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Greetings From Team RAC

As I write this, I am celebrating one year as the Executive Director of RAC – and celebration it is for it has been a year in which I have met wonderful people, made some very dear friends and helped TEAM RAC move forward in to the years that lie ahead.

2007 has been a year of cleaning house and consolidation and we are now ready for what I predict will be one of the most important and exciting years in RAC history. This will be a year when so many of the members' dreams from the past will become reality — the year when RAC once again takes its place as the true leader of reflexology in Canada.

Elsewhere in the Journal, you will find details of the plans we have as well as the news that was given to those members who attended the AGM in Winnipeg last month. Rather than repeating what you will be able to read in the upcoming pages, I would like to take a moment to recognize all the people who have enabled us to get to this place and to prepare for our upcoming major steps forward.

First and foremost, thanks must go to you – the members. Each and every one of you is a member of TEAM RAC and many of you have played a very active part in the positive things that have been happening. For all but the newest members you have been with RAC through many years of difficulty and you deserve thanks for sticking with RAC and for having faith that things would one day turn around. That day has arrived and we thank you!

Being a Board member of any organisation is not an easy task. It can sometimes be frustrating and it is always challenging. The Board role in a not-for-profit association, such as RAC, is even more challenging, especially when working with an association that has had to work, for so long, simply to survive. There is no doubt that each and every Board member, past and current, deserves our thanks for taking on the role and fulfilling it with commitment and belief. The work of future Board members will be easier as a result of all that has gone before.

Special thanks is due to the myriad of volunteers who work in the background in Chapter roles, on committees and panels, and in continually bringing awareness about the benefits of reflexology to the public at large. In the coming year, RAC plans to give even greater recognition and reward to these volunteers. Until then, we offer our sincere thanks.

Last, but by no means least, I must thank the team of dedicated people who handle all of the administrative and educational functions of RAC. In this instance, I will bend the rules slightly and actually name some names as

they deserve nothing less for what they have done in the past months.

Linda Hughs is a long time member of RAC, has served on the Board and has put many hours into proving her commitment to the profession and the Association. She has stuck with what has been, at times, a thankless task often in the face of criticism and, through it all, has maintained a professionalism that is second to none. Many of the things that will be put in place for 2008 are as a result of her work and commitment and I offer her my heartfelt thanks and the thanks of all those who have benefitted and will benefit from her work.

When I first joined RAC, Alana Friesen was a very frustrated receptionist and probably ready to move on. Given the opportunity, she has taken on more and more responsibility and is proving herself to be someone with even greater potential. She is an excellent team member and has a delightful way of making each and every member feel valued and valuable.

Sherri Gunn is a certified Reflexologist and had worked for RAC on a semi volunteer basis but, she too, was ready to move on and, like Alana, has taken the opportunity and really made a difference. Like all the TEAM RAC members she both embraces change and is committed to the Association.

For Chris Wasyluk and Mounia Khattab there is thanks for joining the team and for what you have already done. I have high hopes for each of you in the future.

Valerie Taylor is someone whose work goes on behind the scenes but is absolutely vital to the efficient functioning and development of the Association. She is utterly dedicated and it is not unusual to see her working late at night, early in the morning and on weekends. Her work has enabled RAC to stabilise its financial situation and given us the base from which to move forward. She is a much valued and admired member of the TEAM.

This Journal does not happen by accident and without Deborah Murphy and her excellent team it would not be possible. She has never been simply our Editor but also a creative catalyst for so many other things. She is very much part of the team and I am grateful to her for her commitment and dedication and, not least, for finding that the name Canadian Journal of Reflexology was available – and getting it for RAC. Our thanks go to her for everything she and her team do.

Thank you all for making my first year so enjoyable and for your loyalty and commitment. I look forward to working with you all for many months to come. ❖

Mot de bienvenue de l'Équipe-ACR

Au moment où j'écris ces mots, je marque mon premier anniversaire comme directeur exécutif de l'ACR. C'est un jalon qui mérite être célébré, car pendant cette période j'ai rencontré des gens extraordinaires, tissé des liens d'amitié profonds et aidé l'équipe de l'ACR à aller de l'avant pour se préparer pour les prochaines années.

En 2007 nous avons fait beaucoup de changements en éliminant certaines choses et en consolidant d'autres. Nous sommes maintenant prêts pour ce que, selon moi, sera une des années les plus importantes et excitantes de toute l'histoire de l'ACR. Cette année, le rêve d'un si grand nombre de nos membres deviendra enfin réalité : l'ACR reprendra son rôle de chef de file indéniable dans le domaine de la réflexologie au Canada.

Ailleurs dans la revue, vous trouverez les détails de nos plans pour l'avenir ainsi que les nouvelles partagées avec les membres ayant assisté à l'assemblée générale annuelle à Winnipeg le mois dernier. Au lieu de répéter ce que vous pouvez lire vous-même dans les pages suivantes, j'aimerais prendre un moment pour reconnaître tout le monde qui nous a aidé à nous rendre si loin et à préparer les prochaines étapes importantes encore à franchir.

D'abord et avant tout, je veux remercier les membres : vous. Vous faites tous partie de l'équipe de l'ACR et plusieurs d'entre vous ont joué des rôles importants dans nos réussites récentes. À part les membres tout nouveaux, vous avez vécu plusieurs années difficiles avec l'ACR et nous vous remercions d'avoir demeuré fidèles et d'avoir cru qu'un jour les choses d'amélioreraient. Le jour si attendu est arrivé et nous sommes très reconnaissants de votre appui!

