

Implementing aromatherapy in nursing and midwifery practice

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Summary

- This paper reports the results of a small qualitative study of nurses and midwives who had undertaken a course in aromatherapy, one of the most popular complementary therapies in the UK. In particular, it examines barriers to putting their knowledge into practice.
- Participants had completed the aromatherapy course between 9 months and 2 years previously, and worked in a variety of settings. All were approached via their employing NHS trust.
- The interviews which took place in the clinical area were tape recorded and generally lasted for about 40 minutes.
- Data were analysed using the procedure outlined by Colaizzi (1978) Significant statements were clustered into themes, guided by whether they had a 'look alike/feel alike' quality, and were subsequently validated with the informants.
- The main themes discussed in this paper are the personal and professional benefits that respondents reported from undertaking the course, organizational issues and the frustrations they experienced because of delays in implementing changes in practice.

Keywords: aromatherapy, complementary and alternative medicine, professional accountability, implementing change.

Introduction

The use of aromatherapy, and complementary and alternative medicine (CAM) more generally, is increasing in the UK [House of Lords Select Committee on Science

and Technology (HLSCST), 2000; Fox, 2001; Thomas *et al.*, 2001], which, together with much of Europe, is considerably advanced in its use compared with the US (Goldstein, 2000). As the House of Lords report notes, CAM is the most widely used term, although no single definition exists (HLSCST, 2000). The report quotes the Cochrane Collaboration's definition:

A broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other

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than those intrinsic to the politically dominant health systems of a particular society or culture in a given historical period.

Where we have used an alternative term, this is because we have followed the usage of the author being discussed.

Almost one-third of the UK population have used such treatments, and most want better NHS provision (Foundation for Integrated Medicine, 1997). The House of Lords report quotes 1999 figures from the marketing organization Mintel, and projections from the Royal Pharmaceutical Society of retail sales of £93 million in 1998 (of which £20 million was on aromatherapy essential oils), rising to £126 million for 2002 (HLSCST, 2000). Goldstein (2000) considers that alternative medicine can be distinguished by five features: holism, the interpenetration of mind, body and spirit, the possibility of high level wellness, vitalism, and a view of healing as a co-operative, active process. Douglas (1994) proposes that the growth of complementary medicine, which she also claims is holistic and spiritualized, is part of an increased preference for gentleness:

These are the new style of therapy, light oils from flowers and seeds to pamper the tired muscles, hypnotic trance to unknot deep worry, infusions of herbs to invigorate the spirit. (Douglas, 1994, p. 23)

Increasing use of CAM may also reflect the increasing prevalence of chronic conditions with which orthodox medicine deals inadequately (Goldstein, 2000), and be part of the trend towards a 'consumerist' approach to health care (Meerabeau, 1998; Goldstein, 2000).

Against this must be set, however, the growth in litigiousness and the regulation of health care, and increasing emphasis on informed consent (Rankin-Box, 2002). The drive for evidence-based practice may make it more problematic for practitioners in orthodox health care settings to use unproven interventions. It may also, however, act as a driver to stimulate more research in complementary therapies (HLSCST, 2000), and Goldstein (2000) considers that the emphasis on evidence constitutes a sign of greater acceptance of CAM by the mainstream. Further current features of the NHS are the extension of nurse prescribing, and the development of new roles in nursing and midwifery. There are thus features which may encourage nurses and midwives to adopt CAM, but in a setting which is becoming more risk averse. Although there is considerable commentary on complementary therapies, there has until recently been little empirical evidence on their use in orthodox health care settings (Tovey,

1997), and in particular little research on nursing and midwifery. This paper reports the results of a small qualitative study of nurses and midwives who had undertaken a course in aromatherapy which is one of the most popular complementary therapies in the UK. In particular, it examines the barriers to putting their knowledge into practice.

Organization of complementary therapy

Sharma (1994) stated that the majority of complementary therapists in the UK worked as independent practitioners, in settings characterized by a non-hierarchical ethos, minimum of direct control, and 'apparent conjunction of liberty and non-accountability' (Sharma, 1994, p. 93). Cant & Calnan (1991), in a small study of nine different therapies (but not aromatherapy), also found that whilst some collaboration was desired with the medical profession – often for the pragmatic reasons of referral and publicity – practitioners wished to guard their own identity.

