



ELSEVIER

ABSTRACTS

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This year the conference addressed issues and treatments that surround the menopause and included evaluating Herbal Medicine, Acupuncture and Bowen Technique as well as the underlying mechanisms that may underpin CAM interventions. Christine Barry encouraged us to be reflective and evaluate CAM in an ethnographic and anthropological context, emphasising the value of the patient perspective in increasing demand and subsequent patient perceived satisfaction with CAM. Removing the 'medicalised' emphasis of specific treatment efficacy and encouraging us to begin to look in a more holistic manner at treatment effects, patient satisfaction and indeed of course safety. This emphasised the observation that RCTs provide limited but important causal information in highly selected groups of individuals; how generalisable are they? An issue addressed by Paul Dieppe at our conference last year.

Harald Walach explored non-local quantum-based effects and questioned how they may impact on clinical trials. Lionel Milgrom suggested that these non-local effects might, through our understanding of the theory of quantum mechanics, underpin the effects within the homeopathic process. In a sense these perspectives make us consider whether we can separate specific treatment effect

from the process of receiving treatment within CAM. What is homeopathy without the homeopathic consultation? The sceptic might question whether the homeopathic consultation is any different from visiting a caring conventional GP but the ethnographers would disagree observing that the content and nature of CAM consultations offers a series of entirely different dimensions to those reported within conventional medicine.

Practitioners frequently wish to 'prove' their therapy, but the point of our strategies conference is not to prove or disprove anything. Its aim is to expand peoples understanding of research and how they may approach a research question in a logical, thoughtful, sympathetic and above all else, appropriate manner. The question is everything; the research methodology follows directly from the issues raised by the question. For instance, do we consider acupuncture to be solely about 'the insertion of needles in what is considered to be an appropriate acupuncture point' or do we consider acupuncture to be the whole process of going to see an acupuncturist, having your pulses taken and being quietly questioned for 10 or 15 min about how you feel and what changes there have been since the last consultation. The patients' perception would undoubtedly be that acupuncture represents the whole package; it is possible that the acupuncturist may consider that the critical bit of acupuncture simply relates to the insertion

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of acupuncture needles in appropriate points. The research question needs to be specific, the subsequent methodology and answer then flow logically from the specificity and thought underpins the question.

Many complementary therapists want to 'show it works' so it can be 'available to all on the NHS'. The aim of our conference is not to support or sustain such views but rather to enable people to ask specific, thoughtful and considered questions about how they may evaluate and reflect on their practice. The result of this would inevitably be to improve their critical thinking and skill as practitioners, enable them to develop a process of critical appraisal when evaluating research, but above all else, progress our understanding of health, disease and appropriate treatments through considered research strategies that are relevant to the therapies and questions being investigated.

Our intent within the strategies conference that has now been running for 4 years has consistently been to develop this theme in a sympathetic and supportive environment. We have achieved that again this year and I hope that we have enabled the development of good quality research in a number of UK academic institutions.

Rhetorics of Effectiveness Versus Everyday Practices

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One way of looking at the effectiveness of an alternative therapy system is through scientific and biomedical 'gold standard' randomised controlled trial evidence. However, calls for such evidence to legitimise the integration of alternative medicine into healthcare systems, by both biomedical and political establishments, can be interpreted as deeply political and comprising multiple rhetorical aspects.²

In its purest ideological form, the concept of offering patients only therapeutic interventions that have been proven to work is unquestionably sensible and morally correct. Where the problems arise is in the possible imperfection of the RCT tool as an arbiter of "what works". It can be measuring the wrong things, or the wrong populations and can appear to forget that the real world clinical context is very different to the trial laboratory.

The supposed objectivity of scientific, biomedical forms of evidence can be questioned and there are many weaknesses of the RCT method to provide the right kinds of evidence. One such weak-

ness is that the political aspects of evidence-based medicine can be interpreted as a move to protect the medical professions' need to claim exclusive expertise in healthcare.^{1,9} Another weakness is that actual compliance by practitioners with guidelines derived from such evidence is extremely low (19–36%).¹⁰ The extent to which patients take drugs prescribed for them, as instructed, is similarly low at around 50%.⁷ So, the trials may not be impacting on real world medical practice.

