HEALING AT THE BORDERLAND OF MEDICINE AND RELIGION:

REGULATING POTENTIAL ABUSE OF AUTHORITY BY SPIRITUAL HEALERS

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INTRODUCTION

Although historically, the phenomenon of spiritual healing emerged as a religious practice within the context of specific religious traditions and has traditionally been ascribed only to mystics, saints, and holy persons,¹ in modern times, a variety of spiritual healing practices unconnected with traditional religion have entered mainstream professional health care. These practices are used in a variety of health care professions, from medicine to nursing, dentistry, and other allied health professions.

For example, some physicians either collaborate with (or refer to) spiritual healers² or use "healing energy" through touch" without naming a particular style, school, or technique,³ and a spiritual healing modality known as Therapeutic Touch is part of the curriculum in many nursing schools.⁴ Use of caring or healing touch is increasingly

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1. See e.g. the descriptions of healing ministries of Catholic saints in Alban Butler, Butler's Lives of the Saints (The Liturgical Press 2000).
2. See e.g. Caroline M. Myss & C. Norman Shealy, The Creation of Health: Merging Traditional Medicine with Intuitive Diagnosis 72-76 (Three Rivers Press 1993).
4. See generally Dolores Krieger, Therapeutic Touch as Transpersonal Healing (Lantern
described as potentially useful in various health care settings, from acute care, to surgery, to obstetrical nursing practice; and Reiki, a Japanese form of energy healing, has even been used in efforts to help survivors recover from torture.

Additionally, spiritual healing services are offered by practitioners of “complementary and alternative” medical (CAM) therapies, such as chiropractic, acupuncture, and massage therapy. For example, some practitioners of acupuncture and traditional oriental medicine will practice qigong, a Chinese system of spiritual healing. Similarly, intuitive use of touch is a central component of chiropractic, and is


The reasons for defining modalities as “CAM therapies” are not only scientific, but also “political, social, or conceptual.” Wayne B. Jonas, Policy, The Public, and Priorities in Alternative Medicine Research, 583 Ann. Am. Acad. Pol. & Soc. Sci. 29, 33 (2002). These include lack of a generally accepted explanatory model; the fact that the origin of the practice is outside of the dominant system (e.g. acupuncture); the amount of data or type of data is considered insufficient or otherwise inadequate (e.g. herbalism, megavitamin therapy); the use of the practice is marginalized in that it is not available within conventional hospitals (e.g. relaxation techniques); the teaching of the practice is marginalized in that it is not generally taught within medical, nursing, or graduate schools of the dominant institutions (e.g. nutritional therapy); the amount of research funding, infrastructure, and capacity for investigating the practice is low (e.g. cancer, chiropractic); the practice is not reimbursed by insurance companies and third-party payers; the practice is not readily used for feasibility, acceptability, or other reasons (e.g. clinical ecology, complex lifestyle programs); the practice is not regulated or licensed in most states (e.g. naturopathy); and an aspect of the therapy is marginalized though it is studied under other names or subdivisions (e.g. antineoplastons, shark cartilage). Id. at 33.


central to many forms of massage therapy. Overall, at least 50,000 health professionals provide about one hundred twenty million sessions of spiritual healing to patients annually.

The prevalence of spiritual healing in the provision of health care services receives extensive attention in the Chantilly Report, a 1992 quasi-governmental report to the National Institutes of Health entitled, "Alternative Medicine: Expanding Medical Horizons." The report describes spiritual healing as a collection of different practices centering around spirituality and notions of healing that are used with increasing frequency as part of professional health care, not only in the provision of CAM services, but also within medicine, nursing, and the allied health professions. The report does not offer definitive guidance on ways to sort out differences, if any, between spiritual healing, faith healing, laying on of hands, prayer, intentionality, and related practices, but it does highlight the increasing use of these practices in a variety of health care settings.

The practice of spiritual healing in a secular context, within the provision of clinical care, suggests the possibility of regulating spiritual healing as the professional delivery of a health care service. This article argues that those who purport to utilize spiritual healing in clinical care within a secular (and frequently medical) context should be—and in fact, are—subject to an array of regulatory controls similar to those imposed on other health care professionals. The article: (1) broadly explores how legal rules regulate spiritual healing as a health care (rather than exclusively religious) practice in the U.S.; (2) conceptualizes the kinds of potential abuse of power in the relationship between spiritual healer and client; and (3) evaluates the extent to which legal rules address—or fail to address—such potential abuse of power in spiritual healing as a professional health care practice.

