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Religious Practices and Considerations for Cancer Treatment of
Christian, Jewish, Islamic, and Buddhist Patients

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Abstract

With the vast number of cancer diagnoses each year, it is crucial that comprehensive oncology treatment provides the best possible treatment for all patients. In addition to traditional palliative care, understanding of patients' religious beliefs and practices is an integral piece to providing overall comfort and personalized, integrative care. This paper explores the various religious practices and considerations for cancer treatment of Christian, Jewish, Islamic, and Buddhist individuals, and how healthcare providers can best care for these diverse patients.

Religious Practices and Considerations for Cancer Treatment of Christian, Jewish, Islamic, and Buddhist Patients

In January of 2013, the American Cancer Society predicted that there would be over 1.6 million new cancer diagnoses over the impending year in the United States alone (Siegel, Naishadham, & Jemal, 2013). In a survey of advanced stage cancer patients, 91% of respondents indicated having spirituality-related needs. Of those respondents, 67% wished for their physicians and other medical personnel to consider those needs, and 17% indicated that they received less attention to their spirituality than desired (Pearce, Coan, Li, Koenig, & Abernethy, 2012). Only 39% of patients wish for their physicians to share their same beliefs, but many oncology patients wish to have their religious beliefs and practices acknowledged and honored by the professionals providing their care (Woll, Hinshaw, & Pawlik, 2008). With Catholicism, Judaism, and Islam being three major monotheistic faiths worldwide, Buddhism growing in popularity in the United States over the past decade, and the large number of cancer diagnoses each year, it is vital to discuss how these faiths practice, perceive illness, combat illness, and perceive death so that their belief system can be better integrated into comprehensive oncology care.

Catholicism

General Care

Of the four religions outlined in this document, Christianity is by far the most complex in regard to the number of denominations and variation in beliefs between sects. All Christian faiths believe that there is only one God. Christians believe that God's son, Jesus Christ, was born a man, died to forgive the sins of all people, and conquered death through his resurrection. Christians also believe that, above all, they should love God (Fosarelli, 2011). Woll et. al. (2008)

defines Christianity into three major categories in which individual denominations fall within: Roman Catholicism, Eastern Orthodox, and Protestant. Roman Catholic is one of the largest Christian denomination, with approximately 1.1 billion followers worldwide as of the 2003 data in Clarfield, Gordon, Markwell, & Alibhai.

When Catholics are confronted with illness, including cancer, it is most often believed that there is a reason for their suffering. Through suffering, Catholics find comfort in their community and in their relationship with God. Sickness may be viewed as a way to strengthen faith by experiencing pain like Christ did (Woll et. al., 2008). Because of the connectedness often felt toward Christ's suffering during their illness, medical treatment is only acceptable if it does not interfere with their faith and faith practices. Contrary to this belief, however, is the idea that pain may be relieved by artificial means so long as it does not further harm the patient or hasten death (Woll et. al., 2008). In the Roman Catholic denomination, utilization of modern medicine to treat cancer is encouraged and acceptable. However, Pope John Paul II decreed that "Catholics are not obliged to seek 'extraordinary' or 'disproportionate' means of preserving life", so use of experimental or risky oncology treatments may be refused by a Catholic patient (Narayan, 2006, p. 185).

When caring for a Catholic cancer patient in a hospital setting, accommodation for specific religious traditions should be addressed. Religious symbols such as crucifixes, pictures, and icons are regularly used as reminders of faith and values. When a Catholic patient is hospitalized, placement of symbols around the room should be accepted and encouraged by oncology staff (Narayan, 2006). Additionally, Catholics use prayer, mass (including the Eucharist), and reconciliation as ways to strengthen their bond with God. Respect should be given toward requests for a priest to administer the sacraments of the Eucharist or reconciliation.

Catholic patients may also invite oncology professionals to join the patient and family in prayer with or without the presence of a religious official (Narayan, 2006).

Terminal Cancer and End-of-Life Care

When a diagnosis of terminal cancer is confirmed, Catholics can begin end-of-life preparations. Catholics believe that whether or not they are admitted into heaven is based solely upon the full acceptance of the beliefs set forth by God and their religion (Fosarelli, 2011). A priest may visit the patient and administer the sacrament of anointing of the sick. If an individual has not already baptized and wishes to be, a priest can perform a baptism with holy water (Fosarelli, 2011). Reconciliation may also be performed on behalf of the patient so that they may receive forgiveness for any and all sins before their passing (Clarfield et. al., 2003). However, if the sacrament of reconciliation is not given to the patient, many Catholics believe that “they can repent of their sinfulness [using prayer] even up to the time of their death” (Fosarelli, 2011, p. 19). These ritual preparations of sacrament and prayer are a Catholic individual’s final proclamation of their faith so that they may pass God’s judgment and enter eternal life in heaven.

