Emergency Reiki
Reiki in Hospitals

"It can't hurt. It may help, and that's my job—to help," says Jay Ferrill, paramedic and second degree Reiki practitioner. Ferrill is one of an increasing number of medical professionals who use Reiki alongside (never instead of) conventional emergency protocols in ambulances, emergency rooms, and acute care centers across the country. Indeed, much of the Reiki offered in hospitals is not made available through formal Reiki programs. Reiki often appears informally as healing moments from the hands of Reiki practitioners who are also medical professionals providing standard conventional care. Since Reiki is drawn as needed by the recipient and requires no diagnostic focus from the practitioner, health care providers can easily and invisibly include Reiki as they go about their care routines. Reiki may be invisible, but the results often are not, especially in critical situations.

Such was the experience of Nancy Eos, M.D., a physician specializing in emergency medicine in a rural Michigan hospital. A seasoned ER doc, Eos brought Reiki into her emergency doctoring as soon as she learned first degree in 1990. Eos began placing her hands on patients more often and watching carefully. A physician who also put herself through law school, Eos wasn't interested in leaps of faith, and she had no vested interest in Reiki's performance, but if Reiki could improve her patients' outcomes, she wanted to know. Eos approached her experience with Reiki critically, observing carefully to see if her patients benefited, and alert for adverse reactions. Over six years of integrating Reiki into standard emergency care, Eos watched the seriousness of the pathology leaving her care diminish. She is convinced that emergency patients who receive even moments of Reiki fare better than those who do not. After offering Reiki, Eos watched patients deviate from the usual medical course. "Their situations improved unexpectedly," Eos says, "following a more gentle course of healing that didn't require procedures as frequently and had less serious outcomes than usual for the same condition." She says, "Patients receiving Reiki almost always improved beyond usual medical expectations."

Of course this can happen with any individual patient. Physicians in clinical care see some patients recover against enormous odds while others fail unexpectedly. Eos's clinical observation was that Reiki improved her patients' chances of recovery. Realizing the enormity of this observation, Eos followed nearly all the patients she treated with Reiki. She dutifully admitted patients to the departments appropriate to the details in their charts. Once the patients were admitted, however, they often improved so quickly that the physicians assuming their care were unsure why the patients were in the hospital. In a large inner-city hospital, this might never be noticed. But in the small hospital where Eos worked, it was.

Nurses started noticing that Eos frequently got responses from patients she treated for conditions that are usually unresponsive, such as trauma or asthma. One bold nurse asked Eos point blank what she was doing because the nurse noticed Eos's patients generally

fared better than those of other doctors. The nurses Eos worked with weren't open to learning Reiki themselves but wanted her to give them Reiki and always brought the most serious patients to her. Eos would frequently hear, "Nancy, come put your hands on this patient."

Occasionally, Eos placed hands on a patient who had been triaged to low priority and realized he or she was worse off than the nurses thought. At first the nurses were incredulous when Eos asked for measures not apparently needed, but after watching the outcomes, they came to trust her assessments. One case involved a woman who had jumped out of a moving pickup truck, the kind that is elevated on large tires. Although the victim was restless, yelling and screaming, there was scant evidence of injury. When Eos touched the patient to soothe her, her Reiki hands responded so strongly she knew there was a crisis. Eos had the nurse change the patient's priority. The increased medical attention uncovered four broken ribs, internal bleeding into the lung, and a cardiac contusion. Reiki seemed to stabilize the patient, and the escalation of medical care saved her life. The patient was sent to the trauma center and released two days later.

Does Eos see any downside to using Reiki in the ER? "There was a time when I went through turmoil trying to figure out how much medicine to use and how much to trust Reiki," she says, "I didn't want to miss giving a medication when I was supposed to, but I also didn't want to overdo the meds. I was constantly contemplating how to walk that line using both Reiki and conventional medicine to come to a better outcome for my patient in an emergency situation." Initially, Eos felt the need to be a medical doctor first and use Reiki later, but she soon learned the shortcomings of this process. TPA, the cardiac medication prescribed to help stop a heart attack, costs $1,000 a shot. When a patient arrived in the ER in cardiac distress, Eos would order TPA and offer Reiki while the nurses prepared the medication. By the time the nurse arrived with the injection, the patient no longer required it. Hospital administration inquired why the prescriptions were made up and not used. Eos realized she had to find ways to implement Reiki while doctoring or risk her reputation for cardiac assessment.

Eos wanted to document the benefit she saw Reiki bring her patients. She discussed research possibilities with her ER colleagues, most of whom were also on staff at the University of Michigan medical school, but they couldn't envision a research strategy. The climate of medical research has changed drastically in recent years. Fifteen years ago, conventional medicine was still disparaging complementary and alternative medicine (CAM). Although Eos had permission to use Reiki as a diagnostic tool, she was told not to document Reiki in the chart lest it create unnecessary complications should a lawsuit be filed. Since research projects must be approved by the hospital's internal review board (IRB), it was pointless to proceed.

