), whose subjects were woman with breast cancer receiving radiotherapy treatment and HT. Taylor (2008) studied a group receiving interferon treatment for Hepatitis C and Jain (2009) measured changes in fatigue and cortisol variability in breast cancer patients receiving HT treatment sessions. Another frequently cited study Wicking (2012) appears to have been influenced by the need to use a mock treatment in her desire for scientific rigour in 2008.

Wicking (2012) undertook a randomised placebo control trial (RCT) conducted for a PhD dissertation at James Cook University, Townsville Australia, to examine the effects of Healing Touch on the functional health status of community-dwelling single women over the age of sixty-five. The conclusion showed HT may have a beneficial effect for selected older adults, with the HT group showing a modest improvement in social support and the placebo group showing a decline. It is possible the outcome could have been different if the whole HT treatment package had been delivered in a less clinical style. Older people living alone are known to lack physical touch and if touch therapy elicits a “relaxation response” as Park et al. (2013) explains, then the biological changes that occur in response to nurturing touch may be missing with mock and non-contact touch trials. Part of the potential HT encounter is not being experienced.

Psychological and Emotional Wellbeing

The conclusions reached by Wicking (2012) show no statistically significant difference between the HT group and the mock HT group in psychological wellbeing scores. This is contrary to much of the earlier research on HT where thirteen studies reported positive outcomes for psychological wellbeing, eight of which were RCTs.

Quality of life measures in cancer patients have appeared in three other studies showing HT to have a positive impact on health and well-being by eliciting a relaxation response, reducing pain and anxiety and decreasing depressive symptoms. Post-White et al., (2003), Lutgendorf, (2010) & Jain & Mills, (2010).

Post-White et al. (2003), used a three group, crossover design comprising of 230 participants, (not blinded to group assignment), to test the effects of therapeutic massage versus HT in comparison to presence alone or standard care. Massage Therapy (MT) and HT lowered blood pressure, respiratory rate and heart rate. Pain was reduced after massage therapy and after HT. Nonsteroidal anti-inflammatory pain relief use was lower in the MT group but there was no effect on nausea. This finding supports the same outcome as did my pilot study. Overall MT and HT are reported to be more effective than “presence” or “standard care” alone in reducing pain, improving mood, and lessening fatigue in patients receiving chemotherapy.

Improvement in well-being and longer term quality of life.

Krucoff et al., (2001, 2005).has already been mentioned under the cardiovascular condition of uses for HT Therapy. It also fits here under the above heading. In the MANTRA 1, pilot study, a single HT session was delivered to 118 patients prior to cardiac catheterization, using a pre and post treatment rating. The patients were randomized into five parallel arms, using the noetic therapies: standard care, imagery, prayer, and HT and stress relaxation.

Analysis showed no statistical difference on anxiety measures in any of the five groups but there was a twenty five to thirty percent reduction in adverse events during the six month follow up period for patients treated with any of the four noetic therapies. This suggests they were all effective therapies.

In the MANTRA II study Krucoff et al. (2005) is noted to be one of the few researchers who built on from an earlier pilot study and moved to the next phase. Krucoff et al. (2005) also had the largest sample size seen in the literature but the blending of three therapies could have diluted the results of one therapy or could have negated the effects of the other. In this study arm, HT, occurred once, for a duration of forty minutes and the specific HT technique used was not reported, nor was the level and experience of the Practitioner. This could easily be improved in future studies but it is a weakness in the reporting of this study. In this literature review and in my research, particular attention has been directed toward the HT dose, the frequency and the techniques used, as well as the credentials of the Practitioner.

Symptom Management

Pain and fatigue are subjective measures and while they are hard to define they are also hard to quantify. Pain is often measured on a visual analogue scale (VAS) with a series of faces from happy to sad expressions or a numeric rating scale ranging from 0-10, with zero being non-existent pain and ten being the worst imaginable pain. While most HT studies focus on symptom relief and providing nurturing interventions in high-tech settings as seen in Eschiti (2007), some have used comparison methods such as progressive muscle relaxation in a small study conducted to measure chronic and severe neuropathic pain caused by spinal cord injury (Wardell, Rintala, Duan, & Tan, 2006). Pain reduction was found

to be greater in the HT patient group than the progressive muscle relaxation patient group but this did not reach statistical significance in either group. No significant reduction in the symptom of fatigue in breast cancer patients receiving HT was seen in FitzHenry et al. (2014) who concluded that more work could follow on increasing the dose and “teasing out the therapist effect”. This was also the outcome in this small pilot study of ten patients with leukaemia and again in the work by Hacker et al. (2017) on persistent fatigue in haemopoietin stem cell transplant patients.

Pain in Specific Conditions

Fifteen studies have looked at the efficacy of bio field therapies, in the management of pain. These include pain following bariatric surgery Anderson, Suchicital, Lang, and Kukic (2015), pain management in knee replacement surgery Hardwick, Pulido, and Adelson (2012), osteoarthritis pain, So, Yu, and Qin (2008), cancer pain and its treatment in children, Kemper, Fletcher, Hamilton, and Maclean (2009), Cotton, C, Bogenschutz, Pelley, and Dusek (2014), bio field therapies and cancer pain, Anderson and Taylor (2012), chronic neuropathic pain in spinal cord injury, Wardell et al. (2006) and pain in sickle cell disease Thomas, Stephenson, Swanson, Jesse, and Brown (2013). Some studies have shown that certain types of pain may not respond in the same way in everyone. Therefore despite a lack of statistical significance, some patients could experience effective pain relief while other patients may gain no pain relief at all. In my pilot study the symptoms of fatigue and nausea did not reach statistical significance but there was a modest effect on pain reduction. There are no known contraindications for using HT in any population group including children and babies (Wardell & Weymouth, 2004). Wardell and Weymouth (2004) also suggested HT can be a valuable tool in supplementing traditional approaches to pain relief.

So et al. (2008) conducted a systematic review evaluating the effect of touch therapies for pain relief in adults experiencing any type of pain. This review included RCTs or CCTs and only those studies using a sham placebo or a no treatment control, were examined by two independent reviewers.

Twenty four studies involving 1153 participants met the inclusion criteria. There were five HT studies, sixteen Reiki studies and three using Therapeutic Touch (TT). "Participants exposed to touch had on average a 0.83 units (on a 0 to ten scale) lower pain intensity than unexposed participants." It would appear the more experienced practitioners had a greater effect on pain reduction and the Reiki trials yielded the greatest effects. "Whether more experienced practitioners or certain types of touch therapy brought better pain reduction should be further investigated." (So et al., 2008). It is worth considering that because Reiki is relatively well known therapy there may be an expectation of benefit from the patients thus creating an unexpected bias. However the placebo effect was explored and no statistically significant placebo effect was identified. Two of the five studies evaluating analgesic use supported the claim touch therapies minimize analgesic use.

The most recent research paper on HT and cancer-related pain at the time of writing, came from Gentile D et al. (2018). The design was a pre-test/post-test, observational, retrospective study, comparing the effectiveness of HT and Oncology Massage (OM), on pain experienced by 572 cancer outpatients. A single, forty five minute session of either HT or OM was delivered by a certified practitioner and patients reported their pain using a 0-10 pain rating scale. The findings showed both HT and OM were able to provide immediate pain relief. This is an important finding as undertreated pain is reported to occur in forty percent of all cancer patients. (Deandrea. S, Montanari. M, Mojo. L, & Apolone.G, 2008). Although the duration of the pain relief gained from either therapy was not measured in this

study, it was suggested as a topic for future research as was the patient's attitude towards HT and OM. This study provided information found to be lacking in previous studies and served as a good example of transparent reporting. It is a well- designed study with adequate power so that it could be rated as a "B", meaning "Good". It is a strong clinical study showing statistically significant evidence of benefit. This is a worthwhile contribution to the field of non-pharmacological pain relief in Integrative Oncology. Another strength of this study is the, "non-experimentally, manipulated clinical environment" in which the patients were treated Gentile et al (2018).

Paediatric Pain

One of the few studies involving HT for paediatric oncology patients aged 3-18 years of age is carried out by Wong, Ghiasuddin, Kimata, Patelesio, and Siu (2013) in Hawaii. This was a randomized prospective study over one year. Delivering HT daily for 20 minutes by a Level 1 Practitioner. It found positive responses and was seen as feasible to deliver to children in a hospital setting. Another study reported a retrospective chart review on 1,613 paediatric surgical patients aged between 0-21 years. HT treatment was given post-anaesthesia by one of the two certified HT practitioners using a variety of techniques and measuring the effect on pain and comfort using the visual analogue scale (VAS). Heart rate variability (HRV) and a VAS measure for stress, anxiety, depression, relaxation, vitality and overall wellbeing were the measures chosen by Kemper et al. (2009) in their study involving nine paediatric oncology outpatients. These outcome measures were assessed pre and post either a twenty minute HT session or the rest and "presence" condition during two outpatient visits. Statistically significant differences were found in stress reduction and lower HRV suggesting relaxation.

Studies Using Sham or Mock HT Treatments.

The use of sham treatments is an effort by researchers to remove some of the confounding variables and address criticisms by the detractors of bio-field therapies that they only work because of the placebo effect. Wicking (2012) used weighted gloves to feel like a human hand in her attempt to incorporate a credible sham treatment. All patients in this study wore eye masks to prevent them seeing the practitioner's actions during the seven sessions. Another attempt to use a sham HT treatment was reported in FitzHenry et al. (2014). This pilot study found no beneficial effect of HT on fatigue or QOL and suggested future research may explore increasing dose and teasing out the therapist effect. The control group experienced sham therapy with the sham practitioners instructed to walk around the participant but did not place their hands or arms over the participant's body. They were instructed not to allow their hands or arms to come within 12 inches of the sides of the participant but to hold their arms still or move them randomly. Sham practitioners were given no directions on what to think or any mental activities to perform as had been the case in another study. The sham practitioners were merely required not to speak to the participant during the treatment. This protocol could have had a negative impact on the Healer/Healee relationship as a "healing partnership" was unlikely to form under such circumstances. Building rapport and connecting on a heart to heart level, is an integral part of the HT Practitioner training. It is an example of stripping back the components to find the active ingredient when in reality each ingredient adds to the synergistic effect and is necessary to create the change. The art and science of healing may not be able to be dissected to find the active ingredient to measure. Healing is an art form, it is individualised and dynamic in its delivery. It is not pre-scripted but spontaneous and given with love and without attachment to the outcome.

“He toe -He raupo ano te raupo engari ma te ringa

Ka hang ate whare.”

A Maori proverb written on the wall of the Canterbury University Health Sciences Department.

The English translation says, on their own, toe toe is just toe toe and raupo is just raupo however when combined a house can be fashioned.

A HT technique is a series of hand placements on or above the body but combined with “love”, “presence” and “intention” it has the potential to change the bodies vibrational frequency and therefore its state of health.

Even the term “sham” or “mock” feels uncomfortable as it seems unethical to conceal the truth about what is being done to a person in any situation. FitzHenry et al. (2014) discusses distress or lack of trust that could develop by allowing a patient to expect something will occur but then they find out something different happened. Ethical considerations require that false promises are avoided and this also applies to the benefit expected from the treatment being delivered. This means not overselling the therapy and using a written consent form with clear verbal explanations that are standardised and approved by the research institutional guidelines.

[Studies Using Active Comparators verse HT](#)

At least five study designs used one active comparator vs HT as a way of comparing the effectiveness of HT. Post-White et al. (2003) used massage, HT or “presence” in a three group crossover design with 230 patients, but as Wicking (2012) explains, there is a disadvantage to using a potentially active intervention as a proxy placebo:

If both interventions are equally effective there will be no statistical significance seen between them. This could be because both interventions are effective or because both are causing the placebo effect or even that one is triggering the placebo effect and one is effective. This could place an excessive burden of proof on the intervention that is being tested in this way. An active comparator being used as a proxy placebo would need to have a solid evidence base in its own right and most complementary therapies are still building that support. (p. 53)

Research Changes Over Time

Many complementary therapies lack high level evidence for reasons mentioned earlier but this does not mean they are ineffective. An absence of proof cannot be taken to mean something does not exist. Take the example given by Jonas, *“aspirin and penicillin were widely used before research scientists determined how they work”* (Jonas & Levin, 1999)

Programme Evaluations (Descriptive Studies)

HT training started in the United States in the 1980's and Therapeutic Touch in the 1970's so the types of studies being done have matured and evolved since this time. The 1990's saw mostly qualitative studies, for example Moreland, (1998), Morales & Watson-Druée, (1999); Slater, (1996), qualitative studies about the practitioners of HT, such as Engebretson, (2002), Wardell, (2001) and Weymouth (2004) and descriptive case reports of individual patients as seen in Wardell et al. (2006). At this early stage in the history of HT research, at least thirteen programme evaluation reports came from hospitals and Medical Centres throughout America. Many of these services were provided on a volunteer basis by healthcare employees or external volunteers, lay people or health professionals. Some of the HT practitioners were previous patients who had recovered from cancer and were now

eager to train in HT and help others with a cancer diagnosis. One such programme is “Bosom Buddies” in Hawaii which began in the 1990’s and is the longest running programme for woman with breast cancer. The success of this volunteer programme has spread across the United States under various names. In 2008 I visited both the “Bosom Buddies” Program in Hawaii and the “Healing Partners” Program at Stanford University and I also visited Scripps Centre for Integrative Medicine in San Diego where HT has been used to treat patients since 1993. Client responses were largely positive and consumer demand was usually the trigger for the continuation of HT programme. The 2000’s saw a change in the research type to pre and post case series designs and a few randomised controlled trials with crossover or parallel arm designs. Of particular interest in relation to this literature review is a case series pre-post-test design by Danhauer, Tooze, Holder, Miller, and Jesse (2008). Three, thirty minute treatments per week for three weeks were delivered to twelve inpatient adults with leukaemia. The three validated instruments chosen to measure mood, sleep and the M.D Anderson Inventory for leukaemia, all showed no statistically significant changes pre and post treatment but the single item symptom measures such as pain and overall distress did show statistically significant changes. This was also a mixed methods study and the qualitative responses were strongly positive and requested longer and more frequent sessions be made available.

Both qualitative and quantitative research has a role to play in advancing the body of CAM knowledge within the nursing paradigm. The research shows patients are using and requesting CAM therapies more readily and about 42 percent of 714 American Hospitals surveyed in 2010 were incorporating integrative medicine therapies. (Anderson, Loth, Stuart-Mullen, Thomley, & Cutshall, 2017). The top seven modalities offered were; pet therapy, massage, music/art, Reiki/HT, guided imagery/relaxation methods. Patients do

omit acknowledging their use of CAM therapies to health professional if they sense it will be viewed negatively or there is an uncomfortableness about discussing it (Poynton, Dowell, Dew, & Egan, 2006).

While all research material is of value in building and growing a body of evidence on a subject, it does not all provide evidence to support the use of HT in an evidence-based practice paradigm. It would appear much work has been undertaken by the international organisations, HBB and HTP, in the last five years, as evidenced by the dedicated research sections on their websites. Another example of this was seen in the updated literature review carried out by (Wicking, 2012). Her 2008 literature review was thorough in content and analysis of the studies to date, spanning from the beginning of HT as a nursing intervention in the 1980's, to the publication of her PhD thesis in 2012.

By 2015 Healing Beyond Borders (HBB) had appointed a Research Director and established a Research Committee. The website publishes guidelines for future research and offers suggestions on issues worthy of investigation in HT and the wider field of mind-body therapies. HBB identifies five areas where information is lacking or has not yet been adequately researched. (www.healingbeyondborders.org).

- 1) Research is needed to determine the effect of “dose” of Healing Touch, including frequency and duration of sessions and techniques used, in general and for persons with a particular clinical condition or diagnosis.
- 2) Engagement should be undertaken in bidirectional, translational research between clinical and preclinical studies (basic science) and settings to provide a more complete picture of health, illness and treatment related to Healing Touch.

- 3) Exploration around how Healing Touch might work at the physiological level, particularly looking at stress related immunological, or other independent pathways.
- 4) Determine the contributions of practitioner training, intention, treatment expectation, meaning and context in Healing Touch using a mixed methods approach.
- 5) Present and publish research in peer-reviewed journals whenever possible to build the evidence base. All these suggestions have been recommended by Anderson, Der-Fa, et al. (2015).

If CAM and Integrative Medicine are to be part of the healthcare system in the future, CAM organisations and CAM Practitioners will need to gain credibility within mainstream health organisations and gain support from individual health professionals from various disciplines. To do this there must be more evidence based research, just as rigorous as that expected of Western Medicine, which supports the scientific basis for energy medicine. According to Zick & Benn (2004), the future will bring a blurring of the boundaries between CAM and conventional medicine and this could change the way research is ranked and designed. Conventional medicine is symptom specific and focuses on disease classifications, Zick and Benn (2004) whereas CAM is about the whole person and their community. CAM is holistic and synergistic and the sum of its parts broken down, do not necessarily equal the whole. CAM focuses on the individual and does not lend itself easily to being dissected and pieces studied in isolation like a molecule under a microscope. It is an area of contention when HT practitioners find HT study designs too prescriptive and structured. The spirit of HT and the art of healing itself is diluted in the attention to detail. The essence or the magic of the

encounter is lost. The focus shifts to the task of measuring and recording while the patient/practitioner dyad is compromised.

There is a new era of medicine emerging which is using personalised immunotherapy and genetics. The patient's own cells are used to grow a particular DNA in the laboratory and the new DNA is then injected back into the patient's body in a changed state. This concept is expected to change the way disease is treated and may alter the gold standard for research, which up until now, has been the randomized controlled trial.

"... it won't be diagnosis-based medicine; rather it will be underlying causes and mechanisms that will explain the expression of symptoms or diagnosis." (Zick & Benn, 2004).

One of the difficulties in raising the quality of the research being done, lies in the fact that most people interested in doing research on HT or other energy based therapies, are also the practitioners who observe anecdotal evidence on a case by case basis in everyday life settings. Some of these practitioners happen to be nurses with institutional backing to support their work and facilitate research but there is little funding and the time commitment is exponentially greater than the resources most people working in the health care industry, have available.

"It is an industry where huge profits are made by the controlling pharmaceutical industry, which has a vested interest in continuing to support a "Newtonian understanding of the physical world" Pierce, (2007). The biomedical model of care has little interest in patient quality of life or supportive care if it does not generate money. Supportive care services can provide individualised care and can be personalised to offer a suite of therapies which fit the individual person's symptom and presentation, rather than the disease classification alone.

This could reduce the length of hospital stay and reliance on pharmaceutical drugs and the unwanted effects. It may also help people feel better and save money for a health organisation or hospital but it does not generate money and that means research grants are difficult to find and life in the research world is especially precarious for CAM practitioners. The National Institutes of Health (NIH) is continuing to provide funds directed to support research in complementary and alternative medicine (CAM). They are aware “CAM providers typically have insufficient knowledge of scientific language or research methodology to develop rigorous research proposals without expert help”, Zick & Benn, (2004).

[Healing Touch and Haematological Disorders](#)

A review of the literature found seventeen clinical trials registered on the USA Clinical Trails.gov website, and no HT trials currently registered on the Australia or New Zealand site. Only two of these studies were on patients with a haematological disorder and both have been completed and published.

The first is Danhauer et al. (2008), a pilot study using HT as a supportive intervention for a cohort of twelve, acute adult patients, hospitalized with leukaemia. Nine, thirty minute HT sessions were delivered over three weeks and pre and post treatment measurements concerning distress symptoms and sleep were completed at weeks one and five. This pilot study took place in North Carolina, USA, at Wake Forest University Baptist Medical Centre, inpatient oncology, haematology unit. It has many similarities to this pilot study and helped to inform the research design but a conscious decision was made not to restrict practitioners to using a specific HT technique or restricting the length of sessions to 30 minutes as was the case in Danhauer et al. (2008). This design was probably to create

uniformity and reproducibility. Suggestions for future research included having a control group to follow the natural course of symptoms over time and to compare HT with another intervention that also elicits the relaxation response. Once again the need to look more closely at length and frequency of sessions arose as it has in most suggestions for future HT research. A third suggestion was to gain feedback from the nursing staff's perspective and this has been incorporated into this research evaluation. The next study was Lu, D., Hart, L., Lutgendorf, S., Oh, H., & Silverman, M. (2016), 35 patients undergoing stem cell transplant for malignant haematological disorders were randomized to a HT group or a relaxation group. Both interventions produced improvement in psychosocial measures and showed a shorter hospital stay compared to the historical comparison group of the same year. HT was better tolerated with 100 % of patients completing the protocol compared to 60 % of the relaxation group. The HT intervention consisted of daily HT sessions for seven weeks starting the day after stem cell transplant. The sessions were delivered by two certified HT practitioners working together using specific techniques over thirty minutes. The relaxation therapy protocol arm, was delivered over the same time frame by a clinical psychology student. The relaxation techniques required more conscious participation by the patient and as a result a higher discontinuation rate occurred. This was a pilot feasibility study identifying the ability to recruit, retain and complete procedures and measure change in patient quality of life (QoL) using three recognised assessment tools.

A clinical trial was registered in January 2015, in Nantes University Hospital France and appeared under the search terms; healing touch and leukaemia. The official title was, "The Impact of the practice of touch-massage on the anxiety of patients with haematological disorders hospitalized in a protective environment, a randomized, controlled study." On closer examination, the method involved delivery of three, fifteen minute, touch massage

sessions once a week. Since this is not the same as HT, despite the closeness of the official title, I removed it off my literature review.

Health Related Quality of Life and Supportive Care for Patients with Haematological Disorders

Nine studies referred to Health Related Quality of Life Measures, (HRQOL), and Supportive Care interventions for patients with haematological disorders such as leukaemia. One study came from each of the following countries; Sweden, India, Iran, Italy, UK and the remaining four from the USA.

A further study that fitted this criteria, utilised Healing Touch or Guided Imagery to effect a response in the level of pain, fatigue, nausea and anxiety in patients undergoing chemotherapy.

Although HRQOL is clearly important in leukaemia, a trickle of research has examined leukaemia-specific HRQOL outcomes in clinical trials. Despite the “emotional exhaustion” that comes from living with uncertainty and disruption to life, little has been put in place in clinical settings to address this in a practical way. Patient reported outcomes are becoming increasingly important considerations in research involving drug treatments, clinical practice and policy development. (Cella et al., 2012)

Beattie & Lebel (2011), undertook a literature review about the experience of the caregivers of patients with haematological cancer who were undergoing a hematopoietic stem cell transplant. Caregiver distress was found to be highest pre-transplant and decreasing over time, with caregivers displaying distress levels comparable to or higher than the patients distress levels. Findings like this show a clear need to provide some form of supportive care to the patient’s support people.

Some positive and negative results in the literature to date.

On the positive side, research has been shown to reduce the length of hospital stay associated with coronary heart surgery significantly (MacIntyre et al., 2008) and improve quality of life in patients with cardiovascular disease (Krucoff et al., 2005). Healing Touch has been demonstrated to be safe, efficient, cost-effective to deliver and has high patient satisfaction feedback (Danhauer et al., 2008).

On the negative side, a recent systematic review of clinical trials by Anderson and Taylor (2011) involving "Healing Touch" interventions showed difficulties in replicating results, due to poor detail concerning the manner in which studies were implemented, the combination of other interventions used alongside HT, the lack of standardization in the administration of the therapy and the inclusion of participants with different types of illness, in the same study. There was also considerable variation in the level of training and experience of the HT practitioners delivering HT sessions. The areas identified above, can be easily addressed in the methodology of future research.

Support for Touch

The Touch Research Institute founded by Dr Tiffany Field focused its early research on the benefit of touch with premature babies who were gently stroked 3 times a day. Results showed they gained more weight and left hospital sooner than their counterparts receiving standard care. (Scafidi & Field, 1990). This work is now well established and has led to changes in the way pre-term babies are cared for in neonatal units around the world.

A 2005 review of studies using touch/massage as the intervention in populations with; depression, pain, asthma, chronic fatigue, HIV, pregnancy stress and breast cancer, found a significant level of stress reduction could be demonstrated by measuring urine and salivary assays pre and post massage treatment. These biological markers showed an average

decrease of thirty one percent in cortisol levels (which are raised by stress) and an increase of 28 percent and 31 percent respectively, in the neurotransmitters serotonin and dopamine which are the bodies feel good chemicals. This clearly demonstrates one of the biological pathways responsible for the beneficial stress-alleviating effects of touch via massage therapy (Field, Hernandez-Reif, Diego, Schanberg, & Kuhn, 2005). A similar study using biological measurements in Maville, Bowen, and Benham (2008), measured the effect of HT on stress perception and salivary secreted immunoglobulin A (IgA). Pre and post measurements were taken in twenty- two patients who had never experienced HT. All the participant's experienced three conditions; no treatment, HT alone and HT with music and guided imagery over a two week period. Statistically significant results were reported with raised immunoglobulin levels and lowered perceptions of stress and pain.

[Canada Sets an Example for the Routine Use of Healing Touch.](#)

The first Canadian person to do HT research was Kathy Moreland-Layette in 1998. She used a phenomenological methodology to write her master's thesis concerning the lived experience of woman with breast cancer receiving the chakra connection which is a specific HT technique. Toronto East General Hospital is the first Canadian Hospital to make Touch Therapy available to all patients as a matter of policy. HT is utilised to assist with healing skin wounds, infections and broken bones as well as using it to reduce pain and anxiety in cancer patients (Merritt & Randall, 2002). Very few studies have focused on how to provide supportive care to patients hospitalised with leukaemia. Clinical trials are frequently conducted in this field to determine the safety and effectiveness of new drug treatments but only one non-pharmacological study was found using HT in leukaemia as an intervention for reducing anxiety and stress. As I have already shown, being in a state of chronic stress suppresses the immune system and negatively impacts every system in the body. Research

directed toward relieving stress and anxiety using non-pharmacological methods leads to the field of touch therapies.