12. Id. at 134-142. While far from definitive, the report helped catalogue the nature and extent of the field of "alternative medicine."
13. Id.
14. For some of the unresolved definitional conundrums, see infra n. 16.
Part 1 provides some preliminary working definitions of spiritual healing and attempts to differentiate spiritual healing in a secular context (i.e. as a professional, health care service) from religious healing, which is given a working definition in this article as healing in an exclusively religious context. Part 2 examines whether the potential for abuse of

16. Despite attempts by numerous scholars—as further discussed in Part 1—to provide rigorous definitions for terms such as "religion," "spirituality," and "healing," such definitions are subject to critique as ultimately ambiguous, overlapping, and/or circular. Notably, the United States Supreme Court has had difficulty defining religion—and has even "avoided attempting to define 'religion' and the 'religious.'" Paul Jefferson, *Strengthening Motivational Analysis Under the Establishment Clause: Proposing a Burden-Shifting Standard*, 35 Ind. L. Rev. 621, 644 (2002). Further, definitions of religion seem to change according to the context—for example, the Free Exercise Clause and the Establishment Clause of the First Amendment seem to demand incongruent definitions, so as to "maximize individual liberty, protect individual religious conduct, and limit the constraints on government." *Id.* Even the attempt to assess whether something is "religious," according to whether the activity is associated with prevailing doctrines of a particular religion, is problematic, because religion is "essentially a personal experience and one may have individual beliefs outside the canon of a particular religion." *Id.* at 643.

Indeed, not only does a monolithic interpretation seem impossible, but also, more generally, "[d]efining the term 'religious,' especially at the fringes of its meanings, is an almost Sisyphean task." *Id.* at 644. Moreover, from a psychoanalytic perspective, some would argue religion is merely a "socially constructed and maintained system of internal objects," and that moreover, such internal objects have "no material existence," but rather, are "elaborated over time to meet the experience of practitioners." D.M. Black, *What Sort of a Thing is a Religion? A View From Object-Relations Theory*, 74 Int. J. Psych-Anal. 613, 624 (1993); see Joel R. Paul, *Cultural Resistance to Global Governance*, 22 Mich. J. Intl. L. 1, 24 (2000) (religious culture, like national culture, is an "artificial social construct"); Robin West, *Law, Rights, and Other Totemic Illusions: Legal Liberalism and Freud's Theory of the Rule of Law*, 134 U. Pa. L. Rev. 817, 869 (1986) (religion, conscience, and rule of law are social constructs). To denote religion as a "social construct" suggests perhaps that religious beliefs are erroneous, trivial, or at the least, beyond scientific proof and therefore not subject to serious debate. Personal Communication from Bonnie B. O'Conner (Nov. 20, 2002).

Further, even to denote a particular healing practice or set of health care practices as "religion" or "religious" may be imposing a Western, medical bias on particular modes of existence, since practitioners may experience themselves as simply "being" rather than subscribing to a particular, identifiable set of beliefs. Personal Communication from Bonnie B. O'Conner (Nov. 14, 2002). For example, while Hmong culture does not have a separate category for religion, a Hmong shaman is certainly recognized within the community as practicing a specialized knowledge of certain spiritual matters.

In many cultural frameworks one does not, or need not, identify as "religious" or "spiritual" in a way that is separate from one's cultural or ethnic identity, because the latter identity entails religious and/or spiritual worldviews, interpretations, actions. This is true even in those cultures may not have a world for "religion" or who do not consider religion a separate "department" of culture in the way so-called "Western" cultures do.

Personal Communication from Bonnie B. O'Conner (Nov. 20, 2002).

All sorts of disciplines seem to have their own approach to the definition of religion, and such definitions generally reflect each discipline's particular disciplinary orientation, and that discipline's foundational assumptions. *Id.*

Despite the above caveats, and without attempting to craft definitive responses to the above conundrums, this article attempts to draw preliminary, working distinctions to help frame the way health care practices once considered "religious" or "spiritual" are penetrating mainstream clinical care; hence the title's emphasis on practices at the "borderland" of what historically has been
spiritual healing in the clinical setting *ought to be* regulated. Part 2
reviews constitutional and policy arguments both for and against the
possibility of government intervention into a domain of healing still
considered by many—correctly or otherwise—to be “religious” or at the
least (in light of the distinctions drawn), “spiritual,” and thereby still
beyond the purview and authority of public policy and legal constraint.

Part 3 conceptualizes potential forms of abuse between practitioner
and client of spiritual healing. Such conceptualization is necessary to
determine whether and how legal rules can address issues of abuse. Part
4 reviews the regulatory framework governing use of professional
healing practices generally, and the potential application of these rules to
issues of abuse of spiritual healing.