Être membre d'un conseil administratif n'est jamais facile, quel que soit l'organisme. Cette responsabilité est parfois frustrante, et elle lance toujours beaucoup de défis. Dans un organisme à but non lucratif comme l'ACR, ce rôle pose encore plus de difficultés car nous avons dû travailler si fort pendant si longtemps pour assurer notre survie tout simplement. Il ne peut

y avoir aucun doute que chaque membre du conseil administratif, ancien et actuel, mérite de très grands remerciements pour avoir assumé leurs rôles et leurs responsabilités avec passion et dévouement. Le travail des futurs membres du conseil administratif sera moins difficile grâce à leurs efforts.

Nous voulons également remercier tous les bénévoles qui travaillent dans les coulisses et assument des responsabilités au niveau des régions, des comités et des groupes spécialisés et qui oeuvrent sans cesse pour informer le public au sujet des bienfaits de la réflexologie. L'année prochaine, l'ACR reconnaîtra davantage la contribution de ces bénévoles. Entre-temps, nous vous remercions chaleureusement.

Et pour terminer, je tiens à remercier le groupe de personnes engagées qui s'occupent de toutes les fonctions administratives et de formation de l'ACR. Je saisis l'occasion de contourner un peu les règlements en nommant individuellement certaines de ces personnes car ils n'en méritent pas moins après tout le travail qu'ils ont fait depuis les derniers mois.

Linda Hughan est membre de l'ACR depuis longtemps, ancien membre du conseil administratif et fait preuve de son dévouement non seulement à l'association mais également à notre profession par le grand nombre d'heures qu'elle y consacre. Bien qu'elle occupe un poste parfois mal compris et souvent critiqué, elle a toujours maintenu un professionnalisme à toute épreuve. Bon nombre d'initiatives prévues pour 2008 sont le résultat de son travail et de son dévouement; j'offre mes sincères remerciements ainsi que la reconnaissance de tous ceux et toutes celles qui ont profité et qui profiteront de son travail.

Quand je me suis joint à l'ACR, Alana Friesen était une réceptionniste frustrée songeant probablement à changer d'emploi. Mais maintenant les choses ont changées. En assumant un nombre toujours croissant de responsabilités, elle se révèle une personne avec encore beaucoup de potentiel. Non seulement son esprit d'équipe se voit clairement, elle est

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Mot de bienvenue de l'Équipe-ACR (cont.)

aussi capable de faire de sorte que chaque membre se sent valorisé et important.

Sherri Gunn est une reflexologue certifiée qui travaillait pour l'ACR en tant que bénévole à temps partiel et qui était, elle aussi, prête à changer de milieu de travail. Mais, comme Alana, elle a saisi l'occasion de faire une vraie différence. Comme l'équipe entière de l'ACR, elle est ouverte au changement et est vouée aux objectifs de l'association.

J'aimerais aussi remercier Chris Wasyluk et Mounia Khattab pour s'être joints à nous et pour tout ce qu'ils ont déjà fait. Je sais que vous aurez encore beaucoup de réussites à l'avenir.

Le travail de Valerie Taylor se fait souvent sans qu'on le voit mais il est essentiel au fonctionnement et au développement de l'association. Elle fait preuve d'un grand dévouement en travaillant souvent tard le soir, tôt le matin et pendant les fins de semaine. Grâce à son travail, l'ACR a pu

maîtriser ses finances pour pouvoir aller de l'avant. Nous admirons et reconnaissons sincèrement les efforts de Valerie au sein de notre équipe.

Cette revue ne se publie pas toute seule; sans Deborah Murphy et son excellente équipe, sa production serait impossible. Elle a toujours été beaucoup plus que notre rédactrice, elle fournit une inspiration créative pour une grande variété de projets. Elle fait vraiment partie de l'équipe. J'ai une profonde appréciation de son dévouement, un dévouement qui lui a permis non seulement de découvrir que le nom *Canadian Journal of Reflexology* était disponible, mais de l'obtenir pour l'ACR. Nos plus sincères remerciements à Deborah et à son équipe pour leur excellent travail.

Merci à tout le monde pour avoir rendu si plaisante ma première année et merci aussi de votre loyauté et de votre engagement. C'est avec plaisir que je prévois travailler avec vous pendant les mois à venir. ❖

Reflexology and Cancer Patients

LA REFLEXOLOGIE A-T-ELLE UN IMPACT SUR LA QUALITE DE VIE DES PATIENTS ATTEINTS DE CANCER?

Auteure : Heather Hodgson, MN (infirmière en oncologie), baccalauréat en sciences, RGN, est chef d'équipe de soins cliniques en chirurgie, gynécologie et urologie au Stobhill Hospital Glasgow en Écosse.

RESUME :

Objectif :

L'objectif de cette étude est de déterminer si la réflexologie a un impact sur la qualité de vie de patients au stade palliatif du cancer.

Méthode :

Douze patients au stade palliatif du cancer avec différents types de tumeurs ont été divisés par hasard dans deux groupes. Chacun des patients a reçu soit des traitements de réflexologie soit des traitements placebo. Le type de traitement a été choisi par hasard. Les patients ont tous rempli un formulaire d'auto-évaluation analogue linéaire sur leur qualité de vie. Ensuite, ils ont reçu trois sessions de réflexologie ou de traitement placebo. Les traitements pour les deux groupes ont tous été fournis par la même personne, un réflexologue certifié. Les participants ne savaient pas quelles interventions ils recevaient. Suivant les traitements, les participants ont tous effectué une deuxième auto-évaluation analogue linéaire sur leur qualité de vie.

Résultats :

Tous les participants ont indiqué que leur qualité de vie s'était améliorée, même ceux ayant reçu les traitements placebo. Toutefois, le groupe ayant reçu des traitements de réflexologie a constaté des bienfaits plus marqués. Il y avait une différence significative ($p = 0,004$) entre le groupe de réflexologie et le groupe de traitement placebo.

Conclusion :

Cette étude a démontré que la réflexologie a un impact sur la qualité de vie des patients au stade palliatif du cancer.

L'auteur voulait remercier Elaine Rankin pour son support pendant qu'elle prenait sa maîtrise.