The caregiver’s role in the end-of-life process of Catholic oncology patients is to provide emotional support and pain alleviation while allowing the patient to complete their final proclamations of faith. Advance directives (ADs) may give patients piece of mind that their spiritual needs be met, so they should be discussed between the patient and caregiver (Woll et. al., 2008). Feeding tubes are acceptable but are not a compulsory part of Catholic beliefs since death is seen as a natural part of life (Clarfield et. al., 2003). Catholics approve of the practice of organ donation, so if this is not addressed in an AD the decision can be discussed with the patient or left to the family. At the time of death, it should be expected for family to be by the bedside of the patient so that they are comforted as they pass on to the afterlife (Fosarelli, 2011).

Judaism

General Care

In the Jewish faith, it is believed that “physicians are God’s messengers to heal the sick on earth” (Steinberg, 2003c, p. 635). Woll et. al. (2008) describes Judaism as a *death-defying* religion in which Jewish people wish to prolong life for as long as possible until death is certainly inevitable. This belief encourages the continuation of oncology treatment and the possible exploration of new options (as long as they do not hasten death in any way) until all treatment is determined futile and the cancer is considered terminal. The *Encyclopedia of Jewish Medical Ethics* states that because God created physicians and medicine, he deliberately created a means of healing. God has held both physicians and patients obligated to promoting the preservation of life (Steinberg, 2003c). Likewise, an analysis of the book of Job as a guide to oncology practice emphasized that patient-physician communication is the essential part to achieving effective healthcare (Patterson Balducci, & Meyer, 2002). However, God is considered to be the only true healer, and it is only by his will that physicians are given their abilities. Jewish individuals believe that true healing comes solely from their faith, so when death becomes inevitable it is accepted as a natural part of life (Steinberg, 2003c).

When caring for a Jewish cancer patient, fasting and complementary medicine are both topics which should be discussed thoroughly, if applicable. During *Yom Kippur*, people of the Jewish faith often do not ingest any food or water in fasting. When considering whether or not is it healthy and safe for a patient to fast, a comprehensive overview of the patient’s health and treatment should be considered. If the patient is told by one professional that it is safe for them to fast but another suggests against it, they will always lean toward caution to avoid possible life endangerment (Steinberg, 2003c).

The use of complementary therapies in oncology treatment are often an ambiguous subject among practicing Jews and their Rabbis. It is clear that Rabbis generally “prohibit the *substitution* of unproven alternative therapies for conventional curative therapy” (Steinberg, 2003c, p. 644). However, non-traditional therapy may be sought in conjunction with conventional treatment to alleviate side effects and pain (Steinberg, 2003c). Yet, it is often difficult to define which therapies are appropriate within the Jewish faith. For example, many Rabbis state that meditation as from Eastern cultures goes against the Jewish religion and should not be used. Nevertheless, there are some Rabbis who allow meditation as a complementary therapy if the content is altered to reflect Jewish beliefs and principles (Steinberg, 2003c). Since both the physician and Jewish patient strive to preserve life and cause no harm, possible complementary therapies should be discussed between the caregiver, patient, and the patient’s Rabbi. This will ensure that any chosen therapy will be in concordance with the patient’s faith values and will not cause detriment to the patient’s health.

Informed Consent and Experimental Treatments

Though the medical field strongly emphasizes patient informed consent before medical treatment decision are made, Steinberg’s encyclopedia (2003b) reiterates that “the obligation to preserve one’s life takes precedence over one’s rights over one’s body” in the Jewish faith (p. 555). When a treatment is deemed necessary to preserve the patient’s life and wellbeing, Jewish law states that the patient may not refuse the treatment for any reason. Additionally, Jewish law allows physicians to attempt to convince patients to change their minds or perform an intervention without the patient consent due to their God-given obligation to provide medicine and healing (Steinberg, 2003b). Though this contrasts with the ethical guidelines of western medicine, it has plausible implications when treating Jewish patients in the oncology field.