The article concludes that these rules not only provide a
workable—albeit preliminary—framework for regulating spiritual
healing in the context of professional health care practice, but also
usefully identify categories of abuse of authority. Further, the article
concludes that by formalizing such categories and applying
concluding arguments, existing legal rules target specified variations
on the theme of abuse of authority, and thereby help deter violations of
trust within the therapeutic relationship.

I. SPIRITUAL HEALING IN HEALTH CARE PRACTICES

A. Differentiating “Spiritual” from “Religious” Healing

The phenomenon of religious healing, and the accompanying use
of healing rituals in religious contexts, has been extensively studied by
various scholars.\(^{17}\) Indeed, most practitioners of mainline, Western
religions would be familiar with Biblical examples of religious healing.
For instance, the ancient Israelite priests (or *cohanim*) blessed the people
with healing—the blessing, in its Biblically recorded form, is still used
in synagogues today—and when Moses wished to invest the elders with
his power to rule the Israelites, he did so by laying hands on their heads,
and transmitting to them the *ruach ha-kodesh*, sometimes translated as
“holy wind” or “Holy Spirit.”

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considered, in many camps, “medicine” as opposed to “religion.” In so doing, the article in no
way advocates particular practices or beliefs, but rather evaluates some legal, regulatory, and
ethical conundrums arising out of the integration of beliefs and practices into contexts that
generally are considered predominantly secular and mundane.

Similarly, in Christian tradition, Jesus reportedly transmitted healing energy, among other things, through his touch, and exhorted his disciples to heal the sick. There is a vast tradition of Catholic saints who have had and used associated healing powers. Religious healing practices have had both physical and spiritual dimensions, aiming to restore both health of the body and wholeness of the spirit in terms of its unity with God.

While there are numerous scholarly definitions of "religion" and the "religious," some helpful definitions include these: "practices carried out by those who profess a faith"; "subscribing to a set of beliefs or doctrines that are institutionalized"; and "the outward practice of a spiritual system of beliefs, values, codes of conduct and rituals." And although religious healing continues today—both in mainline, Western religions and elsewhere—the term "spirituality" has entered the general vocabulary to denote persons who are "religious," in the sense of having an affinity for religious ritual and practices (including healing practices)—or at the least, for practices involving calming and clarity of mind and emotions—but not necessarily wishing to be bound to the particular faiths or dogmas of established religious traditions. Increasingly, individuals have wished to identify themselves as "spiritual" rather than as "religious."

Various definitions have been proposed for the broad concept of spirituality. These include: "searching for existential meaning"; "a quality beyond religious affiliation that is used to inspire or harmonize answers to questions regarding infinite subjects"; closer to "the source dimension [that the] everyday [awareness] ... has moved far from ...", a "quality that goes beyond religious affiliation, that strives for

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18. See e.g. John 9 (healing of the blind man); Jas 5: 14 ("Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord."). (N.I.V.). For a list of healings in the New Testament, see <http://www.healingscripture.com/HealingRecord.shtml> (accessed Mar. 1, 2003).

19. David Aldridge, Spirituality, Healing and Medicine: Return to the Silence 32-33 (Jessica Kingsley Publishers 2000). Aldridge traces the historical rise of medicine and consequent decline of church authority over understandings of life, birth, death, and the body—a "rift in the ecology of ideas"—and the recent return, in holistic notions of health, "to the idea that body, mind and spirit are not separate." Id. at 34.


21. Id. at 27 (quoting D. Doyle, supra n. 20, at 303).

22. Id. (quoting J. Emblen, Religion and Spirituality Defined According to Current Use in Nursing Literature, 8 J. Prof. Nursing 41, 43 (1992)).

23. Id. (quoting Michael Lerner, Choices in Healing 115 (MIT Press 1994)).
inspirations, reverence, awe and purpose . . . tries to be in harmony with the universe, strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death”,24 and “a belief system focusing on intangible elements that impart vitality and meaning to life events.”25

Although there are numerous, additional attempts to sort out “religion” and “spirituality,” and to draw clear differences between the two,26 one way to conceptualize a distinction is as follows:

[P]eople can be spiritual without being religious—and religious without being spiritual. Religion is a belief system organized around a prophet, teacher, or set of human precepts. Spirituality is the ability to discover and use our own unique specialness . . . .

[S]pirituality is the process of becoming a positive and creative person.27

In other words, spirituality is not necessarily organized around a specific teacher or set of teachings; and spirituality may be, but is not necessarily, identified with religion.