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DOES REFLEXOLOGY IMPACT ON CANCER PATIENTS' QUALITY OF LIFE?

Author: Heather Hodgson MN (Cancer Nursing), BSc, RGN, is Clinical Team Leader in Surgery, Gynaecology and Urology, Stobhill Hospital, Glasgow, Scotland.

ABSTRACT:

Aim:

The objective of this study was to determine whether reflexology has an impact on the quality of life of patients in the palliative stage of cancer.

Method:

Twelve patients in the palliative stage of cancer with various tumour types were randomized into two groups. They were randomly assigned to receive either reflexology or placebo reflexology. All participants completed a linear analogue self-assessment scale relating to quality of life. All participants then received three sessions of either reflexology or placebo reflexology. The same person, a qualified reflexologist, provided the interventions for both groups. The participants were not aware of which intervention they were receiving. All participants then completed a second linear analogue self-assessment scale relating to quality of life.

Reflexology and Cancer Patients (cont.)

Results:

All participants felt that their quality of life had improved, even those who had received the placebo treatment. The reflexology group, however, reported more benefit than the placebo group. There was a significant difference ($p=0.004$) between the reflexology group and the placebo group.

Conclusion:

This study showed that reflexology does have an impact on the quality of life of patients in the palliative stage of cancer.

Introduction:

Improving physical and psychological wellbeing is one of the core aims of cancer care today. Healthcare professionals should endeavour to use all available resources to meet the physical and psychological needs of patients with cancer. There is now a growing awareness from both patients and healthcare professionals of the benefits derived from complementary therapies.

A great deal of patient literature, nursing and medical journals and government documents describe the wider use of complementary therapies (Walsh and Wilson 1999, Cole and Shanley 1998, Vickers 1998, NHS Confederation 1997, Booth 1994, Primarolo 1994, Cancerlink 1993, Reilly 1983). Reflexology is an example of just one of the complementary therapies available today. It is an ancient therapy that was used over 4000 years ago by the Egyptians. There are documents describing the use of reflexology dating back to 2300BC (Lockett 1992).

Reflexology is the process of gentle but firm manipulation of the feet and/or hands to stimulate specific reflex points of the body. This is based on the principle that there are reflexes running along the body which terminate in the feet and the hands, and that the body's organs and systems are reflected onto the surface of the skin (Norman and Cowan 1989).

Literature Review:

In palliative care the focus is on effective symptom control and psychological support (Bridgeman and Carr 1998). Symptoms and

psychological components are common features of many quality of life scales (Hawthorn 1993). Since promoting and maintaining quality of life is the guiding principle in palliative care (Holmes *et al* 1997), healthcare professionals must seek ways in which to improve quality of care (Barnes 1997). This approach is of particular importance in terminal illness where quality not quantity of life is imperative (Bruera and Lawlor 1998, Bullinger 1992, Cella 1992). At this particular stage in the cancer trajectory, conventional interventions might not be sufficient or indeed appropriate to meet the needs of these patients. Therefore any complementary therapies which could enhance a patient's quality of life should be considered (Bullinger 1992). 'Reflexology is an exciting, absorbing way of introducing new methods of patient care, and its use presents many opportunities for nursing research.' (Lockett 1992).

A great deal of small-scale international research relating to the science of reflexology does exist (Walker 1998, Frankel 1997, Joyce and Richardson 1997, Trousdell 1996, Wang 1993, Flocco 1992). The diversity of research relating to reflexology is wide, covering many illnesses and disease-related, psychological and physical conditions, such as pulmonary function (Fosholt 1992), diabetes (Zhi-gin 1993), chest pain (Berker 1993), constipation (Yue Ying 1996, Zhao 1996) and sinus arrhythmia (Frankel 1997) to name a few.

Several ongoing reflexology research projects can be found in books dedicated to research relating to reflexology (FIM 1998, Walker 1998). Books totally dedicated to reflexology research have been published. Out of 104 research studies examining the effect of reflexology on various illnesses (Walker 1998, CRA 1996), however, only two examine the effect of reflexology in cancer care (Wang Liang 1996, Long Yun 1993).

Overall, the literature review showed a lack of scientific research in relation to the use of reflexology in cancer care and cancer-related symptoms. There was, however, a plethora of anecdotal literature to support the use of reflexology in cancer care (Stevensen 1996, Gillard

Reflexology and Cancer Patients (cont.)

1995, Dobbs 1985). Donaldson (1992), Kean (1992), Rihal (1992), Stanhope-Williamson (1996) and Stevensen (1996) are all practising reflexologists who believe reflexology brings about comfort, relaxation and stress relief in patients with a terminal illness. The findings of this study support their anecdotal findings. The relaxation and wellbeing facilitates an improvement in quality of life because the patients are relaxed, less tense and their stress levels are reduced (Donaldson 1992, Kean 1992, Stevensen 1996).

In the realm of cancer care these features are recognised as having an impact on quality of life and they are commonly used as indicators in quality of life (Hawthorn 1993). Conventional interventions have a limited therapeutic capacity, however, in the reduction of stress and tension, and in the facilitation of relaxation.

Aims of the Research:

A combination of quantitative and qualitative approaches facilitated by a visual analogue scale

was used to address the following research questions:

Do patients report any impact on their quality of life after receiving reflexology?

What are the perceived effects of reflexology?

Should reflexology be available for palliative care patients in a general hospital setting?

Method:

The participants in this study were in-patients in the palliative stage of a cancer-related illness, staying in the surgical and haematology units. The study took place in an NHS district general hospital.

To ensure that participants could provide fully informed consent and minimise bias, inclusion and exclusion criteria were listed. To be included in this study, patients had to be in the palliative stage of cancer, over 18 years of age and willing to participate. Exclusion criteria included pregnancy, psychiatric problems affecting cognitive or speech processes,

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Reflexology and Cancer Patients (cont.)

involvement in other trials, and risk of dying during the initial interview.

