



# Feasibility of Energy Medicine in a Community Teaching Hospital: An Exploratory Case Series

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**W**e came across the following article on the website of The Journal of Alternative and Complementary Medicine and want to share it with you, our readers. It is reprinted with edits for length from *The Journal of Alternative and Complementary Medicine*, published in Volume: 21 Issue 6: June 2, 2015. It was specifically offered as “open research” that could be reprinted and read by the public. The complete article can be viewed at [www.online.liebertpub.com/doi/full/10.1089/acm.2014.0157](http://www.online.liebertpub.com/doi/full/10.1089/acm.2014.0157).

The researchers used an interesting methodology—they recorded the results of one specific energy medicine practitioner applying his unique technique to patients in a community hospital setting. Charlie Goldsmith, the practitioner followed in the study, uses an energy healing technique that he was “gifted” with. This research is of interest and beneficial to all of us in the Energy Medicine field regardless of the technique we use.

## Summary of Study

**Background:** Energy medicine (EM) derives from the theory that a subtle biologic energy can be influenced for therapeutic effect. EM practitioners may be trained within a specific tradition or work solo. Few studies have investigated the feasibility of solo-practitioner EM in hospitals.

**Objective:** This study investigated the feasibility of EM as provided by a solo practitioner in inpatient and emergent settings.

**Design:** Feasibility study, including a prospective case series.

**Settings:** Inpatient units and emergency department.

**Outcome measures:** To investigate the feasibility of EM, acceptability, demand, implementation, and practicality were assessed. Short-term clinical changes were documented by treating physicians.

**Participants:** Patients, employees, and family members were enrolled in the study only if study physicians expected no or slow improvement in specific symptoms. Those with secondary gains or who could not communicate perception of symptom change were excluded.

**Results:** EM was found to have acceptability and demand, and implementation was smooth because study procedures dovetailed with conventional clinical practice. Practicality was acceptable within the study but was low upon further application of EM because of cost of program administration. Twenty-four of 32 patients requested relief from pain. Of 50 reports of pain, 5 (10%) showed no improve-



ment; 4 (8%), slight improvement; 3 (6%), moderate improvement; and 38 (76%), marked improvement. Twenty-one patients had issues other than pain. Of 29 non-pain-related problems, 3 (10%) showed no, 2 (7%) showed slight, 1 (4%) showed moderate, and 23 (79%) showed marked improvement. Changes during EM sessions were usually immediate.

**Conclusions:** This study successfully implemented EM provided by a solo practitioner in inpatient and emergent hospital settings and found that acceptability and demand justified its presence. Most patients experienced marked, immediate improvement of

Even though mechanisms of EM have not yet been established in terms of biomedical science, theories have been advanced,<sup>10</sup> and EM is increasingly being offered to both inpatients and outpatients by major hospitals. The growth and acceptance of EM have resulted largely from patient satisfaction, with some surveys reporting the percentage of “satisfied users” as high as 98%.<sup>11</sup>

Many forms of energy medicine are practiced by trained practitioners within specific traditions, such as Reiki, Healing Touch, and Therapeutic Touch. In addition, however, some solo practitioners discover

*EM is increasingly being offered to both inpatients and outpatients by major hospitals.*

symptoms associated with their chief complaint. Substantial practicality issues must be addressed to implement EM clinically in a hospital, however.

### Introduction

Energy Healing and Energy Medicine (EM) are terms derived from the theory that a subtle biologic or spiritual energy surrounds and permeates the body and can be influenced for therapeutic effect.<sup>1,2</sup> Known by various names in 97 different cultures,<sup>3</sup> the concept of energy healing has been recorded throughout history. The National Institutes of Health includes energy healing therapy in its list of popular complementary and alternative medicine (CAM) methods.<sup>4</sup>

Practitioners of EM treat the patient in close proximity (often with minimal or no physical contact) as well as at a distance (from a different room or even a different time zone). Studies have shown EM to improve pain, anxiety, wound healing, functional status, blood pressure, immune function, relaxation, well-being,<sup>5</sup> cancer outcomes,<sup>6,7</sup> fatigue, mood,<sup>2</sup> fibromyalgia, phantom limb pain, and carpal tunnel syndrome.<sup>8</sup> No report was found in the published literature of increased mortality, morbidity,<sup>8</sup> or serious adverse effects,<sup>1</sup> although some caution in patient selection is advisable.<sup>9</sup>

their ability to effect positive health status changes and practice EM without or in addition to formal training. Many studies have investigated trained practitioners from various schools,<sup>12,13</sup> but few have explored how solo practitioners (those unaffiliated with a particular system of EM) can feasibly be integrated into clinical care.