In a similar vein, a group of scholars of bioethics, attempting to define the physician’s role in paying attention to patients’ religious and

24. Id. (quoting W. McSherry & P. Draper, The Spiritual Dimension: Why the Absence Within the Nursing Curricula? 17 Nurse Educ. Today 413, 413 (1997)).
25. Id. (quoting M. Joseph, The Effect of Strong Religious Beliefs on Coping With Stress, 14 Stress Med. 219, 220 (1998)). Aldridge draws the distinction this way:

Where spirituality is seen as subjective, religion is seen as being social and means subscribing to a set of doctrines that are institutionalized. Thus some people may be spiritual in that they have a sense of being related to the sacred but do not take part in any organized religion. Conversely, others may perform the expected rituals of religious observance but have no personal experience of the divine.

Id. at 66.

26. See e.g. Heinrich E. Benedikt, Spirituality Versus Religion: Principles of Interreligious Understanding and Self Realization (Verlag Lotus Publications 1995) (available on-line at <http://www.heinrichschwabverlag.de>) (accessed Mar. 21, 2003) (proposing that many “get caught in nationalistic slogans or doctrines or religious creeds and dogmas which cause rather painful and violent disturbances and even warlike antagonisms in our already deeply shaken world,” but that it is only through “a spiritual understanding which goes to the root and source of religion itself, which is God, that we can discover the goal of our quest”).

27. Leo Booth, When God Becomes a Drug: Breaking the Chains of Religious Addiction and Abuse 3, 20 (Jeremy P. Tarcher, Inc. 1991). The author is a “recovering” Anglican priest and alcoholic who has recognized within himself an addictive propensity to use religion “to escape loneliness, low self-esteem, and fear of reality . . . [as a] drug.” Id. at 9. He has created programs to help individuals recover from religious addiction and abuse. He attributes spiritual abuse and addiction, among other things, to the “growing awareness of the spiritual emptiness felt by many people—the alienation and shame produced by the negative messages religion often gives,” and his model draws on the Alcoholics Anonymous system of healing. See id. at 23; see infra Part III(B).
spiritual beliefs within the practice of medicine has articulated a distinction as follows:

The term “spirituality” tends to be used as a broader term to refer to that which brings significance, purpose, and direction to people’s lives. The person who has spiritual beliefs and interests searches for (usually nonphysical) sources of meaning, life, wholeness, healing, and hope. The various forms of spirituality may be fluid and individual, taking no classical religious form, or they may be crystallized in the beliefs and practices of a specific religious community . . . . The term “religion” . . . tends to be associated with beliefs, practices, and ethical teachings of specific religious bodies and traditions.28

In light of these various, proposed definitions, spiritual healing, as opposed to religious healing, draws on the healing power of connectedness to the sacred, without necessarily deriving its authority (or persuasive power to its practitioners and recipients) from the tenets or dogmas of any one specific religious tradition.29

Spiritual healing increasingly is prevalent in the delivery of healthcare services. Spiritual healing services can be offered in a variety of hospital settings, in addition to the intensive care unit, such as in clinics specifically dedicated to “integrative health care”—to care that integrates biomedical and CAM therapies and providers. Such services also can be provided as part of rituals intended to help patients heal.30

Indeed, research into links between spiritual practices and health is increasing, as are educational courses in medical schools on the topics of religion, spirituality, and medicine.31

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29. Again, the caveat is given that the article is drawing preliminary, working definitions for purposes of drawing useful distinctions that help analysis of legal rules and regulation. Some actually conflate religion and spirituality—for example, one dictionary defines spirituality as “sensitivity or attachment to religious values.” Merriam-Webster Dictionary <www.m-w.com/cgi-bin/dictionary> (accessed July 8, 2003).

30. Increasingly there is recognition that healing rituals may have powerful, therapeutic effects. See e.g. J. Roche, Creative Ritual in a Hospice, 75 Health Prog. 45 (1994); Ted J. Kaptchuk, The Placebo Effect in Alternative Medicine: Can the Performance of a Healing Ritual Have Clinical Significance? 136 Ann. Int. Med. 817 (2002). On the other hand, exclusive reliance on rituals—to the exclusion of conventional care—can be destructive. See e.g. S. Pfefier, Belief in Demons and Exorcism in Psychiatric Patients in Switzerland, 67 Br. J. Med. Psychol. 247 (1994) (finding that although patients experienced rituals as positive, a negative outcome, such as psychotic decompensation, was associated with exclusion of medical treatment and coercive forms of exorcism). The destructive possibilities of over-reliance on spiritual, to the exclusion of medical, means of healing, is a sub-theme of this article; see infra Part 4(A)(1).