If a patient is suggested to enter an experimental trial, the physician must clearly explain to the patient why the possible benefits outweigh the possible risks. If the physician clarifies that the experimental trial has a moderate or above success rate and could possibly prolong the patient's life, the patient may be more likely to follow the physician's advice. Informed consent would still be necessary to go ahead with treatment, but an emphasis on the treatment's risk/benefit analysis as it appeals to the Jewish belief system may help guide reluctant patients to good prospective treatments. When evaluating whether or not an experimental cancer treatment adheres to Jewish law, Steinberg explains that experimental treatments are permissible if they meet the following criteria: the patient has exhausted all conventional treatments for the disease, the new treatment's statistics favor health improvement over health decline, and the patient will die fairly quickly if no further treatment is found. However, unlike with conventional treatment, the Jewish patient retains their ability to choose not to pursue the experimental treatment if they do not wish to (2003b).

Terminal Cancer and End-of-Life Care

In the event of terminal cancer, oncology professionals should expect the family to be present with the patient during the dying process. A rabbi of the same Jewish denomination should be present as well (Fosarelli, 2011). It is the physician's responsibility during end-of-life care to provide psychological services (if necessary), alleviate as much suffering of the patient as possible, and have compassion for the patient and family as they experience the patient's passing (Steinberg, 2003d). Jewish law states that at no time must food or food supplement (in the form of a feeding tube) be removed from the dying patient, as this removal of a resource which is necessary for healthy human sustenance would be considered the hastening of death (Woll et. al., 2008). Oxygen is also a necessary substance for life, and should never be turned off before the

patient's passing (Steinberg, 2003d). In regard to CPR and life support, there is not a consensus among Rabbis about whether Jewish law supports or denies the use of such measure to prolong life (Steinberg, 2003d). Nevertheless, Jewish ADs are in place for each denomination, and discussion should take place between the physician, patient, and Rabbi before medical ADs are implemented (Woll et. al., 2008).

After death, members of the Jewish faith will prepare the body for burial. This process includes the straightening of the body, closing of the eyes and mouth, and the affixing of the jaw to the head. Any sheets which have been soiled with the blood of the deceased should be collected and buried with the patient. Depending on the family's Jewish denomination, the body may also be washed and clothed in white (Fosarelli, 2011). Organ donation is viewed by the Jewish as a precious gift to others, but permission to donate the organs of the deceased must be agreed upon by the patient's family (Woll et. al., 2008).

Islam

General Care

“Islam means submission, and a Muslim is one who submits” (Fosarelli, 2011, p. 55). This statement from Fosarelli (2011) is a striking explanation of the Islamic faith. Muslims believe that there is only one Allah, and that his will is described in their holy Qur'an (Fosarelli, 2011). The five pillars of Islam and the foundation of the religion are faith, prayer, fasting, charity, and pilgrimage. By working to exemplify these five pillars, people of the Muslim faith submit themselves to the will of Allah and his prophet Muhammad so that they may one day pass over from the physical life to a life in heaven (Woll et. al., 2008). It has also been predicted that between the years of 2010 and 2030, the number of Muslims in the United States will increase from 2.6 million to over 6 million (Guimond & Salman, 2013). Because of this strict adherence

to their faith, the rising number of Muslims, and the intimate nature of cancer and its treatment, it is essential that professionals in the field of oncology have a solid understanding of what is acceptable when caring for Muslim patients.

Woll et. al. (2008) compiled a basic list of considerations when caring for oncology patients within a hospital. One important item was to provide meals that are *halal*, or in concordance with Islamic law. It is also important to respect and allow the visitation of an *imam* (worship leader) if the family is of the Shi'a denomination. Moreover, language barriers should also be assessed by healthcare professionals. Though some patients may have family members who can act as translators, a non-partial translator who is unrelated to the patient should be used whenever possible (Woll et. al., 2008). Finally, Woll et. al. (2008) suggested that Muslim patients be clearly identified as such. This ensures that every caregiver for Muslim patients is aware of the possible accommodations that may need to be made so that the patient's care is in concordance with their faith.

Fasting (restricting one's diet) during the holy month of Ramadan is extremely important for Muslims, since it is one of their five pillars of their faith (Fosarelli, 2011). Fosarelli (2011) stated that the sick are not required to fast over Ramadan. However, Woll et. al. (2008) stated that all medical decisions lie within the patient's family. The Islamic Judicial Counsel (IJC) and the Organization of the Islamic Counsel (OIC) do have published medical advice available, but these groups are not recognized or followed by all members of the Islamic faith (Woll et. al., 2008). When treating a Muslim patient in either outpatient or inpatient oncology units during the month of Ramadan, it is important to discuss fasting plans with the patient. Since it is not required for ill Muslims to fast, suggesting to an extremely ill patient that they do not fast would be appropriate.