Gaps identified in the literature

Gaps identified in the literature have given direction to the design of this Pilot Project; new studies need to have a homogenous patient group, experienced practitioners of a similar level of accomplishment and the same patient practitioner dyads. These were key elements in twelve out of thirteen studies that had significant results according to Rao, Hickman, Sibbritt, Newton, & Phillips (2016). The seven practitioners involved in the BMTU pilot study have all achieved level five HT qualifications. Four practitioners have been internationally certified (CHTP) for over ten years. They were able to choose from the full range of HT techniques, just as they would do in a private clinic setting. The full range of Healing Touch techniques taught in the HBB curriculum were available to them and for the sake of standardisation and reproducibility these were recorded and evaluated as part of the variable findings. The duration of each session was long enough to elicit the “relaxation response” in the Healee and for the healer to feel a sense of completion in the delivery of the session, up to 60 minutes. In a “real world” setting it is possible for a combination of therapies such as music, relaxation breathing, aromatherapy and/or guided imagery to be incorporated into a session but for the purpose of this Research, HT was used alone to limit the confounding variables. One patient did suggest music would have enhanced her enjoyment of the sessions.

Limitations.

Risk of bias is always a consideration in the reporting of any study but it is less likely to occur in a pilot project using a pre and post design when there is no financial incentive to deliver a

particular outcome. Without randomisation, blinding or mock treatments, a totally open, honest and transparent process can take place between the patient and HT Practitioner which encourages a healthy rapport which supports therapeutic outcomes. It is impossible to know what the specific combination of active ingredients are that creates healing on a physical, psychological, emotional and spiritual level. The previous two chapters have put forward possible mechanisms of action.

All Healers, to some extent, have a vested interest in their treatments having a positive impact on the Healee but HT teaches to set an intention for the clients highest good and then to let go of attachment to the outcome. A healing session is a partnership entered into by both parties who contribute equally to the outcome. This is an important concept and one all those involved in HT research must be cognizant of.

The convenience sample of ten patients for research served as their own controls and were self- selected to partake in the HT sessions on offer in the BMTU, for a set period of time.

This was also the same situation as was reported in “Effectiveness of energy healing on quality of life: A pragmatic intervention trial in colorectal cancer patients”, in the Netherlands (Pedersen, Johannessen, & Hjelmborg, 2014)

Ambiguous results

Much of the evidence to date is anecdotal and more research is needed to validate these outcomes and hypotheses. Ambiguous results can occur due to sampling error given the small number of participants in the majority of these studies. It has been suggested that RCTs alone may not be the ideal design for assessing healing effects (Pedersen et al., 2014). Blinding procedures may dilute healing effects by creating uncertainty between patients and healers. HBB Research Brief advocates research on energy healing using controlled trials that include sample size calculations that are powered to the primary outcome. Such trials

should clearly define primary and secondary outcome measures and avoid the use of multiple outcome measures. The Research Brief suggests focusing on one particular non-communicable disease at a time and clearly reporting intervention designs and healer practices to allow for replication. Optimal group size and the importance of continuity with the same healer across all sessions will need to be addressed with further research. The aim of clinical trials using non-pharmacological therapies should progress from a simple demonstration of positive effectiveness to showing statistical significance over a suitable comparator. (Anderson, 2015)

This literature review chapter, has described several important studies in the field of HT and outlined the relevance they have to this Pilot study which used a mixed methods research design incorporating qualitative aspects in an attempt to shed light on some of the ambiguous results from previous HT reviews.

The future

The current health system is unsustainable because of the increasing burden of chronic disease which is a problem facing the entire world. The focus on disease rather than healing has lead most doctors to treat symptoms rather than causes. Prescribing drugs without investigating why the disorder presented itself at this time in the patient's life.

According to (Seligman, 2008) it is clear that patients beliefs about illness, the meaning they attach to treatment and how much they trust their doctor, profoundly affects treatment outcomes. It is clear that the conscious experience of the patient influences disease outcomes. Yet for medical treatments to be scientifically proven the influence of the patients mind is removed by using the double-blind, (neither the doctor nor the patient knows whether they are receiving a dummy pill or the active component), randomised,

placebo controlled trials. This “scientifically proven” method of testing does not lend itself well to CAM treatments because they do not take into account the influence of the mind. The goal of CAM modalities such as “Healing Touch” is to elicit the body’s innate healing ability. Medical science views the human body as a machine that needs fixing and machines can’t heal themselves but humans can and do. They possess a powerful mechanism for healing both psychological trauma and disease, chronic pain or physical illness.” (Youngson, 2014)

[The importance of CAM therapies in nursing.](#)

Expanding the nursing education curriculum to cover CAM therapies, could help to meet the changing expectations of society, when it comes to providing information and opportunities for patients to experience relevant and beneficial CAM modalities alongside mainstream health care. Holistic medicine is an approach to healing that considers the whole person’s body mind and spirit and their interactions in the process of treating disease and promoting health and well-being. Truly holistic medicine and supportive care, delivered in the hospital setting, outpatient or community setting, would be money well spent.

The Society of Integrative Oncology (SIO) clinical guidelines, recommends bio-field therapies such as HT are safe and non-invasive. Clinical practice guidelines on the evidence-based use of integrative therapies during and after breast cancer treatment for example, can be read in the CA Cancer Journal for Clinicians article by Greenlee (2017).

Gazella, (2005) published an interview with Dr Ermininia Guarneri, a cardiologist from Scripps Integrative Health Centre San Diego where she predicts a move towards more personalized medicine. In the future medicine will look at genetic makeup and develop a personalized programme which will treat and prevent illness. Guarneri said, Integrative

medicine lends itself well to personalized medicine. Her hope is for more mainstream implementation of integrative medicine like the modalities she advocates at Scripps although Guarneri says the biggest obstacle to practicing integrative medicine in the USA right now is the financial aspect. Most insurance companies are not paying for the therapies. Patients using complementary therapies have to pay privately in most cases. This is making it hard for integrative practitioners to practice and for some people to access self-care that would improve general well-being. There is also a need for good quality research to be carried out on the integrative medicine model (Gazella, 2005)

Dr Robin Youngson, senior medical specialist working in the NZ public health service believes people who are happy and contented maintain a healthy life style while people who are unhappy, depressed, and anxious and stressed do not maintain a healthy lifestyle. "Healthy bodies begin with healthy minds."(Youngson, 2014)

A study by Eisenberg D et al. (1998) revealed a 20% rise in CAM use from 42% to 62% over a 4 year time period. It has also been suggested from research by Burg, Kosch, Nemis, Allen and Stoller (1998) that CAM use among health care professionals in the State of Florida is higher than that of the general public.

Individualised, holistic, patient- centred care has been part of the nursing curriculum for many years but modern nursing and medical care is being driven by the use of technological equipment and fast paced encounters. The focus is on, evidence-based and scientifically proven diagnostic procedures and pharmaceutical treatments. Insurance companies will cover medical and diagnostic procedures, but not time spent with patients listening to their values, beliefs and fears. The less time spent per patient the lower the cost is likely to be.

Numerous commentators on the subject of the rising popularity of CAM modalities, suggest patients are seeking practitioners who will spend valuable time with them.

If past figures for CAM use in the field of oncology and palliative care are indicative of future use, health professionals could expect to see a rise in the number of patients requesting treatment and information on CAM and Integrative therapies for symptom management or self-care. The demand for energy based, bio-field therapies such as HT is reported by Barnes, Bloom, and Nahin (2007) in Jain et al., (2015) to account for over 1.6 million visits, by adults in the United States, to energy healers in the preceding twelve months. This demand is likely to be patient driven. Fear and anxiety are common responses experienced by people diagnosed with a serious illness regardless of whether it is life-threatening or not. The literature has shown HT has the potential to have a positive impact on symptom management and quality of life without causing any safety concerns.

Conclusion

“Is energy healing an effective non-pharmacological therapy for improving symptom management in chronic illness?” (Rao et al., 2016). Evidence supporting the routine use of HT to manage symptoms associated with non-communicable disease is still questionable, due to the quality of the trials that have been examined. Future researchers are advised to minimise the risk of bias and adhere to the CONSORT statement. (Falci & Marques, 2015 ; Rao et al., 2016). This document has therefore been utilised and completed as it relates to this Pilot Research Study see Appendix C. Although this pilot project was not designed as a randomized trial due to issues of practicality and the deeply held philosophical position of the researcher, that such methodology fails to allow for the “healing partnership” to evolve organically between Healer and Healee in response to the individuals biology and

environment. It is clear to see from reviewing the literature that there has been a maturing in the design, the quality and the quantity of research on HT undertaken in the last ten years. The guidelines from The Strategic Plan (NCCIH, 2016) and the Research Brief from HBB 2015, have helped achieve this rise in standard. As stated in a message from the HBB Research Director, “while all research related to Healing Touch is of value, either to determine efficacy, study design, methods or area of focus, only those studies that are published in peer-reviewed journals will play a major role in supporting the evidence base practice of Healing Touch and its’ inclusion in conventional medical care.”(Anderson, 2015). Unfortunately many Master’s Thesis and PhD dissertations sit in the grey literature and remain unpublished.

“The tree of medicine must be transplanted into a new soil, where its roots can deepen and intertwine to reach a more complex source of healing knowledge and bring together all traditions of healing, ancient and modern.”

Dr Paul Drouin, M.D., IMD Creative Integrative Medicine

This research is important because so little research has been undertaken in the field of HT and even less in the field of HT in patients with leukaemia. Only three studies were found to exist in this specific field. Very few clinical trials have included Health Related Quality of Life measures despite the ‘emotional exhaustion that comes from living with the uncertainty and disruption to life that leukaemia brings. Patient reported outcomes are becoming increasingly important in research, clinical practice and policy (Cella et al., 2012).

Seven studies, (Danhauer et al., 2008), (Cella et al., 2012) and (Buckley, Lee, & Roland, 2016) (Hacker et al., 2017; Lu, Hart, Lutgendorf, Oh, & Silverman, 2016; Miladinia M., 2016;

Shanafelt et al., 2007) each suggest areas needing further study and my work will gather more knowledge to enable better patient and caregiver support into the future.

Chapter Four Methods and Methodology

This Chapter is divided into the following sections;

The research questions, rationale for the study design, the research setting, data collection and documentation. The study participant's sociodemographic data and the intervention and materials utilised. Key dates and the time line leading up to the delivery of the research intervention and practitioner preparation are also part of this chapter.

The final section describes the data analysis which is explained in advance of the results which will be presented in Chapter Five.

Research questions (RQ) and hypotheses (HY)

RQ 1: Is HT feasible to deliver and acceptable to receive by patients hospitalised with haematological disorders?

HY 1: Supportive care in the form of a hands-on complementary modality improves the patient's subjective well-being measures.

RQ 2: Is the patient experience of receiving HT measurable, pleasurable and positive?

HY 2: Certain patient conditions or patient groups respond in a positive way to HT therapy.

RQ 3: What is the optimal effect of repeated HT treatments on patients improved sense of well-being?

HY 3: There is sustained and accumulative effects from repeated HT treatments that persist into the next day

Methods

This Pilot Project was designed as an Experimental, Interventional Pilot Study, using qualitative and quantitative methods to evaluate the effect of delivering a "hands-on" complementary therapy to ten participants hospitalised with haematological disorders. It was

also a feasibility study using a pre-experimental design employed to explore the human element in the delivery of a specific type of human “touch” to provide supportive care over a finite time. Ten patients were self-selected to receive twice weekly HT interactions. The aim was to use pre and post-test measures at each session to rate the feasibility, acceptability and effectiveness of HT therapy for this small cohort. A further goal was to replicate and build on from the work of two other researchers whose findings influenced this research design and who have been discussed in more detail in the literature review in chapter three.

Firstly, Danhauer et al. (2008) whose feasibility study found HT was well received by patients hospitalised with leukaemia and recommended more closely examining the optimal dosage. Secondly, the work of Wilkinson et al. (2002) who carried out a similar pre, post-test design for a Master’s thesis comparing three treatment conditions delivered to 22 patients in their home or at a private clinic. Each session was thirty to forty minutes long and feedback from both the participants and the practitioners was only negative in regard to the time restriction. Discussion on the length of HT sessions was also noted in FitzHenry et al. (2014) who recommended increasing the “dose” of HT to forty five minutes twice a week instead of once a week and strengthening the effect of the intervention by having the same practitioner deliver each session to strengthen the patient provider relationship. However in contrast to this recommendation, Goldberg et al. (2016) concluded, HT may have benefit in reducing anxiety prior to a breast biopsy procedure when utilising a specific technique (magnetic clearing) for as little as fifteen minutes. The effects were reported to be immediate and sustained into the following day.

Methodological Position

This research is based on a positivist paradigm which seeks to establish the effectiveness of HT in a health care setting. This is considered a naturalistic setting from which to collect

data that can be high valid but not necessarily generalizable. The epidemiological design utilised pre and post assessments and semi-structured interviews. Adopting this paradigm meant the researcher was separate from the patient once the interventions begun to maintain objectivity. Data was collated and analysed by the researcher who was not involved in delivering the supportive care but she was trained in the discipline so that she had a clear understanding of the processes and possible outcomes patients could experience.

Setting

This study took place in the BMTU, Christchurch Hospital, New Zealand, in a specialised, 15 bed unit as described in Chapter Two. The majority of beds were situated in single rooms with positive pressure air flow ventilation and ante rooms for handwashing and gowning to facilitate protective isolation conditions. A single ward with four beds provided a setting where patients who were not immune-suppressed could interact with each other and another shared room had two beds. There was a visitor's room with a kitchenette, table, chairs and couches, which was the only shared space available to patients and visitors. A nurse's and doctors station, utility room, staff meeting room and tea room comprised the rest of the main unit and an Apheresis Unit was located at the entrance to the BMTU. "Ranui House" is located across the road and is administered by the South Island Bone Marrow Cancer Trust (SIBMCT) to provide accommodation, care and support for patients and their families from out of town. Two of the ten study participants spent time in this setting and received Healing Touch treatments in their bedrooms at "Ranui House". Patients being nursed in isolation frequently describe feelings of anxiety, frustration, loneliness, and boredom and may become stressed, depressed and disorientated (Ward, 2000). Factors associated with a higher risk of the negative effects of isolation include being male, of lower education, sharing a room, low

satisfaction with visiting times and poor emotional support from nurses. (Biagioli V et al., 2019) The physical setting of a hospital isolation unit and fear of germ exposure, can lead to avoidance of normal touch exchanges such as hugs, kisses and hand holding behaviours. On the other hand, “touch” deprivation is thought to lower immune activity as research by (Lutgendorf, 2010) showed. In this paper HT appeared to preserve immune function by preserving natural killer cell cytotoxicity (NKCC) in patient’s undergoing chemo-radiation for cervical cancer. Intentional therapeutic skin to skin touch, is thought to reduce suffering and enhance patient well-being by ameliorating some discomfort from medical treatment and lessening the side effects of chemotherapy drugs. HT is also known to trigger the “relaxation response” as discussed in Chapter one and is thought to promote diverse dimensions of healing in the face of serious, life-threatening illness. (Benson & Klipper, 2000)

The baseline data was collected by the Principal Investigator (PI) using a semi-structured questionnaire at the patient’s bedside prior to any HT sessions, see Appendix B. The HT practitioner used a structured questionnaire before and after each HT session. See Appendix D. The patient completed a post-treatment symptom evaluation within twenty four hours following each HT session, see Appendix E. This data was stored in a locked briefcase in a locked room for the duration of the study and then taken to the office of the PI for final evaluation and analysis. For the analysis of open-ended questions, a record of anecdotal responses was reproduced word for word and grouped into themes, see Chapter Five Results.

Documenting Sessions

The Practitioners’ time of arrival and departure was documented in the PI’s “Visitor’s Book” along with information that included the patient’s name, date and the start and finish time of each session. Every session was logged in this book by the person delivering it. The “HT

Session Documentation Form” see Appendix D, updated information about the patients’ condition at each intervention. A pre and post treatment rating scale concerning six symptoms impacting quality of life and the HT techniques used by the practitioner were completed with the patient. Techniques were only restricted to standardized HT techniques to allow for dynamic presentations over time and individualized treatment options. The practitioner then left the Modified FACT –leu questionnaire see Appendix E to be completed with 24 hours of the session and handed back to ward staff in a sealed envelope to be collected and collated by the PI. These questionnaires were coded with a letter of the alphabet assigned to each patient rather than using their name to encourage honest feedback. This limited anonymity was necessary to monitor the effect of HT over time and to then answer the third research question which was, what is the optimal effect of repeated HT treatments on patients improved sense of well- being? The associated hypothesis says there is sustained and accumulative effects from repeated HT treatments that persist into the next day. It also suggests there is an accumulative benefit from repeated HT treatments that does not reach saturation over time.

Study Participants

Patients in the BMTU who had completed at least one round of chemotherapy were invited by the Clinical Nurse Specialist (CNS) to participate in the study. The reason being that the CNS knew each patient’s medical history and suitability to participate. Eligible and interested parties were given written information packs containing material about participation in this particular study as well as a consent form, and contact details to arrange a recruitment interview if they choose to be involved, see Appendix A

Patients interested and eligible to participate had their questions answered and consent form signed with the principle investigator who then completed the semi-structured Initial Intake Interview Form, to gather relevant sociodemographic data, see Appendix B.

After this interaction, one of seven specially trained CHTP's was randomly allocated to a patient, as they were available, to administer HT sessions twice a week for the duration of their hospital stay or until the end of the study whichever came first. The study period spanned from April 2017 to September 2017. There was no minimum number of patients required to treat as this was a feasibility study and as such, all eligible patients were invited to participate and those recruited over the course of the intervention period became the study sample. This convenience sample served as their own controls as it was not possible to have a control group during this pilot study. If HT was found to have no effect on patient clinical outcomes then no comparative effectiveness trial need be undertaken in this patient group. If on the other hand HT was shown to have a clinical effect on health outcome measures, then results from this pilot study would help to determine the effect size and provide power calculation for sample size determination for a future comparative effectiveness trial.

A convenience sample of ten participants formed this study cohort, six males and four female's ranging in age from 19 to 63 years. Diagnoses were five with acute myeloid leukaemia, two with Burkitt Lymphoma and three with Non Hodgkin Lymphoma. Two patients identified as Māori, one as New Zealand European and Māori and one New Zealand European and Czech. All participants spoke English as their first language. Four were single, four were married and two were separated or divorced. Fifty percent had used some form of CAM therapy in the past but 100% were naïve to HT. Ten patients who were eligible for recruitment

declined to participate citing, cultural or religious reasons, uninterested in trying the modality or already participating in a research project.

Practitioner training and experience

This study clearly outlines the skill level of the HT practitioners, from the local area who were recruited by the PI to provide HT sessions for the purpose of this research project. A criticism expressed in the Systematic Review of Randomized Controlled Trials on HT by Anderson and Taylor (2011) alerts future researchers to a lack of detail pertaining to practitioner training and experience. Practitioner expertise is a very real variable which may influence outcome. (Wardell & Weymouth, 2004) There were six females and one male HT Practitioner. Five out of seven were internationally certified HT Practitioner's (CHTP's) with more than fifteen years' experience. One was also a HT instructor and two were registered nurses. The two remaining HT practitioners were in the process of becoming internationally certified. Each Practitioner was required to have personal indemnity insurance see Appendix G and a signed Canterbury District Health Board (CDHB) "Visiting Health Professional Agreement" form on file, see Appendix M.

The specific HT techniques utilised during HT sessions and the frequency of their use is documented in Chapter Five p.121. The fact the HTP's were free to choose the techniques they delivered to the patients at each session could be considered both a strength and a weakness of this naturalistic study design. As a strength it allowed a group of seven very experienced HT Practitioners to respond to each individual patients' dynamic presentation. This freedom to choose techniques helped Practitioners to remain true to the art and science of HT as it is taught in the Healing Beyond Borders (HBB) curriculum. The Healing Touch Certificate Programme is overseen by the non-profit organisation Healing Beyond

Borders (HBB) and its role is supporting, educating and certifying Healing Touch world-wide. Choice of HT technique also allowed each Practitioner to be patient focused rather than technique focused and to respond appropriately to each pre-treatment assessment when making the subsequent choice of techniques. A record of the techniques utilised showed that generally a “full body” technique was used to start a session followed by one or two additional techniques to manage specific symptoms. As this was an experimental pilot project, the technique utilisation information could assist in the design of future studies. This would take into account the changing presentation of a person’s energy field on a day to day basis in response to biological and environmental conditions. The ultimate goal in HT is to facilitate a shift into a more balanced and centred state of being for the patients “highest good”.

Intervention and Materials

A goal of this study was to create a setting as close as possible to a regular clinical setting as opposed to an experimental setting. In a “real world” clinical setting the first HT session consists of a consultation in addition to the HT treatment. This was achieved using the Initial Intake Interview Form, see Appendix A. At every interaction the Practitioner does an update and seeks to understand the multifaceted and dynamic issues surrounding the patient’s physical, mental, emotional and spiritual health by asking relevant open ended questions and listening carefully to the answers. This interview was semi-structured to allow for freedom to discuss the course of the patient’s disease and treatment process. A Social Worker and Clinical Psychologist were available to refer to if the Practitioners were concerned about a patient. Informal patient interaction provided another opportunity to answer questions about HT and the research project. Once consent and baseline data was completed patients could begin to receive HT sessions twice weekly. This involved lying supine on their bed, fully

clothed and covered with a blanket. The practitioner placed his/her hands lightly on or slightly above the body following a pattern purported to support the body's natural energy flow. The goal of each HT session was to restore balance and harmony to the body and create a heightened sense of well-being. Each session could last up to sixty minutes and patients were told they may experience a variety of sensations most commonly a sense of inner peace or feeling deeply relaxed and calm. Regular sessions are thought to have an accumulative effect on wellbeing and the third hypothesis put forward stated, there are sustained and accumulative effects from repeated HT treatments that persist into the next day.

The independent variable here is the HT intervention. An investigator created five point Likert rating scale was used to measure the effect of the outcome variables. Zero "0" represented the least amount of a symptom and "5" represented the most. This caused some confusion in relation to the "relaxation" state since more relaxation would intuitively be construed as a positive state and could be rated at a five while Anxiety, Muscle tension, Pain, Fatigue and Nausea when rated a five were less desirable, see Appendix D- Healing Touch Session Documentation Form for the rating scale.

This data were collected prior to the first intervention and again before and after each subsequent HT session. Those patients in the BMTU for the longest time had the most treatments. The patient served as his/her own control and individual scores were added together and divided by the number of sessions received to form the results displayed in the bar graphs presented in chapter five. The least number of sessions delivered was one, due to unexpected early discharge and the most was 18, due to one hundred days of hospitalisation following bone marrow transplantation.

Developing the Role of the Healing Touch Practitioner in the BMTU

Deb Carter the Chairperson of HTNZ Inc. wrote the guidelines for HT Practitioners working in the BMTU, see Appendix G “Professional Protocol for Healing Touch Practitioners Working in the Bone Marrow Transplant Unit”.

The first training session for the seven suitably qualified HT practitioners took place on 24th July 2016. The education session was facilitated by the PI and delivered by Annis Parker, Senior HT Instructor with HTNZ Inc. and International Board member for HBB. Annis runs her own Energy Medicine Practice for people and animals, in Tauranga New Zealand. Coincidentally, she was the Charge Nurse in the BMTU at Christchurch Hospital some years earlier. The half day workshop covered what practitioners’ could expect to feel, see, hear and smell in the BMTU and how they could maintain a calm, grounded, healing presence regardless of the dynamic energy patterns and presentations exhibited by patients and staff. These responses are connected to illness, psycho-social situations and fluctuations during chemotherapy for example. The Clinical Nurse Specialist (CNS) provided education about the diagnoses, presentation and treatment of the patients in this research project and she acted as the liaison person between the PI, the Practitioners and the Medical team during the course of the study.

The preparation and sign-off process took almost a year from the first proposal to the CNS and Haematologist on 21st June 2016 until 3rd April 2017 when the final items relating to Indemnity Insurance and the Māori Consultation Process were available to send to the Research Office of the CDHB, see Appendix J. Te Komiti Whakarite - CDHB Research Consultation with Māori.

An email was sent to all the BMTU nurses on 6th April informing them of the authorisation to commence the HT Pilot Project and therefore they could talk about it with their patients.

Measurement Instruments-Validity and Reliability

The population being surveyed were a random self-selected group of BMTU patients. The purpose of the assessment tools were to measure well-being using the severity of multiple symptoms and the impact of those symptoms on self-reported measures, during the 24 hours post each Healing Touch session.

Debate arose between the Haematologist, CNS and PI over the choice of measurement instrument patients would be asked to complete to measure Health Related Quality of Life (HRQoL). The application submitted to the University of Canterbury Ethics Committee was for the Functional Assessment of Cancer Therapy, FACT-Leu (Version 4) and FACIT-Sp 12 (Version 4), measuring spiritual well-being in people with cancer, (<https://www.tacit.org>). The complete FACT-Leu (Version 4) tool is a comprehensive well validated tool that has four sections covering Physical Well-being, Social/Family Well-being, Emotional Well-being, Functional Well-being plus 17 Additional Concerns to score. This tool could have been delivered and analysed electronically using an iPad or patient computer. It was noted that most patients had their own computer. The complete FACT-Leu tool and FACTIT Sp were deemed (by the BMTU Clinicians) to be much broader than the scope of this study and would have gathered redundant data. It was thought to be too burdensome and detailed for the purpose of a pilot research study which aimed to assess the feasibility, acceptability and effectiveness of HT for patients hospitalised with haematological disorders.