In a review which looked critically at a wide number of published studies and makes proposals for further research, Siahpush (1999) stated that the process of professionalization, including the development of a formalized knowledge base, is the main focus of the literature on practitioners of alternative medicine. Paradoxically, he argued that legal recognition of alternative therapies may come from the actions of orthodox medicine because, as therapies become adopted by conventional medicine, they are portrayed as effective and therefore potentially dangerous. Doctors then argue that alternative practitioners should be legally prevented from practice in order to protect the public. As a result, governments establish registration, training and accreditation programmes. There is therefore, Siahpush argues, a clear distinction between the adoption of a particular therapy by medicine, and recognition of the therapist by medical practitioners.

The literature reviewed by Siahpush (1999) on the relationship between orthodox and alternative medicine has four strands: how orthodox medicine relates to alternative practitioners, doctors' views on the efficacy of alternative therapies, their critique of the knowledge base of alternative therapies, and doctors' use of some of the therapies. Thus, none of the literature reviewed by Siahpush relates to nursing or midwifery. Broadly, the literature finds little professional contact between doctors and alternative therapists, and reports that many doctors view therapies as harmful either in themselves or because serious medical conditions may go unrecognized.

Attitudes may, however, be becoming more favourable (Tovey, 1997). None of the studies reviewed by Siahpush considered aromatherapy specifically. The two alternative therapies used by doctors (generally between 15% and 30% in the studies cited) are homeopathic medicine and acupuncture. It is possible that this may increase over time: Greenfield *et al.* (2000) found that 37% of first year medical students at one medical school used CAM, mainly homeopathy or aromatherapy. Statistically, they were more likely to use it if a family member did, and women rather than men were statistically more likely to use aromatherapy. However, the 1997 report by the United Kingdom Foundation for Integrated Medicine (1997) found that few medical students had an introduction to complementary therapies in their training. However, 71% of nursing education providers offered education in complementary therapies, although this was generally an appreciation rather than sufficient to produce a practitioner.

Goldstein (2000) noted that acceptance of complementary therapies is still minimal in the US, and that as recently as 1993 an American Medical Association guidebook for consumers (Zwicky, 1993) described alternative methods as 'fraudulent' and 'quack'. Tovey's (1997) UK research with complementary therapists showed that, whereas medical consultants were 'dismissive', nurses and GPs were becoming more interested in working with alternative medicine. Graham *et al.* (1998) found in a study of 105 NHS trusts that 61% allowed the use of complementary therapies, mainly aromatherapy, reflexology, acupuncture and massage. Rankin-Box (2002) reported on a 'straw poll' of Royal College of Nursing complementary therapy forum members that use was more common in the private sector, and that it was generally used in addition to nursing care rather than integral to it. Richards, in an interview for an article by Kenny (2000), claimed that initially nurses may be looking for skills to add to their practice, but the focus often shifts to the relationship with patients. Using a therapy such as aromatherapy may enable a trained nurse to give hands-on care which in other circumstances is increasingly being delegated to support workers. Avis, interviewed for the same article (Kenny 2000), stated that there are issues of accessibility and access, as CAM in nursing is generally provided by 'isolated individuals in ad hoc ways.' A recent study of US nurse practitioners (Sohn & Loveland Cook, 2002) indicated that the majority relied on personal experience or journals for their knowledge, and only 24% had received formal education. This parallels the situation in the UK, as identified in the House of Lords report (see below).

Regulation and accountability

The British Medical Association (BMA) (1986) refused to approve alternative therapies because it considered that they were scientifically unproven, but it recognized that many alternative therapists were able to offer more time and compassion than orthodox practitioners. The BMA (1993) report *Complementary Medicine: New Approaches to Good Practice* suggested that doctors required more information on these therapies. In their 1999 evidence on CAM to the House of Lords select committee on science and technology, the BMA saw the issues mainly in terms of doctors 'delegating care' and the problem that in this instance they may not be able to judge the competency of therapists (BMA, 1999). The BMA recommended that defined levels of competence should be set for each therapy, that all students should have a core curriculum of bioscience, and that each therapy should have a single register, enforceable ethics code, complaints procedure, and defined protocol for communicating with the medical profession. The therapies prioritized by the BMA were acupuncture, chiropractic, herbalism, homeopathy and osteopathy, as these are most commonly used and have 'the potential to cause most harm to the greatest number of patients'.