As an anthropologist, I find that it is more fruitful to look for the answer to the question "what works" through attention to evidence that is constructed very differently. I propose moving the spotlight moves from what works in a trial to what works for therapists and patients engaged in everyday, ongoing usage of alternative therapy systems. Ethnographic methodology focuses on people within the contexts in which therapies are provided. Reality for anthropologists is seen as ever changing through a series of processes, which are formed by the interactions and relationships between people, and always affected by the context in which social actions take place. In place of seeking an average for a population, ethnography suggests that we need to look at specific people, in specific contexts and watch what really happens on a daily basis.

Paul Dieppe at this conference last year⁸ called for more qualitative research and methods that "celebrate rather than denigrate context effects". But even qualitative research interviews which are deemed to get closer to real life and are particularly good at depicting the meanings people put on events, can produce versions of reality that tend more to the ideal than the real. Actors can still end up extracted from their everyday contexts. Issues such as social desirability of responses and the inattention of people to much implicit and tacit information in their everyday lives, can distort accounts given in interview. In research in general practice, for example, I have shown how different methods (interviewing doctors and patients; recording consultations; writing reflexive fieldnotes), all produced different information that taken together produces a rich and more complex account of everyday practice.^{5,6}

Ethnographic participant observation is sensitive to the actual practices people engage in rather than the accounts they give and can bring to light very important aspects of "what works". I will present some data from my ethnographic research on tai chi and homeopathy in south London to illuminate the effectiveness of alternative therapies in context, and from the perspective of the practitioners and patients that use them.^{3,4}

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Generalised Entanglement and the Potential Consequences for Clinical Research

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Clinical research and practice normally start from the assumption of separability: we assume that we can observe control groups and treatment groups separately, randomise patients into different groups and thus partial out treatment from placebo effects. The whole of evidence-based medicine is built on the presupposition that there is something like a true and context independent treatment effect, which can be isolated through good research and pinpointed down by meta-analyses. Even clinical practice and health

systems research assumes that provider effects have to be and can be separated from the effects of specific treatments. The whole array of clinical research methodology rests on this presupposition.

We have recently introduced the concept of "Generalised Entanglement" (GET). Entanglement is well known in quantum physics. It refers to the fact that within one quantum system it is not meaningful to talk of separable parts. It is irrelevant how large the system is or where, in terms of distance and time, elements of one system are located. They behave in a correlated fashion and not as separate entities. This has been proven beyond any reasonable doubt for quantum mechanics proper. One normally assumes that such holistic or EPR-correlations die out rather quickly with every interaction a quantum system has with its environment. However, if one introduces a weaker and more generalised version of quantum theory (QT), Weak Quantum Theory (WQT), one can use the formalism of QT with some relaxations and some definitions dropped, and describe systems in a very general form. From WQT it follows that GET can happen in any type of system under the restrictions of certain circumstances: whenever a global description of a system and local descriptions of elements of the system are complementary, these elements should exhibit correlated behaviour through GET.

This very abstract notion can be and has been translated into practical interpretations. It can be used to understand the working of homeopathy. It can be used to reconstruct spiritual healing, and it is likely to be a very generic phenomenon of human interaction. It is also likely that via GET a correlation is set up in clinical trials between treatment and control groups, as long as studies are blinded. One very important corollary of GET is that it cannot be used directly to code signals. This, however, is done in every blinded clinical trial. If a method – and supposedly quite a few CAM methods might be exploiting GET without them knowing – is based on GET the attempt to isolate a causal signal through a blinded RCT will break GET, and hence, lead to false negative or inconsistent results. Thus, the model has profound consequences on research, both positive and negative ones, which will be discussed.

Are Double-Blind Placebo-Controlled Trials (RCTs) Redundant for Testing the Efficacy of Homeopathy? A Critical Assessment of RCT Methodology from the Standpoint of Macro-Entanglement

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Introduction: In general, RCTs have yet to deliver consistent data unequivocally supporting the efficacy of homeopathy. In trying to understand this problem, Weatherley-Jones et al. recently questioned the implicit assumptions of RCT methodology.¹ Crucially, they are that specific (e.g., remedial) and non-specific (e.g., consultation) effects of treatment are considered independent of each other: placebo effects are deducted, supposedly leaving behind specific effects of the remedy.