The resolution of this debate involved an amendment to the UC Ethics Committee for the use of a shorter and less detailed measurement instrument. This became the Modified FACT-Leu Tool comprising of ten questions delivered post each HT session. It lacked the validity, specificity and reliability of the unmodified tool since only a selection of ten questions were retained out of a possible 45 and 12 respectively. Once the questionnaires were printed and

viewed again by the health professionals in the BMTU a further question was removed because it was thought to have the potential to cause distress to participants. “Question 9 stated, “I worry that my condition will get worse” and the choice of answers on this Likert Scale questionnaire that ranged from 0 = not at all, 1= a little bit, 2= somewhat, 3= quite a bit and 4= very much. This was subsequently deleted as requested by the Haematologist and Clinical Nurse Specialist overseeing the Pilot Project.

Below is a presentation of the outcome measures used to answer the three research questions.

Table 1. Summary of outcome measures

Summary of Outcome Measures	Baseline	Pre	Post
Consent	✓		
Initial Intake Interview Form	✓		
Healing Touch Session Documentation		✓	✓
Patient Post Treatment Questionnaire/ Modified FACT Leu			✓
Final Evaluation Questionnaire for patients			✓
Anecdotal Comments			✓
Written Staff Evaluations			✓

The PI/researcher modified tool did produce useful data which was congruent with findings from recent studies on HT in oncology patients. These included findings described by Post-White et al. (2003), Goldberg et al. (2016), and Gentile et al. (2018)

Evaluations were collected from all participants in this study within the twenty four hour period after each HT session, see Appendix E Patient Post Treatment Evaluation (FACT-Leu) Functional Assessment of Cancer Therapy- Leu Quality of Life (QoL).

Patient “A” became the test patient and modifications were also made to the “Healing Touch Session Documentation scoring items in response to his feedback and that of the HT Practitioner. The original items were; Anxiety, Relaxation/ Stress, Pain and Mood on a scale of one to five. The modified version had six items and these were; Anxiety, Relaxation, Muscle Tension, Pain, Fatigue, and Nausea. The numerical scoring key was also clarified. Oral mucositis is acknowledged as a significant symptom common in patients undergoing chemotherapy or radiation treatment. It was not incorporated into the symptoms measured in this study due to the confounding variables it would involve.

All patient evaluations were collected in a sealed envelope to maintain anonymity and encourage honest responses. Nurse’s feedback, a psychologist’s feedback, anecdotal evidence and unsolicited feedback received during this time was collated and used in the final evaluation process, see Appendix F.

The instruments placed in the Appendix were utilised as measurements to assess the clinical effectiveness, feasibility and acceptability of HT for patients and to answer the three main research questions and hypotheses presented on p. 84

[Key dates and the timeline leading up to the commencement of the Pilot project.](#)

The first meeting to discuss the possibility of delivering HT as a relaxation therapy to patients in the BMTU occurred on 31st May 2016. It was an informal meeting in the hospital cafeteria with a Haematologist and Clinical Nurse Specialist. They were interested in providing a service for patient support and well-being but did not have the time to create

such a service or facilitate it. A month later a proposal was presented to key people in the Unit and suitably qualified and enthusiastic HT Practitioners were being invited to form a team who could deliver HT sessions to this particular cohort of patients. Consultation took place with HT New Zealand (HTNZ Inc.), which is an incorporated society and a non-profit organisation governing and training HT Practitioners. The Committee was approached and agreed to be the over-seeing community organisation to provide and vet suitably qualified HT practitioners for the duration of the Pilot Project and into the future.

See Appendix G Professional Protocol for HT Practitioners working in the BMTU.

An application for funding to pay the practitioners had been applied for from “Dry July” funds and five thousand dollars had been granted. Dry July is a charity which receives donations of money from people in Australia and New Zealand who chose to give up drinking alcohol for the month of July to support various projects for cancer patients. A separate bank account was set up to receive this external funding and pay it out on the receipt of practitioner invoices for services delivered. Invoices were sent to the HT Treasurer monthly. The rate was set at \$60 per session, which was the average charged for a HT session in the local community.

On 3rd March 2017 the Human Ethics Committee at the University of Canterbury approved the research proposal, subject to the Canterbury District Health Board ethics application being accepted and forwarded to them.

The HT Pilot Project was finally signed off by the General Manager of Christchurch Hospital on 18th April 2017, see Appendix L.

A meeting was held for the HTP’s in a neutral location off site on 9th May 2017 to provide feedback and an opportunity to share experiences to date. At this stage five patients had signed consent forms and been allocated a Practitioner. The aim was to provide each

patient with two HT sessions per week for the length of their hospital stay. At the time of the first review meeting 12 sessions had been delivered. It was noted by the HTP's that there was more comings and goings of patients between rounds of chemotherapy and medical treatment than had been anticipated so it was decided that the next appointment would be set up at the completion of each session rather than on a regular day of the week. In the event of a practitioner being ill or unavailable at short notice the PI arranged for someone else to fill in, so some patients had two different practitioners.

Sample Sessions for Staff

The team of HT Practitioner's set up massage tables in a quiet room in the BMTU to offer free HT sessions to staff on 29th May 2017 between 2-4pm. The first staff sessions had been well received four months earlier. The aims were to be available to staff starting or finishing a shift, to familiarise medical staff with the pilot project and offer first-hand experience of what HT felt like to receive a HT session.

Data Analysis

Consent was obtained from the patients themselves. Self-determination and confidentiality were ensured during administration of questionnaires and practitioner update meetings about the research project and later in the process of thesis writing. Anonymity was difficult to maintain with a cohort of ten participants in total so letters of the alphabet were used to identify each participant rather than the name. Reliability and validity were further increased by pretesting the questionnaires using the responses of the first participant to consent to the study and feedback from the HT practitioner delivering the questions. Data was collated and graphed to allow it to be visually analysed and descriptive statistical analysis performed using the SPSS programme to determine statistical significance. The data

sets pertain to sociodemographic data, patient responses, techniques utilised in the treatment sessions and nursing staff feedback. Visual analogue scales have been used successfully in a number of HT studies and are a common tool in social science research settings and despite their simplicity are well accepted and validated psychometric tools. The PI was influenced to utilise a 0-5 scale after discussion with a psychology Professor who felt there was little to gain by using the more common expanded rating scale of 1-10.

Chapter five will display these graphs and report on the results drawn from them. The findings will be examined in relation to the research questions. Analysis undertaken to address research question one concerned the feasibility of delivering HT and its acceptability to this patient group. To answer the acceptability question an overall helpfulness question was asked as well as the appropriateness of the length of the session and the responsiveness of the Practitioner to the patient during the session. This also helped to answer question two which asked whether the experience of receiving HT was measurable, and we choose to measure six subjective symptoms by asking the patient to rate them pre and post-test. It was hypothesised that certain patient conditions or patient groups would respond in a positive way to HT treatments. Evaluation comments on pages 129 -131 frequently use the word "relaxed" and therefore this supports the pleasurable and positive patient experience of research question two. Measuring the patient experience is often subjective and open to confounding variables. Chapter six talks about future recommendations and discusses research tools that lend themselves well to CAM therapies. Research question three was approached by assessing FACT Leu Questionnaires which were post treatment patient evaluations completed over the next day which allowed for the "sleep quality" "satisfaction with coping", "energy level" and "bothered by side effects", to be included.

Conclusion

This chapter described the research methods employed. It included the population sample, data collection instrument, documentation and strategies used to ensure the ethical standards, reliability and validity of the research. It presented the qualifications of the HT Practitioners, the selection process, preparation and reimbursement arrangements carried out. This was deemed to be important as this level of information has been deficient in earlier research.

Chapter Five Results

The results of this study are presented from the findings generated by analysing three patient focused instruments discussed in Chapter Four and the Practitioner focused “Healing Touch Technique Tracking Form”. Lastly a collection of all the written comments from patients and staff feedback are grouped into themes and presented as they were written.

Instrument one

The “Initial Intake Interview”, a researcher made questionnaire compiled from samples of historical “Intake Interview Templates” used in the Healing Touch International Curriculum. The Initial Intake Interview was completed by the Principle Investigator (PI) at the patient’s bedside after the Consent Form was signed and prior to any HT intervention.

Table 2: Sociodemographic Data

Demographic/ Clinical Characteristics	Number	Percentage
Age (years)	19-63	Average age 36
Gender		
Male	6	60%
Female	4	40%
Ethnicity		
NZ European	6	60%
Māori	3	30%
Other or mixed nationality	1	10%
Diagnosis		
Acute Myeloid Leukaemia (AML)	4	40%
Non-Hodgkin Lymphoma	4	40%
Burkitt Lymphoma	2	20%
Progression		
Relapse	6	60%
Initial Diagnosis	4	40%
Job Status		
Employed or self-employed	9	90%
Student	1	10%
Awareness of Healing Touch		
Naïve to Healing Touch/bio-field therapies	10	100%
Belief in healing properties of Healing Touch	0	0%
Familiar with any other CAM Therapy		
Yes	7	70%
No	3	30%
Marital status		
Single	5	50%
Married	4	40%
Divorced/separated	1	10%
Religious/Spiritual Belief or Practices		
Yes	8	80%
No	2	20%
Alcohol		
Yes	5	50%
No	5	50%
Coffee		
Yes	5	50%
No	5	50%
Tobacco		
No	6	60%
Ex-Smoker (1 using NRT patches)	4	40%
Energy drinks/ Coke		
Yes	2	20%

No	8	80%
Significant Stress in life prior to diagnosis (work/study, family, financial, grief)		
Yes	9	90%
No	1	10%

Nine out of the 10 patients identified stressful events in their life prior to the diagnosis of this current illness.

Instrument two

The HT Documentation Form gathered pre and post treatment data to answer the first research question; is the patient experience of receiving HT measurable, pleasurable and positive in this homogenous patient group? The patient's answers were collected as part of the HTP's ongoing assessment of the patient pre and post each session. This patient update also helped to inform the HTP's choice of techniques available for him/her to utilise. A patient self-reported symptom rating Likert scale of zero to five (0-5) was used to score the effectiveness of the HT nursing intervention, over six variables; relaxation, anxiety, muscle tension, pain, fatigue and nausea. Each participant's scores were added together and divided by the number of sessions they received to give the mean overall score. These were then graphed to provide a visual description of the results. A gap on the graph means the score was "0" pre and post treatment and therefore it was not a symptom present for that patient at that time.

The T results are presented in the following Figures 2-7.

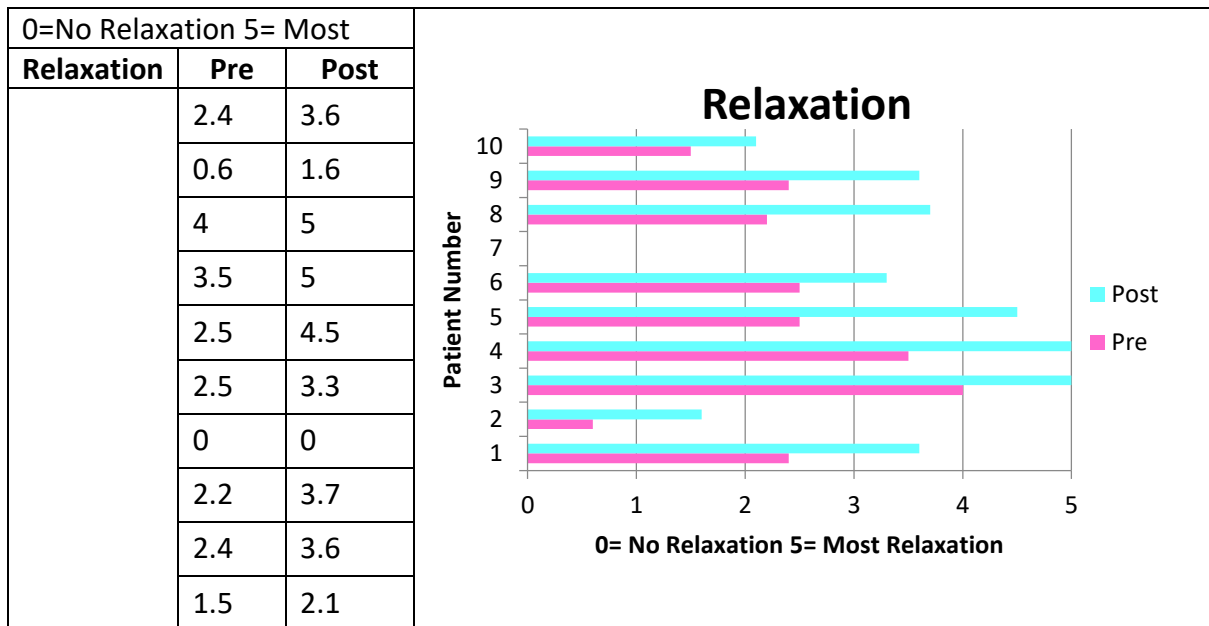


Figure 2 Effect of Healing Touch session averaged

Figure 2 indicates a statistically significant t difference in the mean pre versus post-relaxation score at $t(9) = 6.217$, two-tailed $p < 0.01$. Patients reported a difference in relaxation in the expected direction that is they became more relaxed suggesting a positive HT effect. Here patient “seven” has not rated any level of relaxation.

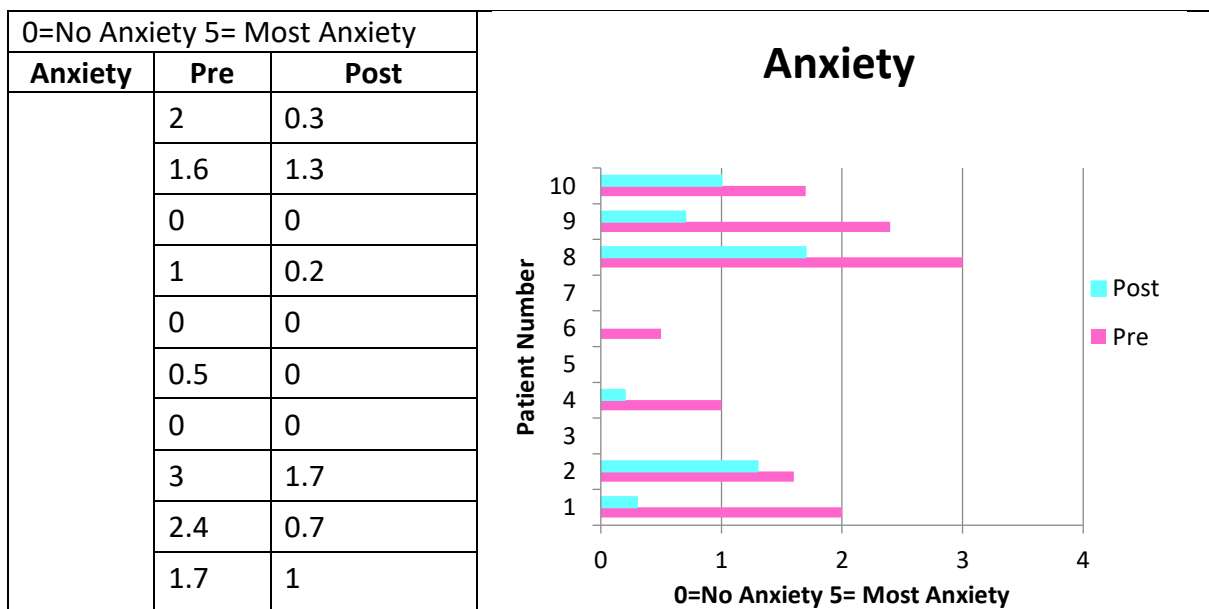


Figure 3 Effect of Healing Touch session averaged

Figure 3 indicates that the mean pre versus post-anxiety scores were statistically significant, $t(9) = 3.304$, two-tailed $p < 0.003$. Patients reported a difference in anxiety in the expected

direction that is they became less anxious which suggests a positive response to the HT intervention. Patient “three” as well as patient “five” and “seven” did not indicate Anxiety was present for them at any level.

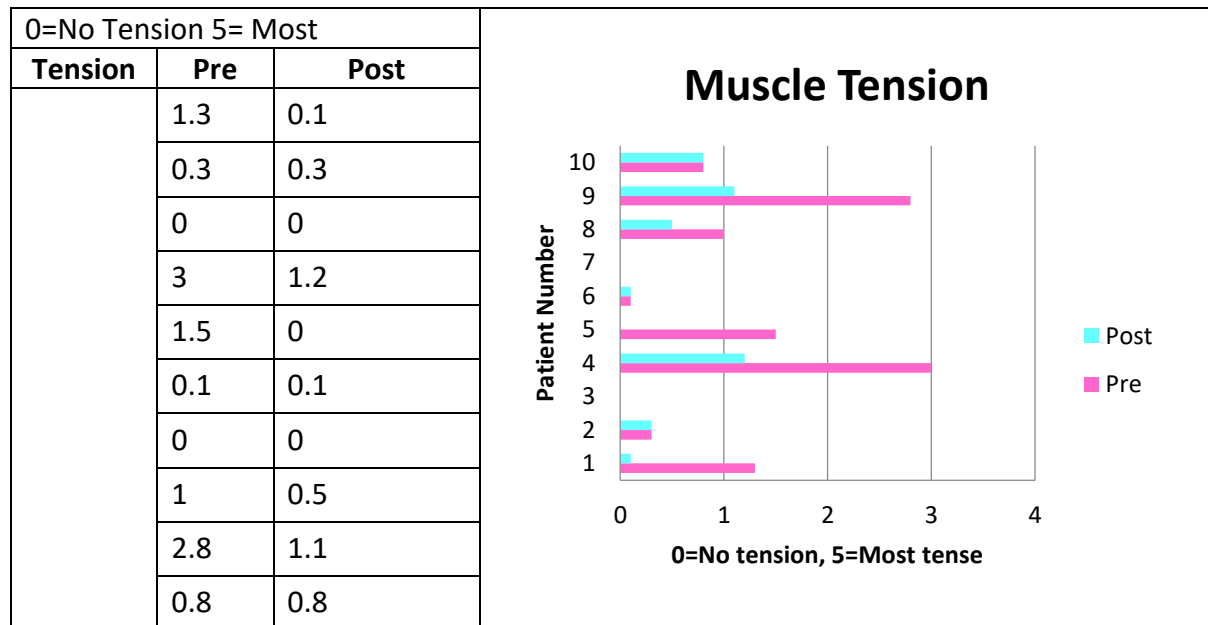


Figure 4 Effect of Healing Touch session averaged

Figure 4 indicates that a statistically significant t difference in the mean pre versus post-muscle tension score was obtained, $t(9) = 2.691$, two tailed, $p < 0.007$. Patients reported a difference in muscle tension in the expected direction that is they became less tense which supports a positive response to the HT intervention. Patient “three” and patient “seven” reported no muscle tension while patients 4 and 9 showed a significant change from pre-test to post-test.

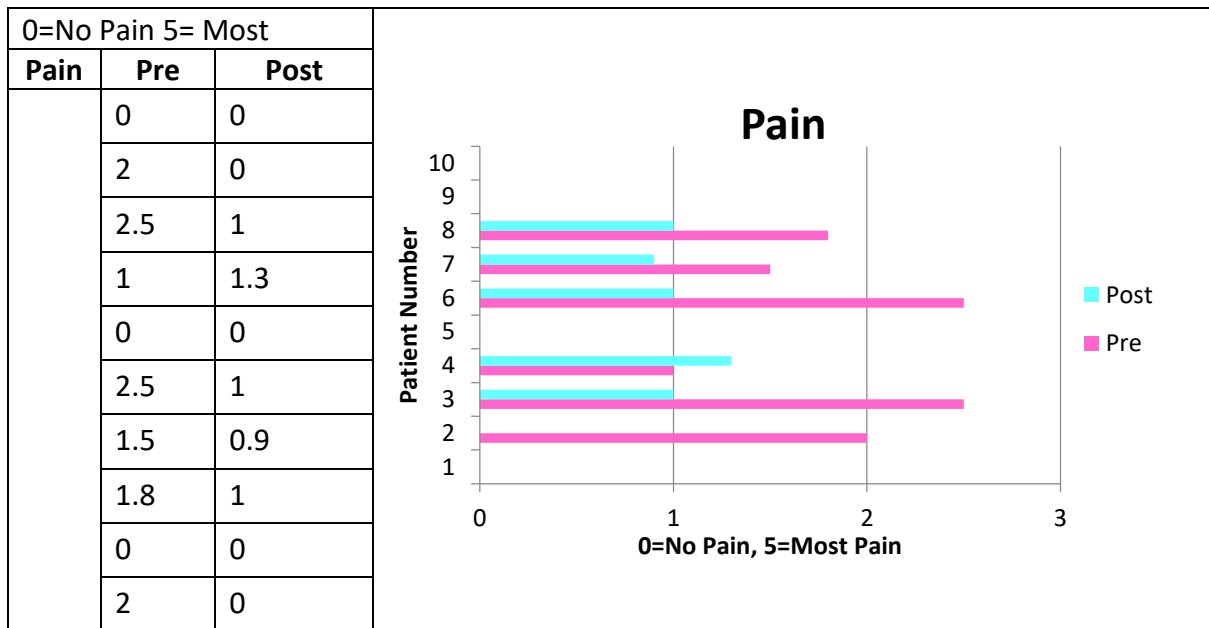


Figure 5 Effect of Healing Touch session averaged

Figure 5 indicates a statistically significant difference in mean pre versus post-pain scores, $t(9) = 2.898$, two tailed, $p < 0.05$. Patients reported a difference in pain in the expected direction that is they reported less pain post-treatment compared to pre-treatment. This figure also shows patient “one” and patients “five”, “nine” and “ten” did not report a pain symptom.

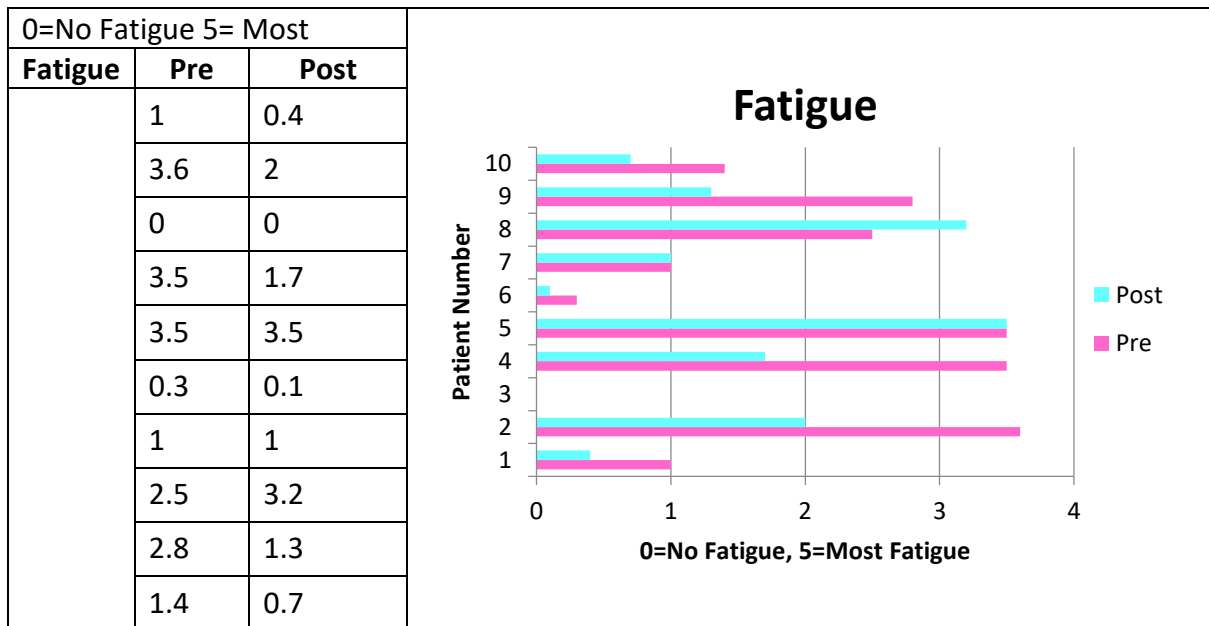


Figure 6 Effect of Healing Touch session averaged

Figure 6 shows there was no statistical significance in the mean pre-fatigue versus mean post-fatigue score, $t(9) = 2.175$, two tailed, $p < 0.058$. Patients reported no change in fatigue from pre to post treatment sessions overall. Only patient “three” experienced no fatigue. Despite no statistical significance there was marked clinical significance in reduced fatigue rating in the responses from patients “one”, “two”, “four” and “nine”.

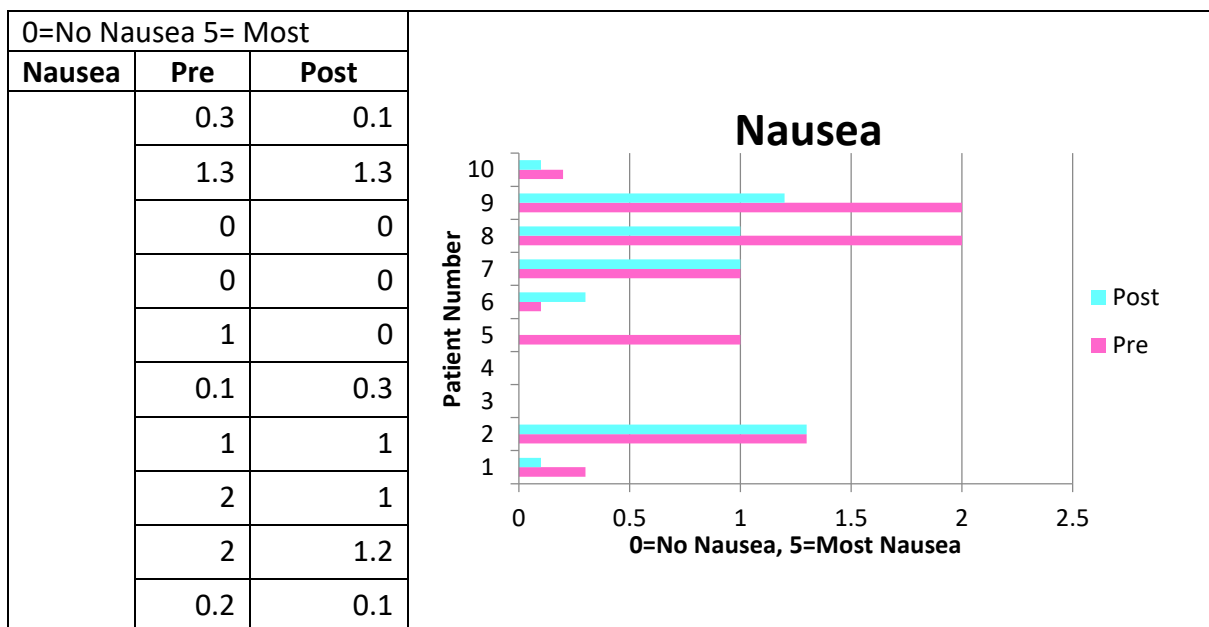


Figure 7 Effect of Healing Touch session averaged

Figure 7 shows there was no statistical significance in the mean reported pre-nausea versus post-nausea scores, $t(9) = 2.002$, two tailed, $p < 0.076$. The patients reported no measurable change in nausea from pre to post treatment sessions however three patients indicated that they were not experiencing nausea at this time in their treatment. Two respondents noticed no improvement pre and post treatment while three patients did feel less nauseous post treatment and patient "six" had an increase in the nausea.