The House of Lords select committee on science and technology report on CAM questioned the evidence base of many therapies, and their report was described by Wintour (2000) as 'damning'. The committee was reported to be 'shocked' at the lack of regulation; however, they recognized that the rise of CAM was driven by public demand. The House of Lords report was critical of nursing organizations for their 'passive' approach to the regulation of therapies in nursing. It recommended that nurses should have some input on CAM in their training, as did the Foundation for Integrated Medicine (1997), because practitioners should know their potential uses, weaknesses and dangers. CAM was divided into three categories by the House of Lords select committee:

- The professionally organized disciplines of acupuncture, chiropractic, herbal medicine, homeopathy and osteopathy, for which there is evidence of effectiveness, and recognized systems of training. Statutory regulation is likely to start with acupuncture and herbal medicine (osteopathy and chiropractic are already regulated).
- Aromatherapy, reflexology and massage, were seen by the committee as unregulated and without a firm scientific basis. However, the committee accepted that they could relieve stress.

- Alternative disciplines which claim diagnostic powers, such as traditional Chinese medicine, Ayurvedic medicine, crystal therapy, dowsing and iridology. These were seen as scientifically unproven and unregulated. Generally, it was recommended that therapies in this category should not be available on the NHS.

Interestingly, the therapies in the second category are popular with nurses, who may be disenchanted with their role and see complementary therapies as a means of enhancing patient care and providing a more holistic approach (Thompson, 2001).

As in other areas of nursing and midwifery practice, there are issues of professional accountability. Budd & Mills (2000) surveyed the CAM professional associations for the Department of Health. They noted that there were 12 organizations registering aromatherapists in the UK, of which 11 belonged to the Aromatherapy Organizations Council. Concern was expressed that in such circumstances a practitioner deemed to be unsatisfactory by one organization might then join another, thus leaving the clients unprotected. A single professional body was recommended.

The delivery of health care is governed by guidelines and protocols. However, there are considerable legal and ethical issues in incorporating CAM into NHS services (Stone, 1999). McVey (1996) highlighted the paucity of national guidelines on the practice of complementary therapies within health care settings. Hubble & Middleton (1995), Lewith (1996) and Cochrane (2002) discussed the nurse's role in giving acupuncture by working on protocols or guidelines set by the medical practice. In secondary care, nurses may formulate policies and protocols for the use of complementary therapies, in consultation with medical practitioners. Johnson (1995) highlighted professional responsibility and the importance of organizational policies in using aromatherapy. The regulatory position relies on the general requirement for a nurse or midwife to abide by their code of conduct (Rankin-Box, 2002), because the regulatory body for nursing and midwifery is not responsible for the standards of other bodies which offer education and training in complementary therapies. The Code of Professional Conduct produced by the new Nursing and Midwifery Council (NMC, 2002) states that:

You must ensure that the use of complementary or alternative therapies is safe and in the interests of patients and clients. This must be discussed with the team as part of the therapeutic process and the patient or client must consent to their use. (Paragraph 3.11).

Continuing professional development

The recent Audit Commission (2001) report *Hidden Talents* identified the average NHS trust investment over £1 million per year in education and training for its health care staff, but the level of spending varies widely and training needs across a service or trust are often not systematically identified. As the report indicated, developing staff is one of the main ways of ensuring that services continue to meet patient needs.

Hidden Talents claimed that, although it is impractical for trusts to demonstrate the benefits of all education and training, there is broad evidence of beneficial effects on the confidence, knowledge and practice of staff. Jordan & Hughes (1998) stated that there has been little empirical research into the outcomes and effectiveness of continuing professional development (CPD). They commented that:

The impact of continuing professional education in the workplace depends not only on the utility of the knowledge acquired during the course, but also on the social context of nursing work, including organizational arrangements and social relationships that affect nurses' ability to apply their new knowledge in practice. (Jordan & Hughes, 1998, p. 1060)

Since then, a review by Nolan *et al.* (2000), arising out of an evaluation of the English National Board for Nursing, Midwifery and Health Visiting (ENB) Framework and Higher Award, concluded that NHS managers should not have a narrow conception of the outcomes of CPD. Personal benefits for the practitioner are also important.