Participants also had to be aware of their diagnosis of cancer, and recognise any contraindications for reflexology, such as acute infection.

A non-probability convenience sample of 12 patients was selected for this study, as it was considered an achievable target. The sample consisted of five female and seven male patients with various tumour types. Their ages ranged from 58 to 80 years. Due to the small sample size it was not feasible to undertake analysis to determine differences relating to tumour size.

The researcher had difficulty in recruiting participants from the surgical unit because there were only eight palliative care patients admitted to the ward during the research period. As a result, participants were enlisted from the haematology ward. Within the limited time allocation, ten other patients from the surgical wards were considered for participation in the study but were not included in the final results for the following reasons:

- Died during study (n=1)
- Too weak to complete the visual analogue scale (n=3)
- Refused to participate (n=2)
- Previous exposure to reflexology (n=2)
- Contraindications to reflexology (n=2)

The director of nursing and quality, surgical service manager and hospital research committee received letters requesting permission to undertake the study. To gain access to patients, letters requesting permission were sent to the patients' consultants and ward managers.

All parties granted access. When a patient agreed to participate in the study, a letter advising of his or her participation was sent to the patient's consultant and general practitioner.

Ethical Issues:

Ethics approval was granted by Lanarkshire ethics committee. All participants willing to participate in the study were required to sign a consent form. The researcher maintained

confidentiality by ensuring that:

- Visual analogue scales were coded and nameless
- Documents were stored in a locked metal filing cabinet until data were entered into a computer
- Written records were destroyed on entry into the computer
- All computer data were destroyed on completion of the study

The researcher was also bound by the UKCC *Guidelines for Professional Practice* in which confidentiality, informed consent and accountability are considered to be important issues (UKCC 1996).

Data Collection Tools:

The tool of choice to collect the data in this study was a modified version of the visual analogue scale (VAS) used by Holmes and Dickerson (1987). The tool was modified to incorporate an open-ended question: 'Are there any more comments you would like to make?'. Permission was granted by the original publisher to use the tool.

Patients completed two separate quality of life visual analogue scales, one pre- and one post-testing. Holmes and Dickerson (1987) showed that the original tool was previously reliable and valid in the measurement of quality of life in patients with cancer. Four out of the 12 patients received the VAS. Unfortunately, however, an omission in the Holmes and Dickerson (1987) tool was noted. Due to a typing error, five of the 28 components of the original tool had been omitted: future ability to earn, recreational activity, ability to eat, texture of food and general restrictions. Due to time limitations and recruitment difficulties the researcher decided, after seeking advice from the study supervisor, to continue with the study. She recognised, however, that these omissions might have impacted on the reliability and validity of this study.

Bias:

Maintenance of internal validity bias was a major consideration. For this reason, another reflexologist who was not the researcher undertook the treatment. A pilot study was

Reflexology and Cancer Patients (cont.)

undertaken to enhance internal reliability and validity, and the actual study was modified in response to the outcomes:

- A previously validated and reliable tool was used
- The tool involved patient self-assessment
- The participants were randomised to either an intervention or a placebo group
- The participants were not aware whether they were receiving the intervention or a placebo
- The author did not conduct the intervention

Pilot Study:

The VAS was piloted to verify the physical handling and ease of understanding the concept of the tool, and also to determine the length of time required for the completion of the VAS. Only two patients were used in the pilot study due to time constraints. The maximum length of time taken to complete the VAS was 15 minutes, five minutes longer than recommended by the tool designers (Holmes and Dickerson 1987).

Following the pilot test a further exclusion criterion was added to the existing list. It was highlighted that participants previously exposed to reflexology would introduce bias. These participants would be able to determine whether they were receiving actual reflexology or placebo reflexology.

Another problem area identified was the time between completion of the first VAS and the initial treatment, and time between the final treatment and completion of the second VAS. The timing of these events had not been determined between the reflexologist and the researcher, which led to timing inconsistencies between patients. The researcher and reflexologist improved communication links by ensuring daily contact with each other. They agreed that intervention would follow completion of the first visual analogue scale within 24 hours and that the second visual analogue scale would be completed within 24 hours of the third intervention.

The timing issue compelled the researcher and the reflexologist to devise a timetable and communication system to ensure that the timing was similar on all occasions.

Data Collection:

The 12 participants completed two separate scales: the first prior to the random assignment of patients into two groups – reflexology or placebo reflexology, the second on completion of intervention. Following consent, the participants were educated on how to complete the scale. After completion of the first VAS, the reflexologist made arrangements to commence the appropriate intervention within 24 hours of consent. The participants in the study were not aware of whether they were to receive reflexology or placebo reflexology. (Placebo reflexology might be, for example, gentle foot massage that does not stimulate reflexology points). The same person, a qualified reflexologist, carried out all of the treatments whether genuine or placebo. (The author is a qualified reflexologist but felt that if she performed the intervention, participants might feel obliged to rate it as better than it actually was as she was the ward manager of the surgical ward. For this reason, another reflexologist carried out the treatment).

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Reflexology and Cancer Patients (cont.)

The length of each intervention was approximately 40 minutes, during which time the reflexologist made social conversation with the participants. On the reflexologist's advice, the intervention was carried out on days one, three and five. This time scale was considered by her to be appropriate, taking into consideration the length of time the participants would be in hospital and the time constraints of the study. Within 24 hours of completion of the intervention the researcher asked the participants to complete a second identical quality of life VAS.

Results:

Advice was sought from a statistician with regard to data analysis for this particular study. The statistician set the p -value at 0.05.

P -values were calculated for the differences between both groups for each of the 18 components of the VAS. Only one of the components was considered to be of

significance, namely breathing with a p -value of 0.026. Constipation was nearly significant with a p -value of 0.056. However, overall the difference between the two groups was indeed significantly different with a p -value of 0.004.