Table 2 presents a summary of the mean, standard deviation and standard error of mean for the main outcome measures Table 2 also shows there was a significant effect on the symptom measured pre/post- test when the right hand column calculation was $p < 0.05$. Overall, the patients reported statistically significant changes in the measures suggesting improvements in anxiety, relaxation, muscle tension and pain. By comparison there was little change in reported fatigue and nausea symptoms.

Table 2. Paired sample statistics

		Mean	Std. Deviation	Std. Error Mean	Sig. ($p < 0.05$)
Pair 1	pre-anxiety	1.22	1.08	0.34	0.000
	post-anxiety	0.52	0.62	0.2	
Pair 2	pre-relaxation	2.16	1.2	0.38	0.009
	post-relaxation	3.24	1.59	0.5	
Pair 3	pre-muscle tension	1.08	1.094	0.35	0.025
	post muscle tension	0.41	0.47	0.15	
Pair 4	pre-pain	1.33	1.02	0.32	0.048
	post-pain	0.52	0.56	0.18	
Pair 5	pre-fatigue	1.96	1.38	0.44	0.058
	post-fatigue	1.39	1.22	0.39	
Pair 6	pre-nausea	0.79	0.79	0.154	0.076
	post-nausea	0.5	0.56	0.17	

Instrument three

The Post Treatment Evaluations-(Modified FACT-Leu) results showed 84% of patients found the sessions either “Quite Helpful” or “Very Helpful” (See Figure 8 below). One person did not find the HT treatment helped him overall, but 95% of respondents felt the length of the sessions were about the right, (see Figure 9). This was a positive result which supported the PI’s rationale that previous research designs published in the literature may have delivered an inadequate dose to elicit the greatest potential benefit from each exposure and accumulated exposures over time. This was supported by analysing responses on the

helpfulness rating scale which showed a strong correlation between the number of sessions and the degree of helpfulness rating, (see Figure 8).

Self-reported rating of perceived health benefits.

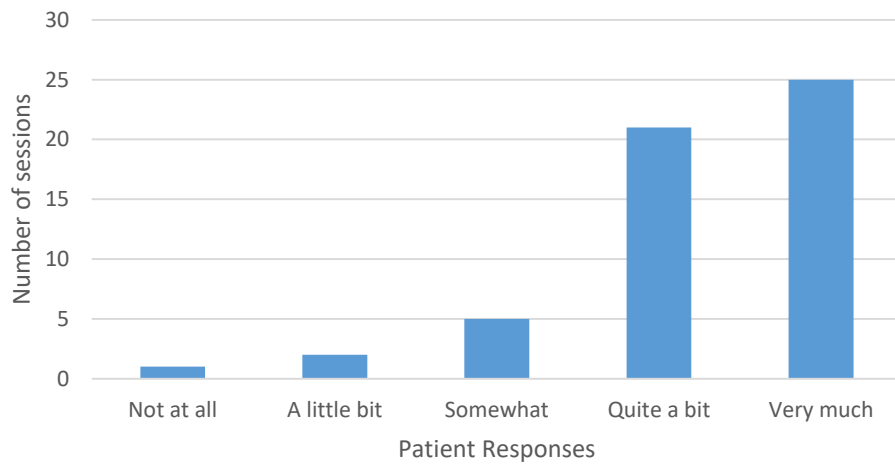


Figure 8: Q9. Overall I have found these sessions helpful

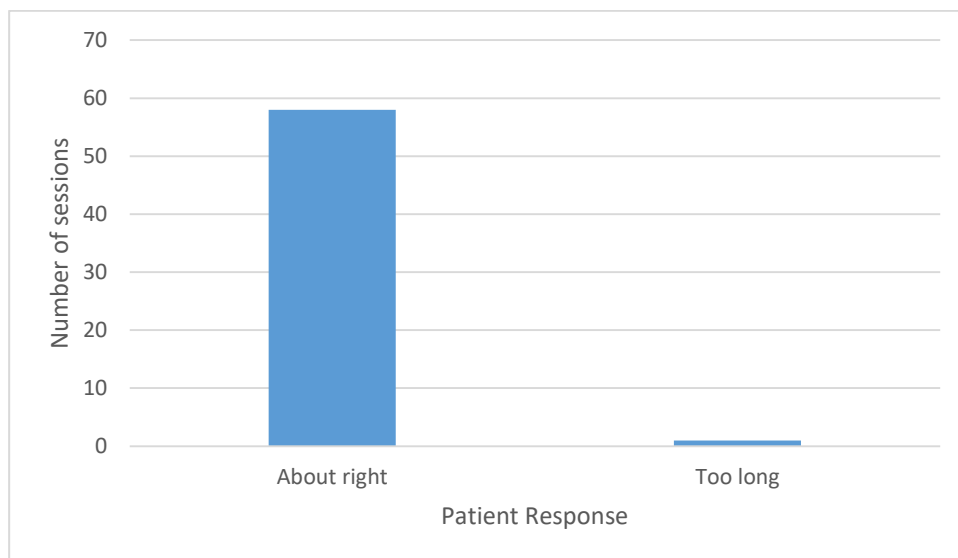


Figure 9: Q10. Was the most recent Healing Touch session

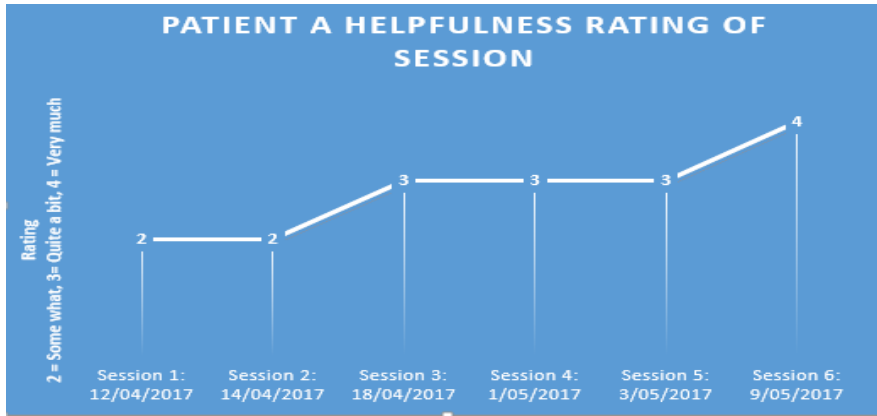


Figure 10: An example of helpfulness rating using Patient A's data.

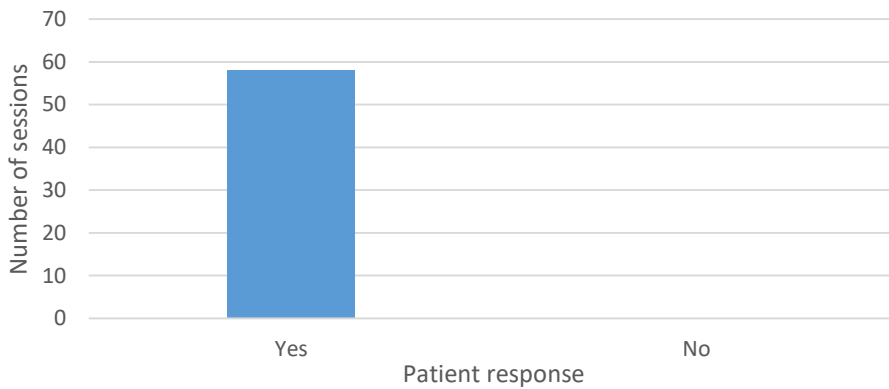


Figure 11 Was the Practitioner responsive to your needs?

All patients felt the practitioner was responsive to their needs, (see Figure 11).

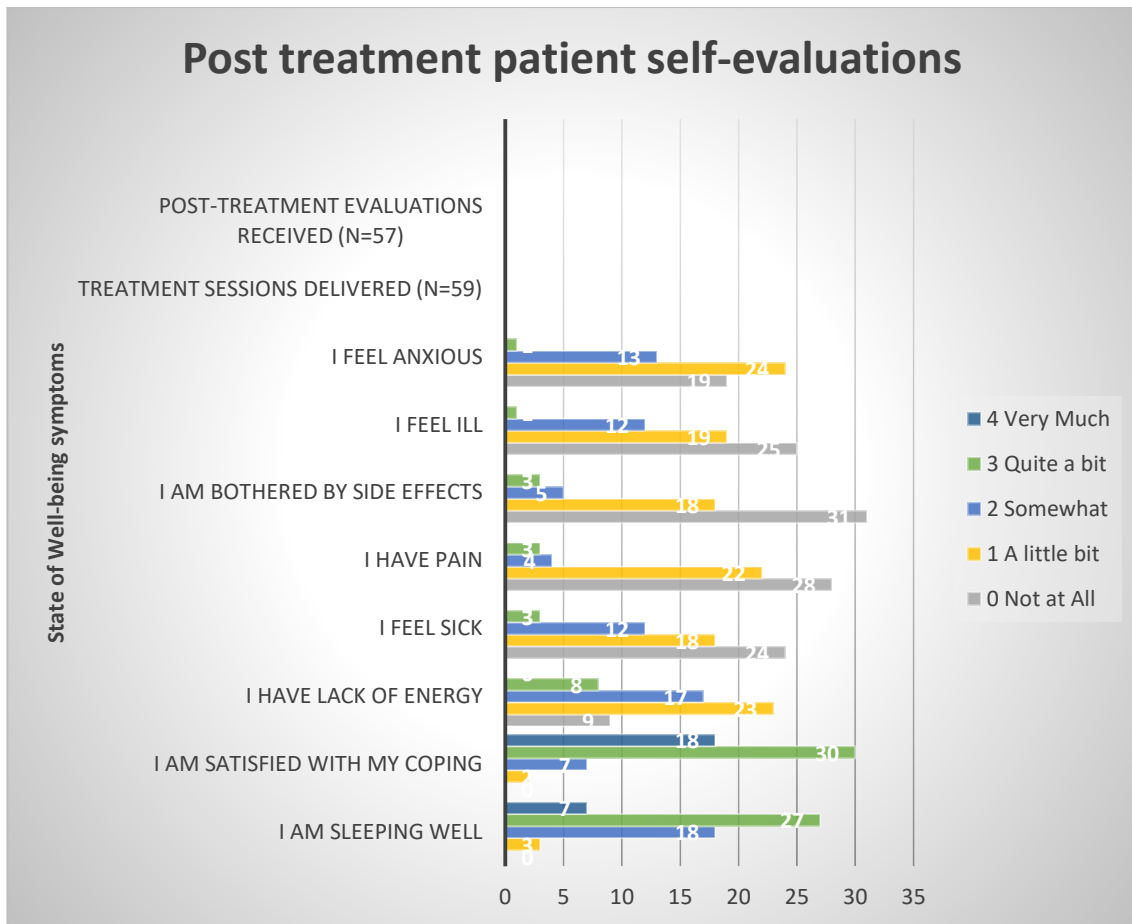


Figure 12 Modified Functional Assessment of Cancer Therapy-Leu (FACT-Leu)

Figure 12 shows the effectiveness of HT on eight areas of physical and emotional health as perceived by the patients up to 24 hours after a HT therapy session. The same material is presented in the form of individual bar graphs for each condition relating to symptom management in response to HT.

[What does this result mean for the three research questions?](#)

The results from the bar graphs support the first research question that looked at whether HT was feasible to deliver and acceptable for patients to receive. Patients looked forward to the HT sessions and 98% said the duration of the sessions at 50 to 60 minutes was about the right. From this response it could be concluded that the delivery of HT was acceptable to patients. Was it feasible to deliver? To answer this question we need to look at funding, timing and

ongoing availability of certified HT Practitioners. As this project was funded by “Dry July” funds to the sum of \$5000, it could be difficult to find ongoing funding for a permanent HT Programme. It may be an initiative the local Bone Marrow Transplant Trust would consider funding. Another option would be to create a HT Practitioner position in the Haematology Department to enable a wider range of patients to receive supportive care. It could also be run as a voluntary programme alongside other voluntary services provided by the hospital. In America and Hawaii volunteer HT programmes run in hospitals, communities and healthcare facilities but this is not a path the PI favours going down due to the belief that HTP’s deserve to be paid for their time and expertise. Financial recompense creates a professional workforce and a greater level of commitment and loyalty to service delivery especially in a location such as Christchurch where there may only be five to ten people available to physically fill such a position. It may be feasible to offer HT sessions on set days of the week to patients who put their names on a list in advance. Timing could then be planned to fit around medical procedures and routines on the ward.

Hypothesis one suggested supportive care in the form of a hands-on complementary modality improves the patient’s subjective well-being measures. The bar graphs were created by adding together relevant data from all the sessions for a particular patient and dividing by the total number of sessions.

RQ 2: Is the patient experience of receiving HT measurable, pleasurable and positive?

RQ 3: What is the optimal effect of repeated HT treatments on patients improved sense of well-being? There is sustained and accumulative effects from repeated HT treatments that persist into the next day

The final question was to rate overall helpfulness of these sessions and this has been produced on a separate graph on page 119. The bar graphs below present each individual question from the patient's Post treatment questionnaire.

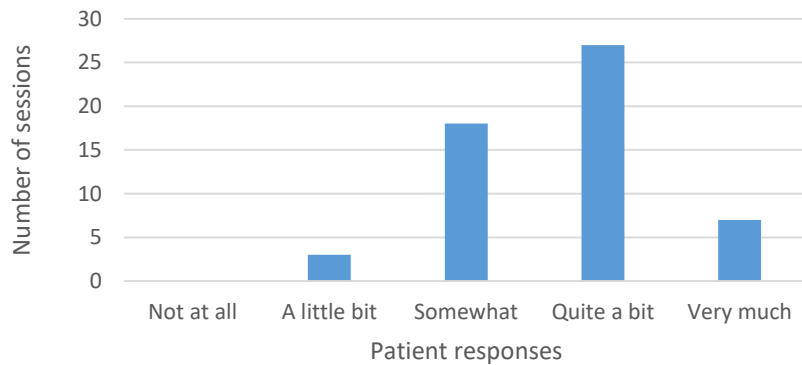


Figure 13 I am sleeping well

The majority of patients were sleeping quite well in the 24 hours post HT sessions and none were experiencing severe sleep problems.

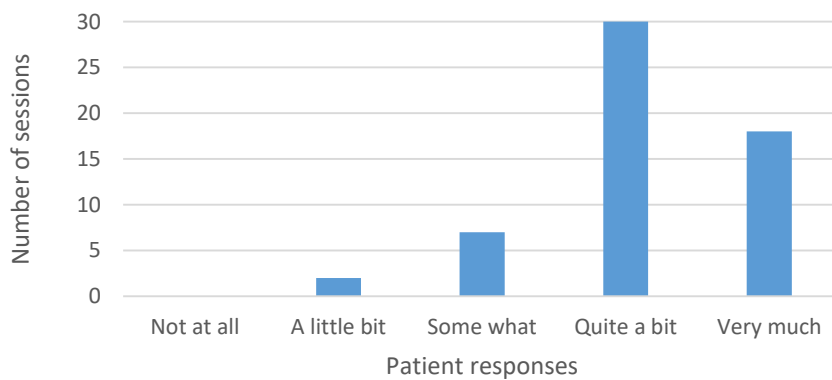


Figure 14 I am satisfied with how I am coping with my illness

Eighty percent of patients (80%) were quite satisfied or very satisfied with how they were coping with their illness.

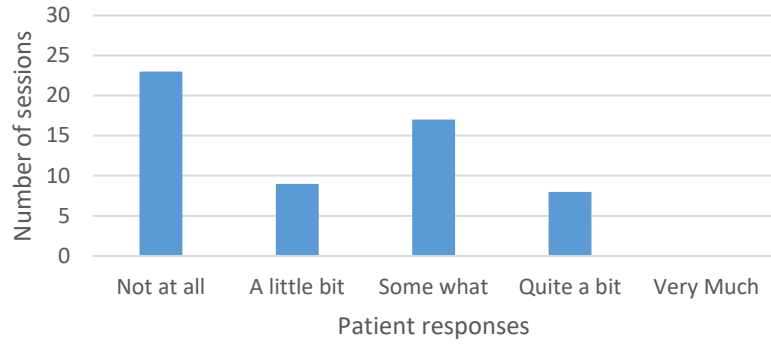


Figure 15 I have a lack of energy

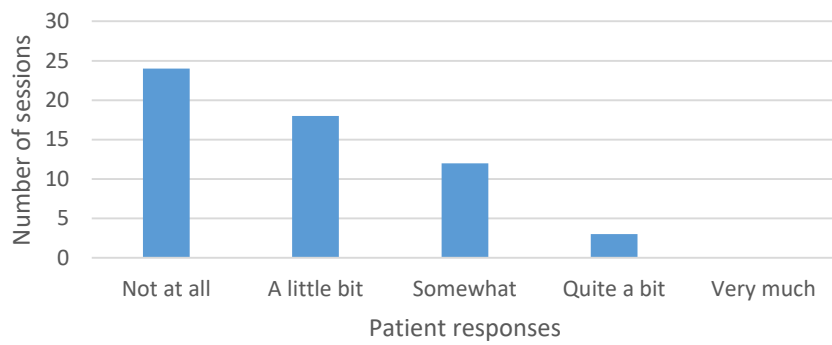


Figure 16 I feel sick

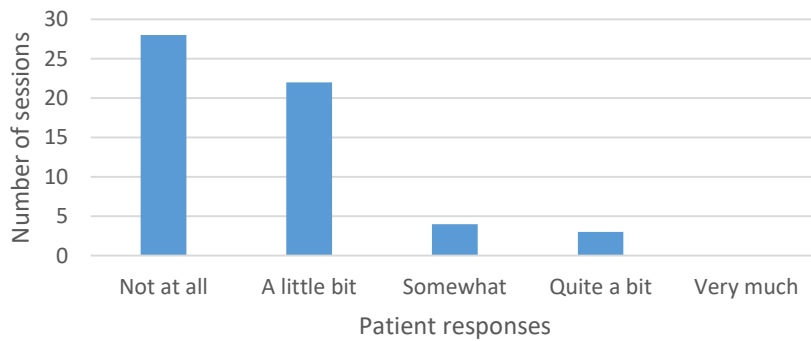


Figure 17 I have pain

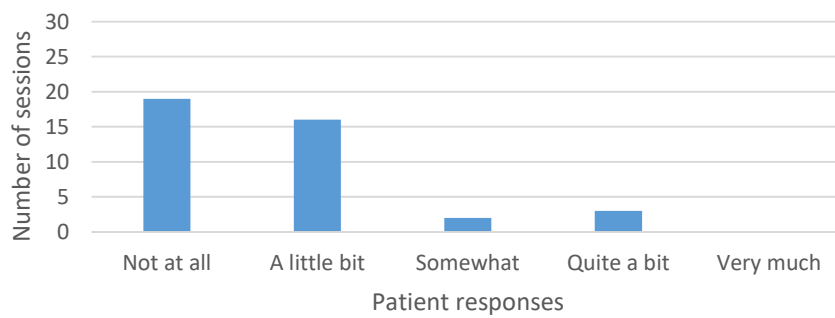


Figure 18 I am bothered by side effects of treatment

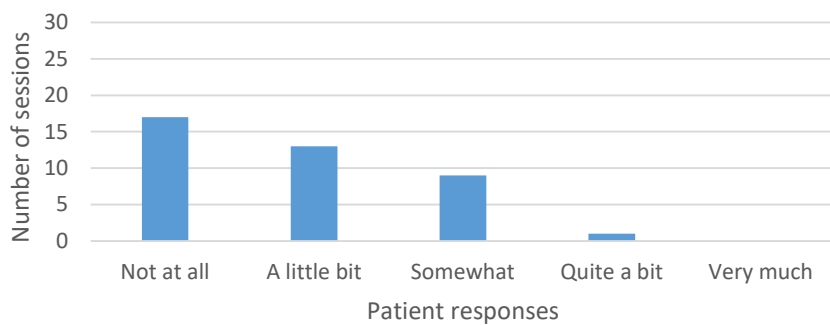


Figure 19 I feel ill

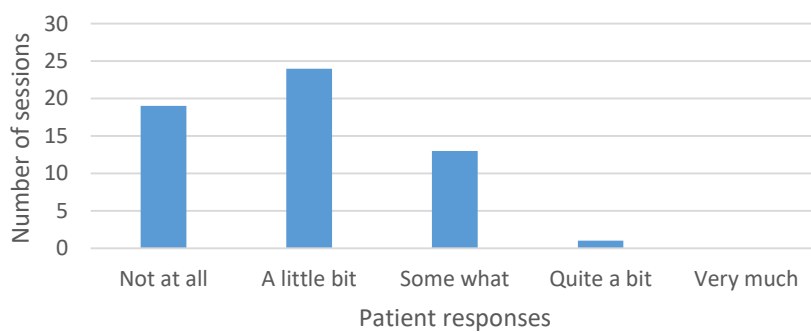


Figure 20 I feel anxious

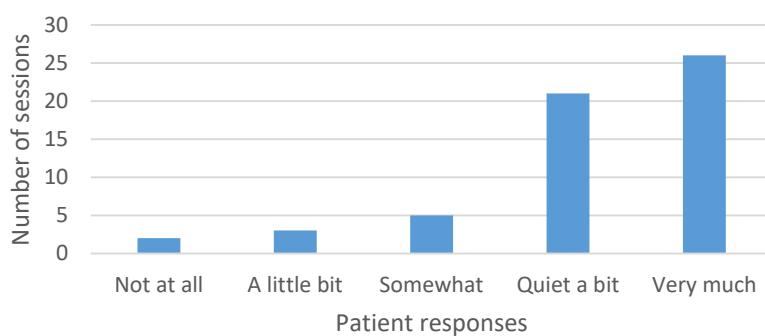


Figure 21 Overall I have found these sessions helpful

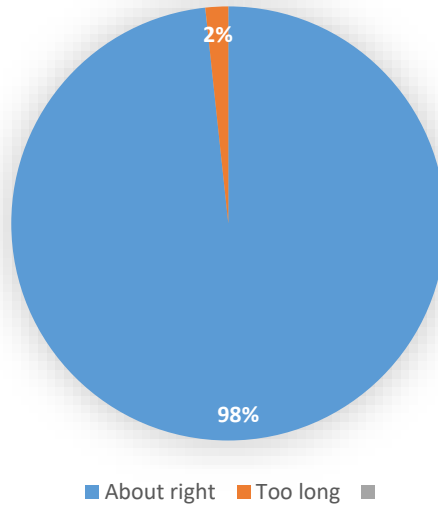


Figure 22 Length Healing Touch session

This pie chart shows that 98% of participants felt the duration of their HT sessions were of a comfortable length with one person suggesting it was too long.

Healing Touch techniques utilised by Practitioners

The figure below records the number of times a particular technique was used during the 59 sessions. It is common practice to use more than one technique per session and often a full body technique is followed by a quicker more specific technique to relieve a particular symptom.

Table 3. Choice of Healing Touch technique

<u>Choice of Healing Touch technique</u>	
Intention Setting, Ground, Release	59
Field Re-patterning	36
Chakra Energising/Connection	30
Noel's Mind Clearing	23
Siphon (Pain Drain)	20
Beak Laser	15
Hands Still	12
Hara Connection	8
Endocrine Balance	6
Immune Boost	6
Chakra Spread	5
Chelation	5
Grand Cross	5
Core Balance	4
Modified Mesmeric Clearing	4
Spiral Meditation	4
Pyramid Technique	4
Headache Techniques	3
Hopi Back Technique	3
Sword Laser	3
Lower Body Connection	3
Spinal Flush/Vertebral Spread	3
Spinal Clearing	3
Amygdala Connection	2
Limbic Balance	2
Lymphatic Clearing	2
Celestial and Ketheric Re-patterning	2
Scudder Meridian Clearing	1

Practitioners were given freedom to choose the HT techniques they felt best suited the presentation of their particular patient on the day. The choices were documented on the HT Patient Documentation Form and the number of times a technique appeared was added up to form the above list. A total of 30 different techniques were utilised by the HTP's and implemented 204 times during 59 HT sessions. It was acknowledged as standard practice to begin each session by; setting an intention, grounding and then carrying out a "Release Method" at the end of the session to disengage from the patient's energy field. Therefore this procedure was not counted as a separate technique. The four most frequently used techniques were; Field Re-patterning, Noel's Mind Clearing, Chakra Energising and Energetic Siphon.