Jordan & Hughes's (1998) study was of how nurses implemented their increased knowledge in biosciences, and this was discussed in relation to nurses' changing roles *vis-à-vis* medicine. Thus, the knowledge they examined is a shared knowledge base with medicine. Aromatherapy, however, raises different issues, as its knowledge base is not accepted by all practitioners and, as referred to earlier, consultants are much less accepting of complementary medicine than are nurses (Tovey, 1997). As aromatherapy is not widely used by medical practitioners, however, nurses who use it may not find themselves potentially in direct competition with doctors, as may the nurses studying bioscience who were studied by Jordan & Hughes (1998). In a later study on the impact of postregistration degrees on practice, Hardwick & Jordan (2002) found that respondents were unanimous in describing their enhanced research literacy, but unable to give any examples of change in their clinical practice. This may have been because the heterogeneity of the student group made it difficult to provide specific clinical examples in the course.

The study

AIM

This paper reports on a small scale qualitative study of six nurses and two midwives who had undertaken a diploma in aromatherapy, in order to find out what changes, if any, they had made in their clinical practice. The data were gathered by Fran Rawlings, who was also the teacher on the course, and so it is recognized that it is important to be alert on the issue of being an 'insider' researcher (Jordan & Hughes, 1998).

SAMPLE

The ages of the interviewees ranged from 27 to 58 years (mean 45.5 years) and length of time since qualification from two and a half to 37 years (mean 17.75 years). They were therefore experienced staff. They had completed the aromatherapy course between 9 months and 2 years previously, and worked in a variety of specialities: two in orthopaedics, two in outpatients, two in learning disability, one in midwifery and one in a special care baby unit. All were approached via their employing NHS trust.

All interviews which took place in the clinical area were tape recorded and generally lasted for about 40 minutes. Each interview was transcribed and a copy sent to the informant for her to check its accuracy.

DATA ANALYSIS

Data were analysed using the procedure outlined by Colaizzi (1978). Significant statements were clustered into themes, guided by whether they had a 'look alike/feel alike' quality (Lincoln & Guba, 1985). These themes were validated with the informants. The main themes discussed in this paper are the personal and professional benefits that respondents reported from undertaking the course, organizational issues and the frustrations they experienced because of delays in implementing changes in practice.

Findings

PERSONAL AND PROFESSIONAL BENEFITS

Not all participants had intended to incorporate aromatherapy in their practice when they began the course. One had no preconceived plans, and another was not sure prior to starting the course what effects aromatherapy had. Five informants stated that they had become more holistic in their approach to care: 'I'm looking at the client as a

whole now instead of just one problem'. All felt that they had 'something else to offer patients', and one commented that it made her feel 'almost as if you are a practitioner in your own right, almost an equal'. Another commented that 'I had one consultant actually referred a patient to me... that's brilliant'. All participants felt that their confidence had increased, and this is often a benefit of continuing education (Warmuth, 1987; Hughes, 1990). Seven stated that they felt more autonomous; however, all five who expressed frustration were also in this group.

Generally, informants were keen to share their knowledge, although two seemed to regard it as private property: 'a bit smug really, because I've not got one over on them but I've seen something that they haven't'. Of these two, one was disconcerted to find that, as a woman of 50, she could be so 'childish' so as not to want others to use the therapy or gain any praise: 'I find it very hard to swallow that I have discovered that about myself'.

Responses about the use of aromatherapy for treating patients (from five out of the eight informants) concentrated mainly on the effects of massage and the moisturizing effect of oil, rather than the active ingredients of the essential oils. There could also be limitations in terms of resources if clients with learning disabilities, who were on state benefits, had to buy the essential oils needed:

They might only get £7 a week. Well, that won't buy a bottle of camomile oil.

Both these responses may indicate that aromatherapy is seen as a pleasant activity akin to beauty therapy, or an adjunct to care, but not as a therapeutic necessity.

ORGANIZATIONAL ISSUES

For those actively involved in introducing a trust policy for the use of complementary therapies, there was a sense that they felt they were acting as change agents:

If we want the backing for it we've got to go via the correct channels and that takes a considerable time... I'm sure that we would get patients referred to us (without going through the trust) but we would be doing it without the trust's backing and it's not worth it.

In midwifery, the practice of using complementary therapies is more generally accepted. However, in this study neither midwife worked in a trust that had a policy or protocol on this, and so they had to restrict themselves to advice and to massage without essential oils. Two nurses worked in trusts which had a policy and protocol, two did not, and two had initiated a clinical trial while a policy and protocol were developed.

One informant in learning disabilities care had been allocated 2 days per week to give aromatherapy massage across the directorate, but generally for the other respondents the provision of the service was limited by staff shortages: 'We are on minimum staff all the time... they are constantly battling for the staff that we have got'. Another stated: 'Our enthusiasm is still there, that hasn't diminished at all. But we hear of other people starting clinics, some of the local health centres have aromatherapists who visit them, and we almost feel we're obviously left behind'.