Muslims believe that sickness is a merciful test of faith from Allah, and that physical pain is a penance for past indiscretions (Woll et. al., 2008). Because of this belief, Muslims may reject the physicians plan to decrease the physical side effects of cancer and its conventional treatments. In the Islamic faith, “medical treatment is considered voluntary... but it is recommended that a patient seeks treatment in the case of a curable disease” (Woll et. al., 2008, p. 3052). When discussing treatment plans with Muslim patients, it is important to address the topics of pain and symptom reduction as well as review intended treatment options. This ensures the patient can feel that they are in control of their treatment so that it corresponds with their individual faith requirements.

Spirituality, Coping, and Wellbeing

A study conducted by Lazenby & Khatib (2012) analyzed the effect of cancer on spiritual well-being of Muslim patients. The most shocking results of the study were the results correlated with lung cancer patients. These patients experienced the most significantly decreased physical and functional well-being scores compared to patients with cancer in all other sites, but they also exhibited the highest scores for spiritual well-being (Lazenby & Khatib, 2012). These results directly reflect the ideals of the Islamic faith. Two anecdotal studies—one surveying breast cancer survivors and another surveying advanced stage breast cancer patients—determined that almost all Muslim patients had the strong belief that their illness was God’s (Allah’s) intention and will, and it was a test of their faith (Harandy, Ghofranipour, Montazeri, Anoosheh, Bazargan, Mohammadi, ... Niknami, 2009; Ahmad, Muhammad, & Abdullah, 2011).

Lazenby & Khatib (2012) concluded that because the Muslim patients in their study linked illness and suffering so strongly with God’s will, the “enduring unmanaged symptoms [were] viewed as part of that trial” (p. 1323). However, accepting that their cancer is the will of

God does not assume Muslim patients are less likely to adhere to treatments and communicate with their physicians. On the contrary, surrendering oneself to the will of God was found to have a positive effect on breast cancer patients' abilities to cope with their diagnosis, and many patients reported having an active role in their medical treatment (Harandy et. al., 2011). The strong faith of Muslim cancer patients should never be seen a detriment to their treatment, but enables them to cope more thoroughly so that they may move forward with whatever course of action is necessary.

Use of Complementary Therapies

An interesting aspect to the Muslim approach to cancer treatment is the usage of unique complementary therapies in conjunction with conventional treatment. In a study conducted by Akhu-Zaheya & Alkhasawneh (2012) the most common forms of complementary medicine used by Muslim Jordanian cancer patients included dietary supplements, reading the Qur'an, and ZamZam water. Dietary supplements used by Muslim individuals as complementary oncology treatment differ from those used by those of other faiths and backgrounds. Honey, olive oil, black seeds, and dates are foods that are mentioned in the holy Qur'an, and were therefore the most commonly used (Akhu-Zaheya & Alkhasawneh, 2012). Oncologists and other healthcare professionals working with Muslim cancer patients should be aware of these common complementary supplements in the event that they may interact or interfere with conventional cancer treatments such as chemotherapy, but no known interactions were mentioned in this study. Reading the Qur'an and praying were the most significant stress relieving activities reported by the Akhu-Zaheya & Alkhasawneh (2012) study with 74.8% and 69.9% of participants using them, respectively. Lastly, ZamZam water—brought back from pilgrimages—

was used by 81.3% of participants who either drank or bathed in the liquid (Akhu-Zaheya & Alkhasawneh, 2012).

Modesty

For Muslim women, modesty is an integral part of their faith and religious practices. The definition of modesty may vary from woman to woman, so communication between oncology staff and patient is key above all. When providing care to female Muslim cancer patients, physicians and nurses of the same sex are strongly suggested (Woll et. al., 2008). “[P]hysical contact (e.g., hand-shaking) and eye contact with men may be unacceptable to some Muslim women”, so assigning same-sex caregivers can alleviate some of the stress of maintaining modesty in the healthcare setting and remove the possibility that the patient may refuse treatment from a male caregiver (Guimond & Salman, 2013, p. 212). When it is possible, Woll et. al. (2008) also suggested performing certain examinations over clothing or a hospital gown and in the presence of another female—preferably a family member. When clothing must be removed for an examination, caregivers should expect some averseness and ensure that the patient is given as much time as she needs to undress and feel comfortable before the examination begins (Guimond & Salman, 2013). Because of modesty concerns, Muslim women often do not seek out screening for cancers which requires invasive procedures such as that for cervical cancer (Guimond & Salman, 2013). Discussions aimed at maintaining patient modesty standards should be upfront when performing invasive screenings or treating female Muslim cancer patients, and discussions and examinations should be tailored so that discomfort and embarrassment is minimized.