Entanglement in homeopathy: What if specific and non-specific effects of homeopathic treatment are not independent but intimately correlated, i.e., 'entangled' in a sense derived and generalised from² the use of this term in quantum theory? What will then be the effect of the RCT methodology? This talk will show that a previously developed entanglement metaphor for the homeopathic process³ predicts entanglement breaking during RCTs by *impeding entanglement formation* altogether, in trials on homeopathic remedies, or *breaking entanglement* once formed, in trials of individualised homeopathic prescribing. Consequently, if entanglement between patient, practitioner, and remedy is a necessary concomitant of homeopathic intervention, then the more rigorously it is tested via the RCT methodology, the less likelihood such trials will positively demonstrate the efficacy of homeopathy. RCT methodology essentially disrupts the very thing it is trying to observe, and is therefore, fundamentally flawed in agreement with Weatherley-Jones et al.'s clinical findings.

Comparisons will be made to a similar effect of observation from orthodox quantum theory known as 'the collapse of the wave function'. In addition, small positive effects of homeopathic intervention shown by RCTs will be considered in terms of entanglement during remedy manufacture. Finally, the opposite entangling effect of double-blinding homeopathic pathogenic trials (i.e., provings)⁴ will be considered.

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Assessing the Effectiveness of Bowen Neurostructural Integration Technique (NST) for Post-treatment Trauma in Cancer Patients

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Aim: To research the effectiveness of Bowen NST (NST) for those with cancer-related trauma through the provision of individualised treatment programmes.

Objectives:

1. To apply techniques of Bowen NST in the context of providing an effective person centred service to people with cancer-related trauma due to treatment.
2. To utilise both quantitative and qualitative research methods to elicit the effectiveness of Bowen NST in a discrete cohort of cancer patients.
3. To elicit patient perceptions of their health and quality of life pre- and post-treatment using qualitative methods.

Introduction: NST is a complementary therapy developed by Micheal Nixon-Livy and close associates of Tom Bowen, who postulated that the body is a self-regulating, integrated biosystem that will return to balance under appropriate stimulation. The NST practitioner addresses biodynamic systems through configurations of hands on movements that stimulate the central, peripheral and autonomic nervous systems, removing physiological and structural disorder.¹ Moves take place at the insertion point and belly of muscles in areas high in concentrations of Golgi nerve receptors. Other moves around joints and ligaments target proprioceptors. A number of them coincide with acupuncture points that stimulate and balance the body's energy. Although there is anecdotal evidence of the effects of NST, no substantial research papers have been published. Several case studies report beneficial effects, e.g. alleviation of frozen shoulder, migraine and lymphoedema. NST is currently offered

to cancer patients through support units. Patients and therapists report improvements in their condition and quality of life but this is not currently quantified or formally reported. Research is needed into the effects of NST (not to treat cancer, rather alleviate the side effects of treatment) and this pilot study aims to address this gap in knowledge and to inform the development of a larger study.

Methods: The pilot study design is pragmatic, investigating effects of NST of a therapist working in the community. Quantitative and qualitative methods will gather information on the patient's condition. Participants follow the following process: recruitment, baseline assessment, NST, interim assessment, NST and final assessment. The proposed study cohorts are patients accessing Cancer Support Centres in the North West Region. The pilot will recruit 20 participants experiencing health problems after being treated for cancer either post-operatively, post-chemotherapy, post-radiotherapy or a combination thereof. They will be randomised to receive immediate or delayed NST. The delayed group, therefore, act as controls. Traumas may include muscle pain, restricted movement, lymphodema, neurological disruption, digestive trauma. **Recruitment**—Patients >18 years old, accessing a support centre, deemed suitable to receive NST will be eligible. Non-eligible patients are those with major pre-cancer health issues and those receiving palliative care. Written informed consent will be adopted and ethical approval sought. **Baseline assessment (30 min)**—Will provide information on the patient's current condition prior to receiving treatment. Consisting of a one-to-one discussion between the therapist and patient, the nature and severity of the trauma will be identified and quantified. Tools such as the quality of life questionnaire (SF36), pain intensity scores, depression and mobility scales will be used together with recording of verbal information. In some cases, physical measurements and/or photographs will be taken. **Bowen NST (1 session = 1 h)**—Although each session is tailored to the individual all patients will receive the same treatment structure, i.e., three sessions (1 per week), 2-week break followed by a further three sessions. The participant remains fully clothed during treatment. The moves used will be determined by the nature of the trauma and which part of the body is affected. A 2-week break is then taken and an *interim assessment* carried out using the same tools as the baseline. NST is then resumed for another three sessions. **Final assessment**—A repetition of the previous assessments.

