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Over the past 25 years in the Western world, complementary therapies (CTs) have increasingly been used alongside conventional medical care for people with cancer, from diagnosis, through treatment, survivorship and into end-of-life care. In the UK alone, it is estimated that up to one third of all persons with cancer use CTs in a supportive role (Smithson et al, 2010). Aromatherapy, together with massage and reflexology, is one of the most popular CTs accessed in cancer and palliative care environments and is included in CT service provision in all the leading cancer hospitals in England, Wales, Northern Ireland and Scotland. Until recently, CT services had their own place in the National Institute of Clinical Excellence guidance manual on cancer services (2004); however, this section has sadly been removed from the latest guidance review, with the risk of negative consequences on continued service provision.

The main reasons that most patients with cancer choose CTs such as aromatherapy are to improve their experience of conventional care, to enhance personal well-being and to help manage symptoms linked with the disease or its treatment. Few patients are seeking active treatment options concerning their disease – they are simply seeking reassurance that the therapy is safe, appropriate and that it will serve to complement their ongoing medical care.

From the patient's perspective, one of the biggest barriers to a positive experience of CT is perceived polarization between complementary therapies and conventional medicine (Smithson et al, 2010). This polarization can be experienced by patients at both a professional and institutional level and highlights the delicate and influential relationship the person has with their general practitioner, their oncologist and/or other key members of their medical team. If the person encounters a reluctance to talk about CTs from their doctor, receives mixed reactions or senses hostility towards CTs, it is likely they will be more anxious and/or less likely to access them as part of their supportive care.

Patient involvement, dialogue, clear communication and education are therefore, more than ever, essential for ensuring continued care provision. In the words of Lewith et al (2010) it is “in our interest to create dialogue between conventional and complementary practitioners treating cancer and in particular for oncologists to allow the patient to play an important, active and informed role in managing their illness and survival.”

Through publication of rigorous and pertinent papers that clearly demonstrate the value of aromatherapy provision in cancer and palliative care, medical professionals are better informed as to the safe and positive contributions of essential oils for persons with cancer - whatever the stage of their journey with their disease. Hence choosing cancer and palliative care as the overall themes for this and the following issue of the IJCA.

Rhiannon Lewis


Aromatic insights into palliative and end-of-life care in Japan: an interview with Tomomi Nakamura

Interview with Tomomi Nakamura

nakamura@konohana-aroma.co.jp

Interview conducted by Rhiannon Lewis

Introduction

Tomomi Nakamura is a clinical aromatherapist, Buddhist priestess, chairperson of the Japan Aromatherapy Welfare Support Association (Nonprofit Organisation/ NPO) and CEO of Konohana Ltd (Japan). Her experience as a practitioner spans 20 years and her remarkable contribution to palliative care and end-of-life support in Japan is described in this interview with Rhiannon Lewis.

Interview

Greetings Tomomi, could you please tell us a little about your background, training and work as an aromatherapist in Japan?

I would like to introduce myself. My name is Tomomi Nakamura. I am a clinical aromatherapist and Buddhist Priestess. I am also the chairperson of the Japan Aromatherapy Welfare Support Association (NPO) and CEO of Konohana Ltd (Japan).

In 2000, I established the Aromatherapy Volunteering Group, which then became the Japan Aromatherapy Welfare Support Association (NPO), or ‘JAWSA,’ in 2015. The main activity of JAWSA is to provide aromacare for patients in the palliative and end-of-life care stages, and for the dying and bereavement care of their family at hospices, hospitals and nursing homes. I work to train nurses and doctors in aromacare every month at various hospitals. I also work with training aromatherapists in aromacare for palliative and end of life care services.

In 2001, I established Konohana Ltd. The main activity of Konohana is to offer an aromatherapy clinic on the 52nd floor of the Yokohama Royal Park Hotel. I also provide aromatherapy massages for pregnancy and post-natal care at hospitals as well as importing and selling Atlantic Aromatics essential oils and products.