Terminal Cancer and End-of-Life Care

According to Islam, treatment for cancer must be continued until it is determined that the illness is irrefutably terminal (Woll et. al., 2008). Clarfield et. al. (2003) stated that Advance Directives (ADs) set by the patient would most likely be accepted by Islam, so oncology professionals may suggest that terminally ill patients use ADs to ensure their care is acceptable if they are ever unable to communicate. Muslims believe that it is necessary to provide what the patient needs for normal sustenance (such as using a feeding tube to provide nutrition), but they do not believe in artificially prolonging the death process (Clarfield et. al., 2003). In regard to life support, there is ambiguity in the Islamic belief system about whether brain death corresponds with the death of the person, so discussions should be held with the family of the patient if ADs have not been set and the patient has been determined brain dead (Woll et. al., 2008). In addition to ADs addressing life support, organ donation status should also be addressed. Typically, organ donation is not allowed in the Islamic faith, but the patient may allow for exceptions if the recipient shared their Muslim identity (Woll et. al., 2008).

During the dying process, the Muslim patient “should be supine and face toward Mecca”, and the room must be clean and quiet enough for ritual prayer (Fosarelli, 2011, p. 58). After death, Muslims have specific rituals to prepare the body for burial which may only be performed by Muslims of the same gender as the deceased. Any individual who is not Muslim must not directly touch the body without the use of gloves (Fosarelli, 2011).

“Preparation of the body includes closing the eyes and mouth; taping the lower jaw to the head; straightening the body; not cutting nails or washing hair; binding the feet together; unclothing the body; and covering the body with a sheet. The family ritually washes, perfumes, and wraps the body in white cotton, while they and the imam pray. For the

washing, cool, pure water, sometimes perfumed, is used. The head of a man is wrapped in a turban; the head of a woman is covered with a veil. In the presence of the corpse, there are prescribed prayers and gestures.” (Fosarelli, 2011, p. 60).

Because the preparation of the body after death is so extensive, oncology caregivers should be respectful of the rituals and allow the family to prepare the body as they see fit. Professionals who are unsure of the specific rituals should ask how they can show respect to both the deceased and the family before entering the deceased’s room.

Buddhism

In 2004, a study determined that between 1.4 and 4 million Americans (approximately 0.07%) were practicing Buddhists (Wiist, Sullivan, St George, & Wayment, 2004). A representative study just four years later found that 0.7% of the American population were practicing Buddhists (Wiist et. al., 2004). Because of the steady increase in adult Buddhists in the United States, it is crucial that healthcare professionals, oncologists included, have a working knowledge of the core concepts of this religion and their implications on healthcare for these patients.

Buddhism is a religion that focuses on personal spiritual growth to attain “Enlightenment”. This Enlightenment is attained by reflection on oneself through practice of the principles set forth by Siddhartha Gautama, “the Buddha”, who believed that the natural processes of life were birth, aging, illness, and death (Chan & Hegney, 2012). Buddhists believe that pain and suffering are separate entities. To a Buddhist, suffering is understood to be the mind’s conditioned response to pain. In her book *Essential Buddhism*, Diane Morgan states that “pain is inevitable [but] suffering is not” (Morgan, 2010, p. 92). The practice of Buddhism using ritual and meditation strives to eradicate personal suffering. In doing so, the Buddhist achieves

Enlightenment (Chan & Hegney, 2012). Because of these philosophies, oncologists must recognize that because Buddhists believe sickness and death are inevitable, the focus of treatment is to aid in alleviating suffering rather than circumventing the inevitable.

When caring for a Buddhist cancer patient, certain accommodations can make their experience more comfortable. It is suggested that the doctors and nurses caring for the patient be of the same gender, if possible (Fosarelli, 2011). This may depend on the individual background of the Buddhist patient, so an open discussion about caregiver gender should be addressed upfront. Visitation by a Buddhist religious leader should also be expected and planned by the healthcare provider. Additionally, patients who require overnight stay in cancer centers or hospitals should be given the option to place an image of Buddha in their quarters for meditation purposes (Fosarelli, 2011). As always, ensuring patient comfort and ability to practice their religion as desired is integral to providing excellent oncology care.

Meditation

In a survey conducted by Wiist et. al. (2012), 99% of Buddhist respondents indicated practicing meditation. Of those individuals, 66% said they meditate once per day or more, and only 1.9% responded that they meditate “never or almost never” (Wiist et. al., 2012, p. 137). During meditation, the focus is on the fluctuations in the mind’s direction and the emotions experienced as a result of the mind’s activity. Meditation allows the Buddhist to recognize the patterns of their mind, and to alleviate their suffering by recognizing that it is merely the pain caused solely by emotion (Chan & Hegney, 2012). In the field of oncology, meditation as a complementary therapy has interested both patients and researchers because of this philosophy.

