

Reiki in hospitals  
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During 17 years of Reiki practice, I have had the opportunity to offer both Reiki treatment and training in a wide range of medical settings. I have been fortunate to collaborate with medical professionals committed to improving patient care by offering non-medical therapies such as Reiki. These colleagues have been invaluable mentors, explaining the inner workings of hospital administration as well as educating me about the concerns such therapies can trigger in physicians, and how best to address them. Implementing Reiki programs in hospitals requires Reiki practitioners to collaborate with people who view disease from a very different perspective than ours, and who also have sincere concern for their patients. In this article, I share my experience in the hopes that you will be encouraged and guided to move forward with a program in your own community. Perhaps you will glean some tips that will speed your path to success.

The healthcare industry in the United States has seen unprecedented changes in the last decade. One of these changes is a shift in the attitude of medical professionals towards the use of non-medical healing therapies such as Reiki. Some providers have seen patients benefit from (or at least not be harmed by) unconventional healing therapies, but even those who have not are becoming increasingly aware that their patients use such interventions. A survey published in *Journal of the American Medical Association* found the American public spends more money out-of-pocket on healing than on conventional doctor visits (Eisenberg DM, Davis RB, Ettner SL, Appel S, Wilkey S, Van Rompay M, Kessler RC. Trends in alternative medicine use in the United States, 1990-1997: results of a follow-up national survey. *JAMA*. 1998 Nov 11;280(18):1569-75.) As a result, physicians of today are less likely to be dismissive of healing therapies outside the medical model than they were just 10 years ago. Physicians of tomorrow are demanding medical school courses on at least the rudiments of complementary and alternative medicine (CAM) in order to feel prepared. These developments give hope that the medicine of the future will be truly integrative, drawing from both conventional, scientific knowledge and the wisdom of traditional, non-scientific approaches.

That cannot happen too soon for Reiki practitioners who work or are seeking to work in hospitals. The desire to relieve suffering is built into every healer. Despite all the benefits hospitals offer, they are repositories of great suffering, not just among patients and their loved ones but also among hospital workers at all levels.

Reiki offers benefits to both patients and their care providers. Reiki brings rapid relief from pain and anxiety, and a calmer, more centered patient is easier to treat. Patients who practice Reiki self-treatment become better partners in their healthcare, more engaged in the healing process. Starting with the very first class, those who learn Reiki are never again alone and helpless with their pain. Care providers who practice Reiki self-treatment can relieve their own stress and refresh themselves so they can function optimally and not feel drained by their patients and the many pressures they face.

Reiki has no medical downsides, no known contraindications. When a full treatment is not feasible, even moments of Reiki during a medical procedure can make patients more comfortable and may facilitate recovery afterwards. Reiki treatments for patients facing chronic illness, especially during long-term and invasive courses of treatment such as chemotherapy or radiation, may significantly improve quality of life and outcomes. The health benefits of stress reduction are well-documented, and existing research provides some evidence that Reiki, even in self-treatment, can reduce stress.

Reiki can be integrated into conventional medical care in three ways:

1. Physicians can recommend Reiki to patients, or refer patients to specific practitioners they know.
2. Medical or non-medical practitioners can give Reiki to patients in medical environments as brief Reiki touch during conventional procedures, as full stand alone treatment, or as part of a research study.
3. Hospital-based programs can give Reiki training to staff, patients, family members, and other caregivers.

The process of integration is supported by educating medical students. During my seventeen years of Reiki practice, I have participated in all of these paths to medical integration, offering Reiki to patients (sometimes during surgery), collaborating in the design and implementation of research (including an NIH-funded study), creating programs where people with HIV or children with cancer or sickle-cell anemia learn First Degree Reiki, training physicians and educating medical students. Although I value every aspect of bringing Reiki into conventional medicine, I have found the greatest satisfaction in creating hospital-based programs offering Reiki instruction to patients. The desire to empower my clients to heal themselves was what motivated me to become a Reiki master.

From the early years of the AIDS epidemic, I felt drawn to train people living with HIV/AIDS (PLWA). The wide-ranging suffering wrought by this horrific disease deeply touched me. When a student of mine became program director at Gay Men's Health Crisis (GMHC) in New York City, I was grateful for the opportunity to teach the clients First Degree Reiki.

Even with strong organizational support for the classes, discussion was needed to align the classes with GMHC policies and procedures. For example, there was no funding available for the classes and GMHC has a policy not to charge clients for services. Mindful that an exchange of energy between the students and the Reiki master supports the process of healing, I sought to implement an exchange that would honor Reiki and engage the students without violating GMHC policy. Waiting for funding was not an option. Fundraising was directed at research or providing necessities such as food or counseling clients how to navigate government aid. The possibility that funding would be forthcoming for an unknown, unproven intervention was nonexistent.