Results: Each assessment will produce both qualitative and quantitative data. Quantitative

data will be analysed using appropriate statistics depending on whether the resulting cohort is parametric or not. Data will be dependent, e.g. numerical scores such as pain intensity will be compared before, during and after treatment. Qualitative information will be transcribed verbatim and thematic analysis carried out whereby common themes will be identified. Transcripts will be read and re-read by a third party to validate emerging themes. The study aims to elicit valuable information as to the effectiveness of NST for cancer-related traumas.

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Exploring the Effectiveness of Traditional Chinese Acupuncture (TCA) for the Reduction of Stress in Adults—A Randomised, Controlled, Crossover Pilot Study

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Aim: The pilot study forms the initial stage of a Ph.D. programme. This stage is exploratory and designed to inform the development of a future RCT.

Subjects: Eighteen volunteers with high self-reported stress levels as measured by the Perceived Stress Scale 14 (PSS-14), currently not receiving complementary or other treatment for stress and its related symptoms.

Methods: Participants will be randomised into three groups. In group 1, six participants will receive weekly sessions of Traditional Chinese Acupuncture (TCA) for a period of 5 weeks, and after a 2-week wash-out period they will receive five weekly sessions as an attention only control (i.e., TCA consultation and relaxation only). The six participants in group 2 will initially receive the five attention-control sessions followed by the five TCA sessions (after the 2-week wash-out). In group 3, six participants will act as a waiting list control. These subjects will be offered TCA once the study is finished.

Outcome measures: For groups 1 and 2, the Perceived Stress Scale 14 (PSS-14) and the Measure Yourself Medical Outcome Profile (MYMOP) will be completed on the day of commencement and com-

pletion of either the TCA or attention only phase for both arms of the study. Similarly, for group 3, the six participants will complete the two questionnaires at weeks 1, 5, 7 and 12.

A salivary cortisol sample will be taken at four points in time: (1) immediately upon waking in the morning; (2) 30 min after waking; (3) 3 h after waking; (4) 12 h after waking and the exact time will be recorded. These samples will be taken over a total 12-week time period: on the two consecutive days prior to commencement of the study, on the day following each TCA or control intervention and on the same day for each week of the 2-week wash-out. In group 3, the samples will be taken at the same time points. Salivary cortisol concentration will be measured by using a High Sensitivity Salivary Cortisol Enzyme Immunoassay.

Data collected for each participant will be anonymous and analysed at the end of the study to determine whether acupuncture has had a demonstrable effect in reducing stress, and whether the diurnal cortisol profile is a useful outcome measure for research into complementary medicine and the treatment of stress.

Investigating Complex Systems in Herbal Medicine: Reflections on the Black Box

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Finding suitable methodology to investigate a complex system is a challenge. Can treatment by herbal practitioners, a complex intervention, be evaluated within a randomised controlled trial?

“Changing with Herbs” is a randomised, controlled pilot study of the effectiveness of treatment of menopausal symptoms by medical herbalists. Currently nearing completion, this study investigates the effects of treatment by herbal practitioners, which is multi-faceted and develops over time within a therapeutic relationship. Forty-five menopausal women recruited from one GP practice in Bristol were block randomised between treatment and waiting list control groups, both completing outcomes measures at the same time points. The treatment consisted of a full 5-month individually tailored, holistic course of treatment from

one of three local members of the National Institute of Medical Herbalists with follow-up data collected after 6 months. Three outcome measures were used: a validated scale specific to the condition (the Greene Climacteric scale); a patient-centred instrument with a quality of life element (MYMOP2), and a qualitative feedback questionnaire. Challenges with this trial included: gaining ethical approval; funding; and finding a research sponsor when not working within academia or the NHS. Two issues extended the time taken and hence the cost: setting stringent exclusion criteria, which prolonged recruitment, and unexpected events in the participants’ lives. Success of this methodology was indicated by a typical incidence of menopausal symptoms within the population, low drop out (2%), good patient compliance with treatment, substantial data collection (97%) and positive patient feedback. A waiting list randomised controlled trial with several outcomes measures proved a suitable methodology for investigating a complex intervention.