A study conducted by Yeon Hee Kim, Hwa Jung Kim, Ahn, Seo, & So Hee Kim (2013) examined the “Effects of meditation on anxiety, depression, fatigue, and quality of life of women

undergoing radiation therapy for breast cancer”. Using the Hospital Anxiety and Depression Scale (HADS), it was determined that patients in the meditation condition experienced a 1.33 point decrease in anxiety where the control group experienced a 0.08 point increase in anxiety. However, HADS results also determined that there was no significant decrease in depression between meditation and control conditions (Kim et. al., 2013). The Revised Piper Fatigue scale was used to assess patient fatigue levels, and the meditation condition was found to have a decrease in fatigue of 0.48 points compared to an increase of 0.60 points in the control condition. Overall, quality of life of patients in the meditation condition was found to improve 13.29 points compared to an increase in 3.69 points for the control group (Kim et. al., 2013). Therefore, meditation was found to have a significant effect on decreasing anxiety and fatigue of breast cancer patients as well as increasing patient quality of life.

Reiki

Reiki is a physical practice founded by 20th century Buddhist, Mikao Usui, and was later introduced to the clinical setting by a pupil of Usui (Fleisher, Mackenzie, Frankel, Seluzicki, Casarett, & Mao, 2013). William Rand of the International Center for Reiki Training states that “Rei” translates to “God’s wisdom or the Higher Power”, and “Ki” translates to “life force energy” (2013a). In the Buddhist belief system, the body contains “chakras”—centers of energy relating to certain parts of the soul—and “meridians” which the energy flows through from chakra to chakra. It is also believed that when a person experiences negative emotions, the chakras can become damaged and unbalanced (Rand, 2013b). The physical practice of Reiki involves the practitioner placing his or her hands on or above the patient to draw the Reiki (a naturally occurring and readily available “divine energy”) from the universe into the body so that it can balance and heal the patients “life force energy” and the various chakras in which it resides

(Rand, 2013b). The practice of Reiki is not used by all Buddhist individuals, but it is a viable complementary therapy option which has become more popular for oncology patients of diverse religious beliefs and backgrounds.

Psychological benefits of Reiki.

Much of the research that has been conducted regarding Reiki and its effects on the wellbeing of oncology patients has been focused on psychological changes—one of those being the effect of Reiki on anxiety. A study conducted in 2011 by Beard, Stason, Wang, Manola, Dean-Clower, Dusek, ... and Benson regarding the effects of Reiki therapy on 54 men with non-metastatic prostate cancer found that there was a 0.10 correlation between Reiki and decreased anxiety compared to a 0.02 correlation between relaxation response therapy (RRT) and decreased anxiety (Beard et. al., 2011). Birocco, Guillame, Storto, Ritorto, Catino, Gir, ... and Ciuffreda, (2012) studied the effect of Reiki on anxiety of oncology patients receiving chemotherapy. The average initial Visual Analog Scale (VAS) anxiety score was found to be 6.77 ± 2.20 , but after the fourth Reiki treatment, mean anxiety scores dropped to 2.28 ± 2.91 (Birocco et. al., 2012). Furthermore, a study conducted Fleisher, Mackenzie, Frankel, Seluzicki, Casarett, and Mao (2013) assessed 162 cancer patients receiving Reiki using a “modified distress thermometer”. An approximate fifty percent decrease in distress (3.80 reduced to 1.55) and a >50% reduction in anxiety (4.05 reduced to 1.44) was documented (Fleisher et. al., 2013).

The effect of Reiki on oncology patient depression is another significant area of study. Beard et. al. (2011) identified a minor significant improvement in Center for Epidemiologic Studies-Depression (CES-D) for those participants identified as “depressed” prior to treatment. Additionally, just as Fleisher et. al. (2013) found largely significant data for anxiety

improvement due to Reiki therapy, it was also shown that depression improved over 50% when comparing pre-Reiki to post-Reiki scores (2.54 reduced to 1.10).

Among the qualitative results obtained by Fleischer et. al. (2013), there were a significant number of patient responses indicating positive effects in various aspects of life. “The most common words used to describe the feelings evoked during a Reiki session were ‘relaxed,’ ‘relaxation,’ and ‘relaxing.’ Patients also expressed feelings of peacefulness, warmth, and calm” (Fleisher et. al., 2013, p. 3). Other noted phenomena were a heightened sense of connection to the self and to others, increased positive beliefs in the body’s ability to heal, and feeling more deeply understanding of one’s emotions and emotional responses (Fleisher et. al., 2013). The overall positive experience of Reiki was shown by Fleisher et. al. to be comprehensive in its effects on cancer patient emotional, spiritual, and psychological well-being.