I completed my training in holistic massage in the United Kingdom during 1998, and then went on to study professional aromatherapy (IFA, IFPA) in Japan in 2000. Since then, I have furthered my knowledge and skills in various places around the world including training in advanced techniques such as Hawaiian Lomi Lomi; hot stone massage;

Figure 1. Aromatherapy clinic at Yokohama Royal Park Hotel
the ‘M’ Technique, advanced massage techniques; reflexology for cancer care; the chemistry of essential oils as well as aromatherapy and massage for pregnancy and babies.

I have been working in aromacare for patients in palliative and end-of-life care since 2000. My starting point and main reason for pursuing aromacare for palliative care with patients was because I gave aromatherapy massages for pain relief and mental support to my mother who received oncology treatment and thus saw first-hand the benefits that aromatherapy could offer.

I make visits to four hospitals, four nursing homes for the elderly and one hospice to provide aromatherapy massage. I have also provided a series of aromatherapy massages for a terminal stage patient alongside nurses in his own home. I teach aromatherapy to nurses and doctors at three hospitals and teach care managers at community general support centres, as well as students at a university. I teach aromacare for palliative and end-of-life care to aromatherapists. I hold aromatherapy workshops and provide aromatherapy massages for patients, their families and medical staff in some events at these hospitals. I also provide aromatherapy workshops to juvenile delinquents within a juvenile restoration support facility at the police station.

I have also joined the department of General Medicine at Nagoya University Hospital as an aromatherapist and Buddhist priestess of integrative health care.

I am currently researching about the score of oxytocin secretion before and after a 60-minute aromatherapy massage with doctors and university professors. Additionally, I write abridged translations of international research papers for a Japanese aromatherapy magazine. My aromatherapy work has since been introduced in the teaching materials of high school students.

**What is the current state of aromatherapy care in hospitals in Japan?**

In Europe and America, it appears that many hospitals and hospices have introduced aromatherapy into palliative care over the years. Unfortunately, in Japan, it is not common for aromatherapy to be used in palliative and end-of-life care in these settings. I have especially not heard about aromacare used within acute-care wards. It is more common to see the use of aromatherapy massage for post-natal patients in the obstetrics and gynaecology departments, inhalations for counselling in hospital psychiatry departments and by means of hand massages for elderly patients within nursing homes.

In hospitals that do provide aromacare in palliative and end-of-life care, there are cases where nurses who have undergone training in aromatherapy are available to provide hand massages and/or inhalations for patients. However, in most cases, they are providing this aromacare during the recesses of their normal duties and/or on holidays and through overtime work. In these cases, it can
be said that continuity to provide aromacare in palliative and end-of-life care is difficult. It is often hard for aromacare to be provided directly to patients by aromatherapists who are not doctors or nurses in hospitals; part of the reason for this is the need to provide confidentiality regarding patient data and/or the maintenance of responsibility in the case of adverse events.

What about end-of-life care and palliative care?

Japan uses the World Health Organisation’s definition of palliative care as reference:

“Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care:
• Provides relief from pain and other distressing symptoms;
• Affirms life and regards dying as a normal process;
• Intends neither to hasten or postpone death;
• Integrates the psychological and spiritual aspects of patient care;
• Offers a support system to help patients live as actively as possible until death;
• Offers a support system to help the family cope during the patients illness and in their own bereavement;
• Uses a team approach to address the needs of patients and their families, including berevement counseling, if indicated;
• Will enhance quality of life, and may also positively influence the course of illness;
• Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Said end-of-life care refers to health care, not only of a person in the final hours or days of their lives, but more broadly encompasses the care of all those with a terminal condition that has become advanced, progressive, and incurable”.

There are palliative care teams such as doctors, nurses, counsellors, pharmacists, nutritionists, social workers and rehabilitation therapists present at hospitals in Japan. However, it is not common that complementary therapies and therefore therapists are included within the palliative care system at this current time.

In Japan, end of life and palliative care is typically delivered as part of the inpatient and outpatient service within hospitals, hospices and nursing homes, as well as in visiting nursing care services. The breadth of this service will usually depend on the facilities and organisations themselves.