31. Harold G. Koeng, Foreword, in Dana E. King, Faith, Spirituality and Medicine: Toward
In a larger sense, the focus on spiritual care reflects not only increasing interest among health care providers, patients, and others in spirituality (as thus defined), but also a broader cultural phenomenon connected to what Mircea Eliade has denoted, "creative encounter . . . with archaic—as a matter of fact, prehistoric—spiritual values." This is far more than a series of "encounters with oriental spiritualities"—of meetings between Western science and Eastern religion—as is frequently presupposed. Rather, the encounter with shamanism, the religious expression of prehistoric humanity, has parallels in theatre, literature, poetry, and music, as well as health care. It represents a delving into initiatory ordeals to forge a more "structured, stronger personality" that integrates the physical and spiritual worlds.

The increasing prevalence of spiritual care in health care environments suggests a quiet yet profound cultural revolution, in which the instrument and vessel of divine grace has shifted—at least for many health care providers and their patients—from the exclusive domain of the saint or sage to the province of the ordinary individual. The spiritual gift of offering healing is understood as accessible to many or most persons, and the skills of spiritual healing as open to anyone who is willing to undergo the requisite training; in short, the gift of healing is no longer seen as emanating entirely from divine dispensation and thereby falling into a particularized religious tradition.

B. Spiritual Healing: Secular or "Religious"

Cultural phenomena aside, from a scientific perspective, at present one could argue that there is little consensus evidence concerning safety, efficacy, or mechanism of therapies in the clinical domain associated with spiritual healing. Further, the evidence validating any claims by spiritual healers concerning the effects of their practices on health or the physical body presently ranges from dubious to mixed, or at best,
promising.  

As such, members of the scientific community could argue that these spiritual healing practices should be viewed as "religious" in the sense that they have not received complete validation through scientific study, and therefore inevitably must draw on belief and subjectivity. Therapies that do not have satisfactory, objective, scientific proof, the argument goes, must rely on subjective belief, and hence fall into the realm of faith or religion. The above argument adds to earlier definitions of religion, by opposing religious to scientific truth: to the extent that "religion" involves a set of "practices carried out by those who profess a faith," then the absence of sufficient, reliable scientific data, coupled with the necessity of belief in the modality and its theoretical underpinnings, would suggest that spiritual healing remains in the domain of "religion" and not "medicine."  

While the argument has merit, there are several compelling arguments for treating these practices as secular—i.e. as capable of operating, and thereby of deserving regulation, outside an exclusively religious framework. First, these practices are offered by health care practitioners of many, divergent religious faiths—unlike, for example, prayer "treatments" by Christian Scientists, all of who operate from a common set of enumerated beliefs about God. Similarly, practitioners of spiritual healing in the clinical domain may apply different training and styles of spiritual healing, without necessarily ascribing the potency of these methods to a particular form of worship or particular conception of God. They may not necessarily share among themselves the kind of distinguishing marks of religion, such as a commonly held, "sincere and meaningful belief which occupies . . . in the life of its possessor a place

39. See John Astin, E. Harkness & Edzard Ernst, The Efficacy of Distant Healing: A Systematic Review of Randomized Trials 132 Ann. Int. Med. 903 (2000) (concluding that "[t]he methodologic limitations of several studies make it difficult to draw definitive conclusions about the efficacy of distant healing. However, given that approximately 57% of trials showed a positive treatment effect, the evidence thus far merits further study"); see Cohen, supra n. 7, (citing literature). All this could, however, clearly shift in either direction. See e.g. Healing, Intention and Energy Medicine (Wayne Jonas & Cindy Crawford eds., Churchill Livingstone 2003).  

40. Eliade likely would insist that irrespective of the level of scientific evidence for a given therapy, one studying such a therapy should have an actual "encounter" with it, and thus have "passed beyond the stage of pure erudition—in other words, when, after having collected, described, and classified his documents, he has also made an effort to understand them on their own plane of reference." Mircea Eliade, A New Humanism, in supra n. 32, at 35, 38 (referring to study of religious phenomena by the historian of religion). Eliade adds: "Works of art, like 'religious data,' have a mode of being that is peculiar to themselves; they exist on their own plane of reference, in their particular universe. The fact that this universe is not the physical universe of immediate experience does not imply their nonreality." Id. at 39.
parallel to that filled by the orthodox belief in God [of religious traditions],"41 (one proposed definition for "religion" from the U.S. Supreme Court).