Table 1: Summary of psychological data: Reiki therapy.

Study	Sample	Methods	Results
Beard et. al. (2011)	54 males over 30 years old with non-metastatic prostate cancer, receiving radiation therapy	Randomly assigned to weekly RRT, Reiki, or control, and randomly evaluated using STAI, CES-D, FACT-G	Reiki indicated a positive trend on STAI assessments, however no significant total change between variables
Catlin & Taylor-Ford (2011)	189 outpatient chemotherapy patients	Random assignment into control, Reiki, and “sham” Reiki. Demographic survey before treatment, 14 HTCQ questions and Well-Being Analog Scale before and after treatment.	Reiki vs. “sham” showed minor improvement in comfort from Reiki compared to latter, but improvement in well-being was consistent and significant by both test conditions.
Birocco et. al. (2012)	118 patients (mean 55 years) receiving chemotherapy; subgroup of 22	VAS data recorded before and after 30-min Reiki sessions, subgroup attended 4 sessions	Mean VAS anxiety 6.77→2.28
Fleischer et. al. (2013)	213 cancer patients: 162 received one treatment, 51 received multiple	Modified distress thermometer and patient open-format written responses after sessions	Distress 3.80→1.55 Anxiety 4.05→1.44 Depression 2.54→1.10

Physiological benefits of Reiki.

Reiki therapy appears to be a plausible complementary therapy option for cancer patients seeking improvement in physiological responses related to both the disease and its treatment. Pain related to cancer and conventional cancer treatments is one of the most common symptoms experienced by patients. Between 75-90% of all patients with cancer will experience moderate to severe pain during their illness and treatment (Running & Seright, 2012). Birocco et. al. (2012) VAS results showed that, for perceived pain, the average patient score prior to Reiki therapy was 4.44 ± 3.22 ; the mean patient pain score after four Reiki sessions was 2.32 ± 2.38 —a significant 48% reduction. (Birocco et. al., 2012, p. 291-294). This finding was further supported by the 2013 study by Fleisher et. al. which found a 54% reduction in pain levels of oncology patients who attended all four 30-minute Reiki sessions. Reiki as a complementary therapy for cancer pain management is even recommended by The Society for Integrative Oncology because it is safe to combine with conventional oncology treatments (Running & Seright, 2012).

Jain, Pavlik, Distefan, Bruyere, Acer, Garcia, ... and Mills (2012) randomly assigned female breast cancer survivors to control, energy healing, or fake energy healing treatments. Salivary cortisol levels were recorded before and after treatment conditions. Though there was a significant leveling of cortisol curves in the energy healing group compared to the control group, there was no significant findings between true and false energy healing treatments. These results, may indicate that energy balancing is not the true cause for decreased stress and cortisol levels; rather, the interaction between patient and caregiver is what may be influencing these physiological changes. However, the energy healing condition did produce significant results in leveling patient cortisol levels, and is therefore a viable option for addressing the physiological components of stress in oncology patients.

Cancer patient's energy levels, sleeping habits, and appetite are also often affected by the disease and conventional treatment. Tsang, Carlson, and Olson (2007) demonstrated a significant decrease in patient-reported fatigue in Reiki conditions compared to rest conditions. In the Fleisher et. al. (2013) study, greater than 50% decrease was found for fatigue in patients receiving Reiki therapy. Jain et. al. (2012) found that fatigue was reduced in both true energy healing and imitation energy healing groups, but there was a slightly larger effect found from the true energy healing. In a recent study conducted by Marcus, Blazek-O'Neill, & Kopar (2013), it was determined that 43% of oncology patients receiving Reiki treatment noticed improved sleep habits and 30% of patients indicated improved appetite.

One of the most interesting studies regarding Reiki's effect on cancer patients was conducted by Lutgendorf and Mullen in 2008 (as cited in Hart, Freel, Haylock, & Lutgendorf, 2011). The study sampled 60 women receiving chemoradiation treatment for newly diagnosed cervical cancer. Each woman was randomly assigned to six weeks of healing touch, relaxation, or control conditions. The most unique results of this research indicated that while control and relaxation conditions both showed significant decrease in natural killer cell activity over the course of conventional treatment, those patients receiving healing touch maintained significantly higher NK cytotoxicity (Hart et. al., 2011). The increase of NK cell activity as a result of healing touch therapy may possibly point toward energy therapies as a way to boost immune function during conventional chemotherapy and radiation which are notably harsh on the body.