For my part, I felt content to offer the classes initially as community service. The exchange was clear to me—the clients would get to learn Reiki, and I would get to

demonstrate that Reiki self-treatment can benefit even those who are seriously ill. GMHC agreed to implement a research project to evaluate our results. Yet I knew the value of engaging people in their healing process. Recognizing that self-expression is open to anyone at any level of skill, and is itself beneficial, we invited students to create an article of self-expression—such as a poem, artwork, or simple statement of intention—and bring it to class.

GMHC provided clients a hot midday meal. Margo Davis (a student who later became a Reiki master) visited GMHC during lunch for a couple weeks before the class to enroll clients. She set up a table with information about Reiki and a class schedule and invited everyone who expressed interest. We made it clear that no one would be able to join the class once it had started, and that it was necessary to attend all 4 sessions in their entirety. A staff member who knew the clients helped Margo enormously by targeting those who were both likely to be interested and able to participate in group classes. This support was invaluable to the success of the enrollment process. Family members, partners and caregivers were invited to participate in the classes.

To support the clients' needs, we organized the classes around the meal. Class met for 4 hours daily, for 4 consecutive weekdays. The continuity of meeting everyday created a retreat-like experience, and the long sessions meant that there was lots of time for students to share. Even now, PLWA frequently suffer substantial alienation; their marginalization was far worse ten years ago. Consequently, many of the clients had not been involved in group activities since becoming ill. The students bonded readily in Reiki class, often feeling so good about their participation that they subsequently joined support groups. We also held Reiki reunions periodically. It was very gratifying to see how many of the students continued using Reiki and to hear their stories. In those days before the advent of protease inhibitor combination therapies, many students used Reiki to support themselves through serious medical crises. In the midst of severe chronic illness, students frequently expressed gratitude for simply feeling better about themselves, which they attributed to their Reiki practice. At a time when it was not uncommon to lose a friend every month, the students shared poignant stories of seeing Reiki bring peace and comfort to their dying friends. They also spoke of how being able to relieve friends' suffering helped the students bear the loss.

Teaching at GMHC led me to meet Robert Schmehr CSW, a Reiki practitioner and longtime meditator who worked in the HIV/AIDS clinic of New York City's Beth Israel Medical Center. This clinic took a comprehensive approach to patient care, offering mental health, case management and dental, as well as medical, care. In addition to this well-rounded program, Robert was creating a complementary therapies program to offer the clients Reiki, music therapy, shiatsu, meditation and yoga. After an initial meeting with the psychiatrist and other therapists, Robert invited me to present Reiki as an in-service to clinic staff in November 1996.

This was my first presentation to medical professionals. It felt like an entrance exam and I wanted to be well-prepared. Robert generously shared his experience, expanding my awareness of the disease and of the harm-reduction model of care. He sensitized me to

the specific medical and psychosocial needs of the clinic's patients. The patients at this inner-city HIV clinic largely came from an underserved population. Most of them were infected by injection drug use or through being a partner to an injection drug-user. Patients typically had multiple diagnoses, often including psychiatric disorders. Their histories frequently included sexual abuse, domestic violence and incarceration. About 80% of the patients were male. Robert's expertise and my experience at GMHC gave me the information I needed to explain to clinic staff how Reiki could benefit their patients.

I took a deliberately conservative approach to the presentation. Mindful of the aversion scientists have to illogical thinking, I carefully structured my presentation. At the very beginning, I acknowledged that I have no medical credentials and that I viewed Reiki as a way to support the very good medical care offered at the clinic. Then came a description of Reiki in simple, straightforward language, drawing on medical understanding of stress reduction. While acknowledging Reiki as a spiritual healing practice, I was careful to avoid unnecessary metaphysical references that might be controversial. I gave an overview of the research to date, admitting its limitations. Knowing I was speaking primarily to clinicians, I shared anecdotes from GMHC classes and explained that Reiki poses no evidence- or reason-based risk to patient safety. Then I offered the staff an experience of Reiki. Walking around the room placing one hand on a head, I offered Reiki to two people at a time. (Most people will experience something with even 30 second exposure to one-handed Reiki.) Participants were then invited to share what they experienced in their brief encounter with Reiki. In most such presentations, a few participants mention feeling heat, noticing a change in breathing, or feeling calmer or more centered. The session ended with questions. The Beth Israel presentation was well received and the staff agreed to offer Reiki classes at the clinic. The presentation was so successful that I continue to use this basic format.

I learned from this experience that medical professionals are often reluctant to expose themselves before their colleagues. For example, a doctor who remained silent at this first in-service later joined one of my private Reiki classes. Once convinced he was in a room of like-minded people, he spoke freely of his introduction to Reiki. He had come to the hospital presentation in the second day of a migraine, which resolved during his moments of Reiki touch. He had not, however, felt comfortable sharing such a dramatic experience with his colleagues.