Second, unlike the case of religious healing—in which most explanatory models entirely derive from commonly agreed, theological constructs—attempts have been made to offer scientific explanations for some of the phenomena reported by practitioners and their clients. Such explanations do not rely on faith or belief, any more than scientific hypotheses in general can be said to be faith-based.42 For example, some scientists have postulated the existence of a unifying, biologically based field of information that can be accessed by practitioners of spiritual healing;43 while others have looked to electromagnetic explanations and still others to new theories of physics.44 Irrespective of the apparent success of—and controversy surrounding—such explanatory attempts,45 they suggest that practitioners and clients can have experiences of these practices without subscribing to a defined religious dogma or creed.

Third, many of the steps in these practices are described in such a generic way that the practitioner who does choose to incorporate a religious practice is free to draw on multiple religious traditions for inspiration. For example, Therapeutic Touch describes several basic steps in the process of healing through spiritual energy. These include centering, focusing on intent, scanning (or assessing the human energy field), directing healing energy to benefit a client, and facilitating

42. Of course, arguments have been made that scientific inquiry can be faith-based, in the sense of assuming certain premises and dismissing worldviews incompatible with these assumptions. See e.g. Paul Root Wolpe, The Maintenance of Professional Authority: Acupuncture and the American Physician, 32 Soc. Prob. 409 (June 1985). Thus, for example, when acupuncture came to the forefront of medical attention in the U.S. in the early 1970s, physicians and medical societies dismissed acupuncture principles as "Oriental hocus-pocus." Id. at 587-588 (quoting George A. Ulett, Acupuncture Treatments for Pain Relief, 245 JAMA 768, 769 (1981)).
43. See e.g. Beverly Rubik, Energy Medicine and the Unifying Concept of Information 1:1 Alt. Ther. in Health & Med. 34, 37 (Mar. 1995). Similarly, the Samueli Institute is a nonprofit organization, with links to laboratories in academic research centers internationally, that is attempting to elucidate scientific explanations for mechanisms underlying healing phenomena, including those associated with healing. The Samueli Institute defines "healing" as: "those physical, mental and spiritual processes of recovery, repair and renewal that increase order, coherence and wholism in the individual, the group and the environment."<www.siib.org/vision.asp> (accessed July 8, 2003).
release. In the first step of Therapeutic Touch, centering, the practitioner can use his or her preferred meditative practice to attain a quiet, calm, centered space within; no particular religion or religious practice is specified.

Similarly, in describing the preparation for a technique known as "pranic healing," the founder of this modality, Choa Kok Sui, describes the most important practice as exerting intentionality. Use of this concept does not depend on religious dogma or faith. Although Kok Sui recommends that practitioners who are religious do incorporate meditation, prayer, and an invocation in their use of pranic healing, his advice to the healer who relies on religion, is: "Pray for a few minutes any religious prayer you are used to." Thus, although Kok Sui advocates use of prayer by "the religious," he does not recommend use of any specific prayer or prayer within any specific religious tradition. For Kok Sui, there is no wrong choice and no penalty for invoking the wrong deity or turning to the wrong religion. Simply put, the optional "religious" practice is described sufficiently generically that the practitioner can draw on almost any religion; one could say that Kok Sui is not so much an advocate of religious pluralism, as an advocate of spirituality by the religious. In like fashion, practitioners of Reiki permit drawing on any, all, or no religious traditions for inspiration and centering.

The fourth reason to view spiritual healing practices that are offered in the clinical domain by non-clerical personnel as falling outside an exclusively religious paradigm, has to do with the blurring of the boundaries between religion and therapy. That is, it becomes increasingly difficult to distinguish between religious healing practices centered on affirmations of faith, and practices aimed at therapeutic benefit irrespective of whether the patient or provider subscribes to a particular set of beliefs. For example, some evidence has accumulated

46. See generally Delores Krieger, The Therapeutic Touch: How to Use Your Hands to Help or Heal (Prentice-Hall 1979); Therapeutic Touch (Béla Scheiber & Carla Selby eds., Prometheus Books 2000).
47. Krieger, supra n. 4; see infra Part C.
48. Kok Sui, supra n. 38, at xvii.
49. Id.
50. Cf. Diana L. Eck, A New Religious America (Harper San Francisco 2001) (exploring how Americans of all faiths and beliefs can engage with one another to shape a positive religious pluralism).
that suggests a correlation between religious practices and physical health. It has been suggested that even the attitude of the practitioner toward the patient can impact healing; or in conventional terms, it is recognized that the patient's attitude toward the therapy—the so-called "placebo effect"—can have therapeutic benefit.

In light of this work, many have begun advocating a role for the physician in helping the patient access his or her own source of religious practices for potential physical, as well as emotional and spiritual, dimensions of healing. The profession of psychotherapy also has witnessed a call for integrating spiritual healing approaches and techniques, given these developments, distinctions between "psychotherapeutic" and "spiritual" interventions might be difficult to make, or might depend, not on who is providing the intervention, but on how that intervention is framed. Such developments arguably blur the lines between "religious" and "therapeutic" use of prayer, as well as between "religion" and medical use of access to religious practices.