Table 2: Summary of physiological data: Reiki therapy.

Study	Sample	Methods	Results
Tsang, Carlson, & Olson (2007)	16 patients diagnosed with cancer, recently completed chemotherapy, scored 3+ on ESAS tiredness questionnaire	FACT-F, FACT-G prior to Reiki or rest and after 7 th Reiki or rest treatment; ESAS before and after each Reiki or rest treatment	Reiki is effective at decreasing fatigue levels as well as pain and anxiety.
Lutgendorf & Mullen (2008) [As cited in Hart et al. (2011)]	60 women undergoing chemoradiation for newly diagnosed cervical cancer	Randomly assigned to healing touch, relaxation, or control conditions, 6 weeks	Relaxation and control groups indicated decline of NK cytotoxicity, while healing touch condition preserved cytotoxicity
Birocco et. al. (2012)	118 patients (mean 55 years) receiving chemotherapy; subgroup of 22	VAS data recorded before and after 30-min Reiki sessions, subgroup attended 4 sessions	Mean VAS pain 4.4→2.32
Jain et. al. (2012)	Female breast cancer survivors between 18-70 years of age, treatment completed	Randomly assigned to bio-field healing and mock bio-field healing; measured MFSI-S, CES-D, FACT-G, questionnaires and salivary cortisol measurement	Fatigue reduction in both groups, slightly less in mock group. No statistical changes on FACT-B. Biofield healing showed significant leveling of cortisol compared to control, but nonsignificant compared to mock treatment.
Fleischer et. al. (2013)	213 cancer patients: 162 received one treatment, 51 received multiple	Modified distress thermometer and patient open-format written responses after sessions	Pain 2.58→1.21 Fatigue 4.80→2.30
Marcus, Blazek-O'Neill, & Kopar (2013)	47 cancer infusion center patients receiving volunteer Reiki services	Patients given surveys with questions on a 5 point scale	43% reported improved sleep 30% reported improved appetite

Terminal cancer and end-of-life care

Since Buddhists believe that both illness and death are natural parts of the process of life, the diagnosis of a terminal illness is usually accepted more easily than it is by those outside of the Buddhist religion. After designation of terminal illness, a Buddhist might view additional attempts to cure the disease as futile and a renunciation of the belief that death is inevitable and natural (Chan & Hegney, 2012). Treatment of physical symptoms and pain may continue so long as they do not interfere with the patient's control over their ability to meditate, and in no

circumstances may measures be taken to shorten the dying process such as removing a patient from life-support (Chan & Hegney, 2012). It is important for physicians and other healthcare professionals to understand that, to the Buddhist, death will happen in its own time. Both the prolonging of suffering and the hastening of death interfere with this natural process.

End-of-life beliefs should be discussed with both the patient and immediate family members. Buddhists believe “organ donation is a supremely selfless gift to others”, so suggesting the patient become an organ donor is appropriate if organ donor status is not already defined (Fosarelli, 2011, p. 6). While the patient experiences the dying process, they should have clear consciousness, the ability to meditate, and should be placed lying on their right side with relaxed, extended legs. Crying and strong emotions should not be shown in the presence of the patient, because Buddhists believe this is detrimental to the patient’s Enlightenment (Fosarelli, 2011). After-death practices can vary by person and denomination. Common practices include waxing over the eyes of the deceased, placing a coin in the mouth, and washing and wrapping of the body. If a monk is present at the time of death, healthcare professionals should also expect an hour of prayer after the time of death. The body does not need to be present for this prayer, but accommodations should be made to allow this ritual to take place (Fosarelli, 2011). Furthermore, many Buddhists believe that “the soul remains with the body for three days”, and the body must not be left alone or cremated within that time frame (Fosarelli, 2011, p. 8).

Conclusion

Medical professionals working in the oncology field are providing care in one of the most overwhelmingly intimate healthcare settings. Oncology caregivers who strive to understand patients’ spiritual and religious beliefs acknowledge that intimate care does not merely describe the hands-on treatment of the illness. The intimacy of oncology treatment is rooted in providing

comprehensive care that encompasses patients' medical, physical, emotional, spiritual, and religious needs. By obtaining knowledge regarding various religious practices and beliefs, oncology professionals can better individualize patient care. This working knowledge can also ensure greater patient comfort, satisfaction, and wellbeing. Even though oncology physicians and nurses are not trained to guide or give counsel about spirituality, providing an environment where diverse religious beliefs and practices are accepted, discussed, and accommodated for may make the inevitable intimacy of cancer just a little less overwhelming.

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