Bowen et al.<sup>14</sup> suggest that feasibility studies are valuable when few published studies or data exist for a particular intervention and the sociocultural context of an intervention is unclear. Both of these considerations apply to patients and providers at community hospitals with respect to interventions involving solo EM practitioners. Bowen et al. believe that feasibility studies can lay the foundation for more rigorous research of therapeutic interventions by exploring their acceptability, demand, implementation, and integration, among other factors. Investigations for these dimensions of EM are needed to make future research in community hospital settings possible.

The present study investigated the feasibility of implementing EM with a single solo practitioner in the conventional inpatient, outpatient, and emergent settings of a community teaching hospital. Aspects



of feasibility examined were acceptability, demand, implementation, and practicality, assessed in part through clinicians' qualitative responses.<sup>14</sup> The study also documented conventionally recorded clinical changes immediately following EM.

## Method

This feasibility study and prospective exploratory case series were conducted at Lutheran Medical Center, a full-service community teaching hospital located in Brooklyn, New York. The hospital's institutional review board (IRB) approved the study by expedited review in 4 days. The last author (K.J.) was the administrator of the IRB but was not a voting member or reviewer of the IRB. He was asked to meet with the medical director, the chair of the IRB, and the vice president for professional affairs to answer questions about EM, the practitioner, and the study before approval.

A solo EM practitioner with 14 years of experience who had recently seen patients at the YinOva Center, a holistic wellness center in Manhattan, provided the EM sessions. The director of the YinOva Center (J.B.) founded the inpatient acupuncture program at Lutheran Medical Center in 2003 and was a trusted colleague. The decision to work with the EM practitioner and conduct the study was based on the director's experience with and knowledge of his work. While Lutheran Medical Center had osteopathic residency programs and an osteopathic medical school onsite, was oriented toward whole-person care (body, mind, spirit, and community), and was open to CAM,<sup>15</sup> no CAM or EM programs other than osteopathy and acupuncture existed at the time of the present study.

The EM practitioner was oriented to the medical center by the Volunteer Department, through which he was processed. The last author (K.J.) approached the physician unit leader and head nurse manager of three patient centers in the hospital to obtain permission to conduct the study on their units. Permission was granted for all three, after which this author conducted a brief in-service training for the unit's physicians, nurses, and allied health staff. The forms of energy medicine and the process of the study, includ-

ing inclusion and exclusion criteria, were explained in a session lasting 15 to 30 minutes, depending on questions. The process of approaching the units and obtaining approval took about 2 weeks.

After the training, any health professional on the unit was eligible to identify a patient for potential inclusion, a process that took an additional week and required personal encouragement by the last author to initiate. The EM practitioner was supervised by attending physicians, residents, and nurses in study locations. Study physicians and the patient's attending physician approved each patient's participation and verified inclusion and exclusion criteria. Approved patients were approached by a member of the study team to obtain informed consent. Outpatients and nonpatients were evaluated and enrolled in a similar way.<sup>9</sup>

Using their clinical judgment, physicians identified as potential participants adult patients, employees, or friends or family of employees who had signs and symptoms that were not responding to traditional medical therapy or were only slowly responding. Patients deemed to have secondary gains for their medical condition or who were unable or unwilling to communicate with the research team regarding the effects of the energy medicine session were excluded from the study. Assessments by which improvement was typically gauged in this clinical setting were specified for each individual patient on the basis of the judgment of his or her treating physician.