A Pragmatic Randomised Controlled Trial to Compare Usual Care Versus Usual Care Plus Acupuncture to Assess the Quality of Life of Patients Receiving Chemotherapy for Breast Cancer

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Aim: to determine the effect of traditional Chinese acupuncture on health-related quality of life measures for breast cancer patients undergoing chemotherapy.

Methods: 270 patients with breast cancer will be recruited for the study through the Oncology department at the Western General Hospital, Edinburgh. Participating patients will be randomised into one of two groups: (1) an acupuncture group and (2) a non-acupuncture usual care control group. Randomisation will be by stratified permuted blocks. Stratification will be by age/menopause and chemotherapy regime. Outcome measures will be Measure Yourself Medical Outcome Profile (MYMOP), global quality of life, functional scales and symptom scales (EORTC QLQ-C30 and QLQ-BR23) and a fatigue scale. A secondary analysis of data regarding use of adjuvant medication, plus neutrophil count and haemoglobin will also be undertaken.

Qualitative assessment will involve in-depth interviews with 20 patients to explore attitudes to acupuncture therapy, trial acceptability and themes that are important to the patient. These

data will be analysed using inductive techniques. A pilot study of 30 patients is included in the protocol.

Sample size: The study has been powered to detect mean population differences of 0.66 units in MYMOP between the two treatment arms. This corresponds to two-thirds of the patients benefiting from acupuncture by one category of MYMOP. For this difference, there is 90% power to detect a statistically significant difference at the 5% level of significance if the sample size is 118 patients per group. Allowing for some attrition we plan to recruit a total of 270 patients.

Research outcomes relating to NHS implementation potential: if the trial demonstrates that acupuncture is effective in alleviating the adverse effects of chemotherapy on quality of life, it will offer an opportunity to deliver the maximum dose of chemotherapy to patients, thus minimising the risks of disease recurrence. From the patient perspective, it will make chemotherapy a more acceptable treatment. If the anticipated benefits are not demonstrated, it will provide objective RCT evidence that the NHS should not provide this service to patients undergoing chemotherapy.

An Exploratory Study of the Efficacy of Reflexology for Women with Idiopathic Constipation

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This study is a pilot and hence hypotheses are being explored, rather than tested. It is envisaged that results will inform the development and undertaking of a larger scale evaluation of reflexology as an intervention for women with constipation.

The research aims to determine:

1. The value of providing reflexology as an intervention for women with idiopathic constipation.
2. The potential impact of this therapy for the bowel physiology and biofeedback service.

Study design: A prospective one-group exploratory test-retest pilot study is underway. 20 female patients who present to a nurse led biofeedback service with idiopathic constipation will be recruited. A checklist will be used to screen for symptoms indicating need for urgent clinical referral. All participating patients will receive the intervention. This consists of a course of six reflexology treatments at weekly intervals, each lasting 35–45 min. This treatment will be evaluated under "normal" service conditions, leaving the practi-

tioner free to give individualised patient treatments. Outcome measures are administered at baseline and again following the sixth treatment, on completion of the intervention. Patients are assessed before and after the intervention using a standard assessment proforma, are required to undergo gut transit studies and are asked to complete a bowel diary for 1 week before the intervention commences and again following the sixth treatment. Participants are also asked to complete the Hospital Anxiety and Depression Scale (HAD), the Short form 36 (SF36) and the Holistic Complementary and Alternative Medicine Questionnaire (HCA MQ) at baseline and again following the sixth treatment.