There is a health insurance system used in Japan. The patients’ monetary burden is kept below the specified limits under the high-cost medical care benefit system, which compensates for excessive medical costs. There is an advanced elderly medical service system and nursing care insurance service, more of which can be read about via:

www.mhlw.go.jp/file/06-Seisakujouhou-10800000-Iseikyoku/0000056917.pdf

How do Japanese people generally approach issues of death and dying? Are there specific traditional and cultural issues to respect and understand?

There are many traditional Buddhist funerals and Buddhist memorial services in Japan. Many Japanese families will hold a wake (held on the night before the funeral) and a funeral service at a temple and/or a funeral hall when a family member or friend is going to pass away. Afterwards, many friends and family will gather for a Buddhist memorial service on the forty-ninth day after the death and for the 1st, 3rd, 7th and 13th year anniversary of the death. We also go to visit graves during the vernal equinoctial week and the O-bon vacation (a festival of the dead or Buddhist All Soul’s Day, August 13-15), and we pray that the souls of those who have died will find happiness in the next world.

Generally speaking, there is no spiritual care provided within Japanese hospitals. Unfortunately, it is not an accepted common practice to provide traditional Buddhist spiritual care for patients in palliative care. Perhaps due to factors such as the trend towards nuclear families and the aging of
caregivers, at this time, about 80% of people die in hospitals – however, generally speaking, death education has not progressed for nurses, doctors and other medical staff.

There is usually a pastoral care worker only within specifically Christian hospitals. Typically, there is no pastoral care worker present within general hospitals. Therefore, many patients and their family do not partake in spiritual care. The Japanese nursing theory uses the American nursing theory - this method upholds a different view of religion and culture, and so typically, there is a big gap in death education.

Furthermore, many Japanese traditionally have the thought process that they do not want to trouble their family, so they typically endure difficult situations and do not voice their pain or their wishes. Patients often will respect remaining family opinions over their own opinions.

**So would you say that end-of-life care planning is still limited in Japan?**

Many Japanese people hold a negative image regarding death. Because of this, they are often not well prepared for questions such as:

- ‘What kind of medical treatment do I want to receive when I get sick?’;
- ‘Do I want to receive life-prolonging treatment?’;
- ‘Do I want to participate in organ donation?’;
- ‘What kind of funeral do I want?’;
- ‘What about making a will?’.

In more recent years, a Japanese magazine coined the original concept of the word ‘Shu-katsu’. Shu-katsu is a blanket term of activity undertaken to prepare for the end of your life. The phrase was most popular in 2010, then began to gain recognition among Japanese seniors. Recently, there has been an increase in thinking towards starting end of life planning, especially with people over the age of 70. However, people under the age of 60 typically do not think about end of life planning. Their thought processes are geared more towards enjoying living life, such as the maintenance of a good diet, an increased activity in sports and hobbies, and so on - more so than end of life planning.

**To your knowledge, are there any end-of-life care associations in Japan?**

I am more familiar with a few aromatherapy associations and bodies - a great example of this would be ‘Soleil’. Soleil is an aromatherapist-dispatching department managed by the IFPA accredited aromatherapy school ‘Japan Ecole de Aromatherapie’ (JEA). Soleil started sending JEA school graduates to day-care centres for seniors to provide aromatherapy massages in the late 1990’s as a part of their training and the formal set up of Soleil as an institution was in 2004. Their work is centred within many types of institutions, such as obstetrics and gynaecology, palliative care wards, day-care centres and nursing homes for seniors, as well as in centres for mentally challenged people, psychosomatic clinics, visits to nursing stations, osteopathic clinics, and general hospitals. In 2017, the total number of massages provided annually by therapists linked to Soleil came to approximately 8000, and 120 therapists regularly visited 24 institutions between twice a week to once a month on average.