But even more directly, as suggested, attempts have been made to secularize both the learning process for, and practice of, spiritual healing in various health care professions—particularly, in nursing. And like the distillation of various religious traditions of laying-on-of-hands into a reproducible technique that can be taught in the nursing school curriculum (as in Therapeutic Touch), many analogous "religious" practices have been adapted and adopted to yield therapeutic benefit in

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53. See e.g. Larry Dossey, The Dark Side of Consciousness and the Therapeutic Relationship, 8 Alt. Ther. in Health & Med. 118 (2002).

54. See e.g. Koenig, et al., supra n. 52.


56. One could also argue that professions such as osteopathy, which have become mainstream and comparable to the medical profession in status and legal authority, represent the gradual secularization of practices initially based in spiritual discoveries. See Michael H. Cohen, Complementary and Alternative Medicine: Legal Boundaries and Regulatory Perspectives 140, n. 67 (Johns Hopkins U. Press 1998) (noting shift from AMA policy of forbidding physician association with osteopaths, to judicial criticism of a state board rule that attempted to perpetuate a distinction between M.D.s and D.O.s); Ted J. Kaptchuk & David M. Eisenberg, Varieties of Healing 2: A Taxonomy of Unconventional Healing Practices, 135 Ann. Int. Med. 196, 198 (2001) (noting that osteopathy has "reconfigured itself and has become 'conventional,' in the sense of DO's having 'equivalent status' to M.D.s"). Ironically, the discoveries of Andrew Taylor Still, the founder of osteopathy, had roots, like those of Palmer, the founder of chiropractic, in magnetic healing.
other secular settings. For example, self-directed “mindfulness meditation”—an attempt to calm the mind and focus on the breath in the present moment—has emerged from Buddhist meditation practices and ripened into a secular practice of potential therapeutic benefit, not only for patients in psychotherapy (as well as medicine), but also in professional relationships such as attorneys and clients in alternative dispute resolution.

Similarly, Transcendental Meditation (TM) has attracted practitioners who are not bound to religious teachings from the East but rather desire techniques to calm and still the mind. Indeed, meditation, the “central plank of ancient spiritual disciplines,” historically nestled within specific cultural contexts and codes, has been, in many contexts, secularized—and in some cases, reduced to a physiological “relaxation response.” In similar fashion, the National Center for Complementary and Alternative Medicine (NCCAM) at the National Institutes of Health gave eight million dollars to fund a research center at the Maharishi University of Management in Fairfield, Iowa, to pursue research involving the health benefits of TM and other techniques. At some

57. See e.g. Saki Santorelli, Heal Thy Self: Lessons on Mindfulness in Medicine (Bell Tower 1999).

58. For example, a recent conference at the Pepperdine School of Law had a workshop on “mindfulness in mediation.” See <http://law.pepperdine.edu/straus/conferences/workshops.shtml#6> (accessed Mar. 2003). The program notes state that:

Mediators aspire to provide the most appropriate service to the parties, but face many barriers to fulfilling that aspiration. One major barrier is that they often have trouble concentrating and listening—to others and to themselves. They are distracted by a welter of thoughts, emotions, bodily sensations and habitual modes of reacting. Often these factors are beneath conscious awareness. Mindfulness—a systematic method of paying attention, deliberately, in the moment, without judgment—can help mediators gain awareness of their mental and emotional processes and their habitual reactions, ultimately enabling them to perform better and to get more satisfaction from their work.


60. Aldridge, supra n. 19, at 94-95.

61. Id. at 95 (citing the work of Herbert Benson); see Herbert Benson, The Relaxation Response, in Mind Body Medicine 233-257 (Daniel Goleman & J. Gurin eds., Consumer Reports Books 1993).

62. The funding helped establish a Center for Natural Medicine and Prevention, with a proposed research agenda to include: “basic study of mechanisms of meditation on atherosclerotic CVD (arterial vasomotion, cardiac autonomic tone, and psychosocial risk factors); a clinical trial of effects of meditation on carotid arteriosclerosis, CVD risk factors, physiological mechanisms, psychosocial risk factors, and quality of life in older Black women with CVD].” See <http://nccam.nih.gov/training/centers/descriptions.htm#4 > (accessed July 8, 2003) and the website for the Center <www.mum.edu/CNMP> (accessed July 8, 2003).
point, the boundary between "religious" practices and mental health techniques also becomes blurred. It may also be that, as scientific understanding increases, the tendency to dichotomize science and the religious—particularly as regards CAM therapies—also changes.