Physicians have different solutions to the which-to-do-first dilemma they face as medical professionals and Reiki practitioners. Patricia Bailey, M.D., shared hers in the periodical *Hospital Physician*.[i] According to her account, a thirteen-year-old girl who had overdosed on her mother's tricyclic antidepressants arrived in cardiac arrest at the emergency room where Bailey worked. The patient did not have sufficient vital signs to

be admitted. Nonetheless, the medical team tried for two hours to resuscitate her. With no medical options left, Bailey placed her hand on the girl's forehead to call the code. Bailey was trained in Reiki, and as her hand rested on the girl's forehead, the physician felt Reiki being drawn. The patient's blood pressure rose sufficiently that she was admitted and taken to cardiac care.

Bailey visited the teen after finishing her ER shift that night. The electroencephalogram was flat, indicating the patient's brain was not active. It was expected that the girl would be declared legally dead within twenty-four hours. Although Bailey used Reiki at the holistic health clinic where she worked, she did not usually bring Reiki into standard emergency care. Now that she was a visitor rather than a physician, Bailey felt she could freely offer Reiki. While receiving Reiki, the patient opened her eyes. She was released a week later. Her only lingering symptom was a minimal cranial nerve palsy.

As chief of pediatric acute care at New York City's Lenox Hill Hospital from 1995–2000, Lawrence Palevsky, M.D., F.A.A.P., was responsible for the care of children in the neonatal and pediatric intensive care unit (ICU). He routinely used Reiki to enhance medical outcomes. Palevsky was called into the delivery room as the attending pediatrician whenever there was the possibility that a baby might be born in distress. When this occurred, Palevsky first made sure the infant had adequate airway breathing and circulation. As long as sufficient airway breathing and circulation were maintained, he did not feel the need for medical intervention other than oxygen, even if the baby were flaccid, non-responsive, weak, or not crying. Instead, Palevsky used Reiki, placing hands on the head and torso for at least ten to fifteen minutes while continuing to carefully monitor vital signs. Usually the infant's eyes would open within that amount of time. As vital signs began to normalize, the baby would move around and develop increasing tone in his body. Palevsky was soon able to clean, dry, and swaddle the infant and bring him to the mother, thus avoiding the need for further medical intervention.

Palevsky found Reiki benefited babies born suppressed from obstetrical interventions such as forceps or extractions that were used due to perceived fetal distress, and babies with distress caused by maternal complications, such as cord around the neck or prolonged labor. Whereas the neonatal intensive care nurses were accustomed to intervening, Palevsky, who spent nine years working ICU and ER, used Reiki and watchful waiting. While giving Reiki, Palevsky diligently observed and monitored the babies. Reiki treatment did not interrupt medical care and continued until the baby had clear vital signs that did not warrant further medical intervention. If the respiratory distress didn't resolve or the baby seemed to be getting more distressed, Palevsky would take appropriate medical intervention, continuing Reiki as possible in the neonatal intensive care unit.

Nearly all the distressed or suppressed babies Palevsky treated with Reiki were prevented from being admitted into the ICU. Palevsky always continued monitoring his patients after Reiki treatment stopped and followed them until they went home. None needed further medical intervention. Those that avoided admission to the neonatal intensive care

unit did not deteriorate, and all went home. All babies who went into the newborn nursery had no further medical incidents and went home in a timely manner.

One afternoon, a twelve-year-old boy awoke asking for pain medication the day after orthopedic surgery to insert a rod into his spine. Palevsky went to his bedside and, in the presence of his mother, placed hands under and around the boy's head to offer Reiki. The patient was asleep within minutes, without needing medication.

Palevsky gave Reiki during nebulizer treatment for asthmatic children, infants, and adolescents in the ER, ICU, inpatient unit and in his private medical office. At the same time, he would often teach them how to breathe. Some children with mild wheezing, in fact, responded with Reiki and proper breathing technique and did not need the nebulizer. Palevsky's experience has convinced him that Reiki can safely minimize or avoid medications. Since all medications and medical procedures carry risk, physicians agree, the less intervention, the better.

Even in a medical environment, it's important to remember the distinction between healing and cure. Eos remembers one man who had a dramatic turnaround before dying. The ambulance arrived with a patient whose heart had stopped beating forty minutes earlier and who had not responded to the advanced cardiac procedures used at the scene and en route to the hospital. Since it had been so long, the dispatcher, expecting the patient to be pronounced DOA, sent the ambulance to Eos's hospital even though they did not have an ICU. To avoid hospital charges, Eos jumped into the ambulance to pronounce the patient, touching him as soon as possible, as she always did. Realizing he had been gone for forty minutes and would likely have brain damage if he recovered, Eos immediately removed her hand. Although the patient remained comatose, his heart returned to normal sinus rhythm. The emergency technician was flummoxed. "That was straight line as we were coming in. We tested it twice in the last five minutes to make sure," he said.