**In your opinion, what are the main benefits of aromacare in hospitals? Where does aromatherapy have the biggest contribution?**

Many patients feel fear, anxiety and have painful thoughts regarding medical interventions within hospitals. In my experience, I think that aromacare provides pain relief, a reduction of anxiety, reduction of tension, helps the healing of mental trauma and increases a feeling of happiness to help improve the quality of life of both patients and their families. It actively supports the maintenance of the patient’s welfare. Aromacare can also benefit the patient’s entourage such as the medical staff by reducing stress and promoting care.

Care is “手当て” in Japanese. “手” is ‘hand’, “当て” is ‘touch’; it means to touch the body with one’s hand. Touching symbolises great care when the individual gently strokes the body and/or holds the hands of the patient.
be treated (hands, feet, facial, back or head), which is then performed on the patient's bed. Patients are encouraged to choose their favourite essential oil; however, I select the essential oil when the person cannot communicate. I will interpret the patient's expression when selecting, and gradually bring the scent closer to their nose in order for them to signal if they enjoy and agree with the aroma. I often use a blend of jojoba and sweet almond oil as a base. The total percentage of essential oils is 0.5%.

I also provide aromatherapy massages to elderly patients at one hospice and three nursing homes once a month. In total, I will work with 30 patients a day. The age of the patients treated range from age 70 to 106. Massages are of 15 minutes’ duration and consist of a hand massage at the patient's wheelchair or bedside.

Aroma mouth care
The mouth care method that I have developed is offered for patients at one hospital. In total, I have treated 30 patients a day since July 2016. The age of the patients range from 40 to 96. All patients are within the palliative care stages. Aromacare for the mouth is added alongside regular oral hygiene care such as mouthwashes or oral care sponges and is used to further clean the oral cavity after every lunch as a mouth rinse. It is comprised of one spray (equivalent to one drop) of Japanese mint Mentha arvensis L (also known as cornmint) essential oil into 300 ml of water.

Japanese mint is classed as a food additive in Japan. Previously, for 9 months, my mouth care formula comprised a hydrosol combination of Eugenia

Which are the essential oils that you find Japanese people most respond to?

Japanese patients tend to like Santalum austrocaledonicum (sandalwood), Chamaecyparis obtusa (hinoki), Lindera umbellata (kuromoji), Boswellia carterii (frankincense), Citrus junos (yuzu), Rosa damascena (rose) and Citrus sinensis (sweet orange). Sandalwood, hinoki, kuromoji and frankincense are frequently used in Sado (Japanese tea ceremony) and Kodo (traditional incense-smelling ceremony) since ancient times in Japan. These essential oils are commonly used and thus familiar in Japan. Elderly patients in particular like and connect with these aromas.

Can you give us some examples of the type of care you provide?

I provide a number of aromatherapy care solutions for my patients, such as massages, mouth care and as an aid for sleep problems as well as making deodorizing sprays for patients in palliative and end-of-life care at two hospitals, one hospice and three nursing homes. Below, I have outlined the processes of each aromacare method in more detail.

Aromatherapy massage
I provide aromatherapy massages to patients at two hospitals. I visit one hospital once a month, another once every two months. In total I will massage around 10 patients a day. The age of these patients range from age 40-96. All patients are in the palliative care stage. In terms of who receives treatment, requests are taken from patients and their families, as well as the doctors and nurses. Massage lasts for 15 minutes and the individual chooses which part of the body they would like to
caryophyllata (clove), Melaleuca alternifolia (tea tree) and Mentha spicata (spearmint) - however these ingredients were not classed as food additives. So, at the request of a nurse, the previous formula was changed to the one that is now used.

**Aroma sleep care**

Aroma sleep care is provided to patients at two hospitals. Many patients have problems sleeping in the palliative care stages. To remedy this, I put two drops of *Lavandula angustifolia* (lavender) and *Citrus sinensis* (sweet orange) oils - one drop of each - on a piece of facial tissue/handkerchief. The nurse will then put this facial tissue near the patient's pillow at 20:00 and remove it at 06:00. This blend helps relax and ease the person into a comfortable sleep.