During each session, the solo EM practitioner was accompanied by a research team member and usually by other hospital staff already working with the patient, such as a nurse. Pretreatment assessments were made and recorded by a research team member with respect to the patient's expressed chief complaint. The EM practitioner was introduced to the patient and inquired about symptoms and goals for treatment, sitting at the bedside or in proximity to the patient. He sometimes positioned his hands over the affected area. No physical contact occurred between him and the patient. This generally lasted





for a minute or two at a time, allowing the practitioner to receive ongoing feedback from the patient. He repeated the process several times as needed to address different problem areas, adjusting his method on the basis of information supplied by the patient. For some patients, the practitioner “energized” water that the patient then drank. This was done as follows. While with the patient, the practitioner placed his hands in proximity to a cup of water already in the patient’s room and mentally directed energy to it without touch, in the same way as with the patient. The patient would then drink the water.

At the session’s conclusion, post-treatment assessments were recorded by the research team; these assessments of pain and other clinical indicators were carried out according to the hospital’s standard of care. Some patients received additional sessions as reported in the tables, depending on improvement, availability, and the patient’s wishes.

Summary descriptive statistics were created for two subgroups of patients: those with complaints of pain and those requesting help with symptoms or signs not related to pain. Improvement of pain was rated as none (no change), slight (pain scale improvement of 2 points or less, or qualitative rating only), moderate (pain scale improvement of 3–5 points), and marked (improvement of 6 points or more). Pain that resolved completely (pain scale score, 0 of 10) was also classified as a marked improvement. Improvement of symptoms and signs other than pain was also rated on a scale of none, slight, moderate, and marked. The system by which standard assessments in our setting

*For some patients, the practitioner “energized” water that the patient then drank.*

were converted into this rating scale was developed by consensus of all authors.

Acceptability of EM was investigated by determining whether physicians would recommend patients for the study and whether patients would accept such treatment. Demand was investigated by recording the complaints for which patients and physicians requested EM sessions. Implementation was investigated by assessing whether the study’s in-service and referral system resulted in a manageable number of sessions. Practicality was investigated by assessing the resources, time, staffing, and credentialing needed to carry out the study.

The chi-square or Fisher exact test was used to determine significance of differences between assessments of change by subgroup of demographic and clinical characteristics.

### Results

Thirty-two patients were treated with EM as part of the study. The 24 patients who requested relief from pain had a mean age of 55.5 years (range, 25–87 years). Four (17%) were male and 20 (83%) were female. Eighteen (75%) were inpatients, and 6 (25%) were outpatients or employees. To view Table 1, Results of Energy Medicine with Pain, [click here](#). Of the 50 individual reports of pain, 5 (10%) showed no improvement; 4 (8%), slight improvement; 3 (6%), moderate improvement; and 38 (76%), marked improvement.

Twenty-one patients had a wide variety of issues other than pain. To view Table 2, Effect of Energy Medicine on Symptoms Other Than Pain, [click here](#). Their mean age was 59.9 years (range, 22–87 years). Eight (38%) were male, and 13 (62%) were female. Seventeen (81%) were inpatients, and 4 (19%) were outpatients or employees. Of the 29 non-pain-related symptoms and signs, 3 (10%) had no, 2 (7%) had slight, 1 (4%) had moderate, and 23 (79%) had marked improvement. Assessments of change did not differ by sex, age, location of symptoms, use of charged water, or severity of symptoms in either the

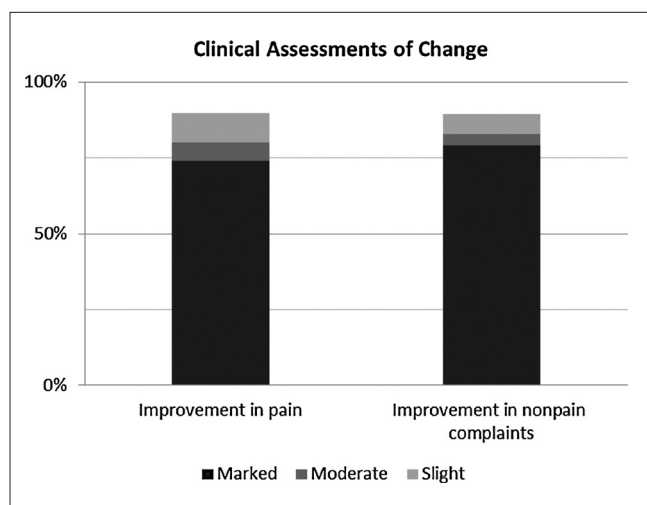


FIG. 1. Percentage of assessments of improvement in patients with pain and nonpain complaints.

pain or the nonpain group ( $p>0.05$ ). The accompanying physicians noticed that when change took place during an EM session, that change was immediate.