The data was analysed using the Mann-Whitney U test and descriptive statistics. The difference between the reflexology group and placebo group was found to be $p=0.004$. All the participants ($n=6$) in the reflexology group reported an increase in their quality of life, compared to 33 per cent ($n=2$) in the placebo group. All the participants ($n=12$) found the intervention to be relaxing (Fig. 1).

As illustrated, 100 per cent ($n=6$) of the reflexology group reported an improvement in quality of life. However, in the placebo group only 33 per cent ($n=2$) noted an improvement, 33 per cent ($n=2$) noticed no difference and 33 per cent ($n=2$) reported a deterioration in the quality of life score.

Impact on Quality of life:

Table 1 lists the 18 components of the VAS. It shows that only four components (22 per cent) in the placebo group improved quality of life compared with 16 (89 per cent) of the reflexology group.

The areas which demonstrated the greatest improvement were appetite, breathing, constipation, diarrhoea, fears of the future, pain, nausea, sleep, communication and tiredness.

To clarify further exactly which areas of quality of life were affected, a frequency table was prepared and comparisons were made between the reflexology group and the placebo group (Table 2). Again, the reflexology group demonstrated a greater improvement. At least 17 per cent ($n=1$) of the reflexology participants reported an improvement in 100 per cent ($n=18$) of the components, compared to 67 per cent ($n=12$) within the placebo group. The frequency of reporting an improvement in each of the components also differed between the two groups. The reflexology group reported an improvement more frequently in 89 per cent ($n=16$) of the components compared to 0 per

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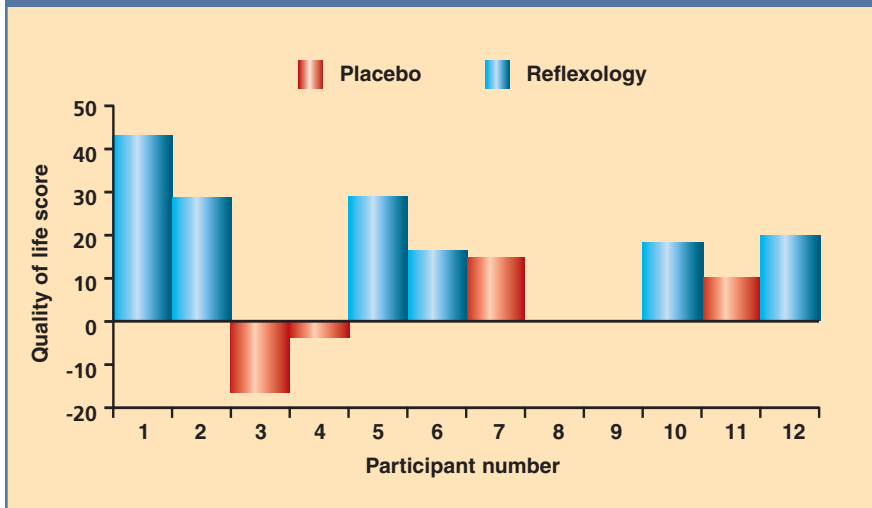
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Reflexology and Cancer Patients (cont.)

Fig. 1. Quality of life scores for all participants



cent in the placebo group. Micturition and mood had equal frequency of improvement for both groups.

Comments From Participants:

After completing the two visual analogue scales, there was a section on the assessment form for participants to add their comments to determine whether they enjoyed the intervention or not. It was also hoped that the researcher would be able to ascertain whether reflexology should be offered to patients being cared for in the hospital setting.

All 12 participants commented on the intervention. Without exception, each of the participants enjoyed the intervention whether it was reflexology or placebo reflexology. Thirty three per cent (n=4) of all the participants found the intervention to be relaxing and 17 per cent (n=2) found it to be calming. There was an overall impression that all the participants had found the experience to be both enjoyable and comforting. The participants used adjectives like 'wonderful' and 'marvellous' to describe the experience. Indeed, one of the participants stated that even the physiotherapist had noticed a difference in his breathing after receiving reflexology.

From the results it was concluded that all participants received some comfort from the intervention, be it reflexology or placebo

reflexology. However, only 33 per cent (n=2) of the placebo group benefited from an improvement in their quality of life, compared to 100 per cent (n=6) of the reflexology group. Within the reflexology group the participants reported an improvement in all components of the quality of life scale (n=18), compared to 67 per cent (n=12) in the placebo group.

However, despite there being an improvement reported in 67 per cent (n=12) of the components, the frequency of improvement was

Continued on page 14

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at 905-714-0298
or see website at

www.canadianchampissage.com
for workshop dates.

RAC 2007 AGM - Winnipeg, October 19th

RAC 2007 AGM Winnipeg, October 19th

The 2007 AGM was held in Winnipeg, MB, last month and attracted a good attendance. Participants heard the new plans for 2008 and beyond, including:

- A continuing education programme will become operative from January 1st 2008. This will be based on a 3 year cycle with a requirement for 30 credits (=60 hours) during that period. Credits can be gained in three categories – RAC accredited or approved activities of all kinds including volunteerism (a minimum of 50% of credits must come from this category); all non-RAC professional activities directly related to and within the scope of the reflexology profession (maximum 25% of credits); and a variety of professional activities that support reflexology and reflexologists but are not necessarily approved or accredited by RAC (maximum 25% of credits).
- The Continuing Education Programme and professional development process will be a requirement to maintain Membership as a RAC Professional Reflexologist – part-time or full-time, practicing or non-practicing.
- All certified and fully paid-up Professional members of RAC will immediately be eligible for the RCRT (Registered Canadian Reflexology Therapist) designation
- To maintain the RCRT designation, certified professionals must commit to the following
 - A yearly membership in good standing with RAC;
 - Keeping continuing education credits current; and
 - Compliance with the Bylaws, Codes of Conduct, and Ethics and Standards of Practice as set forth by the Association.
- From January 1st, 2008, all active members of RAC will automatically be enrolled as members of the RAC Chapter closest to their place of residence. Once individual members

have completed the required sign up process with that Chapter, a sum of \$15 will be paid, by RAC, to the Chapter. This will be an annual process and is aimed at both increasing Chapter membership and developing greater networking opportunities for members.