**Aroma deodorizing spray**

An aroma deodorizing airborne spray is used at each diaper-changing period in two hospitals since 2017. This blend was made in collaboration with seven nurses. It is comprised of *Cymbopogon martini* (palmarosa), *Citrus limon* (lemon) and *Mentha x piperita* (peppermint) essential oils mixed with ethanol and 500ml of water. The total percentage of essential oils is fixed at 2%. We tried several formulations and we opted for this blend, as it most reduced discomfort and embarrassment for patients, their family and medical staff.

**Aroma deceased care**

In Japan, nurses provide post-mortem care after the patient's death. Post-mortem care is called 'Angel Care' in Japanese. After the diagnosis of death by the doctor, the nurses provide general post-mortem care such as removing medical equipment, giving the patient a blanket bath, putting on a kimono, crossing the hands at the chest and providing cosmetic/aesthetic care. Aroma deceased care is additional to this regular post-mortem care. For example, in the blanket bath, six drops of essential oil mixed with bath oil are added to a bucket of hot water for washing the patient. Additionally, in Japan, in order to prevent the drying of the deceased's skin, nurses sometimes use olive oil and/or cream; in these cases, I provide essential oils with the oil and/or cream to apply to the deceased's hands and feet. Beautiful hands are particularly important because they are traditionally crossed over the deceased's chest.

I train nurses and doctors in aromatherapy at three hospitals, and I also teach aromacare in palliative and end of life care for aromatherapists.

**Aromatherapy training for nurses and doctors**

I provide aromatherapy training for nurses and doctors at three hospitals. At one hospital, I have taught classes once a month since 2015, and at another once every two months since 2016, and before that, four times a year since 2014.

Subjects taught cover basic aromatherapy principles, including:

- What is aromatherapy
- How essential oils are obtained
- History and distillation of essential oils
- How to apply essential oils
- General cautions and further topics.

I also teach advanced aromatherapy:

- Introducing the evidence base of clinical aromatherapy
- Aromatherapy care for patients for palliative and end of life care
- How to do an aromatherapy massage for patients
- How to apply essential oils for patients at the hospital and further topics.

I run a workshop that covers an introduction to aromatherapy, wherein I encourage the participant to create items such as massage oils, hand creams,
bath oils, lip balms, insect sprays etc., which is comprised of the individual’s own essential oil blend, to take home with them.

This method of aromatherapy training is to encourage enjoyment of aromatherapy and incorporation of aromacare into the trainee’s daily life. The aim is that nurses and doctors will be able to offer aromacare to patients on a daily basis at their hospital. I would like trained aromacare nurses to be in every medical ward, so that trained nurses can provide specialist care for patients together with aromatherapists.

**Donation of essential oils**

After I have completed aromatherapy training with nurses and doctors, I then make a donation of essential oils, carrier oils, hydrosols etc., to encourage them to continue using it themselves and integrating aromatherapy into their routine care. I would like for nurses and doctors to continuously use aromacare both at home and in the hospital.

**Experience aromatherapy massage**

After aromatherapy training for nurses and doctors, I also give each person an aromatherapy massage. The massage lasts 15 minutes and involves the hands, feet, facial area, back and/or head. My aim is for them to enjoy aromatherapy massage and experience how it can be beneficial in both relaxing the patient and caring for their wellbeing.

Aromacare in palliative and end-of-life care training for aromatherapists

In palliative and end-of-life care training for aromatherapists, subjects covered include:

- The concept of palliative care
- The concept of end-of-life care
- Application of essential oils in palliative care (i.e. massage, inhalations, bathing, mouth care, sleep care, pain care and mourning care)
- The use of essential oils for patients in palliative care as well as other subjects.

In terms of massage training, the most effective techniques are taught in order to benefit patients and includes the location and methods of massage for various body regions and the checking of pressure in touch as well as the speed and softness of each movement.

We also invite and encourage participation by experts from various fields such as palliative care physicians, palliative care certified nurses, chaplains and care workers, to develop and broaden their abilities in their respective work.