The stabilized patient was transported to the nearest ICU, an hour away. He remained stable overnight, and died the next day of complications. The additional time allowed the family to gather and say goodbye. The ICU made it possible to honor the patient's desire to donate his organs.

Eos had other experiences in which she felt Reiki made it possible for patients to have their final wishes honored. An elderly woman with chronic obstructive pulmonary disease had recently been told she could die at any time, and was visiting relatives when she was brought to Eos's ER. The patient refused to be intubated and insisted that she be taken by ambulance to her regular doctor, who was 220 miles away. This happened fifteen years ago, and neither the ER staff nor the patient's primary care physician felt the patient could survive the trip in an old ambulance without intubation under the care of basic EMTs, but the patient was adamant. Eos used Reiki as she was able, and even the patient noticed she felt better afterwards, but the benefits didn't hold. Eos obtained the necessary releases, and the ambulance left in a snowstorm with the patient's oxygen level below 50% (normal is 97–100%). The patient survived the trip and died two days later.

Now in private practice in upstate New York, Eos continues to use Reiki for her patients whenever possible, and finds the experience quite different. She says, “In private practice, the benefit of Reiki is not seen as fast. In the ER, even chronic conditions are always acute, but private practice is an everyday affair. It’s not precipitous, it takes longer, it’s less dramatic.” Healing in non-critical scenarios may also involve emotions that need attention. Eos says, “In emergency care, the immediacy of the crisis makes emotions less important than the physical life and death threat.”

Although Ferrill often felt Reiki sensations in his hands while caring for patients, his situation as a paramedic, and perhaps his temperament as a Reiki practitioner, differed from Eos. As a paramedic, Ferrill was the first line of emergency medical care. His job was to record the chief complaint, its history, and medications, and to assess and, if necessary, stabilize the patient. “Sometimes there would be a lot of care in the home, and then we’d transport the patient to the hospital,” he says, “but the scene time would shorten considerably in cases of trauma, when we’d quickly stabilize the patient and rush to the hospital. Ferrill says, “I was always figuring out what to do next. I’d place a hand anywhere when I would think of it, but mostly I was absorbed in medical thinking, so I wasn’t watching the patient’s response to Reiki in terms of vital signs or even noticing how long I was giving Reiki.” In non-critical moments, Ferrill would let his hand rest on the patient. Although he noticed patients calming down when he did so, Ferrill doesn’t know what to attribute to Reiki and what is just the result of supporting someone in crisis. It was not possible for him to follow patients’ progress once they were admitted to hospital. Ferrill also worked as a paramedic in the ER, which he found similar to ambulance care in that it was fast paced with no time for follow-up. He has never noticed an adverse reaction to Reiki.

Seventy-five per cent of West Coast firefighters are cross-trained as paramedics. In addition to his training as a firefighter and paramedic, Greg Wiley is a first degree Reiki practitioner. “I’m not thinking Reiki until I’ve slowed down a bit,” he says, “but sometimes feeling Reiki in my hands cues me into thinking this would be a good time to do Reiki. Then I realize I already am.” Wiley offers Reiki while seated behind the patient’s head during ambulance transport, and notices Reiki’s instantly calming effect especially on someone who is very anxious, such as an elderly patient who has fractured a hip. Wiley also counts on Reiki to help soothe family members when the patient has died before the ambulance arrives, placing a hand on the shoulder or by the shoulder blade as he offers consolation. In all these situations, Wiley says, “We’re already allowed in their personal space. They’re already open to our help, and Reiki doesn’t distract me from what I need to do.”

A patient with an injury or illness that requires care but is not an emergency may go to an acute care facility, especially if he doesn’t have a family physician or if it is off-hours. Todd Patton, M.D., has worked in acute care settings for seventeen years and has been practicing Reiki for the last year. “I think Reiki can be helpful in acute care,” he says. Patton points out that patients are usually somewhat anxious in a doctor’s office. Anxiety is amplified in urgent care because patients come with an acute illness or injury to be

treated by an unknown doctor rather than their familiar, trusted physician. “The fast pace of urgent care in a clinic setting makes it difficult to take time for extended Reiki treatment, but I place hands as I can,” Patton says. “I have noticed Reiki flowing during urgent care visits. I hold splints longer as they harden to mold them and let Reiki flow. I also sometimes hold an injured area gently as I talk to a patient to take the history before doing the formal exam. Reiki often will flow then.” Although Patton notices a calmness in his patients when Reiki is flowing, he admits that one cannot know how much of it is Reiki and how much of it is just being present with a patient, exuding a calm, open demeanor. There may be no way to ascertain or quantify Reiki’s benefit to patients needing emergency or acute treatment, but equipping medical professionals with healing hands can’t hurt, and may help, and that’s their job—to help.

If you are using Reiki in any medical environment, whether as a Reiki practitioner in a formal program or a medical professional integrating Reiki into conventional care, please tell us about your work by filling out the brief medical Reiki questionnaire at www.ReikiInMedicine.org. There is a direct link from the homepage.

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[i] Bailey P. Healing touch. Hospital Physician. 1997;33(1)42.