- Work will commence to establish Provincial Chapters across Canada with a view to fostering Chapter growth at the grass roots level, both by increasing chapter membership and by increasing the number of chapters across Canada.
- All RAC memberships will run for one year from the date of the first sign up and there will no longer be pro-rated memberships.
- With effect from January 1st 2008 all new memberships and reactivated lapsed memberships will attract a one-time joining fee of \$75 plus tax.
- New education programmes will be launched during 2008 and will commence with a new *Anatomy and Physiology* distance education programme that can be taken on-line.

These were the key elements of the future plans. Questions regarding the above can be directed to marcus.summersfield@reflexolog.org. ❖

ASSEMBLÉE GÉNÉRALE ANNUELLE 2007 Winnipeg, 19 octobre

L'assemblée générale annuelle de 2007 ayant eu lieu le mois dernier à Winnipeg (MB) a connu une bonne participation. Ceux et celles présents ont pu découvrir les nouveaux plans pour l'année 2008 et plus loin. Parmi ces plans notons les suivants :

- Un programme de formation continue sera mis en vigueur le 1^{er} janvier 2008. Le programme aura une structure de 3 ans et exigera la réussite de 60 crédits pendant cette période. Trois catégories de crédits

ASSEMBLÉE GÉNÉRALE ANNUELLE 2007 (cont.)

peuvent être obtenus : activités de toutes sortes certifiées ou approuvées par l'ACR, y compris le bénévolat (un minimum de 50 % des crédits doivent entrer dans cette catégorie); activités professionnelles liées directement au domaine de la réflexologie non menées par l'ACR (maximum de 25 % des crédits); et une variété d'activités professionnelles à l'appui de la réflexologie ainsi que des réflexologues mais qui ne sont pas nécessairement certifiées ni approuvées par l'ACR (maximum de 25 % des crédits).

- Le programme de formation continue et le processus de perfectionnement professionnel seront dorénavant obligatoires pour tout réflexologue professionnel membre de l'ACR, que cette personne soit à plein temps ou à temps partiel, qu'elle exerce ce métier ou non.
- Si tout critère d'admission est satisfait, le membre sera nommé **RCRT** : *Registered Canadian Reflexology Therapist* (réflexothérapeute canadien autorisé).
- Afin de maintenir le titre de RCRT, tout professionnel certifié doit satisfaire aux critères suivants :
 - maintenir un abonnement annuel valide à l'ACR;
 - demeurer à jour dans ses crédits de formation continue; et
 - se conformer aux lois, normes et codes éthique et de conduite prescrits par l'association.
- À compter du 1^{er} janvier 2008, tout membre actif de l'ACR deviendra automatiquement membre de la section provinciale de celle-ci située le plus près de son domicile. Aussitôt que le membre ait complété la procédure d'abonnement de la section, une somme de 15 \$ sera payée à la section par l'ACR. Il s'agit d'une procédure annuelle dont l'objectif est de croître l'effectif et de créer des possibilités de réseautage toujours grandissantes pour les membres.
- Le travail d'établir des sections provinciales à travers le Canada commercera bientôt avec

l'objectif de faire épanouir les sections au niveau local en augmentant l'effectif ainsi que le nombre de sections au pays.

- Tout abonnement à l'ACR sera d'une année à partir de la date d'abonnement. Aucun abonnement au prorata ne sera offert.
- À partir du 1^{er} janvier 2008, tout nouvel abonnement et abonnement échu réactivé seront sujets à un frais d'inscription unique de 75 \$ plus taxe.
- De nouveaux programmes de formation seront lancés en 2008 en commençant par le programme de formation à distance *Anatomy and Physiology* (anatomie et physiologie) disponible en ligne.

Voilà les éléments saillants des plans pour l'avenir. Veuillez envoyer toute question sur ce qui précède à l'adresse suivante : marcus.summersfield@reflexolog.org. ❖

NEW! - ADVANCED CERTIFICATE IN ANATOMY & PHYSIOLOGY COURSE

DISTANCE LEARNING PROGRAMME

This certificate is being offered by RAC in partnership with



Aromaflex. Aromaflex is a New Zealand based, internationally-recognised school, that is accredited with relevant New Zealand and Australian education bodies including the NZ Qualifications Authority, under the provision of the Education Act, and its amendments.

The aim of the Certificate is to provide reflexologists with a more advanced understanding of the anatomy, physiology and pathology of the human body.

The completion of this certificate is recognised internationally and those who certify will be eligible for entry into other schools and training programmes around the world.

Full details are available at
www.reflexologycanada.ca
or by contacting RAC at (204) 477-4909 or
memberservices@reflexolog.org.

Reflexology and Cancer Patients (cont.)

greater in the reflexology group compared to the placebo group.

The researcher understood that the participants in the placebo group could have experienced the relaxation, a sense of calm and comfort because the actual placebo reflexology held its own relaxing properties. This was demonstrated by the components of the quality of life tool, which improved for the placebo group – namely sleep and tiredness. However, the placebo reflexology was not therapeutic compared to reflexology and did not impact on the other components. Nevertheless, the researcher was encouraged by the fact that all the participants enjoyed the experience.

Discussion:

Difference between pre- and post-intervention scores:

There was a significant difference between the two groups ($p=0.004$). This suggested that the group receiving reflexology had an increase in their quality of life in response to the intervention. This was an encouraging finding as it indicated that quality of life, as reported by participants, improved in response to reflexology. This therefore suggested that reflexology could be considered as being a therapy which enhances quality of life.