"Every session builds on and re-enforces prior sessions and helps to create a healing grid that strengthens the individual. When a change occurs in an individual, it affects the planetary field, shifting interactions consciously and unconsciously.... The evolution of the healer is also shifting to a higher vibration. Both the client and practitioner are then radiating healing energy into the planetary field. This radiant healing energy ripples outward and influences their families and relationships, extends into their communities, and then out into the world" (Wardell et al., 2014 p.194).

[Comments/Feedback from the patient group](#)

The feedback and comments from the study participants has been grouped into themes; responses, symptom relief and recommendations. Research question number two, asks if the patient experience of receiving HT is measurable, pleasurable and positive?

Responses grouped by theme.

These responses suggest HT was able to provide a pleasurable and positive state which included symptom relief. Nine out of 25 patient feedback comments used the word “**relaxed**”.

The responses that follow are transcribed from the patient evaluation forms.

“Today was great, so relaxed I fell asleep.”

“Relaxing- lots calmer than at the start of the session”

“Leg restlessness mitigated from treatment”

“Extremely relaxed”

“Relaxed, very tired still, abdominal pain and nausea gone.”

“Sleep easier now, cleared chest wheeziness”

“Loved it, felt very relaxed and enjoyed the sense of touch, could immediately feel relaxation at the beginning of the session”

“Legs felt better with nerve pain gone”

“Very, very relaxed”

“Last night was the best night’s sleep even though I didn’t feel better in the morning”

“I slept/sleeping so much better, my head is clear, I am more aware of what’s going on, my pulse has dropped to 90 from 100, I’m not feeling anxiety like before. My Mum also felt the benefit of my HT treatment, she enjoyed it and that night she slept well”

“It (HT) helped everything. I feel calm and relaxed after each session, I have lots of snoozes”

“I enjoyed that”, “I feel revitalised”

"I can feel the energy change in my body, a lovely whoosh of warm energy fills my entire body and I feel so relaxed"

"Look forward to the healing sessions"

"I felt the twitches, I feel lighter now"

Recommendations from patients.

There were some suggestions for improving the HT experience which are grouped below.

"Felt good, very relaxed but think it would be better to do the session on the bed (instead of the chair) next time"

"Maybe a little more quiet time after the session-maybe ½ an hour- just to sleep and be still."

"Maybe some ambience sounds, water, rain etc"

"Don't have people coming in and out of the room while having session"

Unsolicited responses from relatives have been included and follow.

"Felt it (HT) was helping to make him able to cope with treatments better"

"Patient said she loves HT and would be recommending it, especially thought men should have it.

Other patient responses documented included;

Felt it was a great and welcome addition to treatment"

"This has been an enjoyable thing to be involved in let's hope it keeps going"

“I still love my treatments (HT) and look forward to them, they are so helpful” (her comment after 14 sessions).

Staff Feedback

The impression gained by the staff who completed a questionnaire at the end of the Pilot Project was that most patients enjoyed HT. It was seen by the staff as a great service and most hoped it would continue to be available. One particular comment said “It’s a fantastic way for patients to focus on something helpful and good during their treatment, which can be pretty awful.” HT gives patients “time-out” from the medical world they are forced to remain in for long periods of time. It was seen as a bonus that the HT sessions were provided free of charge and on the ward. While the referral process was easy there were some challenges in explaining the purpose of HT to patients and recruiting them to the study in the first instance. A suggestion was made to advertise the sessions more so all patients are aware and have the opportunity to participate. It was also suggested that complementary therapies had a greater presence on the ward and were incorporated into treatment regimes. Eleven staff partook of the HT sessions offered to them on two occasions and those staff were the greatest advocates for recruiting the study cohort. The staff also mentioned finding the HT sessions relaxing both mentally and physically and in a busy and stressful working environment this was seen as positive self-care. There are hospitals such as “Queen’s Hospital” in Honolulu that offer staff HT sessions on a regular basis.https://www.healingtouchprogram.com/content_assets/docs/current/Queens%20Medical%20Center.pdf Volunteers have been doing this for more than 10 years and also run classes to teach HT techniques to those who are interested. This could well be seen as an insurance policy against the high level of stress and “burn-out” observed amongst health

professionals in both primary and secondary care settings. See Appendix F Programme Evaluation for Ward Staff.

The literature review in Chapter three, discussed studies of energy healing confined to human subjects and HT. The results suggest HT has shown efficacy in reducing anxiety, improving muscle relaxation, aiding stress reduction and relaxation as well as creating a sense of well-being. There is less evidence to support a link between HT treatments and a reduction in pain and nausea. These findings are supported by the comments and feedback shared from written patient evaluations. The frequent reference to “feeling relaxed” and calm and looking forward to the HT sessions while experiencing relief from certain symptoms, suggests HT has the potential to improve health related quality of life (HRQoL) in this cohort at least. Some patients also experienced a reduction in pain, nausea and fatigue while others did not. HT was found to significantly improve pain, nausea and anxiety in patients undergoing bariatric surgery, Anderson, Suchicital, Lang, & Kukic, (2015). While the findings of Cook (2004), do not support a beneficial effect of HT for fatigue or HRQoL. It is important to note that in this particular study, the HT Practitioners were instructed not to physically touch the patient or engage in dialogue. This research design may have greatly impacted the efficacy of the HT therapy and for this reason a recommendation from this study for future research, was to explore increasing dose and teasing out therapist effect. An attempt has been made in this pilot study to carry out both these recommendations hence the sessions lasting 50-60 minutes and the same HTP for each patient. Reporting the level of Practitioner training and qualification was another recommendation followed in this study. The duration of symptom relief gained from HT therapy was not measured and has also been suggested as a topic for future research throughout the literature (Engebretson & Wardell, 2007).

Summary

This chapter provides an analysis of the data collected and statistical tests applied to that data. Despite the small sample size results support a statistically significant difference in “pre/ post” tests showing improvement in relaxation, pain, muscle tension and lower anxiety levels. While the symptoms of fatigue and nausea were not statistically impacted by HT therapy there were clinically significant improvements for some patients. From the patient responses it seems to suggest the “dose” (length of the session) was about right at fifty to sixty minutes. By comparing the post treatment scores with the correlating symptom on the FACT-leu questionnaire up to 24 hours post session, there appears to be support for hypothesis three which suggests, a sustained and accumulative effect occurs from repeated HT treatments which persists into the next day. It could be argued that HT does not reach saturation because even the patient who received 18 treatments reported ongoing benefits that were not confined to the measurements chosen for this pilot study. This was demonstrated by the following words written in the free text box of her evaluation, “I still love my treatments and look forward to them, they are so helpful” (evaluation sheet after session 14).

According to the Practitioners providing the HT sessions, patients displayed the “relaxation response” more quickly with each successive session and a lesser “dose” may have provided similar benefits once the patient was familiar with the HT process. Therefore it could be argued that a certain number of “priming” sessions may create the best platform from which to build individual dosing regimens followed by sessions of lesser duration but using targeted techniques for symptom relief. Longer term effects, after 24 hours were not

measured and therefore further research would need to be carried out to say whether the effects of HT were sustained or not sustained over a longer period of time.

Feedback from staff appears in Appendix F and is generally very positive and supportive of the HT Pilot Project. The nurses who took the opportunity to experience a HT treatment for themselves found it easier to explain to their patients what was involved and were most supportive towards the Practitioners presence in the BMTU. All the staff made an effort to avoid unnecessary interruptions during treatments but suggested signage on the patient's door would have helped them unwittingly disturb the treatment.

Chapter Six Discussion and Conclusion

Research question one asks; is HT feasible to deliver and acceptable to receive by patients hospitalised with haematological disorders? From the data gathered to date HT would appear to be a positive and well received complementary therapy. The related hypothesis states that supportive care, in the form of a hands-on complementary modality (HT) improves the patient's subjective well-being measures. It became clear as time went on that the more sessions a patient experienced the more quickly they exhibited the "relaxation response". This appeared to decrease sympathetic arousal as evidenced by a change to a slower respiratory rate and heart rate and presumably oxygen consumption. Once the patient was observed by the HTP, to be in a calm, relaxed state they were presumed to be an "alpha" brain wave pattern, which is deeply relaxed. It was hypothesised that they would receive the same benefits from a shorter duration and "dose" of HT after some initial "priming" sessions. Research question two asks if the patient experience of receiving HT was measurable, pleasurable and positive. There may be better tools available to measure this and I suggest also measuring biological markers in the endocrine or immune systems using blood that is already being drawn often for platelet and white cell count monitoring. This could lend weight to demonstrating an effect that is more quantitative than qualitative and subjective. (Lutgendorf, 2010). Another example of this is seen in a well-designed study measuring haemoglobin and haematocrit levels in response to Therapeutic Touch, another bio-field therapy similar to HT by (Movaffaghi Z, Hasanpoor M, Farsi M, Hooshmand P, & F., 2006) The second hypothesis suggested certain patient conditions or patient groups respond in a positive way to HT therapy. It would appear that most patients respond in a positive way even if that is to experience an emotional release. The effect of HT has been shown to be safe in a

wide range of conditions and for all ages and therefore this hypothesis is redundant (Post-White et al., 2003).

Research question three asks, what is the optimal effect of repeated HT treatments on patients improved sense of well-being? There could be many reasons why patients experience an improved sense of well-being. As we have already discussed in chapter two, the synergistic effect of bio-field therapies makes it almost impossible to tease out an active ingredient and in so doing the effect is likely to be diluted.

Hypothesis three suggested there were sustained and accumulative effects from repeated HT treatments that persisted into the next day and for at least 24 hours. This was a finding of (Kristoffersen, Stub, Knudsen-Baas, Udal, & Musial, 2018) The pre-post changes in this Norwegian study of people visiting Healers, found it took an average of 4.1 treatments for changes to occur. The study participants reported substantial improvement of symptoms, improved well-being and activity level after a healing session but also some negative effects which dissipated within 24 hours. Conversely, participants in the BMTU study showed pre and post changes from the very first HT session but the perceived benefit did increase as the number of sessions increased. The results of this study strongly support a dose response effect for HT.

Post-White et al. (2003) looked at symptom management in cancer care, and found improvement in fatigue and pain compared to those treated with massage or “presence” alone. Pain and fatigue were not found to be statistically impacted in the BMTU study but some individuals experienced symptom relief.

Despite recent advances in chemotherapy and transplant methods, patients with haematological malignancies still suffer from a reduced sense of well-being and reduced HRQoL from the side effects of drug treatment and lengthy hospitalizations. An inability to

relax, heightened anxiety, muscle tension, pain, nausea and fatigue are just six symptoms this study seeks to address. They are said to be symptoms patients often experience and seek to manage by themselves (Temtap & Nilmanat, 2011) Sleep disturbance and low mood are also issues for these patients and appear to fluctuate in correlation to the six subjective symptoms measured pre and post HT sessions. This pilot study measures the efficacy and acceptability of delivering HT (bio-field therapy) as a supportive “hands-on” intervention to 10 patients residing in the BMTU over a four month period in 2017. The results showed HT can be performed in BMTU setting with anxious and very sick patients with no adverse effects. It is feasible to recruit CHTP’s to safely deliver treatments in a highly medicalised setting.

Three main areas have been identified in the literature review as lacking in previous studies Wardell and Weymouth (2004). Therefore an effort was made to address practitioner training and experience, and this has been written about in chapter four, specific techniques, statistical analysis and discussion about a control group or suitable comparator follows in a discussion about the strengths and limitations of this study (Anderson & Taylor, 2011).

Specific techniques

The four most frequently used HT techniques by the HTP’s are; “Field Re-patterning”, “Noel’s Mind Clearing”, “Chakra Connection and Chakra Energising” and the “Siphon” (also known as a Pain Drain technique). These techniques have been described in detail in Appendix I, along with the indications for their use.

Statistical analysis

Statistical analysis was undertaken using the SPSS programme and the results of the mean, standard deviation, standard error mean and two-tailed t-tests appear in Table 2 p.109.

To summarise these results it can be said that a statistical significance was seen in the mean pre versus post-**relaxation** score at $p < 0.000$. Patients showed a statistical difference in **anxiety** becoming less anxious which suggests a positive response, $p < 0.003$. A statistical significance was seen in the mean pre versus post-**muscle tension** score $p < 0.007$. Patients scores showed they felt less **pain** post treatment $p < 0.05$. These four symptoms; relaxation, anxiety, muscle tension and pain, reached statistical significance while **fatigue** $p < 0.058$ and **nausea** $p < 0.076$ didn't quite reach the .05 level of significance. Despite no statistical significance in the level of fatigue there was marked clinical significance in these symptoms which occurred for patients "one", "two", "four" and "nine". Most patients showed no measureable change in nausea. Three patients were not experiencing this symptom at all and one patient felt more nausea after HT. A number of issues could be involved here and they were not examined.

Clinical significance applies to changes seen in some patients which suggest they experienced a greater response than the average response for most of the patients. So while there may not be enough of a change overall to make statistical difference for some people the response may be significant. This is an important phenomenon in the health field where drugs work well for some patients and create side effects and fail to improve conditions in other patients for example.

Strengths and Limitations

No other research has been found that gives HTP's freedom to choose (from within the HT Curriculum), the techniques they felt best suited the patient presentation at each session. While it could be argued that such a variable contributes to poor quality research, it could also be seen as bringing greater authenticity to the delivery of HT as it would be delivered in a "real world", naturalistic setting. What was standardised was all the patients were naïve to HT therapy and 100% had no expectation or belief in the effectiveness of HT. Another strength is that only HT techniques were used as opposed to a common scenario where a combination of modalities such as guided imagery and music are incorporated into HT sessions. A combination of modalities was avoided in this study to reduce the number of confounding variables. Rationale for encouraging experienced HTP's freedom to choose the techniques they deemed most beneficial for the patient at each interaction, was simply to allow the "healer to heal". The art and science of Healing Touch cannot be reduced to a single "one size fits all" technique which previous studies have tried to do to in an effort to show scientific rigour. In the attempt to find the active ingredient much has been lost or discarded as HT has been stripped back to a mechanical process devoid of meaningful human interaction. Looking back at the four ways the heart communicates with the body, p.16-17 we begin to get a glimpse into the complexity of the human energy field. Hands, heart and head create a synergistic biological dance that alters exponentially when another's hands, heart and head connect.

Confounding Variables

Other influences that could have had an effect on the results of this study are the placebo effect, the nocebo effect and the Hawthorne effect. The timing of anti-emetic drugs and

chemotherapy treatments was not examined but they certainly are worth considering as confounding variables.

The placebo effect is an example of how the mind can control the body. Whenever an intervention takes place, be it a drug therapy or CAM therapy there is an expectation that something will occur, therefore the mind can create the effect which causes the biological change. Patients given an inert substance or sugar pill can expect to get a benefit and so they do. This is testament to the body's powerful internal resources and is a positive effect to be harnessed rather than a negative effect to be removed. Studies of the placebo effect are not confined to pharmaceuticals and CAM/Integrative therapies. An example of the power of the placebo effect has also been demonstrated in the surgical field. A randomized, placebo-controlled trial on the effects of knee surgery for 180 patients with osteoarthritis concluded the entire benefit of knee surgery was due to the placebo effect. Improvements occurred as often in the "fake surgery" group as the surgical intervention groups (Moseley et al., 2002). Such findings can redirect the health dollar to areas where it will deliver the best value for money. Funding research is an important step in this process. It is worth noting that 100% of the patients in this study had no belief in the effectiveness of HT.

The nocebo effect is the power of negative beliefs and is the opposite of the placebo effect. It is a negative or harmful side effect to an inert substance. Positive and negative beliefs impact health and life. "It is not our genes, but our beliefs that control our lives" (Lipton, 2005, p. 114).

The Hawthorne effect can occur when someone responds in a certain way because they are being watched or perceive they are being watched. Participants in this study were fully informed of the purpose of the study and were well aware when they were receiving HT

treatments twice a week. They were being observed during each session by the HTP in a partnership process rather than an observational one. Despite no previous experience of HT they could have anticipated a beneficial effect and therefore the impact of the Hawthorne effect is possible (Burns & Groves, 2005).

The use of a small sample of convenience as opposed to a randomized sample and a control group means the results of this study cannot be extrapolated out to apply to any other group or the general population. This study was conducted over a four month period under a specific set of circumstances involving patients receiving different chemotherapy and drug treatment regimens which could not be accurately reproduced for a repeat study. It is acknowledged that results from this particular, unique population, were measureable, pleasurable and positive for this particular group and therefore affirmed the main research question. The research question asked, "Can HT improve the patient experience in a group of hospitalised adults receiving intensive chemotherapy for haematological malignancies? Evidence has been presented and data collected that suggest HT can improve the patient experience and it is feasible to deliver and acceptable for patients to receive. It appears to have improved the experience of this cohort and supported their health related quality of life (HRQoL). Supportive care in the form of a hands-on complementary modality is more likely than not to improve the patient's subjective well-being measures.

[Recommendations for future research](#)

The goal for this pilot study has been met by demonstrating the ability to recruit and retain participants and to receive a high rate of positive qualitative feedback from the patients and staff suggesting a HT Programme is feasible to deliver, acceptable to receive and a positive

patient experience. The best way to carry out future HT research may be to utilise a comparator that has a known benefit to measure against HT. Gentile D et al. (2018) utilised HT and Oncology massage as a comparator and Kemper et al. (2009) used rest as a comparator against HT in paediatric oncology patients. Others have used mock HT Jain (2009) and Wicking (2012), while Jain et al. (2012) used Guided Imagery in conjunction with HT in post-traumatic stress disorder.

Hypnosis and acupuncture could also be useful comparators since there is some clear evidence as to the efficacy of these two modalities in certain conditions.

A cooperation between healers and researchers such as in the BRIDG Programme, <https://helfgott.nunm.edu/building-research-across-inter-disciplinary-gaps-bridg/bridg-t90-program/> would be most beneficial in moving the art and science of energy healing modalities into mainstream healthcare.

The patient experience of receiving HT was able to be measured, and could be better measured in the future by using different tools such as the (Patient Reported Outcome Measures Information System (PROMIS) which has been developed specifically for CAM and IM modalities. PROMIS is an NIH-funded initiative established in 2004 as a cooperative network to develop and validate patient reported outcomes (PROs) in global health, physical function, fatigue, pain, sleep/wake function, emotional distress, and social health.

“Currently, the PROMIS network consists of 12 research sites and three administrative centre’s that are developing PROs in several new domains and performing validation studies of PROs in new and existing domains.” <https://commonfund.nih.gov/promis/index>

Anecdotal comments from patients and post treatment evaluations showed HT was a pleasurable experience to receive and it delivered positive subjective benefits to all but one patient, on one occasion. There are sustained and accumulative effects from repeated HT treatments that persist into the next 24 hours and possibly days longer.

Certain patient conditions or patient groups respond in a predictable way to HT therapy. For example, chronic conditions are thought to respond best to more frequent HT sessions over a longer period of time. Repeated HT treatments do not appear to reach a saturation point as the body is continually adjusting to its environment to find balance and harmony on all layers of it's being; physical, mental, emotional and spiritual. Patients who are frail or weakened by their disease or the treatment of it (in the case of chemotherapy), may require shorter HT sessions with minimal techniques being used. This is why it is appropriate to trust the Healer to assess the patient's dynamic presentation at each encounter and for the Healer to be given the freedom to heal, even in a research setting if we are to achieve the best possible outcome for the patients highest good.

Conclusion

Many nursing theorists, including Jean Watson believe that human care can only be effectively practiced and demonstrated when there is an interpersonal relationship between the patient and the nurse. Current nursing practice has become very task orientated and reliant on technology to the point that patients experience very little physical touch. This state is reflective of Western Society in general. In interviews with a group of self-identified holistic nurses, Slater (1999) found the one concept expressed by every nurse was "presence", using oneself as the primary therapeutic nursing tool. Described as "willing to be with the patient in silence, non-judgemental, without an agenda and most importantly allowing time and space to heal. Slater 1999 states, "Presence appears to be the hallmark of

a holistic nurse.” Clearly nurses can be an instrument of healing and many seem to recognise this on some level. However in the staff evaluation feedback it was the Clinical Psychologist who had the most difficulty relating to the term “Healing Touch” and felt uncomfortable using it around patients with cancer.

“I really struggle with the name-“Healing Touch” being used with cancer patients. It causes confusion from the outset about its purpose alongside medical treatments.

Patients have reported that they don’t like it being called this” Psychologist

Overall patients appeared to appreciate the supportive, relaxing HT interventions and none withdrew from the study. Based solely on this study of 10 participants one could not conclude that HT is consistently effective or ineffective but it does show clinical significance and did detect some statistical significance in four out of the six symptoms of interest. This was also the case in

There was a reduction in anxiety, muscle tension and pain and an increase in the state of relaxation. While there was no statistical difference for the symptoms of fatigue and nausea individual patients did report significant clinical benefit. Eighty-seven percent of participants found HT to be quite helpful or very helpful and just one patient found the duration of the session too long. Previous research designs may have delivered an inadequate dose of HT to elicit the greatest potential benefit from each exposure. This research suggests there is an accumulative effect that takes place and does not reach saturation over time.

Danhauer et al. (2008) found HT was well received by patients hospitalised with leukaemia and recommended more closely examining the optimal dosage. Wilkinson et al. (2002) carried out a similar pre, post-test design comparing three treatment conditions delivered to 22 patients. Each session was thirty to forty minutes long and feedback from both the

participants and the practitioners was that this timeframe was too short. FitzHenry et al. (2014) recommended increasing the “dose” of HT to forty five minutes twice a week instead of once a week and strengthening the effect of the intervention by having the same practitioner deliver each session to strengthen the patient provider relationship. Those recommendations served to inform the design of the current study. This research has shown a larger study is feasible and that HT can be seamlessly incorporated into the hospital setting for patients with haematological disorders without interfering with ward routines. Demands on nurses time does not allow them to spend the “hands-on” quality time with patients as they would like to. One nurse commented to her patients HT Practitioner; “it was almost a relief to know your patient was receiving this special one on one, quality, time when I couldn’t be with him as much as he needed. I wish all of my patients took the opportunity to receive this nurturing care, I could see how relaxed the ones who did do it were.”

The results have shown that HT can be a positive contributor to wellbeing in the Bone Marrow Transplant Unit (BMTU) and that HT therapy could be offered to all patients with minor changes to delivery and funding arrangements. Further research into the duration of symptom relief and longer term effects of HT are warranted. A key finding suggests that previous research designs may have delivered an inadequate dose of HT to elicit the greatest potential benefit from each exposure. This research suggests there is an accumulative effect that takes place and does not reach saturation over time.

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Appendices

Appendix A Information Pack, Consent Form, Information for Participants

relaxing ... calming ... energizing

What is Healing Touch?
Healing Touch is a relaxing nurturing energy therapy. Gentle touch assists in balancing your physical, mental, emotional and spiritual well-being. Healing Touch works with your energy field to support your natural ability to heal. It is safe for all ages and works in harmony with standard medical care.



How can Healing Touch benefit you?

- Calming anxiety, depression
- Decreasing pain
- Strengthening the immune system
- Enhancing recovery from surgery
- Complementing care for neck & back problems
- Deepening spiritual connection
- Supporting cancer care
- Creating a sense of well being
- Easing acute & chronic conditions

Healing Touch research suggests that there are many benefits. Individual experiences will vary.



Where is Healing Touch Used?
Healing Touch is used in a wide variety of settings including hospitals, long term care facilities, private practices, hospices, and spas. Janet Mentgen, RN, founded Healing Touch in 1989 as a continuing education program for nurses, other health care professionals and lay persons. Today, Healing Touch has spread throughout the world and is taught in universities, medical and nursing schools and other settings internationally.

It is endorsed by the American Holistic Nurses Association since 1997. Practitioners and Instructors are certified through Healing Beyond Borders, supported by its research department and expertise in health care integration. Healing Touch continues to grow rapidly, spreading healing light worldwide.

Who are Certified Healing Touch Practitioners?
The Certified Healing Touch Practitioner (CHTP) credential is widely recognized in energy therapy training. Look for the CHTP credential to assure the highest standards. All CHTPs:

- Complete a rigorous training and certification program
- Abide by a professional Code of Ethics and Standards of Practice

"My pain level dropped from unbearable to manageable after just one session."
- Marilyn Cummelin, Chronic pain sufferer

www.HealingBeyondBorders.org



A Healing Touch session feels like a nurturing radiance that flows through and around you. Each individual experience is unique and based upon your individual needs.

"I receive Healing Touch to bring in serenity, balance and love. Healing Touch is my monthly infusion of peace."
— Andrea Rietsch, Mother of three



Healing Beyond Borders
Educating and Certifying the Healing Touch™

Healing Beyond Borders
445 Union Blvd., Suite 105
Lakewood, CO 80228
303.989.7982

www.HealingBeyondBorders.org

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healing touch
nurturing energy therapy

Healing Beyond Borders
Educating and Certifying the Healing Touch™

Participation Consent Form

Project Title: The Effectiveness of Healing Touch, a bio-field therapy providing relaxation and supportive care, for hospitalised patients receiving treatment for Haematological Disorders

I agree that

- I have been given a full explanation of this project
- I have read the information sheet and have had an opportunity to ask questions about the study.
- I am taking part in this study at my own free will.
- I understand what will be required of me if I agree to take part in this project.
- I understand that my participation is voluntary and that I may withdraw at any stage without penalty.
- I understand that any information I provide will be kept confidential to the researcher and that any published or reported results will not identify me.
- I understand that all data collected about me for this study will be kept in locked and secure facilities at the Bone Marrow Transfusion Unit or the University of Canterbury Health Centre and will be destroyed after five years.
- I understand that I am able to receive a report on the findings of this study. I have provided my email details below for this.

- I understand that if I require further information I can contact the researcher, Wendy Risdon or supervisor Kate Reid. If I have any concerns I can contact the Chair of the University of Canterbury Human Ethics Committee Private Bag 4800 Christchurch (human-ethics@canterbury.ac.nz)

By signing below, I agree to participate in this research project.