FRUSTRATION

Inability to provide a service, having undertaken the course, was a source of frustration: 'It's just so long-winded to get it up off the ground' and 'They don't seem to be overly interested, and again, as I said, they don't give us the time or resources that we can carry on'.

This was a pervasive theme, illustrated by these further quotes from other participants:

So I think I am more angry at higher management... they seem to be happy to send you on these courses... but they seem to open the door for the course and shut it when it finishes; they don't seem to have any insight into anything further that happens after the course finishes.

I would say that I could feel irritated and annoyed with the establishment but I have to put it into perspective. I feel it's a waste of my having gone through such a requirement. You realize ways in which you can actually make it work and then your ideas are kind of squashed by the management.

Another felt frustrated:

Because I know I could make that person happier and I often find myself thinking, I could help with that.

However, views could be mixed, since the first informant also stated that she had been asked to spearhead the project to implement complementary therapies within the trust. Another who expressed her annoyance also said that, whereas she had expected a battle to have the therapy taken seriously, it had been 'plain sailing'.

Discussion

This was a small scale study whose findings are not generalizable, although it adds to the body of literature on how nurses and midwives put CPD into practice.

All respondents in this study stated that they felt more confident, and seven out of the eight said that they felt more autonomous; however, like the nurses studied by

Jordan & Hughes (1998), many found that implementation of their knowledge was blocked by staff shortages and this resulted in frustration. Unlike respondents in Jordan and Hughes' study, and several of the studies reviewed by Nolan *et al.* (2000), they did not report overt blocking by either doctors or senior nurses. The greatest delay was caused by a lack of policies and protocols, reflecting the fact that these practitioners were introducing knowledge from another 'sector' (Tovey, 1997) into orthodox practice.

As the literature reviewed earlier has shown, generally nurses are more in favour of complementary therapies than are other, more powerful gatekeepers such as doctors. In relation to aromatherapy in particular, the HLSCST (2000) viewed it as lacking a scientific basis, but as relatively harmless and capable of relieving stress. It may, therefore, be a therapy which is accepted relatively easily in orthodox health care settings, but which is seen as a pleasant 'extra' and not a priority in times of staff shortage.

All participants had obtained their managers' agreement for attending the course, as all were funded from the CPD budget. We suggest therefore that if staff are being sponsored for a course which extends their practice, the need for policies and protocols should be taken into account at the time that attendance on the course is agreed, in order that the knowledge may be put into practice on the practitioner's return. As Jordan & Hughes (1998) stated, the impact of CPD depends not only on the knowledge imparted, but on the social context in which nurses (and midwives) work. The Audit Commission (2001) report *Hidden Talents* recommended that NHS trusts should develop an organization-wide culture that values training and teaching by all staff, combined with effective management systems. This is essential if the benefits of CPD are to be realized both in terms of the benefits to patients, and also job satisfaction for staff who are able to put new skills into practice.

References

- Audit Commission (2001) *Hidden Talents: Education, Training and Development for Healthcare Staff in NHS Trusts*. Audit Commission, London.
- British Medical Association (1986) *Alternative Therapy: Report of the Board of Science and Education*. BMA, London.
- British Medical Association (1993) *Complementary Medicine: New Approaches to Good Practice*. BMA, London.
- British Medical Association (1999) *Evidence on Complementary and Alternative Medicine*. Briefing paper. BMA, London.
- Budd S. & Mills S. (2000) *Professional Organisation of Complementary and Alternative Medicine in the United Kingdom 2000*. A