Impact on quality of life:

Within the placebo group only four quality of life components improved: appetite, tiredness, sleep and micturition. One reason why the micturition result might have improved was due to the fact that one of the participants gave it a high rating

after a urethral catheter was removed. Another important point is that the sample size was so small that it might not have been truly representative.

In comparison to the placebo group, only two of the components in the reflexology group did not demonstrate an improvement. Micturition remained unchanged and concentration showed a reduction. It could be argued, therefore, that reflexology did impact on quality of life, as 89 per cent ($n=16$) of the components demonstrated an improvement. These components, both physical and psychological, were considered important features of quality of life for patients with cancer (Holmes and Dickerson 1987, Hawthorn 1993).

Corner *et al* (1995) reported similar findings using the same quality of life outcome tool, but with aromatherapy massage instead of reflexology. They evaluated the use of massage and essential oils on the wellbeing of cancer patients. Only 33 per cent ($n=3$) in the control group reported an improvement in all their symptoms, identical to the findings in this paper. An earlier study using

Table 1. Visual analogue scale total changes and mean changes calculated for each group

COMPONENT CHANGE	PLACEBO (n=6)		REFLEXOLOGY (n=6)	
	TOTAL	MEAN	TOTAL	MEAN
Appearance	-4	-0.7	2.5	0.4
Appetite	1	0.2	17.5	2.9
Breathing	0	0	13	2.2
Communication (doctors)	0	0	6.5	1.1
Communication (family)	0	0	3.5	0.6
Communication (nurses)	0	0	4.5	0.8
Concentration	-1	-0.2	1	-0.2
Constipation	-3	-0.5	34.5	5.8
Diarrhoea	-2	-0.3	16.5	2.8
Fear of future	0	0	14	2.3
Isolation	-1	-0.2	0	0
Micturition	8	1.3	1	0.2
Mobility	-2	-0.3	4	0.7
Mood	-4	-0.7	3	0.5
Nausea	-3.5	-0.6	11	1.8
Pain	-2	-0.3	13	2.2
Sleep	6	1	5	0.8
Tiredness	12	0.2	14.5	2.4

Reflexology and Cancer Patients (cont.)

Table 2. Frequency of improvement in each component for both groups

COMPONENT	PLACEBO (n=6)		REFLEXOLOGY (n=6)	
	FREQUENCY	PER CENT	FREQUENCY	PER CENT
Appearance	0	0	5	83
Appetite	1	17	3	50
Breathing	1	17	5	83
Communication (doctors)	0	0	2	33
Communication (family)	0	0	2	33
Communication (nurses)	0	0	2	33
Concentration	2	33	4	67
Constipation	1	17	4	67
Diarrhoea	1	17	3	50
Fear of future	2	33	4	67
Isolation	0	0	2	33
Micturition	1	17	1	17
Mobility	1	17	2	33
Mood	2	33	2	33
Nausea	0	0	1	17
Pain	1	17	4	67
Sleep	3	50	4	67
Tiredness	1	17	4	67

reflexology and placebo reflexology (Oleson and Flocco 1993) reported that only 19 per cent (n=3) of participants with pre-menstrual symptoms responded to placebo reflexology.

The only scientific study to examine the impact of reflexology in patients with cancer, also examined the impact that reflexology had on individual quality of life components (Long Yun 1993). These components were incorporated in the VAS. The findings presented within this article differed to those findings of Long Yun (1993). In this study, pain control, relief from constipation and sleep were achieved to a greater extent than Long Yun (1993), yet relief from anorexia and nausea were poorly achieved.

From the comparison in Table 3 the researcher was encouraged by the pain, constipation and sleep results but was disappointed in the anorexia and

nausea components. However, Long Yun had double the sample size.

Pain, constipation, anorexia and nausea were included in the top 11 symptoms causing major distress to patients with cancer (Holmes and Dickerson 1987), but each of these components are considered to be important to incorporate into numerous quality of life scales (Hawthorn 1993). The researcher also had anticipated a greater improvement in nausea and anorexia

based on the findings of Long Yun (1993).

Conclusion:

This study showed that reflexology does have an impact on the quality of life of patients in the palliative stage of cancer. Despite these encouraging results, however, the findings of this study cannot be generalised to the main population due to the small sample size. All the participants benefited from the intervention by being comforted in some way, although the reflexology group benefited more in terms of improved quality of life as perceived by the participants.

Table 3. Comparison of post-intervention results from Long Yun (1993) with this pilot study examining the impact of reflexology on pain, constipation, sleep, anorexia and nausea

COMPONENT	LONG YUN (n=12)	HODGSON (n=6)
Pain	42 per cent (n=5)	67 per cent (n=4)
Constipation	16 per cent (n=2)	67 per cent (n=4)
Sleep	50 per cent (n=6)	67 per cent (n=4)
Anorexia	92 per cent (n=11)	50 per cent (n=3)
Nausea	84 per cent (n=10)	17 per cent (n=1)

Reflexology and Cancer Patients (cont.)

Does reflexology impact on the quality of life of patients in the palliative stage of cancer?

Yes, although it could be debated that both groups benefited because they were relaxed and comforted in some way by the intervention. Nevertheless, the results indicated that the participants who received reflexology reported an improvement to their quality of life.

What are the perceived effects of reflexology?

For participants receiving reflexology, improvement in breathing was the only individual significant result. However, other findings indicated that participants in the reflexology group reported an improvement in 16 of the 18 quality of life components, especially constipation, appetite, diarrhoea, tiredness, fear of the future, pain and nausea.

Should reflexology be available for palliative care patients within a general hospital setting?