Name: _____

Date: _____

Signature: _____

Email address: _____



Information for Participants

Dear

My name is Wendy Risdon and I am currently studying towards a Master's Degree in Health Science at the University of Canterbury. As part of my study I am undertaking research into the value of using "Healing Touch" (HT), a relaxing, hands-on therapy, to provide complementary care, for patients hospitalised with haematological disorders.

I want to understand, if the quality of life, of people who are hospitalised for a long time, because of severe illness improves if they have therapies that involve gentle touch. I am specifically looking to understand the effect of one particular therapy: "**Healing Touch.**" This therapy is a gentle, nurturing hands-on or just above the body, technique used in many hospitals in 30 different countries. It is reported to be safe for all ages and conditions. Previous research about patient quality of life, in haematological disorders has focused on, the management of side effects from medical treatment or the physical symptoms of the illness. Very few studies have looked at the overall benefit of complementary care, like HT or focused on the psychological effects experienced by individuals, even though it is well documented that patients commonly experience chronic stress.

An initial interview will be completed, to gain relevant background information, after the consent to participate has been signed.

If you want to participate, a registered HT professional will give you once or twice weekly touch therapy sessions, in your room for up to 60 minutes at a time. You are not required to do anything during the sessions, you may choose to close your eyes and rest. This takes place with you fully clothed, in the afternoon or evening. You will also be given questionnaires to

fill out within 3 days after each session. These will take approximately 5 minutes to complete. I am interested in your views, so staff will not be able to help you do this. You can ask family or friends for assistance in filling out the questionnaires.

The results of the project may be published, but you can be assured of complete confidentiality of the data gathered in this investigation: your identity will not be made public. To ensure anonymity and confidentiality, any information that is collected throughout the Pilot Project will be securely stored in a locked filing cabinet in a lockable room at the BMTU and destroyed after the required time of the University, of 5 years. Participant's names and any other details that clearly identify the participants will not be used to maintain confidentiality.

A Master's Thesis will be written at the completion of this research. This is a public document and it will be available through the UC Library. You may receive a copy of this by contacting the researcher by email or phone when it is available. The project is under the supervision of Kate Reid who can be contacted at kate.reid@canterbury.ac.nz.

She will be pleased to discuss any concerns you may have about participation in the project. If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050

Fax 0800 2 SUPPORT (0800 2787 7678)

Email: advocacy@hdc.org.nz

You can also contact the Chair of the University Human Ethics Committee by phone (03 364 2987) or by email: at human-ethics@canterbury.ac.nz

I wish to invite you to participate in this study. All participants are able to withdraw from the study up until the time of data analysis by texting or emailing Wendy Risdon.

If you agree to participate in the study, please contact the researcher by txt or phone to arrange a time to meet, which is convenient for you. At this time it is possible to answer any questions or concerns that you have before signing the consent form and agreeing to participate in the study.

Thank you for considering participating in this study.

Wendy Risdon (Registered Nurse and Masters Research Candidate)

Phone: 027 6224061

Email: wendy.risdon@canterbury.ac.nz

Kate Reid (Supervisor)

Email: kate.reid@canterbury.ac.nz

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any concerns to

Address: The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch

Email: human-ethics@canterbury.ac.nz

Appendix B Initial Intake Interview Form

Healing Touch Initial Intake Interview

Date ___/___/___

Practitioner:	Client:
Phone:	Age:
Email:	Occupation:

Medical Diagnosis:

Are you familiar with any Complementary or Alternative Treatments?

What was your life like before being diagnosed? (Social Support/Living Situation, family, alone, pets etc):

Is there any relevant information you wish to share about yourself?

Medical Problems/Health History (circle what applies):

Blood Disorders	Heart	Lung	Digestive	Thyroid/hormonal	Bronchitis	Liver
Asthma	Heart Attack	Circulation	Stomach	Gall Blader	Stroke	Reproductive Organs
Urinary Tract	High Blood Pressure	Clot	Colon	Sexual Assault/Abuse	Eating Disorder	Seizures
Cancer	Diabetes	Vision	Kidneys	Hearing	Depression	Weight Problems
Headaches	Serious Accident/Trauma	Alcohol/Drug Problems	Allergies			

What prescribed medicines are you taking? (Including any vitamins and/or herbal supplements)

Do you use? Alcohol Recreational Drugs Tobacco Caffeine

Nutrition:

Water Intake: Glasses per day _____

What has your sleep been like since you've been in hospital? **Sleep Patterns:**

Healing Touch Initial Intake Interview / Page 2

Is there anything that is concerning you at the moment?

Personal Stresses: Use Scale from 0 (no stress) to 10 (extreme stress) from:

Illness:	Work:	Relationships:	Finances:	Loss:	Other:
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What do you normally do in your life to relax? Self Care:

Exercise/Sports	Hobbies	Friends	Support Groups	Meditation/Prayer	Other
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Describe: _____

Are there any Religious/Spiritual Practices and/or Beliefs important to you?

Do you have any thoughts you would like to share about your current illness?

Is there anything else you want to ask me?

Do you have any questions about me or about Healing Touch?

Consent Form Completed: Yes / No

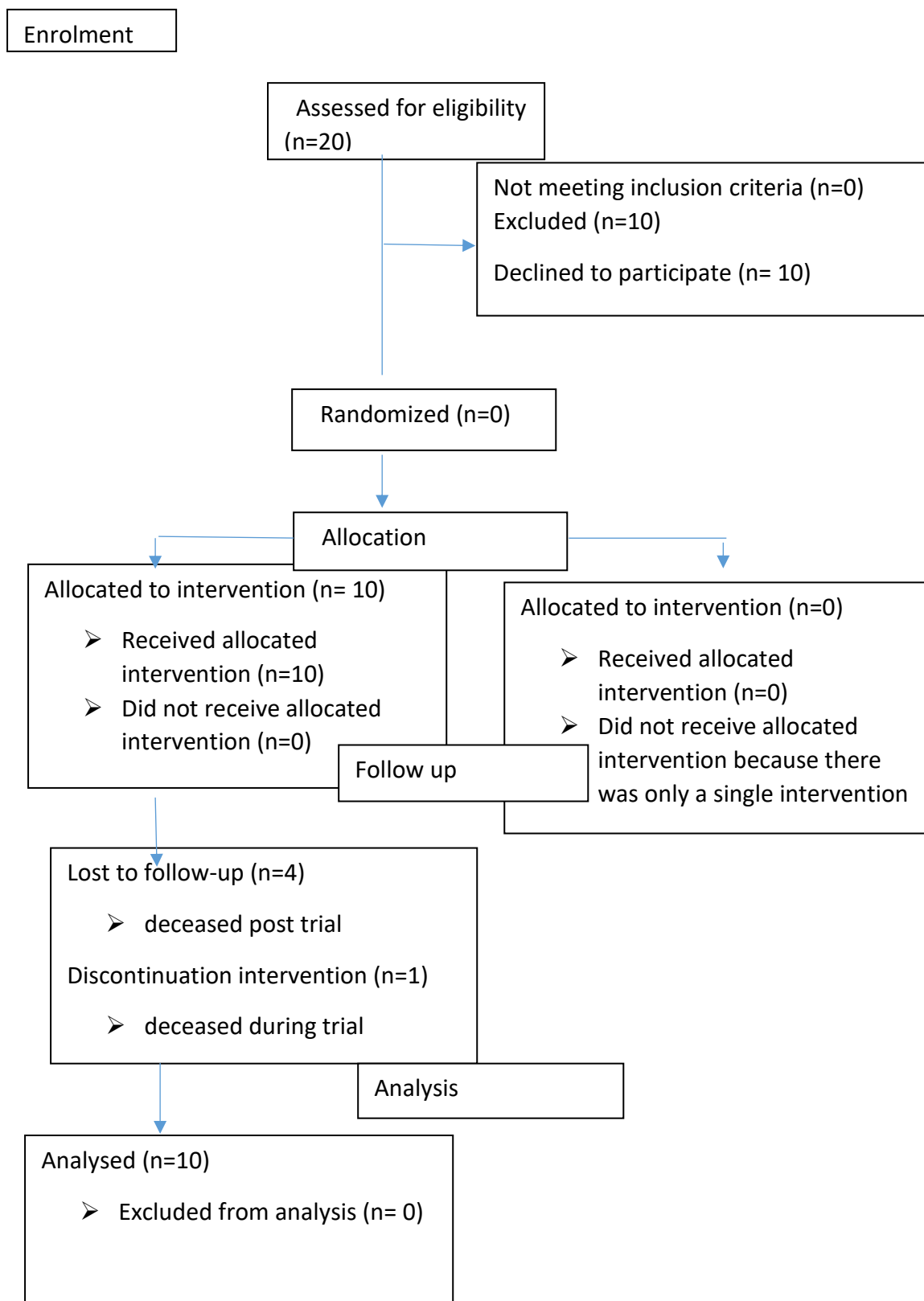
Written Information given: Yes / No

Pamphlet and Website given: Yes / No

Contact Person:

How to make or cancel an appointment for Healing Touch:

Consort 2010 Flow Diagram



Appendix D Healing Touch Session Documentation

Healing Touch Session Documentation

DATE ___ / ___ / ___

Patient Name:	
Phone:	Age:
Practitioner Name:	Session #:
Client Feedback from previous session:	

Medical Diagnosis (if available):

	PATIENT RESPONSE (Pre-Tx)	PATIENT RESPONSE (Post-Tx)
	Anxiety Level: (Pre-Treatment Anxiety Level: _____)	Anxiety Level: (Post-Treatment Anxiety Level: _____)
	Relaxation Level: (Pre-Treatment Level: _____)	Relaxation Level: (Post-Treatment Level: _____)
	Muscle Tension Level: (Pre-Treatment Tension Level: _____)	Tension Level: (Post-Treatment Tension Level: _____)
	Pain Level: (Pre-Treatment Pain Level: _____)	Pain Level: (Post-Treatment Pain Level: _____)
	Fatigue Level: (Pre-Treatment Fatigue Level: _____)	Fatigue Level: (Post-Treatment Fatigue Level: _____)
	Nausea Level: (Pre-Treatment Nausea Level: _____)	Nausea Level: (Post-Treatment Nausea Level: _____)

Treatment Start Time:
Treatment End Time:
Treatment Duration:

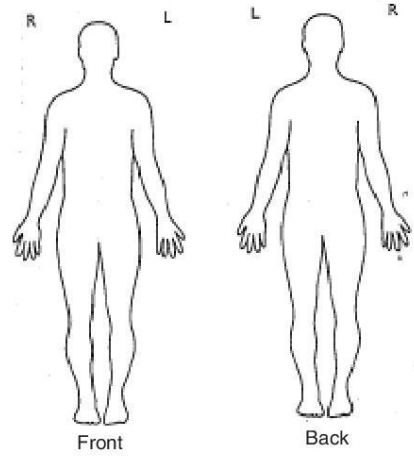
Additional Notes/Comments:

- * Anxiety Level: 0-5 (0 = No Anxiety 5 = Most Anxiety)
 Relaxation Level: 0-5 (0 = No Relaxation 5 = Most Relaxation)
 Muscle Tension Level: 0-5 (0 = Not Tense 5 = Most Tense)
 Pain Level: 0-5 (0 = No Pain 5 = Most Pain)
 Fatigue Level: 0-5 (0 = Not Tired 5 = Most Tired)
 Nausea Level: 0-5 (0 = No Nausea 5 = Most Nausea)

Healing Touch Session Documentation

What would you like out of this session? Mutual Goal:

Pre-treatment Assessment:



Type of treatment interventions used:

- | | | |
|---|--|--|
| <input type="checkbox"/> Chakra Connection | <input type="checkbox"/> Opening spiral | <input type="checkbox"/> Laser to... |
| <input type="checkbox"/> Modified Mesmeric Clearing | <input type="checkbox"/> Lower Body Connection | <input type="checkbox"/> Break Finger Laser |
| <input type="checkbox"/> Chakra Spread | <input type="checkbox"/> Opening spinal flow | <input type="checkbox"/> Siphon to... |
| <input type="checkbox"/> Chakra Energizing | <input type="checkbox"/> Vertebral Spiral | <input type="checkbox"/> Wound sealing |
| <input type="checkbox"/> Field Repatterning | <input type="checkbox"/> Hopi back technique | <input type="checkbox"/> Mind clearing - Noel's Mind Clearing |
| <input type="checkbox"/> Hands Still | <input type="checkbox"/> Closing spiral | <input type="checkbox"/> Headache Techniques |
| <input type="checkbox"/> Hands in motion | <input type="checkbox"/> Scudder Meridian Clearing | <input type="checkbox"/> Immune Boost |
| <input type="checkbox"/> Chelation | <input type="checkbox"/> Spinal Work- 3 parts | <input type="checkbox"/> Etheric template repatterning |
| <input type="checkbox"/> Lymphatic Clearing | <input type="checkbox"/> Ground & Release | <input type="checkbox"/> Celestial & Ketheric Template Reppatterning |

Post-treatment Assessment:

Client experience/Feedback:

Practitioner Observations:

Follow up appointment/plan:

Post Treatment Questionnaire

Healing Touch Pilot Project

Please mark one number per line to indicate your response as it applies to the past 24 hours since your Healing Touch session

Date of last Healing Touch Treatment: _____ (dd/mm/yy)

Ref #		Not at all	A little bit	Some what	Quite a bit	Very much
1	I am sleeping well	0	1	2	3	4
2	I am satisfied with how I am coping with my illness					
3	I have a lack of energy					
4	I feel sick					
5	I have pain					
6	I am bothered by side effects of treatment					
7	I feel ill					
8	I feel anxious					
9	Overall I have found these sessions helpful					

Please circle the answer that applies to the questions below

10 Was the most recent Healing Touch session too long too short about right?

11. Was the Practitioner responsive to your needs? YES NO

12 Please share your experience of the session or suggest how could we improve future sessions? Please write your suggestions below or on the back. Thank you

Appendix F Programme Evaluation for Ward Staff. Questionnaire Results

1. What is your impression of the usefulness of this service for patients?

"Good feedback from patients, probably some who said "no" may have benefited if (they) understood more"

"Very useful, feels good to be able to offer something holistic"

"Great service, would be good if it could continue"

"It's a fantastic way for pts to focus on something helpful and good during their treatment, which can be awful"

"Mixture, some have found it very helpful"

"Most of the patients enjoyed it"

2. What worked well?

"Patients felt more relaxed after each session"

"A different non-medical approach- time out from the medical world"

"Giving all patients the opportunity to participate or think about participating. Having the sessions on the ward so pts didn't have to go too far. Asking staff to discuss the option with patients"

"Helped patients relax and be more mindful of their own mental health"

"Ease of referral"

3. What were the challenges?

"Timing"

"Trying to engage more pts and find the time to attend"

"Unsure"

"Explaining its role/purpose to patients, other than giving them the leaflet"

"To recruit new people as they were unaware of the idea of "Healing Touch"

4. What could be improved?

"It could be better if we have more resources available"

"A name change! Focus more on calmness and relaxation maybe?"

"Possibly advertise the sessions more so all patients are aware and have the opportunity. Unsure what the sessions consisted of so cannot comment on further improvements"

"When service in progress, patients often interrupted as unaware they were having HT especially in Room 8" (multi bed unit)

5. Do you have any recommendations for the future delivery of Complementary Therapies?

"Privacy- signs, healing touch in progress"

"Would be better if complementary therapies had a greater presence on the ward and incorporated into treatment regimens"

"I really struggle with the name-“Healing Touch” being use with cancer patients. It causes confusion from the outset about its purpose alongside medical treatments. Patients have reported that they don’t like it being called this”
“Making more resources available readily and more sensible timing”

6. Did you experience a Healing Touch session when it was offered to staff? If so how was it beneficial to you?

A total of 11 staff had sessions- benefits expressed in writing were;

“Very relaxing, almost assisted into a meditative state”

“I wanted to go however the sessions were on when I wasn’t on or during a busy shift. I couldn’t get to a session unfortunately”

I felt so relaxed after the session not only mentally but physically as well”

“Mixed (feelings) - was a relaxing setting”

Three staff chose not to have Healing Touch most common reason was

“I did not want to-not ready, lack of time”

Appendix G Professional Protocol for Healing Touch Practitioners Working in the Bone Marrow Transplant Unit and “AON” Indemnity Insurance, Application for Non-Nurses

2

complementary therapy which can reduce unpleasant drug side effects and enhance patient comfort while promoting dimensions of healing in the face of serious or life-threatening illness.

Healing Touch has enormous potential for creating a greater feeling of wellbeing and improving quality of life. It has been referred to by patients, as “the glue that holds me together emotionally, when my physical body feels as if it’s been hijacked.”

Healing Touch is a gentle complementary energy-based approach to health and healing. The goal is to restore harmony and balance to the energy system through a heart-centered caring relationship using contact and non- contact touch techniques.

Research suggests that Healing Touch greatly benefits those who receive it, complements conventional health care and is safe for all ages.

Background Studies specific to Healing Touch interventions have focused on managing the symptoms of pain and anxiety, and stress; decreasing the side effects of cancer treatments, promoting faster post procedural recovery, improving mental health; using Healing Touch with the elderly to improve pain, appetite, sleep, behaviour patterns and functional abilities, increasing relaxation and promoting a sense of well-being as well as stimulating the immune system.

Practitioner Role:

Wendy Risdon, a Healing Touch nurse practitioner, has developed this project opportunity. During the 12 week trial Wendy will require HT practitioners to provide treatment for patients in the BMTU. They will use standardised techniques, standardised documentation and will have a robust reporting system that will provide Wendy with regular information to gather data for her project and subsequent ongoing studies and research.

Wendy will do all initial enrolment interviews with patients desiring to be part of the project to gather consent and baseline data.

Healing Touch session Documentation will be done by Practitioners with the Patient Assessment and Evaluation Tool (Herth Hope Index Tool) or (Cancer Behaviour Inventory Tool Brief Version)

Communication between Practitioners will occur weekly in the first 3 weeks of the project to standardise documentation and delivery of techniques and iron out any problems. Wendy will be available by cell phone or email for more urgent matters in between times. She will visit the BMTU 2-3 times a week The nurses in the BMTU will deal with all medical concerns and be informed of any concerns a patient may have and express to the Healing Touch Practitioner.

Practitioners will be randomly allocated patients who have consented to receive HT and partake in the Pilot Project. They will be contacted by email or cell phone to arrange suitable appointment times and each patient will have 12 sessions available to them at no cost to the patient.

Opportunities for Healing Touch New Zealand Incorporated as an organisation:

1. To have a team of seven Certified Healing Touch Practitioners(CHTP's), and two Apprentices (under the guidance of their Mentor or other CHTP), to be involved with providing regular Healing Touch Treatments in the Bone Marrow Treatment Unit at the Christchurch Public Hospital.
2. With assessment of the programme's success, there may be an opportunity for an ongoing Healing Touch presence and study of Healing Touch, within the Unit.
3. Will give Healing Touch NZ the opportunity to raise the awareness of Healing Touch Bio-field Therapy within the CDHB and into the community at large
4. Will give Healing Touch NZ the opportunity to develop a cohesive team of practitioners, working for the highest intention towards the same goal.
5. The Team of Certified Practitioners: Wendy Risdon, Deb Carter, Gwyneth Steenson, Sharon Gardiner, Jane Carter, Karen O'Carroll, Pauline Leask
6. The Team of Apprentice Practitioners: Dayle Hunt (Mentor - Wendy Risdon) Ian Thurlow (Mentor – Deb Carter, Wendy Risdon)

Wendy's plan is to obtain Ethics Committee Approval for a research proposal to evaluate this Pilot Project using the data gathered by the Healing Touch Practitioners in the course of a treatment session and through formal pre and post treatment questionnaires. If approved this would form the research for a Master's Thesis in Health Sciences. These documents form part of the appendices to this Protocol

Requirements of Certified Healing Touch Practitioners:

- a. Have a wish to provide a 'Heart- centered' approach to healing within a traditional health setting.
- b. Are current members of Healing Touch New Zealand (HTNZ).
- c. Are currently Certified with Healing Beyond Borders/Healing Touch International (HBB / HTI).
- d. Will be using standardised Healing Touch techniques appropriate to the requirements of the patients.
- e. All practitioners and students are governed by our International Code of Ethics/ Standards of Practice.
- f. Each individual Practitioner will invoice HTNZ, at least monthly, for sessions completed in the bone marrow Unit.

- g. Because each individual Practitioner will be sharing patients within each week, it will be important for regular meetings of practitioners to discuss findings and success.
- h. 'Self -Care' will be considered extremely important and encouraged to be part of a weekly practice for each individual. Whether this takes the form of a Healing Touch session received, or other body or energy work. The importance of a continual and elevated energetic vibration whilst working with chemotherapy needs to be emphasised.
- i. Also recommended is the regular offer of 'group supervision'. A space and opportunity to process any events that happen within the programme, as a Practitioner, watching and supporting the challenging journey of patients travelling within the Bone Marrow Unit.
- j. Each Practitioner will sign an individual contract with the Project Manager (Wendy Risdon) outlining requirements and expectations for the project. All assessments will be at the request of Wendy. i.e. Practitioner competency, appropriate documentation and evaluation
- k. Continuing and ongoing updates of qualifications of Practitioners are recommended including a current First Aid Certificate.
- l. Any indemnity insurance is the responsibility of the individual Practitioner.
- m. Will be inducted into the Bone Marrow Unit by staff and educated on processes and procedures around chemotherapy treatment and patient requirements. May be asked as standard procedure, to undergo a police check.
- n. Each Practitioner will be required to work within the stated Health and Safety policy developed for Healing Touch Practitioners working in the Bone Marrow Unit.
- o. Patient confidentiality and privacy is expected, in accordance with our International Code of Ethics/standards of Practice.
- p. Reference Code/ Standard 10: Confidentially, and will be paramount. (HTNZ Code of Ethics).
- q. Any Practitioner working within the unit will be required to sign a confidentiality agreement.

Requirements of Apprentice Practitioners:

- a. Have a wish to provide a 'heart- centered' approach to healing within a traditional health setting.
- b. Are current members of Healing Touch New Zealand (HTNZ).
- c. Work under the umbrella and close guidance of their Mentor who will be in the unit at the same time or designated Senior CHTP acting as a mentor, present in the ward.
- d. Will be using standardised Healing Touch techniques appropriate to the requirements of the patients.

- e. All practitioners and students are governed by our International Code of Ethics/ Standards of Practice.
- f. Each individual Apprentice will invoice HTNZ, at least monthly, for sessions completed in the bone marrow ward.
- g. Because each individual apprentice will be sharing patients within each week, it will be important for regular meetings to discuss findings and success.
- h. 'Self -Care' will be considered extremely important and encouraged to be part of a weekly practice for each individual Practitioner. Whether this take the form of a Healing Touch session received or other body or energy work. The importance of a continual and elevated energetic vibration whilst working with chemotherapy needs to be emphasised.
- i. Also recommended is the regular offer of 'group supervision'. A space and opportunity to process any events that happen within the programme, as an Apprentice practitioner, watching and supporting the challenging journey of patients travelling within the Bone Marrow Unit.
- j. Each Apprentice will sign an individual agreement with the Project Manager (Wendy Risdon) which will outline requirements and expectations for the project. All assessments will be at the request of Wendy i.e. Apprentice Practitioner competency, documentation and evaluation.
- k. Continuing and ongoing updates of qualifications are recommended including a current First Aid Certificate.
- l. Any indemnity insurance is the responsibility of the individual Apprentice.
- m. Will be inducted into the Bone Marrow Unit by staff and educated on processes and procedures around chemotherapy treatment and patient requirements.
- n. Each Practitioner will be required to work within the stated Health and Safety policy developed for Healing Touch Apprentice Practitioners working in the Bone Marrow Ward.
- o. Patient confidentiality and privacy is expected, in accordance with our International Code of Ethics/standards of Practice.
- p. Reference Code/ Standard 10: Confidentially, and will be paramount. (HTNZ Codes of Ethics).
- q. Any Practitioner working within the unit will be required to sign a confidentiality agreement Technique Choices and Rationale.

Points to Reflect upon as a Practitioner:

1. We are here to provide a "healing" space. We are not offering a 'cure'
2. Working with bone marrow means esoterically we are working with the golden residing soul and spirit of the individual. So precious, so individual. Our assistance may offer our patients, via Healing Touch, an opportunity to have a deeper connection with their spiritual essence. This in turn may provide some clarity for their journey.

3. Stay within your realms of practice which in this case is energy work. In 'walking the top of the fence-line' we keep a neutral stance for individuals to find their own answers.
4. Following Chemotherapy the body is in a 'die back' mode.
Chemotherapy causes the entire body energy structure to immediately collapse as it is a body shock. The intention is that all aberrant cancer cells will be in die-off along with the healthy cells, using conventional medicine. The end result is that organs may be functionally challenged and the immune system may be fully compromised. This results in a variety of uncomfortable physical symptoms for the patient.
5. At some point the patient may be neutropenic. This means that this patient has no resistance to any disease/unwellness therefore your standards of hygiene and wellness are vitally important. Healing Touch may assist and encourage the redevelopment of white blood cells within the bone marrow to increase and support the immune system.
6. The balancing of the WHOLE body will encourage the cells to rebalance and activate the body's capacity to heal.
7. All techniques need to be assessed against the energy levels and wellness of the individual patient. Employing the 'less is more' ideal so that simple full body techniques are enough to support at times of chemotherapy or radiotherapy. Other more robust techniques may be employed at other stages.
8. Ongoing discussions around the effectiveness of techniques at group meetings will consolidate the study and use of techniques.
9. As all treatments will probably be on a hospital bed the importance is that we are flexible with how we achieve techniques. Intention is important if positioning is tricky. Not only will there be positioning but there could be many different Intravenous lines or ports.