- second report to the Department of Health. University of Exeter, Exeter.
- Cant S.L. & Calnan M. (1991) On the margins of the medical marketplace? An exploratory study of alternative practitioner's perceptions. *Sociology of Health and Illness* 13(1), 39–57.
- Cochrane M.A. (2002) Establishment of a nurse-run acupuncture treatment for hay fever. *Complementary Therapies in Nursing and Midwifery* 8, 17–20.
- Colaizzi P. (1978) Psychological research as the phenomenologist views it. In *Existential Phenomenological Alternatives for Psychology* (Valle R. & King M., eds). Oxford University Press, New York.
- Douglas M. (1994) The construction of the physician: a cultural approach to medical fashion. In *The Healing Bond* (Budd S. & Sharma U. eds). Routledge, London, pp. 23–41.
- Foundation for Integrated Medicine (1997) *Integrated Health Care: A Way Forward for the Next Five Years? A Discussion Document*. Foundation for Integrated Medicine, London.
- Fox M. (2001) Access to complementary health care: why the NHS is the key. *Complementary Therapies in Nursing and Midwifery* 7(3), 123–125.
- Goldstein M.S. (2000) The growing acceptance of complementary and alternative medicine. In: *Handbook of Medical Sociology* (Bird C., Conrad P. & Fremont A., eds). Prentice Hall, Englewood Cliffs, pp. 284–297.
- Graham L., Goldstone L., Ejindu A., Baker J. & Asiedu-Addo E. (1998) Penetration of complementary therapies into NHS trust and private hospital practice. *Complementary Therapies in Nursing and Midwifery* 4(6), 160–165.
- Greenfield S., Innes M., Allan T. & Wearn A. (2000) 1st year medical students' perceptions and use of complementary and alternative medicine. Paper given at the Medical Sociology Conference, York, September 2000.
- Hardwick S. & Jordan S. (2002) Issues and innovations in nursing education. *Journal of Advanced Nursing* 38(5), 524–535.
- House of Lords Select Committee on Science and Technology (2000) *Complementary and Alternative Medicine*. The Stationery Office, London.
- Hubble M. & Middleton M. (1995) A nurse's role in complementary therapy. *Complementary Therapies in Medicine* 3, 171–174.
- Hughes P. (1990) Evaluating the impact of continuing professional education (ENB 941). *Nurse Education Today* 10, 428–436.
- Johnson G. (1995) Complementary therapies in nursing. Implications for nursing using aromatherapy as an example. *Complementary Therapies in Nursing and Midwifery* 1, 128–132.
- Jordan S. & Hughes D. (1998) Using bioscience knowledge in nursing: actions, interactions and reactions. *Journal of Advanced Nursing* 27(5), 1060–1068.
- Kenny C. (2000) Quest for healthy alternatives. *Nursing Times* 96(49), 10–11.
- Lewith G. (1996) An account of nurses' role using complementary therapies. *Complementary Therapies in Nursing and Midwifery* 2(5), 130–133.
- Lincoln Y.S. & Guba E.G. (1985) *Naturalistic Enquiry*. Sage, Beverly Hills.
- McVey M.L. (1996) Policy development. *Complementary Therapies in Nursing and Midwifery* 2, 41–46.
- Meerabeau E. (1998) Consumerism and health care: the example of fertility treatment. *Journal of Advanced Nursing* 27, 721–729.
- Nolan M., Owen R., Curran M. & Venables A. (2000) Reconceptualising the outcomes of continuing professional development. *International Journal of Nursing Studies* 37, 457–467.
- Nursing and Midwifery Council (2002) *Code of Professional Conduct*. NMC, London.
- Rankin-Box D. (2002) Ethics and quality in complementary therapy education. *Nursing Times* 98(2), 40–42.
- Sharma U. (1994) The equation of responsibility: complementary practitioners and their patients. In: *The Healing Bond* (Budd S. & Sharma U. eds). Routledge, London, pp. 82–103.
- Siahpush M. (1999) A critical review of the sociology of alternative medicine: research on users, practitioners and the orthodoxy. *Health* 4(2), 159–178.
- Sohn P.M. & Loveland Cook C.A. (2002) Nurse Practitioner knowledge of complementary alternative health care: foundation for practice. *Journal of Advanced Nursing* 39(9), 9–16.
- Stone J. (1999) Using complementary therapies within nursing – some ethical and legal considerations. *Complementary Therapies in Nursing and Midwifery* 5, 46–50.
- Thomas K.J., Nicholl J.P. & Coleman P. (2001) Use and expenditure on complementary medicine in England: a population based survey. *Complementary Therapies in Medicine* 9(1), 2–11.
- Thompson C. (2001) Oil on troubled waters? *Nursing Times* 97(15), 24–25.
- Tovey P. (1997) Contingent legitimacy: UK alternative practitioners and intersectoral acceptance. *Social Science and Medicine* 45(7), 1129–1133.
- Warmuth J. (1987) In search of the impact of continuing education. *Journal of Continuing Education in Nursing* 18(1), 4–7.
- Wintour P. (2000) Alternative health therapies under fire. *The Guardian* 27 November, p. 8.
- Zwicky J.F. (1993) *Reader's Guide to Alternative Methods*. American Medical Association, Chicago.