The researcher recognised that this was indeed a small-scale study with limitations. Nevertheless, this study would suggest that the provision of reflexology for palliative patients within the general setting could be beneficial. Not only did the patients in this study enjoy the intervention, they were also 'relaxed', 'comforted' and achieved relief from some of their symptoms. Furthermore they demonstrated an improvement in their quality of life.

Recommendations:

The researcher recognised that for the results to be acceptable, a large-scale study needs to be designed. The design should be such that the shortcomings of this study are addressed. The limitations could be addressed by:

- Having a representative sample size.
- Taking into consideration any conventional therapy the patient is receiving, for example, laxatives for constipation.
- Designing the study so that the investigator is unaware of the intervention that the participant is receiving.
- Using all the quality of life components identified within the Holmes and Dickerson (1987) quality of life tool.

For further information on complementary therapies, visit www.healingonline.co.uk

Implications for Practice:

- The results show that reflexology does improve quality of life for patients suffering from cancer. However, a larger scale study needs to be conducted to make the results more valid.
- Reflexology is one of many complementary therapies that can provide benefits to patients. However, it remains an under-represented area within the health service.
- Some nurses already provide some basic complementary therapies such as hand or foot massage, which has implications for training.

Acknowledgements:

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ASK AN EXPERT – INSURANCE CORNER

CAN I PREVENT CLAIMS FROM HAPPENING? No - but you can minimize the chance of a claim happening.

Each year we receive dozens of claims from therapists across Canada. Most of these claims are the result of bodily injury to a client from a slip and fall or an accident within the home or clinic.

Many of these claims cannot be prevented but you can reduce the severity and frequency of claims. Since most claims happen around the home and clinic, the immediate area needs to be maintained and monitored. In the winter a properly cleaned and salted walk is the bare minimum you need to do. In some instances, additional railings or anti-slip surfaces may need to be installed. In the summer walkways need to be clear of debris, toys, etc.

Inside your home or business, make sure there are no loose carpets or stair treads and there are sufficient handrails that are properly installed. A thorough inspection of the furniture in your unit is required on a regular basis, including hinges on cupboards, shelves attached to the walls, mirrors, etc.

With all too much frequency, a claim arises from a treatment table. Tables have collapsed or tipped over due to loose fittings or worn parts. Tables need to be inspected daily and any sign of wear or damage needs to be addressed promptly.

A few moments of prevention is all it takes....

David Stark and Gail Smith are Registered Insurance Brokers with Lackner McLennan Insurance Ltd. They can be reached at 1-800-265-2625 or www.lmicanada.com.

Reflexology and Cancer Patients (cont.)

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The Gift Of Healing - Betty's Story

Author: Jennifer Jupp has been RAC certified since 2000. She currently practices reflexology in Trail, BC.

In a previous issue of this newsletter, in my article titled *Reflexology - Against All Odds*, I mentioned that it was my practice to give gift certificates for reflexology treatments to not for profit organizations for use in fundraising events. Betty's story was born from this practice.

In November of 2001, my mum asked if I would donate a gift certificate to her seniors group for its Christmas raffle. I agreed, and the winner of the certificate was Betty, a woman I had known all of my life.

At the time, Betty resided in an intermediate care facility in my former hometown of Nakusp, BC. I made arrangements to conduct the treatment at her residence. Upon arrival on the appointed day, I had a brief visit with Betty, in order to get reacquainted, before beginning the reflexology routine. Betty was very interested in learning about reflexology and its benefits. I explained that reflexology helped to increase circulation, reduce stress, and promote the natural functioning of the body. After we discussed the fact that Betty had long suffered from insomnia, I added that many clients told me they slept better after a session. Part way through the appointment, Betty's son and daughter-in-law, Joe and

Linda, arrived to visit her. Joe and Linda also had many questions about reflexology. At the end of the treatment, Betty told me how much she had enjoyed it. She asked me to come and visit her the next time I was in town and I told her I would be happy to do so.

The following day I received a call from Linda. She was very excited to inform me that Betty had called to inform her and Joe that she had enjoyed a very sound night's sleep following our session. I was pleased to hear this news — it was, by her own account, the first time Betty had slept through the night in many years! Linda confirmed that the nursing staff at the care facility were used to Betty being up several times every night in the past year. Each time Betty awoke she also had difficulty getting back to sleep. The nursing staff were able to confirm that Betty had slept through the previous night and had been pleased that she had woken up well rested for the first time in a very long time.

I continued to give Betty regular reflexology treatments for the next several years. She always seemed to welcome my visits and enjoy the reflexology sessions and the resulting benefits. I'm sad to say that Betty passed away in the Fall of 2005. I miss her, but the strength of her character and her reminder of the importance of the gift we have to give, will continue to inspire me. The gift of healing gives something in return - that's Betty's story. ❖

Something to say? We're listening!

Canadian Journal of Reflexology publishes articles relating to all areas of reflexology practice, the business of reflexology, and related or complementary treatments. If you have information to share with Canadian reflexologists we'd like to hear from you.

Articles written by RAC members may also be eligible for the RAC Writing Award of \$500 and a one-year RAC membership. Award details are available at www.reflexologycanada.ca.

For submission guidelines contact
editor@CanadianJournalOfReflexology.com or 902.442.3882.

Parlez svp....nous écoutons!

La revue canadienne de réflexologie publie des articles qui se rapportent à la pratique de la réflexologie, les affaires et les médecines douces connexes. Nous sommes intéressés à partager avec nos lecteurs vos idées et vos témoignages.

Les soumissions d'articles provenant de membres risquent de gagner un prix de 500,00\$ ainsi que la cotisation annuelle des frais de membres. Les détails de ce prix d'écriture se trouvent à la page web : www.reflexologycanada.ca

Un guide au sujet des soumissions est disponible.
Contactez 902.442.3882 ou editor@CanadianJournalOfReflexology.com.

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