Data will be analysed using appropriate parametric and non-parametric tests depending on the data generated. If there is a suggestion of efficacy (i.e., increased bowel frequency, decreased gut transit time or improved patient perception of symptoms and quality of life), effect size will be evaluated to facilitate a power calculation of the required sample size for proceeding to a randomised controlled trial. Ethical approval has been gained and recruitment commenced. While the study is ongoing, initial results indicate that most participants perceive that the reflexology is beneficial for their bowel problem. Some participants have reported increased frequency of bowel motions or improvement in stool consistency.

The Safety of Chinese Herbal Medicine: A Pilot for a National Survey

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Objectives: To establish the feasibility of conducting a national safety survey involving patients of herbalists monitoring and reporting adverse events associated with the routine practice of Chinese herbal medicine.

Methods: In June 2004, we invited 549 herbalists who were members of the UK Register of Chinese Herbal Medicine to ask 10 consecutive patients to participate in the survey. Consenting patients returned their baseline survey forms direct to the research centre. Four weeks later, patients were sent a follow-up questionnaire in which they reported adverse events that they perceived were caused by the Chinese herbal medicine over the previous 4 weeks. We analysed the data, exploring types and frequencies of adverse events as well as assessing potential risk factors using multi-level

logistic regression taking into account the clustering of patients with practitioners.

Results: Of the 161 responding practitioners of Chinese herbal medicine, 71 agreed to participate, 13% of the total membership. One hundred and ninety-four patients returned baseline questionnaires, an average of 2.7 patients per practitioner. One hundred and forty-four (74%) patients completed the 4-week follow-up questionnaires. A total 20 patients, who were treated by 14 of the herbal medicine practitioners, reported 32 adverse events associated with Chinese herbal medicine over the 4-week period (14% of patients, 95% CI: 9–20%). No serious adverse events were reported. The most commonly reported adverse events were diarrhoea, fatigue and nausea. When controlling for potential confounders, patients consulting for Chinese herbal medicine for the first time were more likely to report an adverse event than repeat attenders (OR 3.03; 95% CI: 1.03–8.89, $p < 0.02$).

Conclusion: In this pilot, the recruitment rate was low with only 13% of practitioners participating, and only 27% of potential patients returning consent forms, raising questions about potential bias. This research has provided some useful data, which will assist in the initiation of future studies.

The Bowen Technique—Pre-menstrual Syndrome

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Below is the work that I have done on the migraine and asthma conditions and the outcomes obtained. I am in the process of developing a new protocol to study pre-menstrual syndrome and I would like your advice on its development; an outline of the protocol for the PMS study will be presented.

Aim/Purpose: Previous studies aimed to establish a record of the response of the migraine and asthma conditions to a course of the Bowen technique. The study on PMS would be to establish similar data. Volunteers will be recruited from the National Association for Pre-Menstrual Syndrome.

Method: In previous studies, the volunteers completed a questionnaire (open and closed questions) at the start and end of the research period. A diary was maintained for the duration of the research period.

In the migraine and asthma studies, Bowen treatments were administered by qualified therapists, but the exact procedures used were left to the discretion of the individual therapist. Complementary

therapies address the person as a unique individual and it was felt that prescribing the procedures would breach this.

Results: The migraine study: 79.5% positive response (39 volunteers in all, 10 (26%) experienced a decrease in frequency of migraine, 9 (23%) a decrease in severity, 11 (28%) a decrease in frequency and severity).

The asthma study: Eighty-three percent reported a reduction in the frequency of asthma attacks (24 volunteers in all).

Eighteen (75%) reported a reduction in the severity, 18 (75%) reported using less medication, 14 (58%) reported responding better to their medication, 17 (71%) reported sensitivity to triggers had reduced. Only 15 of the 24 volunteers used peak flow meters at home, all 15 (100%) reported their readings had improved.

Conclusions: The Bowen Technique is an effective complementary treatment to be considered in addressing the migraine and asthma conditions.

The Use of Yoga in the Management of Childhood Asthma—An Exploratory Study of Attitudes

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Objectives: Several studies have shown the benefit of yoga in adult asthma, but few have investigated its use in childhood asthma. Before planning an RCT, we wished to explore the views and attitudes of both yoga teachers and parents of children with asthma.