I think it is very important to routinely introduce aromacare in palliative and end-of-life care at more hospitals for future medical services provided in Japan. Further to this, I am conducting activities that encourage and promote aromatherapy training for nurses and doctors as well as the introduction of palliative and end-of-life care training for existing aromatherapists.

**How does your role as a Buddhist priestess help you in your work?**

Whilst providing care for palliative care and end-of-life care for patients at the hospital, I then felt the necessity to gain a better understanding regarding perceptions of life and death as well as religious views. For this, I undertook Buddhist studies at university and graduate school for six years, and gained my master’s degree in Buddhist studies in 2018. I became a Buddhist priestess in 2017 and am currently studying under a chief priest at the temple. I aim to complete a Buddhist Clinical Pastoral Education course at graduate school after I
finish my studies at chief priest school. I would like my work to combine aroma, touch and compassion for my patients.

Declining birth rates and the aging population is one of the major social issues facing Japan. Japan's life expectancy is 80.98 for males and 87.14 for females, the highest in the world. There have been many instances in which elderly women have been left alone at end-of-life and who died without family support. As a Buddhist chaplain, I would like to be there for patients and the elderly who are in these circumstances without family to care for them.

My goal is to become a qualified Buddhist chaplain (a pastoral/ spiritual care worker) in order to help patients and their families, as well as medical staff, with not only aromacare and therapeutic touch techniques, but by also having the ability to listen to and care for others in difficult circumstances.

Where do you see the future in Japan with aromatherapy?

In terms of contemporary medical care within Japan, I often feel there is not enough emphasis on holistic healing approaches for patients in hospitals. Medical care needs to cover more than just physical healing - I believe that psychosocial and spiritual welfare needs to be implemented as part of the cure for human diseases. Aromatherapy covers the realm of psychosocial and spiritual relief, and it has been shown to reduce pain, lessen anxiety, reduce tension, help the healing of mental trauma as well as help to maintain feelings of wellbeing, which in turn improves the quality of life of both patients and their family.

I have joined the department of General Medicine at Nagoya University Hospital as an aromatherapist and Buddhist priestess of integrative health care. I am now providing aromacare for patients generally, not just in palliative and end-of-life care. I feel that aromatherapy should play an important role in the fields of medical treatment, nursing, and welfare for all patients in the future.

You recently have experienced aromatherapy as part of your own healing journey. Please tell us more.

I would like to discuss my own experience with aromatherapy healing. In December 2017, I was informed that I had thyroid gland cancer. I underwent surgery and was an in-patient for 8 days in March 2018. During this period, I used aromacare such as inhalations, massages, mouth care, blanket baths and sleep aids for myself in hospital. I was afraid, I was very nervous, and had anxiety and painful thoughts regarding my upcoming medical interventions within the hospital. Aromacare provided me not only with pain relief and a reduction of anxiety, but was also a source of relaxation and helped the healing of mental trauma that were caused by my time undergoing treatment.

In particular, it was a huge source of relaxation when my husband gave me a daily foot massage. Gargling with Japanese mint oil water was effective for my mouth sores after surgery. Inhalations - breathing in, breathing out with an aroma - were a great source of meditation for me, and I was able to feel much calmer after the process. Personally, I was particularly surprised that my aroma preference had completely changed before and after my surgery. In the past, I chose deeply sweet and relaxing aromas like rose, Citrus aurantium (neroli), frankincense, Styrax benzoin (benzoin), sweet orange, sandalwood, kuromoji and lavender and used these prior to my surgery. Post-operatively, I discovered that I now prefer clear and refreshing aromas such as peppermint, Eucalyptus globulus (eucalyptus), Juniperus communis (juniper berry), lemon, hinoki and yuzu.

Although this experience was damaging to my body, I feel it was a great opportunity to truly understand the physical and mental suffering that my patients must go through. It helped me realize again that aromacare helps promote a beautiful and comfortable healing experience and it remains for me a deeply rewarding occupation.