We again faced a lack of funds when starting the hospital program. Robert and I felt strongly that practitioners needed to be paid if Reiki were ever to be taken seriously in hospital medicine, but we also knew it would be easier to attract funding with a documented track record. I chose to trust Robert's vision of a fully funded program, and started teaching. Although the classes were time-consuming (I taught First Degree Reiki in 4.5 hour sessions given on 4 consecutive days, allowing extra time for the evaluation process), I was learning so much through this work, and it was expanding my Reiki so dramatically that it did not feel unbalanced to teach the first classes pro bono. We instituted a program evaluation to document the students' experience of Reiki. Robert was eventually successful in funding the program so that practitioners are compensated.

Robert met with patients referred by their physicians for a complementary therapies assessment. Those patients who were able to participate in group classes in a meaningful way were invited to join the program. As at GMHC, having someone on staff who knew the clients and could assess their readiness for participation was critical to successful enrollment.

In both the GMHC and hospital-based HIV Reiki programs, approximately one-third of those who enrolled didn't show up for the first class. Dropouts are very common in HIV services, where clients often feel poorly and frequently have to travel long distances to receive care. Staff members were surprised by the high rate of completion among those who made it to the first class.

Once the program was under way, I stayed in touch with the clinic physicians, letting them know I valued their feedback and suggestions. The physicians reported no downside to the program. They noticed patients practicing Reiki self-treatment evidenced reduced stress and pain, improvements in sleep and digestion, and seemed to handle life better. Patients felt more stable and were more reasonable in their interactions with medical caregivers. Some highly motivated patients were able, under their doctors' supervision, to reduce psychiatric medications. Other patients became more open to using what conventional medicine offered, perhaps because they felt less overwhelmed, or perhaps because Reiki helped manage side effects. Many patients used Reiki to support their recovery from substance use, so vital to maintaining health. These improvements may be attributable not to Reiki touch alone, but also to the empowerment of self-treatment, the ability to access healing directly.

These staff observations were very similar to those reported by Eileen Chapman and Geraldine Milton of the Reiki Journey Clinic at Windana Community Centre in Melbourne, Australia, a drug and alcohol withdrawal facility. It is encouraging that in both situations, the observations were made by healthcare professionals who were not Reiki practitioners.

As the director of complementary therapies, Robert observed that both patients and medical staff responded to the program. In addition to noting concrete benefits in pain and stress management, Robert saw the Reiki program teach patients to experience themselves as something more than just a body in pain. He noted the profound impact of engaging patients in such a metaphysically-oriented dialogue in a credible hospital setting. Robert also noticed that medical providers often began to think beyond the mainstream medical model when they observed improvements in their patients' functioning and well-being. Robert cautioned that Reiki is not a panacea. Not everyone will respond to training, or be able to notice the powerful and sometimes subtle improvements Reiki brings.

Robert also created a complementary therapies treatment program offering Reiki, shiatsu, and cranial-sacral therapy, which is currently supported by both private and public funding. We wrote policy describing the training and experience required of Reiki practitioners offering treatments at the clinic. We also wrote ethical guidelines for

practice. In order to avoid unnecessary confusion for those clients learning Reiki in the clinic, we standardized treatment protocol to that which was taught in class. Although some clients are very regular in receiving Reiki, shiatsu is a much more popular treatment at the HIV clinic.

The Reiki program was later expanded to St. Lukes-Roosevelt Hospital Center. I have also created classes for children with cancer or sickle cell anemia, their families and caregivers at Columbia Presbyterian Medical Center. The establishment of such programs is a very slow process. Sadly, Reiki classes are not currently being offered at the clinics. Budget cuts have required staff to take on more duties. Successful enrollment in an underserved population involves a painstaking process to identify patients who can both value the class and participate comfortably in it. This process requires a considerable commitment of staff time, time which is currently not available.

Documentation supports the integration of Reiki into conventional medical settings. A 7 month follow-up survey was instituted at GHMC using a questionnaire I designed with a staff researcher. The data were unfortunately lost when GMHC relocated, but not before we did some preliminary data assessment. The survey pointed to a direct relationship between Reiki practice and functioning, and an inverse relationship between Reiki practice and pain. Immediately after the class, students reported practicing Reiki self-treatment daily. They also reported high functioning in daily life, and low levels of pain. Over time, the surveys showed their Reiki practice became less consistent. Irregular self-treatment was soon accompanied by reduced functioning and increased pain. Perhaps because the students were feeling poorly, they then began practicing Reiki more regularly; we again saw increased functioning and decreased pain.