Methods: This is a two-part postal questionnaire study. The first questionnaire was sent to 500 yoga teachers in the southeast who completed it anonymously. The second part of the study will be a self-completed postal questionnaire sent to all parents of children with asthma across four primary care centres in Brighton and Hove. Both questionnaires include quantitative and qualitative items.

Results: Results of part 1 of the study showed that all teachers thought a trial would be useful and that perceived potential benefits outweighed practical reservations. Of the yoga teachers who had used yoga to treat a child with asthma there was a high-perceived efficacy. The majority view was for each yoga class to last at least 45 min with 8–10 children per class, twice a week for 6–10 weeks.

Conclusions: Once yoga teachers' and parents' views have been explored, we will progress to a clinical trial if appropriate.

The Effect of the Bowen Technique on Childhood Asthma Project

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The result of the first treatment on a 2-year-old child in November 1999 was so marked that I decided to initiate a study to see whether this was a lucky chance, or whether Bowen could make a real contribution to helping childhood asthma. Over the past 5 years, with over 100 cases to look back on, the initial hopes have been well rewarded.

The Bowen Technique is a very gentle therapy where we make rolling type moves over muscle and tendons in specific parts of the body. Depending on the age of the child, the treatment can take anything from less than one minute to maybe 15–20 min to perform. Children love the treatment (usually!) which finishes with a gentle “spider” move on the face which has many of them talking about it all week!

The evidence I have gathered from treating the children myself is that they respond immediately in most cases. Where they do not respond, then there is usually something rather more than allergic asthma going on. As an example, a 4-year-old responded well and immediately, but would then sometimes be in hospital 2 days later with pneumonia. It has now been discovered that she has a partially collapsed lobe, which also led to plugging. The Brompton have stated that her asthma has changed for the better.

To illustrate to importance of the effect of Bowen, I will summarise three cases, which are typical.

1. A 14-month-old boy had been coughing continuously for 6 months and was on Ventolin, which had no effect. He was due to be put on Becotide in 2 weeks time. He was waking five times a night, coughing, but also increasingly holding on to his mother for up to half an hour in fear as he could not breathe. She was 7 months pregnant and exhausted. I gave him a first treatment a year ago, which lasted about 40s, three sets of moves on the back, three on the front. He stopped wheezing shortly after and stopped coughing 3 days later. He has not been on Becotide, and 1 year on is still fine.
2. A 13 year old, who regularly needed Ventolin several times a night and was often unwell for up to 3 or 4 weeks. School attendance was only 77%.

After his first treatment (15 min), he stopped using his Ventolin and, apart from a few minor episodes, has been free from most symptoms for the past year. He was away from school for only 2–3 days in the next term and last December had a bad bout of flu, which would have had him away from school for 3–4 weeks, his mother says, but he only missed 2 days. She was so impressed, she came and joined my class.

3. A 6-year-old girl could not run more than 20 yards without needing her inhaler. She had to be taken home early most days from school as she was unwell, daily. She only managed about 2 days a week in total time at school. She suffered frequent colds, chest infections and asthma attacks (a very common feature with children, I find). Her first treatment 15 months ago lasted about 6 min. She was starting a cold and wheezing quite badly. The next day she ran home from school, and has not stopped running since. The cold stopped (also a frequent feature of Bowen) and the wheezing had stopped by the end of that first treatment. Her mother has been able to go back to work as the child is now “normal” for the first time in her young life.

All of these are typical outcomes. There are many similar stories throughout the Bowen community. However, I decided to do the study so that I could present the findings first hand. It now needs to be incorporated into a proper Research study and I am willing to allocate time to do that in conjunction with a specialist unit.

I have also just initiated an “Asthma Nurse” 1-day course in Bowen, which is gathering a lot of interest.

In summary, Bowen is totally complementary, does not interfere with any medication, but does help the need for medication to be reduced quite quickly in many cases, it is easy to administer and only takes a very short time to do. It has been difficult to get doctors to accept its large potential because there is no research to back up the claims. There is a very large shortage of respiratory specialists and Bowen could help reduce the number of cases they need to see. Additionally, lost school days are reduced dramatically. Perhaps, even more important, is the fact that the daily/hourly anxious watch parents have to keep on asthmatic children is dramatically changed for them from the start of treatment.

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