Practitioner Self Care:

1. Own health – physical: emotional: mental: spiritual:
2. Centering – being calm and keeping it simple.
3. It is important that you leave your personal emotional 'stuff' outside the Unit.
4. The Unit itself will have many emotions flying around. Practice expanding your auric field, maintaining an absolute calm within and without, no matter what you hear and see, radiate calm as you move and do not pick up other people's 'stuff'. Stay grounded and centered.

The staff will also radiate their personal distresses as they too have other lives and don't necessarily have your skills. There also tends to be a cumulative energy in the building. Nothing that a good energy cleaning wouldn't fix and that can be done silently and without anything except energy by sending love through the entire area. That will have an amazing effect.

5. Sharing with and 'supervision' with your own mentor or colleagues.
6. Always remember you are a **TEAM** member.
7. You are also radiating an area of calm for an extended period of time.

The Environment:

1. Hygiene
2. Creating calm, within you, despite the presence of all sorts of machinery/ equipment.
3. Quietness when talking. There is little privacy in a hospital.
4. Privacy.
5. Documentation.
6. Confidentiality.
7. Debrief possibilities.
8. Establishing a rapport with the client.
9. Boundaries. - Only doing HT and absolutely nothing else.
10. Recognising that you could possibly be interrupted due to another issue for the patient/hospital staff or activity.

The Patient:

1. Simple Full Assessment.
2. Less is ALWAYS best - these patients could be seriously compromised.
3. Every session will be new.
4. There will be so much going on for these patients. It may be months or years before you hear of any long, term results of life changes and that will be a bonus. Just know their Soul 'logs it". That is all that needs to happen.
5. Don't ever be surprised if, when you see the person again everything has collapsed again. Just be surprised if it hasn't.
6. Be cognisant of the client's beliefs.
7. You will be using ultrasound all over the body, due to the number of IV lines, catheters or injection sites they have.

Techniques:

- All Techniques throughout the Level 1-5 Healing Touch Curriculum are available to be used when working with patients within the Bone Marrow Unit.
- Keep it simple. These patients are frequently very fragile and with you holding a higher energy frequency the work will be completed more quickly. **Less is always best.**

Full Body Techniques:

1. **Full Body Connection** – includes the activating, energising and connecting of all organs and chakras.

NB * Notice that this technique is suggested first. There is no point in doing any Field work first as there will be no field surrounding the body, all organs and cells will be doing very little. It will be interesting for you to observe as time goes on whether these folk maintain their energy structures. Mostly, the structure collapses after every chemo or major medical intervention.
2. **Chakra Spread** – Transition through an aspect of treatment or ultimate transition of death (this technique may also be taught to family to enable this support for their family member (significant other – may not be a family member).

The importance of Chakra Spread is that it encourages communication between a significant other and the patient. The ‘significant other’ feels they are doing something as they tend to feel helpless. Don’t focus on death and if asked a possible outcome say ‘you don’t know.’ because that is the truth.
3. **Magnetic Clearing** – clearing extraneous chemicals from the physical system and energetic structure to enable the re-ignition of the energetic and physical systems.
4. **Back Treatment and Spinal Work** – Often patients have a very sore spine as treatment continues. This will help cool the nervous system within the spine and assist to give clearer neurological messaging.
5. **Hara Alignment** – To anchor the central Hara and core to assist the healing process.
6. **Immune Boost** (Advance Practice Technique).

Pain Relief Related Techniques:

1. **Pain Drain** – or energy drain – Sometimes there can be an abundance of energy in an area which may feel overwhelming to the individual. It may appear as heat or pain.
2. **Ultrasound** – breaking up congestion in organs or around areas of flat bone of sternum or hips, encouraging the production of white blood cells. Ultrasound would be the choice as these people are fragile and gentleness, kindness, calmness and quietness are invaluable assets. Even 'bumping their energy field will be felt so set your intention well.
3. **Mind Clear** – Cooling and calming of the nervous system and assistance with pain relief or headaches and mental worry.
4. **Laser** – Any repair of wounds or surgery - work carefully.

Ethics Committee:

It is the duty of Healing Touch New Zealand (HTNZ) to uphold our standards in order to safeguard the public while protecting the character of all Certified Healing Touch Practitioners and Instructors.

Healing Touch New Zealand has an ethics committee of appointed members with educational background and/or experience in ethics. It is with great care, thoughtful consideration, and with checks and balances that this process is conducted.

Healing Touch New Zealand has an Internationally approved Standards of Practice, Scope of Practice, Code of Ethics, and Instructor Guidelines, in alignment with Healing Beyond Borders, Educating and Certifying the Healing Touch®, which are utilised as the criteria to review and investigate formal complaint(s). Any or all complaints that cannot be resolved within NZ can be referred to the Healing Beyond Borders Ethics Committee for due consideration and assistance as long as all decisions sit within New Zealand law.

Ethical Committee Process:

All complaints or concerns must be in writing prior to consideration by the HTNZ Ethics committee.

Upon the receipt of a complaint(s) or concern(s) regarding the professional conduct or practice of a student, practitioner or instructor:

1. All matters are confidential and only the HTNZ Ethics committee and HTNZ Committee Members have access to this material in order to protect the individual under investigation and those who have been potentially harmed.
2. The Ethics Committee conducts a preliminary review of the complaint(s) and if there is deemed sufficient risk to the public, if certified, the individual's certification(s) is placed under immediate temporary suspension.

3. The individual is immediately informed by certified letter that a formal complaint has been received regarding any ethical breaches by the individual, and is notified of any action of suspension that is immediately taken.
4. The individual is given the opportunity to respond in various phases of the process.
5. The matter is then investigated fully and reviewed by the Ethics Committee. The committee heartfully deliberates all aspects of the case and takes into consideration the severity of the complaints, the potential risks to the public, the potential for rehabilitation or remediation.
6. Recommended action(s) are determined by the appropriate committees.
7. The individual is informed by certified mail of these recommendations and actions taken by HTNZ.

This process is based upon the Ethics Process Summary of Healing Beyond Borders – Educating and Certifying the Healing Touch®

Support and Reflection – Healing Touch NZ

July 2016

Methods of support/ supervision during this project by Ian Thurlow

Complementary Therapy -Healing Touch Pilot Project:

The opportunity to meet with the intention of supporting one another and offering a space for individual and collective reflection, may be of value in its own right, and of more value than a process named "supervision".

The experienced nature of the Healing Touch practitioners involved in the Complementary Therapy Healing Touch Pilot Project will mean that each will have their equivalent of professional supervision in place now, working for them and meeting their particular needs.

This proposal is about the opportunity to support and reflect on the evolving experiences resulting from the Project.

One of the possible outcomes of meeting for support and reflection is an individual decision to extend self-care by taking a particular issue to supervision.

The group could have the common purpose to provide the opportunity for support and reflection, and if it was decided to be of value to the Project group, could also provide a thorough, regular overview of the Project participants work. The intention could be to evaluate, maintain and, when appropriate, improve the quality of the practitioners' work.

In an environment that would be confidential, non-judgmental and safe, the practitioners may bring the issues that are relevant, and seek clarification, explore options, confirm or change decisions, take time to reflect, and receive support for who they are in the role as a Healer Practitioner within the Project.

Organisational and Administrative Matters:

The nature of a group offering support and reflection would need to consider a number of factors including:-

The need for facilitation or leadership, or not.

Frequency- to be negotiated and fluid
 Length of sessions
 Venue
 Time
 Cost
 How to cancel or postpone a session
 Any requirements of the "Project"

Circle of Support and Reflection:

This structure and way of meeting could begin as a process to meet the needs of the Healing Touch practitioners engaged with the Pilot Project. It also has the potential to be the basis of all the meetings and gatherings of Healing Touch NZ, given that the values of support and reflection align closely with the values and principles of the organisation.

Some possible guidelines for how a Circle of Support and Reflection may be:

Give and receive welcome. *Within the group we support each other's learning by giving and receiving (generosity, hospitality, welcome, inclusion)*

Be present as fully as possible. *Be in the group with your doubts, fears and failings as well as your convictions, joys and successes, your listening as well as your speaking*

What is offered in the circle is by invitation, not demand.

Speak your truth in ways that respect other people's truth. *Speak from your centre to the centre of the circle, using "I" statements, and trusting people to do their own sifting and sorting.*

No fixing, rescuing, advising or correcting each other

Learn to respond to others with honest open questions. *Help "hear each other into deeper speech".*

When the going gets rough, turn to wonder. *Set aside judgement to listen to others, and yourself, more deeply.*

Attend to your own inner teacher. *Pay particular attention to your own reactions and responses.*

Trust and learn from the silence. *Treat silence as a member of the group. After someone has spoken, take time to reflect without immediately filling the space with words.*

Observe deep confidentiality, and double confidentiality

Attached in the hard copy form to the end of this document for the Practitioners at our meeting was:

1. Code of Ethics/Standards of Practice (HBB)
2. Statement of Scope of Practice (HBB)
3. Ethics Process Summary (HBB)
4. Business Ethics (HBB)



Health Professionals Insurance Plan

**Professional Indemnity/Medical Malpractice
Legal and disciplinary defence costs
Loss of earnings during hearing/enquiry**

INTRODUCTION

Changes to Accident Compensation, Mental Health and other legislation mean that today's health professionals and medical practitioners face increased risk in their everyday activities. These legislative and social changes have made it necessary for you to take responsibility for your own professional protection and financial security.

Instead of relying on insurance or indemnity agreements from employers or unions, you can have your own specially designed insurance plan.

This plan is portable, which means you can take it with you if you change employment. This is a significant advantage over the system where many health professionals rely on their employers for indemnity and may be left uninsured when they resign or retire.

This insurance plan enables you to purchase your own unique high quality insurance plan at an affordable premium.

Please note the cover is for anywhere in New Zealand, this policy does not cover you while working overseas.

HOW DO I OBTAIN COVER?

Complete the application form and either email/fax or post to **Aon New Zealand, Professional Risks, P.O. Box 2517, Wellington 6140**. Aon will then send you your policy and certificate of insurance.

THE COVER

PROFESSIONAL INDEMNITY/ MEDICAL MALPRACTICE

This insurance provides cover for:

- \$500,000 in respect of each and every claim and \$1,000,000 in the aggregate.
- This section of the cover does not involve any excess, i.e. all claims are paid in full up to the amount of cover.
- Cover includes costs awarded against you as well as legal and other defence costs, whether the case against you is successful or not.

LEGAL AND DISCIPLINARY DEFENCE COSTS

This section will cover legal costs and expenses incurred in the defence of any action or enquiry brought against you such as Medical Disciplinary Hearings, Committees of Enquiry, Courts Martial, ACC Enquiries, Privacy Complaints Tribunal, Coroners Courts and the like.

LOSS OF EARNINGS

As a result of attendance at a court of enquiry because of a claim against you.

For Health Professionals, the policy pays up to \$1,000 per week for a maximum of 13 weeks.

PUBLIC / GENERAL LIABILITY – OPTIONAL EXTENSION – \$1,000,000 for any one loss

Covering your legal liability to the public for bodily injury and/or damage to third party property arising from your practice activities but excluding bodily injury resulting from a treatment process – covered by Professional Indemnity/Medical Malpractice above.



HOW DO I MAKE A CLAIM?

For immediate Claims response call: Aon New Zealand, Professional Risks Division, Ph +64 4 819 4000

WHAT IS NOT COVERED BY THE PLAN?

Like all insurance policies, there are number of exclusions. These are reasonable and full details are contained in the policy folder.

WHO MANAGES THE PLAN?

This Plan is managed by Aon New Zealand, the world's number one Retail Insurance Broker. The Company's heritage in New Zealand goes back to the 1930s.

The role of Aon is to manage the plan on behalf of the Insurers, but with responsibility to act in the best interest of you, the customer, at all times.

WHO IS THE INSURER?

QBE Insurance (Australia) Limited ABN 78 003 191 035, Incorporated in Australia is a specialist Insurer which transacts insurance business through professional Insurance Brokers. The Company is New Zealand's largest Medical Malpractice Insurer and has Standard & Poor's A+ (good) claims paying rating.

WHO QUALIFIES FOR THIS SCHEME?

The plan is available to all qualified health professionals.



**HEALTH PROFESSIONALS
APPLICATION FORM**



This Form constitutes a part of the Professional Indemnity/Medical Malpractice and Public Liability covers as may be arranged on your behalf.

Name including title			
Mailing Address		Post Code	
Email Address			
Telephone Number		Mobile Number	

Please state fully the nature of your Occupation / Profession	
Please advise qualifications and date obtained	
Please advise name of Medical School you attended and your date of registration if applicable	
Please advise Professional Bodies or Associations you belong to	

Insurance History

1. Is this a continuation of previous cover through Aon?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If NO who is your current Insurer?		
2. Has any Insurer:		
i. Declined a proposal for Professional Indemnity/Medical Malpractice Insurance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ii. Required an increased premium or imposed special terms?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
iii. Declined to renew the insurance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
iv. Cancelled the insurance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If any answer in Q2 above is YES , please give details below:		
3. Have you ever been the subject of any claim or complaint for medical malpractice, negligence, error or omission, or has there been any disciplinary proceedings or inquiry (include current inquiries) in connection with the standard of care provided by you?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. Are you aware of any circumstances which may give rise to a claim or complaint being made against you?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If YES to Q3 or Q4 above, please give details below:		

Optional Cover

Do you require cover for Public / General Liability (third party bodily injury or property damage)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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Declaration / Acknowledgement

I hereby declare that the above statements and particulars are in all respects complete and true, that they are material and that I have not suppressed or misstated any material facts and I agree that this application form shall be the basis of the contract with underwriters and deemed part of the insurance coverage issued to me and that the insurance will not be in force until the application has been accepted by the underwriters or their representatives.

I understand and accept that the policy will NOT provide cover in respect of any incidents which were known to me prior to the date cover is granted by insurers.

Signature: _____ Date: _____

CATEGORIES FOR HEALTH PROFESSIONALS

Category 1 \$304.75 or \$368.00 to include Public Liability	• Audiometrists	<input type="checkbox"/>	• Clinical Dental Technicians	<input type="checkbox"/>	• Dietitians	<input type="checkbox"/>
	• Dispensing Optician	<input type="checkbox"/>	• Kinesiology	<input type="checkbox"/>	• Counsellors / Social Workers	<input type="checkbox"/>
	• Lactation Consultants	<input type="checkbox"/>	• Massage Therapist (Non-Member)	<input type="checkbox"/>	• Medical Laboratory Technologists	<input type="checkbox"/>
	• Melanographer	<input type="checkbox"/>	• Music Therapist (Non-Member)	<input type="checkbox"/>	• Nurses / Health Care Assistant	<input type="checkbox"/>
	• Occupational Health Nurses	<input type="checkbox"/>	• Occupational Therapists	<input type="checkbox"/>	• Podiatrists	<input type="checkbox"/>
	• Reiki	<input type="checkbox"/>	• Reflexologists	<input type="checkbox"/>	• Sonographer	<input type="checkbox"/>
	• Ultra Sonographer	<input type="checkbox"/>	• Nutritionist	<input type="checkbox"/>	• Chakra Counselling	<input type="checkbox"/>
	• Dance Therapist (Non-Member)	<input type="checkbox"/>				
Category 2 \$419.75 or \$483.00 to include Public Liability	• Acupuncturists	<input type="checkbox"/>	• Aromatherapists	<input type="checkbox"/>	• Behaviour Therapists	<input type="checkbox"/>
	• Bowen Therapists	<input type="checkbox"/>	• Charge Medical Radiation Tech	<input type="checkbox"/>	• Clinical Hypnotherapist	<input type="checkbox"/>
	• Psychologists	<input type="checkbox"/>	• Craniosacral Therapists	<input type="checkbox"/>	• Health & Safety Consultants	<input type="checkbox"/>
	• Homeopaths	<input type="checkbox"/>	• Indian Head Massage	<input type="checkbox"/>	• Medical Herbalists	<input type="checkbox"/>
	• Natural Therapists	<input type="checkbox"/>	• Naturopath	<input type="checkbox"/>	• Neuro Linguistic Therapy	<input type="checkbox"/>
	• Neuromuscular Therapist	<input type="checkbox"/>	• Nordic Walk	<input type="checkbox"/>	• Play Therapists	<input type="checkbox"/>
	• Relaxation Massage	<input type="checkbox"/>	• Yoga or Sports Coaches/ Pilates	<input type="checkbox"/>	• Clinical Exercise Physiology	<input type="checkbox"/>
	• Art Therapists (Non-Members of ANZATA)					<input type="checkbox"/>
	• Beauty Therapists (appearance Nurses) if using Botox premium will be \$500 excluding admin fee, GST & PL					<input type="checkbox"/>
	• Bio Meso-therapist (cross between acupuncture/natural therapy)					<input type="checkbox"/>
Category 3 \$540.50 or \$603.75 to include Public Liability	• Anaesthetic Technicians	<input type="checkbox"/>	• Audiologist	<input type="checkbox"/>	• Feldenkrais Method	<input type="checkbox"/>
	• Medical Scientists	<input type="checkbox"/>	• Orthotists	<input type="checkbox"/>	• Physio Coach	<input type="checkbox"/>
	• Physiotherapists	<input type="checkbox"/>	• Personal Trainer	<input type="checkbox"/>	• Lymphatic Drainage Therapy	<input type="checkbox"/>
	• Laser Therapy Treatments – pain relief or skin and hair removal. If Botox involved additional \$250+GST					<input type="checkbox"/>
	• Medical Physicists and Engineers (excluding claims arising from owners of equipment and other users)					<input type="checkbox"/>
	• Nuclear Medicine Technologist (effective from 23/07/2014)					<input type="checkbox"/>

Health Professionals Association & Other Specialists

	Professional Indemnity only	Including Public Liability
• NZ Speech Language Therapists (Members & Non Members)	\$230.00 <input type="checkbox"/>	\$293.25 <input type="checkbox"/>
• Members of Massage New Zealand	\$281.75 <input type="checkbox"/>	\$345.00 <input type="checkbox"/>
• Art Therapists Members of ANZATA	\$281.75 <input type="checkbox"/>	\$345.00 <input type="checkbox"/>
• Dance Therapy New Zealand	\$281.75 <input type="checkbox"/>	\$345.00 <input type="checkbox"/>
• Music Therapy New Zealand	\$281.75 <input type="checkbox"/>	\$345.00 <input type="checkbox"/>
• NZ Institute of Medical Radiation (Members & Non Members)	\$281.75 <input type="checkbox"/>	\$345.00 <input type="checkbox"/>
• NZ College of Mental Health Nurses	\$281.75 <input type="checkbox"/>	\$345.00 <input type="checkbox"/>
• NZ Council of Homeopaths	\$362.25 <input type="checkbox"/>	\$425.50 <input type="checkbox"/>
• NZ Association of Medical Herbalists	\$345.00 <input type="checkbox"/>	\$408.25 <input type="checkbox"/>

Unless otherwise noted an administration fee of \$50.00 is included in the premiums quoted and all premiums are inclusive of GST.

APPENDIX 1



Healing Beyond Borders

Educating and Certifying the Healing Touch™

INTERNATIONAL CODE OF ETHICS / STANDARDS OF PRACTICE FOR HEALING TOUCH PRACTITIONERS and STUDENTS

PURPOSE:

The following Code of Ethics/Standards of Practice guide the energetic and holistic practice of Healing Touch.

DEFINITION:

Healing Touch is an energy therapy in which practitioners use their hands to enhance and balance the physical, mental, emotional and spiritual well-being of their clients.

GOAL:

The goal in Healing Touch is to restore harmony and balance in the energy system, facilitating the client's self healing process.

CODE/STANDARD 1: Scope of Practice

Healing Touch practitioners integrate and practice Healing Touch within the scope of their education, training, current licensing and credentialing. They represent themselves to the public in accordance with their credentials and practice within the guidelines of Healing Touch International's Scope of Practice statement.

CODE/STANDARD 2: Collaborative Care

Healing Touch is a holistic therapy that is complementary to conventional health care and is used in collaboration with other approaches to health and healing. Healing Touch practitioners must know the limits of their professional competence. Health/medical conditions are to be followed by health care professionals. Referrals are made to appropriate health care professionals as needed.

CODE/STANDARD 3: Self Development

Healing Touch practitioners work from a theoretical and practical knowledge base of Healing Touch. They integrate self care practices to enhance their own physical, emotional, mental and spiritual well-being. They maintain a commitment to ongoing learning and self growth.

CODE/STANDARD 4: Equality and Acceptance

The practitioner and client are equal partners in the process of healing. Honoring individual autonomy, growth and self empowerment, clients will be respected and valued at all times regardless of race, creed, age, gender, disability, sexual orientation or health condition. The Healing Touch practitioner respects the individual spiritual beliefs and practices of the client. Healing Touch does not promote a particular spiritual practice.

CODE/STANDARD 5: Communication and Education

Information given to the client is individualized according to the expressed need, context and personal situation. The explanation about the treatment is conveyed at the level of the client's understanding. Healing Touch practitioners act as a resource for appropriate education materials that can support the ongoing self care of clients.

CODE/STANDARD 6: Healing Touch Process

The Healing Touch practitioner obtains essential health information, an energy assessment, and sets mutual goals. Appropriate interventions are applied, the energy system is reassessed, and client feedback is obtained. This process serves as the foundation for understanding the health/healing needs of the client and promoting client safety.



Healing Beyond Borders

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CODE/STANDARD 7: Intention

Healing Touch is offered only for the benefit of the client, with intention for his or her highest good. The Healing Touch practitioner acts with the commitment to Do No Harm.

CODE/STANDARD 8: Creating a Safe Healing Environment

Healing Touch practitioners provide a safe, welcoming, supportive and comfortable environment that is conducive to healing. Consent for Healing Touch therapy and permission for hands-on touch is obtained. The practitioner is free from the influence of alcohol, recreational drugs, or prescription medication that would compromise their judgment, actions, or interfere with safe practice for the patient. The practitioner is physically, emotionally and mentally capable of providing for the patient's care and safety during the entire Healing Touch session. The practitioner is dressed in a non-revealing manner, clean and professional in appearance, with a minimum of scent. The patient is empowered to give feedback, modify or discontinue the session at any time. Safe and clear professional boundaries are maintained. Touch is non-sexual and non-aggressive and respects the patient's boundaries. The practitioner does not engage in romantic or sexual relationships with our clients. The patient is clothed except in professional therapy contexts involving physical or medical interventions requiring disrobing, in which case appropriate draping is provided.

CODE/STANDARD 9: Principle of Healing

Healing Touch practitioners recognize and honor the client's unique self healing process. The individual is acknowledged as a complex being, who is part of a social system, and is interactive with and is acted upon by their internal and external environments.

CODE/STANDARD 10: Confidentiality

Client confidentiality is protected at all times. Treatment findings are documented appropriately specific to the practitioner's background and setting. Client records are secured in such a way as to protect privacy and be in compliance with professional and legislative regulations. Client written permission must be obtained prior to release of or reporting of any record or information.

CODE/STANDARD 11: Quality Care

Healing Touch practitioners maintain a commitment to a high standard of quality care. The practitioner obtains supervision and consultation as needed from Certified Healing Touch Practitioners and other qualified professionals.

CODE/STANDARD 12: Professional Responsibility

Healing Touch practitioners represent Healing Touch to the public in a professional manner by exercising good judgment, practicing with integrity and adhering to this HBB Code of Ethics/Standards of Practice.

Standards of Practice Approved: 6/1996

Code of Ethics Approved: 6/1996

Code of Ethics Revised: 2001

Standards/Code of Ethics Combined/Approved: 12/2006, Revised: 2/2014

Healing Touch International, Inc. Board of Directors

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445 Union Blvd., Suite 105 • Lakewood, Colorado 80228 • (303) 989-7982 phone • (303) 980-8683 fax
www.HealingBeyondBorders.org



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STATEMENT OF SCOPE OF PRACTICE HTI Healing Touch Certificate Program

PURPOSE: This Scope of Practice statement defines four levels of Healing Touch Practice.

DEFINED LEVELS OF PRACTICE

I. Student of Healing Touch International has at the minimum completed a Level 1 course taught by a Certified Healing Touch Instructor and is actively participating in the Healing Touch educational program.

II. Healing Touch International Practitioner Apprentice (HTI – PA) has completed Level 4 and is participating in a minimum one-year mentorship process with a Certified Healing Touch Practitioner.

III. Healing Touch International Practitioner (HTI – P) has completed the 100 contact hour preparation coursework within Levels 1 through 5 and has received a Certificate of Completion issued by Healing Beyond Borders.

IV. HTI Certified Healing Touch Practitioner (CHTP) is a Healing Touch Practitioner who, in addition to completing the program, met the certification criteria and was approved by the Healing Beyond Borders Certification Board.

V. HTI Healing Touch Level 1 Instructor-in-Training has completed the HTI Level 1 Instructor Training and is working on the continuing coursework required by the HTI Healing Touch Instructor Certification Application.

VI. HTI Certified Healing Touch Instructor (CHTI) is a Certified Healing Touch Practitioner who in addition has completed the HTI Level 1 Instructor Training and has met the certification criteria by the Healing Beyond Borders Certification Board.

VII. HTI Healing Touch Level 2, 3, 4, or 5 Instructor-in-Training is an HTI Certified Healing Touch Instructor (CHTI) who has completed the HTI Instructor Training for the advanced class level and is working on the continuing coursework required to be approved as an instructor for the corresponding class level.

VIII. HTI Healing Touch Level 2, 3, 4, or 5 Instructor is an HTI Certified Healing Touch Instructor (CHTI) Level 1,2,3,4, or 5 has completed the coursework for the corresponding class instructor level and is approved by the HTI Instructor Advancement Committee to teach the corresponding class level.

HEALING TOUCH EDUCATIONAL PROGRAM DESCRIPTION

The Healing Touch curriculum is designed as a multi-level continuing education program. As a continuing education model, it builds upon an individual's previous foundational health care professional preparation.