After consulting with a senior researcher in touch therapies, I designed a program evaluation for the hospital HIV classes. As with the GMHC survey, student participation was voluntary. It is neither ethical nor is it good science to require students to be involved in any kind of research. Participating students completed 2 written questionnaires, standardized scales that have proven research validity, before and after 20 minute Reiki practice sessions on the third and fourth day of four consecutive class sessions. One practice session was self-treatment; on the other day, students received treatment from another student randomly assigned. One questionnaire assessed pain and the other measured anxiety. The results of the program evaluation were reported in the March 2003 issue of the peer-reviewed medical journal *Alternative Therapies in Health and Medicine* (available on MEDLINE or at [www.pamelamilesreiki.com](http://www.pamelamilesreiki.com) under references and resources/articles). We found a significant reduction in both pain and anxiety after 20 minutes of Reiki treatment. Self-treatment and treatment from another student gave the same improvement.

Practitioners who want to bring Reiki into conventional medical settings such as hospitals, nursing homes, and hospice would do well to become familiar with existing Reiki research. Few studies have been reported, and most are flawed but the number of Reiki studies is growing, and the quality improving, in part because of the increasing availability of funding for research on unconventional treatments. The most useful Reiki

studies reported through 2002 are summarized in “Reiki: Review of a biofield therapy—history, theory, practice, and research,” published by the peer-reviewed medical journal *Alternative Therapies in Health and Medicine*, March 2003. (This paper is now available for download from my website [www.pamelamilesreiki.com](http://www.pamelamilesreiki.com), under references and resources/articles.) Information about current Reiki research funded by the National Center for Complementary and Alternative Medicine (NCCAM), of the National Institutes of Health (NIH) is available at <http://nccam.nih.gov/>. The public can search the Complementary and Alternative Medicine (CAM) section of PubMed at [www.ncbi.nlm.nih.gov/PubMed/](http://www.ncbi.nlm.nih.gov/PubMed/) without charge.

Reiki practitioners wanting to do research often approach me for advice. My advice is very simple—collaborate with a professional researcher and a physician working in the population being studied. Sound research will help conventional medicine appreciate what Reiki can offer patients, but individuals who are not trained in research methods are unlikely to be able to design and conduct studies that will have credibility in the medical community. Even conventional physicians and nurses are poorly equipped to engage in research unless they have specific training in research methods. All research involving human subjects (not just patients but also students, workers, and others) must be approved by an Institutional Review Board for Research with Human Subjects (IRB). Researchers must submit a detailed written description of their research, how they will conduct it, and why, to the IRB of the institution(s) where they will do their research. They must also obtain formal informed consent from every subject, and the consent document must conform to IRB requirements. In addition, special consent must be obtained for the collection of personal medical data.

Those who are seriously interested in conducting research might consider attending the two-day workshops offered by the Touch Research Institute (TRI) of the University of Miami medical school. More information about the seminars, and about the extensive research done by TRI is available at the website [www.miami.edu/touch-research/](http://www.miami.edu/touch-research/). Although the studies done by TRI are not specifically Reiki, they can help potential Reiki researchers to understand the problems of developing a research question, creating a study design, and measuring the effects of an intervention.

Although the importance of research in bringing Reiki into hospitals is clear, the value of documenting the benefits of both treatment and training programs is often overlooked. Something as simple as showing that Reiki-treated patients have greater satisfaction and comfort while undergoing medical treatment than patients not given Reiki can be significant in winning the support of hospital administration. Positive changes in the behavior of clinic patients can be tracked by gathering statistics regarding adherence to care, such as showing up for appointments, taking medications and, when applicable, maintaining sobriety. Presenting data that compare hospital stays of patients using Reiki to those of similar patients who do not use Reiki demonstrates not only the benefits of Reiki but also an appreciation of what is important to both hospital administrators and insurance companies.

I encourage Reiki practitioners to write up case reports that credibly document the use of Reiki as part of a comprehensive treatment program. This may be best accomplished in collaboration with a medical provider. Guidelines are available on my website [www.pamelamilesreiki.com](http://www.pamelamilesreiki.com) under references and resources/articles—“The Bridge to Conventional Medicine.”

Reiki practitioners who serve people with chronic illness know that Reiki is a natural support to conventional medicine. But Reiki will be welcomed into conventional medical environments only when medical professionals and administration recognize the benefits this gentle and deceptively simple practice offers. Our challenge as Reiki practitioners is to communicate these benefits in a respectful way to medical caregivers and administration. We must cultivate patience and clarity so that we can present Reiki—the practice, the theory, and our clinical observations—simply, without making undocumented claims or raising controversial issues, leaving room for others to draw their own conclusions. If we can do that, we can establish relationships with gatekeepers that will enable us to carry Reiki into medical environments and alleviate a much broader scope of suffering than can be touched by private practice alone.

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If you are offering Reiki in a medical organization, please email me a description of your program, where it's located (include contact information) and how long it has been in existence. Perhaps we can include it in a future “Reiki in Hospitals.”