Regarding acceptability and demand, physician referrals came largely from a small group of early adopters on each unit and, within 2 weeks of the first in-service, training met the capacity of the single EM practitioner. Most patients were favorable to EM once approached. Those who declined EM did so for various reasons: religious beliefs, pain so intense they did not want any interaction, “not wanting to be bothered,” or a conviction that it would have no benefit (nonbelief). Most patients who found improvement exhibited both relief and surprise, to varying degrees. Some felt disappointment after an unsuccessful attempt, but most patients in whom the intervention was unsuccessful were neutral, perhaps an indication of low pre-intervention expectations.

Implementation of EM was smooth. The study team found no significant change introduced by the EM sessions in their routine medical practice because it dovetailed with conventional goals of care and clinical assessments of progress. A few referring physicians commented that the speed of recovery was enhanced

in patients who perceived positive clinical results; most did not inquire about the outcome. Regarding practicality, the study was practical in our setting because it was time limited, relied on assessments physicians typically make, and was staffed on a volunteer basis. The resources determined from carrying out the study that would be needed to implement EM as a formal program in the hospital were not available on the hospital's tight operating budget; thus, this EM program was not practical in our setting outside the study.

### Patient example 1

Patient 31 was a 45-year-old woman with a diagnosis of metastatic breast cancer since 2003. Given the progression of her disease, pain became a major morbidity. On this admission, she presented with severe upper abdominal pain that had worsened in the previous 2 days. She reported that pain intensified with movement or touching of the affected area. During EM, she lay on her bed. In the room were two medical attendings and the EM practitioner. On initial assessment, the patient stated that her abdominal pain was improved to a score of 6 of 10 since admission but that she had significant (7 of 10) mid-lower back pain. The practitioner placed his hands approximately 10 inches above her right upper abdomen for approximately 20 seconds without touching her. Immediately afterward, she rated the abdominal pain to be 0 of 10. He addressed her lower back by placing his hands several inches over her umbilicus, after which she reported a pain score of 0 of 10. The practitioner asked her about the location of the cancer and did further work on the liver area. The patient was reassessed 15 minutes later and reported a sustained relief from pain in both areas.

### Patient example 2

Patient 24 was a 72-year-old woman who presented to the emergency department with bilateral worsening knee pain, inability to walk, and inability to bend her knees. She had been told that she needed bilateral knee replacements, but her cardiac status contraindicated surgery. The patient arrived with her husband, who was sympathetic to her pain and frustrated by her inability to ambulate and the ineffectiveness of her



pain medication. Before EM, her pain was 10 of 10 in both knees. She had less than 5 degrees of active range of motion. Passive range of motion was 3.5 degrees in the left knee and 0 degrees in the right knee. After the session, her pain was 0 of 10, and she had full active range of motion in both knees. She stood up and walked with a cane, smiling. Her husband applauded and said that he hadn't seen her do this in many years.

## Conclusion

The authors found the results of this feasibility study encouraging regarding the acceptability, demand, and implementation of energy medicine in an inner-city

*The authors found the results of this feasibility study encouraging.*

community hospital setting. The practicality of carrying out a study with a single volunteer practitioner was good, albeit different from implementing an ongoing program that needs to be supervised by hospital staff. The next step regarding feasibility could be a study that explores methods for finding and screening local EM solo practitioners (whether volunteer or paid) and for integrating them into conventional clinical settings.

This study provides some guidance as to how EM can be applied clinically, especially in inpatient settings. It suggests that EM has a beneficial effect in some patients and provides some methodologic information that could be used in the design of stronger studies, such as funded feasibility studies of the integration of EM into conventional clinical settings. €

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