Each level includes both didactic and experiential learning in which participants use specific healing interventions. The program of study is carefully sequenced in five levels of instruction: Levels 1, 2, 3, 4, and 5. Certificates of attendance with approved continuing education credits are issued at the completion of each level.

The Healing Touch student undergoes a rigorous and comprehensive program that includes 100 hours of standardized curriculum with Certified Healing Touch Instructors. After completion of Level 4, the student begins a minimum one-year mentorship with a Certified Healing Touch Practitioner and documents a minimum of 100 Healing Touch sessions. The Healing Touch program places emphasis on self-care and development of the student. In addition, the student participates in an extensive reading program as well as a wide variety of complementary therapies.

HEALING TOUCH CERTIFICATION PROCESS

Prior to 1996, certification was provided by the American Holistic Nurses' Association. Healing Touch International, Inc. Certification Board has provided certification since 1996.

DESCRIPTION OF HEALING TOUCH INTERNATIONAL

Healing Touch International, Inc. doing business as Healing Beyond Borders is a non-profit educational corporation established in March 1996. It provides the following programs and services:

- Certification as a Healing Touch Practitioner
- Certification as a Healing Touch Instructor
- International Directory of Certified Practitioners and Instructors
- International Code of Ethics/Standards of Practice for Healing Touch Practitioners
- International Scope of Practice Statement
- Ethics Committee
- Healing Touch Research
- Integrative Health Care Nurse Consultant Program
- Annual International Conference
- Special Interest Groups
- Continuing Education
- HTI Healing Touch Certificate Program
- Professional Development
- Leadership and Support for countries developing Healing Touch programs

LEGAL BASIS FOR HEALING TOUCH PRACTICE

The legal basis for Healing Touch practice is the same as for manual and biofield interventions. The legal basis for practice is inherent under the auspices of the professional preparation of the practitioner who adds Healing Touch to his/her foundational discipline. The individual's professional discipline, educational preparation, and credentials provide the legal parameters for the practice of Healing Touch. This holds true for any manual and biofield therapy.

Approved: 1/18/2000

Updated: 11/25/2005, 2/20/2009, 3/05/2010, 3/2014

HTI Board of Directors

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www.HealingBeyondBorders.org

Appendix I Techniques Used by HT Practitioners –

The four most frequently applied Healing Touch Techniques in this study are described below.

Field Re-patterning

Definition a technique that can be used to address the entire body or specific areas to assist in moving one's energy to an increasingly balanced state.

When moving hands through the whole field:

- | | |
|---|---|
| 1. Move the hands through the field 2-4 inches above the body. | Work is done in the etheric layer. |
| 2. Starting at the head, brush down and away from the body in a gentle and calming motion, sweeping and dropping any energetic debris out of the field. | The pattern of energy flow is from head to foot: movement returns the cleared energetic debris to universal energy. |
| 3. Repeat these sweeps down the body to the feet until field is smooth and symmetrical. | Indicating the field is re-patterned. |

When addressing a specific area:

- | | |
|---|--|
| 1. Move the hands through the area above the disruption or blockage.
If there is more than one area to address, begin with the upper ones. | The pattern of energy flow is from head to foot. |
| 2. Move the hands close above the area using a gentle cupping and pushing motion. | To sweep away blockages |

Holding: Use after completing above activities

- | | |
|---|---|
| 1. Hold hands on or above the affected part of the body until the flow is re-established. | To stimulate energy flow |
| 2. When addressing the entire field, place hands where convenient or where the patient directs. | Energy flows to area of need. Avoid the crown until your personal skill set and vibration are highly developed. |

Application

Field re-patterning can be used to address chronic discomfort or injury within specific areas of the body (eg, shoulders, neck or fingers). Can also be used on the

whole field to break up areas of congestion seen with conditions such as depression, anger, anxiety, agitation, stress, burns, bites, pain, headaches, and nausea.

(Anderson, Anselme, & K, 2017) p.67

Noel's Mind Clearing

Implementation

- | | |
|--|---|
| 1, Cup hands under the occipital ridge, fingers on each side of the spine. Apply gentle pressure with fingertips. | Opens entire chakra system. |
| 2. Cup the parietal ridge midway on the back of the head with fingers parallel and thumbs resting atop the fontanelle. | Normalizes blood pressure and connects with the heart. |
| 3. Place the little fingers in the indentations above the ear and align the remaining fingers up the head toward the crown, | Balance right and left hemispheres of the brain. |
| Run energy between the hands until undulating energy is felt as a pulse in both hands. | |
| 4. Place three fingers on either side of the larynx. | Balances thyroid and parathyroid. |
| 5. Place fingers of one hand on the back of the neck (C2 to C5) and fingers of the other hand on the brow from the hairline. | Connects hindbrain and cerebral cortex (helps re-establish impulse inhibition). |
| 6. Place fingers of each hand on brow with little fingers at the inside of the eyebrow and the index finger at the peak of the hairline. | Influences inner sight. |
| 7. Move little fingers of each hand to the outer aspect of the eyebrows, leaving the index finger at the peak of the hairline. | Influences physical vision. |
| 8. Gently stroke across the brow, starting at the bridge of the nose to the hairline. | |

- | | |
|--|---|
| 9. Starting at the edges of the eyebrows, gently brush over the cheeks down to the chin | Releases stress in the temporomandibular joint (TMJ). |
| 10. Cup the jaw with fingers pointing toward the thyroid. | Relaxes the jaw and energizes area. |
| 11. Place the left hand over the heart chakra and the right hand on the side of the head with the thumb pointing toward the crown. | Addresses pineal gland, pituitary gland and hypothalamus. |
| 12. Place both hands over the heart chakra and brush from heart chakra up and out over the shoulders. | Gentle completion. Be mindful that hands are non-intrusive. |

Siphon (Pain Drain)

Definition

An energetic siphon using gravitational gradient to create an energy flow, draining or drawing off congested energy from a superior location to a lesser congested, inferior location.

Implementation

- | | |
|--|---|
| 1. Place the left hand over the congested area. | The left hand is the receiving hand. The right hand is the sending hand. |
| 2. Place the right hand inferior to the congested area | Uses gravity to accentuate the intensity of the flow. |
| 3. Pump the right hand as needed to start the flow and continue to siphon until the flow subsides. | Indication of gradient equilibrium. |
| 4. Reverse the hand positions and raise the left hand above the body. | Refills drained area with universal healing energy via the energy siphon mechanism. |

Application

Siphon reduces congested energy, such as pain, oedema, inflammation, infection, or emotional congestion, such as grief, anger, fear and shame.

(J. G. Anderson et al., 2017) p. 87

Chakra Connection and Chakra Energising

Implementation

In sequence, the minor chakras of the limbs and major chakras of the body are held using both hands. One hand is placed over the lower chakra while the other is placed over the one above it.

The technique is full body, moving from the feet to the head. Both hands are needed to establish the flow between chakras.

When the flow feels free and unencumbered, the next connection can be made. The chakra connections are made in the following sequence:

1. Right foot to knee; knee to hip
2. Left foot to knee; knee to hip
3. Hip to hip
4. Root to Sacral
5. Sacral to Solar Plexus
6. Solar Plexus to Spleen
7. Solar Plexus to Heart
8. Heart to Thymus
9. Right hand to elbow; elbow to shoulder
10. Left hand to elbow; elbow to shoulder
11. Shoulder to shoulder
12. Thymus to Throat
13. Throat to Brow
14. Brow to Crown
15. Crown to Transpersonal Point (with left hand's palm facing away from the Crown)

(J. G. Anderson et al., 2017) p.59

Canterbury
District Health Board
Te Poari Hauora o Waitaha

5th April 2017

Wendy Risdon
Health Sciences
University of Canterbury

Re: Healing Touch, a bio-field therapy providing relaxation and supportive care, for hospitalised patients receiving treatment for leukaemia.

Tena koe Wendy,

Ka nui te mihi tenei ki a koe me tou roopu o nga Kairapukorero ki te hapai o te kaupapa whakahirahira mou, moku mo tatou katoa. Ko Rapunga Korero te mea nui. No reira tena koe me te roopu o ka Kairangahau, tena koutou katoa.

Thank you for submitting your research to Te Komiti Whakarite. When providing Māori consultation for multi-site applications we are satisfied any concerns we may have, are covered by the lead site, Nigel Harris, Ngāi Tahu Consultation and Engagement Group, University of Canterbury.

However as the Māori Consultation committee for the Canterbury District Health Board, we would like to outline our general comments for consideration.

It is important to acknowledge the issues pertaining to ethnicity and to consider how ethnicity data will be collected in your study. Given the issues around ethnicity data collection in hospital databases this information should be collected in demographic information as part of the research. The Census 2013 ethnicity question is the preferred tool in recording ethnicity.

Inclusion of accurate contact details for Hauora Māori- Māori Health worker in the study's Participant Information Sheet would be an important addition for those Māori participants enrolled in your study. Theona Ireton is the Hauora Māori- Māori Health worker attached to BMTU.

Allowing a support person or whānau member to accompany the participant during research interviews/visits/sessions is a positive inclusion that is in keeping with the values of manaaki / caring and tautoko / support and provides an increased security for Māori participants ensuring improved participation in the study.

Researchers need to be aware of the importance of explaining to Māori participants and/or their whānau how the study/research data will be stored, any security measures, the length of time and the process that takes place up to the destruction of the data.

Dissemination of the study/research findings in a summary form to participants is a user friendly approach to keeping people informed and their contribution valued. Researchers must take care to ensure that Māori participants understand and agree on which information is to be published in what formats and forums. Some instances where Māori have been powerless to stop the inappropriate dissemination of information have generated unease within Māori communities.

Te Komiti Whakarite

245 Antigua Street, Christchurch. Private Bag 4710, Christchurch, New Zealand
Telephone: (64) (3) 364 0640 Ext: 88474 Facsimile: (64) (3) 378 6018

It is a requirement of the ethics approval process that a final report be submitted when the research is complete. A copy of the report should be provided to me at that time. Te Komiti Whakarite would be willing to assist in the dissemination of your findings once your project has reached a conclusion. We are committed to building on-going relationships with researchers in the hope of improving Māori health.

Please contact me should you need any other information that may not have been included in the letter relevant to your research.

Heoi ano

A handwritten signature in blue ink, appearing to read 'Eru Waiti', is positioned above the printed name.

Eru Waiti
Chairperson
Te Komiti Whakarite

Appendix K University of Canterbury Ethics Committee Approval



HUMAN ETHICS COMMITTEE

Secretary, Rebecca Robinson
Telephone: +64 03 369 4588, Extn 94588
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2017/10

3 March 2017

Wendy Risdon
School of Health Sciences
UNIVERSITY OF CANTERBURY

Dear Wendy


The Human Ethics Committee advises that your research proposal "Healing Touch, a Bio-Field Therapy Providing Relaxation and Supportive Care, for Hospitalised Patients Receiving Treatment for Leukaemia" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 1st March 2017, and the following:

Please amend where complaints to the ethics committee can be forwarded, instead of "Educational Research Human Ethics Committee", we are simply the "Human Ethics Committee". In addition, when you receive feedback from your CDHB ethics application, please forward this to us for our records.

Best wishes for your project.

Yours sincerely

pp. 

Associate Professor Jane Maidment
Chair
University of Canterbury Human Ethics Committee

Appendix L Canterbury District Health Board General Manager Sign-off

Canterbury
District Health Board
Te Pōari Hauora o Waitaha

Research Office Project ID	17023
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RECEIVED
12/11/16

Audit Project Request for Locality Authorisation within CDHB

Instructions:

1. Complete the form. Please provide detailed answers as the CDHB Locality Authorisation will ONLY be provided for that outlined in this application.
2. Print the form and obtain approval/s from Clinical Director and Service Manager from the host department where the audit will be conducted.
3. The following **MUST** accompany your Locality Authorisation Form:
 - a. Ethics Approval Letter or HDEC Out-of-Scope Letter
 - b. Source of Funding – where applicable

*** Please note – additional documentation or evidence may be requested by the Research Office to assist with processing your application*
4. Send the completed form along with the required documentation to Research Office, Level 5 Christchurch School of Medicine, University of Otago, Christchurch or send via email to cdhb.researchoffice@otago.ac.nz.
5. The Research Office will endeavor to process your locality within 5 working days WHEN ALL THE DOCUMENTATION REQUIRED IS RECEIVED.

RESEARCHER TO COMPLETE AND ATTACH ALL REQUIRED DOCUMENTATION

1. Research Team

CDHB Principal Investigator	Wendy Jar	Email:	Wendy.jar@cdhb.health.nz
CDHB Contact Person:	Wendy Jar	Email:	As above
Coordinating Investigator and Organisation:	Wendy Risdon Health Sciences Department University of Canterbury	Email:	wendy.risdon@canterbury.ac.nz
(if CDHB is not the lead site) Contact Person:	Wendy Risdon	Email:	As above

Other parties involved (e.g. Sponsors, Collaborators, other Sites)

7 Healing Touch Practitioners affiliated to Healing Touch NZ Inc (see list below) to provide the treatments.

Healing Touch Practitioners

Wendy Risdon
RN, CHTP, PG Dip HealSc, Masters Candidate, Project Co-ordinator

Deb Carter
Dip Tchg, CHTP/I Chairperson Healing Touch New Zealand Inc.

Karen O'Carroll
CHTP

Gwyneth Steenson
RN, CHTP, CAT, M HealSc (Nursing-Clinical)

Jane Carter
RN, ND, CHTP

Sharon Gardiner
CHTP

Pauline Leask
HTP, Diploma in Natural Health

Dayle Hunt
Dip Strategic Intervention, Certificate in Chinese Medicine, HT Level 4, TRE Level 1 (Trauma Release Exercises)

Ian Thurlow
B.Ed, Dip Healing Energies, HT Level 4

Handwritten notes:
 1-4-17
 ✓
 ✓
 Is NZNO Council
 Expires 1.7.17

2. Audit Details

2.1 Research Office Project ID:
 RO# 17023

2.2 Audit Title/Protocol Number:
 "Healing Touch, a Bio-Field Therapy Providing Relaxation and Supportive Care, for Hospitalised Patients"

Receiving Treatment for a Haematological Disorder"

2.3 Audit timeline

Start date:	3 rd April 2017
End date:	30 th June 2017

2.4 Brief Summary of the Overall Audit

Current management of patients experiencing unwanted side effects from their condition or treatment of their haematological disorder relies predominantly on pharmacology which in itself can create adverse effects.

The primary purpose of this pilot project is to improve Health Related Quality of Life (HRQOL) for patients hospitalised with any type of haematological disorder using Healing Touch (a bio-field, energy based modality). Healing Touch (HT) arose in the nursing field in the 1980s and is described as a patient-centered modality in which the practitioner and recipient participate jointly in the healing process. HT is categorized as a mind-body therapy and involves the direction of healing energy through the practitioner's hands to facilitate general health and well-being. HT is most demonstrable when used to treat symptoms affecting patient-reported outcomes encompassing health-related quality of life, including anxiety, stress, fatigue, and pain as a supportive care intervention for patients who are hospitalized for their condition.

Positive human touch could be the one thing that is common to all people and lacking in most high-tech medical environments. The Unit has recognised the potential benefit to the patients of providing supportive complementary therapy in the form of Healing Touch, to improve health related quality of life at a time when they are facing a life threatening illness. These patients have long hospital stays which can impact negatively on physical, mental, emotional and spiritual wellbeing.

This pilot will occur on the Bone Marrow Transplant Unit (BMTU) at Christchurch Hospital (CH). All eligible patients will be invited to participate and those agreeing will become the study sample.

There will be an initial pre-treatment assessment, treatment sessions will be offered either weekly or twice weekly. A questionnaire post each session will be completed by the participant within 72 hours of each session.

Healing Touch sessions will be approximately 40-60 minutes long. The patient will be fully clothed either sitting in a chair or lying on a bed.

Anonymity will be maintained throughout the project by using a numbering system. All data collected will be stored in a lockable cabinet.

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2.5 Which best describes the type of audit you will be conducting – Please tick

	Systematic evaluation of aspects of health or disability support service delivery by considering measurable indicators of performance and/or quality.
	Quality assurance activities aim to improve health and disability support services by assessing the adequacy of existing practice against a standard.
	Programme evaluation is a type of audit where a whole programme is evaluated, rather than specific interventions.
X	Evaluation studies aim to determine the relevance, effectiveness and impact of activities in the light of their objectives. Several types of evaluation are distinguished, including evaluation of the structure, process and outcome of an activity
	Outcome analyses involve the assessment of health and disability support service quality by reviewing health care information to evaluate outcomes without comparing them against a standard. For example, clinicians may retrospectively examine health care notes and perform descriptive analyses to determine the outcome of medical treatment or course of a particular illness.
	Benchmarking aims to improve practice through the comparison of two or more health and disability support services.
	Public health investigations explore possible risks to public health, are often of an immediate or urgent nature, and are often required by legislation. Examples are investigations into outbreaks or clusters of disease, analyses of vaccine safety and effectiveness, and contact tracing of communicable conditions.
	Public health surveillance involves the monitoring of risks to health by methods that include the systematic collection, analysis and dissemination of information about disease rates.
	Pharmacovigilance (post-marketing surveillance) involves monitoring the adverse effects of pharmaceuticals after their introduction into the general population, by such methods as the spontaneous reporting of adverse events and the monitoring of all adverse events for a restricted group of medicines (prescription event monitoring).
	Resource utilisation reviews evaluate the use of resources in a particular health or disability service activity, for example, by reviewing health records to determine health care inputs such as chest X-rays for patients with a particular diagnosis.

2.6 Describe the methods/ procedures that will occur within CDHB (Note that locality authorisation will only cover the procedures that are detailed here)

This is an Evaluation Study, using Qualitative methods to evaluate the effect of delivering a "hands-on" complementary therapy. Measurements will be in a form of a patient questionnaire. There will be an initial intake interview/questionnaire and then a symptom assessment questionnaire following each session. These will be given in paper form for patients to self-administer or if they prefer a friend or relative can complete it with them.

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3. CDHB Resources Used

3.1 Access to CDHB Patient Data – Please specify data source (e.g. HealthOne, Health Connect South, Existing patient registry, Tissue bank samples, Data warehouse, non-electronic Clinical Records)

Not required

3.2 CDHB Participants - Please outline the Recruitment Process and Number

Inpatients on the BMTU who have a haematological disorder will be invited to participate in this project. Patients who are interested will be given an information packs about Healing Touch, as a supportive care, complementary therapy. Included in this pack will be information on Healing Touch, the participation consent form and information for participants. The nurses will give out the packs and in conjunction with the healing touch practitioners will arrange the first session for those who are agreeable to participating in the project.

The consent form will be signed prior to the first session. A minimum of 10 patients would be desirable to complete this project.

3.3 CDHB Staff – please outline key CDHB staff and their specific tasks for this audit

	Name	Department	Role in the Audit	Key tasks
1	Wendy Jar	BMTU		
2	Dr Emma-Jane	Haematologist		
3				
4				
5				
6				
7				
8				

3.4 CDHB Facilities (list specific location/s and department/s where the audit will be conducted e.g., Burwood, Orthopaedic Dept.)

	Location / Department	Methods / Procedures at this Facility
1	BMTU	Healing Touch Relaxation Sessions in patients own room/bed space area in the afternoon or evening up to twice a week
2		
3		
4		

3.5 Other Resources Required – please specify

Lockable filing cabinet

4. Evidence Required – THE FOLLOWING SHOULD BE SENT ALONG WITH THE COMPLETED LOCALITY AUTHORISATION FORM:

4.1 Ethical Approval or Out-of Scope Letter

- a. If the project is “outside ethics review” then CI / PI should sign and date
- b. If the project has been approved by HDEC, please ensure to request locality on-line via the HDEC website. You will need to type in our email address cdhb.researchoffice@otago.ac.nz

	Reference Number	Date of letter
HDEC :		
HDEC – Out of scope :		
Institutional approval :	University of Canterbury	3.3.17
Not required : (sign here) <i>Wendy Risdon</i> ✓		7 th March 2017

4.2 Funding: Outline any funding sources for this Audit (e.g. *internal departmental funds, scholarships, external funding source, grants*)

“Dry July” Charity funding for cancer patients amount \$5000 and more is available.

Research Office Project ID	17023
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RESEARCHER TO ORGANISE APPROVAL FROM RESPECTIVE MANAGERS

Coordinating or Principal Investigator:
I hereby confirm that all information contained within this application is true and correct. I will take professional responsibility to conduct this research at CDHB and ensure all consents and approvals are obtained and sighted by the Research Office before research commences. Further, I confirm that conducting this research at CDHB will have no adverse effect of the provision of publicly funded health care at this locality

Signed: Wendy Risdon Date: 7th March 2017

Wendy Risdon

5. Approval From All Areas Where Resources are Accessed

Approvals: *I hereby authorise this application to undertake this research within this CDHB Department and guarantee the availability of adequate facilities, equipment, staff and any special support which may be required as detailed in the application. I confirm that it is in accordance with current CDHB policy*

Department Name:	1.	2.	3.
Clinical Director	Dr Mark Smith		
Signature	<i>Mark Smith</i>		
Date	21/03/2017		
Service Manager	Jane Trolove		
Signature	<i>Jane Trolove</i>		
Date	22/3/2017		
Other Approving Manager Name			
Title			
Signature			
Date			

RESEARCH OFFICE TO FACILITATE APPROVAL FROM CDHB GENERAL MANAGER/S

General Manager sign-off

This research will take place in your hospital, do you approve it?

Hospital 1	Pauline Clark General Manager	<i>Pauline Clark</i>	18/04/17
	Christchurch Hospital Name:		

Hospital 2	<i>Name:</i>	<i>Signature:</i>	<i>Date:</i>
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BACKGROUND

- A This document sets out the terms and conditions pursuant to which access to CDHB and its patients will be granted to Visiting Health Professionals.
- B Where the Health Professional is an employee of the University of Otago, then the agreement entered into in 1995 between CDHB and the University of Otago, Christchurch School of Medicine, shall also apply.

TERMS & CONDITIONS

- C. Access is granted by CDHB to its premises, facilities and patients upon the following conditions, namely that the Health Professional:
 - C.1 will only conduct administrative and clinical procedures that he/she is both skilled and experienced to undertake and then only in accordance with accepted professional standards and CDHB's standards and protocols and only at the request of and to the extent requested by CDHB;
 - C.2 will only conduct research or experimental procedures on patients that are agreed in writing in advance with CDHB and that have received written Ethics Committee approval and then only in accordance with the conditions of such Ethics Committee approval;
 - C.3 will comply with all statutory obligations including but not limited to the provisions of the Health & Disability Commissioner's Act 1994 and any code issued thereunder;
 - C.4 will abide by all fire and health and safety procedures of CDHB;
 - C.5 will abide by all other policies and procedures established by CDHB;
 - C.6 will notify CDHB immediately upon becoming aware of any matter which may affect the Health Professional's right of access (whether through the contracting of a communicable disease or otherwise);
 - C.7 will not make any statement to the media concerning CDHB or its patients without the prior written approval of the Chief Executive Officer of CDHB;
 - C.8 upon the expiry or earlier revocation of the right of access will return to CDHB in good working order (subject to fair wear and tear) all equipment supplied by CDHB;
 - C.9 will submit to such routine screening as CDHB requires of its own personnel from time to time (currently MRSA screening);
 - C.10 will carry out and comply with all lawful and reasonable instructions given by CDHB as appropriate to the tasks being performed;
 - C.11 will respect the confidentiality of all information (whether relating to patients or the organisation) obtained while performing duties at or for CDHB and will not under any circumstances divulge such information to persons not entitled to receive such information.
- D. The Health Professional will receive no remuneration from CDHB for services performed at or for CDHB under this Agreement.

- E. The Health Professional has none of the rights powers and privileges of an employee of CDHB and enters CDHB's premises at his/her own risk. CDHB may withdraw this right of access.
- F. Suitable clean protective clothing shall be made available by CDHB where the nature of a particular duty or duties would either continuously or intermittently render the Health Professional's personal clothing or uniform liable to excess soiling or damage or expose the Health Professional to injury, infection or excess discomfort through biological chemical or physical hazards. Such protective clothing shall remain the property of CDHB and as such shall be laundered or otherwise cleaned free of charge.
- G. If the visiting health professional is to perform work that would ordinarily require similar CDHB staff to have a Practising Certificate or equivalent, as well as indemnity insurance, then the visiting health professional will also require such documentation. These documents will need to be produced before this form can be signed.

HEALTH & SAFETY

- Observe all Canterbury DHB safe work procedures and instructions
- Ensure your own safety and that of others
- Report any hazards or potential hazard immediately
- Use all protective equipment and wear protective clothing provided
- Make unsafe work situations safe or, if they cannot, inform your supervisor or manager
- Co-operate with the monitoring of workplace hazards and employees health
- Ensure that all accidents or incidents are promptly reported to your manager
- Report early any pain or discomfort
- Take an active role in the Canterbury DHB's rehabilitation plan, to ensure an early and durable return to work
- Seek advice from your manager if you are unsure of any work practice

DECLARATION

I acknowledge that I have read and understand the contents of this document and agree to be bound in all respects to the terms and obligations it imposes on me.

Full Name (Health Professional) **Signature** /...../.....

Professional Leader **Signature** /...../.....

Department

Supervisor **Location** **Duration**

<u>ADDITIONAL AUTHORISATION FOR "ACTIVE STATUS"</u>		
<u>VISITING HEALTH PROFESSIONALS</u>		
<u>Staff Category</u>	<u>Authorising Officer</u>	<u>Signature</u>
Senior Medical	Medical Advisor	_____
RMO	RMO Medical Advisor	_____
Nursing	Director of Nursing	_____
Allied Health	Head of Relevant Department	_____
Other (<i>specify</i>).....	General Manager	_____