In short, spiritual healing need not necessarily be equated with religion and the religious, but can also be viewed as practiced by persons without a specific religious predisposition.

Because of the varieties of understanding just described, for purposes of analyzing regulation of healing, this article offers a preliminary working definition of "religious healing" as healing in an exclusively religious context, and uses "spiritual healing" to denote a wider domain, including religious healing, as well as practices that can be offered in a secular context, such as the use of Reiki or Therapeutic Touch as a nursing service within a hospital.

C. Energy Healing as a "Frontier" Health Care Practice

In addition to this distinction between exclusively religious healing and a broader concept of spiritual healing, a further definitional wrinkle is worth noting. In many quarters, the term "energy healing" has come to denote spiritual healing in a secular (health care) context typically by providers other than religious personnel (i.e. other than clergy).

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64. One recent attempt involves using complexity theory to explain phenomena previously understood only through the lens of CAM disciplines. See e.g. Zhu Jianping & Ken Rose, Chinese Medicine and Complexity, 3 Clin. Acupuncture & Oriental Med. 77 (2002).

65. Theoretically, an atheist or agnostic could practice Therapeutic Touch, although this assertion would be debated by those who believe that to practice a technique such as Therapeutic Touch is to adopt a particular set of beliefs akin to those adopted by the "religious." In a sense, this harks back to the earlier tautology (if it is not scientific, it is religious), and to the earlier argument as to what is "religious," both of which may be essentially unsolvable. A similar problem arises when one tries to define Spirit or spirit—or what it means to be spirited, or to practice mind-body-spirit medicine; again, the definition might differ depending on who is invoking the definition (for example, a practitioner of Christian Science, a Navajo healer, a minister, a practitioner of Japanese acupuncture, a physician in the emergency room). The problem is compounded by the fact that some practices involve actual "laying on of hands" whereas others do not necessarily require contact with the physical body, and, according to proponents, can even be done from a distance (as in so-called "distant healing," which relies, according to some theorists, on "non-local consciousness," the notion that information and healing accessed through consciousness is not dependent on limitations of space and time). See infra n. 229 and accompanying text.

66. Much of the discussion also uses the words "spiritual healer" and "spiritual healing," to
“Energy healing” is frequently the language of choice by practitioners (and patients) of therapies such as Reiki, Therapeutic Touch, Polarity Therapy, and other forms of spiritual healing in the context of professional health care services. 67

“Energy healing,” however, also is often used (by some) interchangeably with “spiritual healing,” thus confusing the terminology as well as the conceptualization of what energy healing purports to be, how it purports to work, and in what ways its application within a mainstream health care setting partakes of (or fails to partake of) practices classically considered “religious.” Further, the fact that a member of the clergy—as opposed to, say, a nurse—offers a patient Therapeutic Touch does not transmogrify the practice into the category of “religion”; and similarly, the fact that a nurse prays with a patient does not transmogrify prayer into energy healing. It may be impossible to sort out the definitional confusion at present, since this would require a much deeper understanding of the scientific mechanism, if any, of the various practices; and a resolution of larger, perhaps multidisciplinary issues, such as the relationship between meditation, prayer, and the theoretical transmission of mental energy or consciousness for the purposes of healing.

For the moment, one current conceptualization that may help clarify these issues describes energy healing as “a set of therapies based on the projection of spiritual or mental energy through intentionality and consciousness.” 68 In this definition, the term “intentionality” refers to mental processes and is free from connotations of attachment to a specific religion. And, as noted, the “projection of spiritual or mental

denote healing practices by both religious and secular personnel.


68. Cohen, supra n. 7, at 129. This can be conceptualized as including at least three different, but somehow linked, kinds of phenomena: (1) potentially explainable transmissions of informational patterns between humans in the form of bio-electromagnetic energy; (2) transmissions of informational patterns that are physically, emotionally, and spiritually mediated between individuals in close proximity—for example, by laying on of hands—that presently cannot yet wholly be accounted for in material or physical terms; and (3) nonlocal phenomena such as distance healing that may or may not be phenomena of body, mind, or spirit (however one defines each of these concepts). Id. at 10. Recently, the Samueli Institute for Informational Biology sponsored a symposium which organized a list of working definitions and terms, ranging from “attention,” to “biofield,” to “nonlocality” in healing, to “healing” (“those physical, mental, social, and spiritual processes of recovery, repair, renewal, and transformation that increase wholeness, and often (though not invariably), order and coherence”), to “spirituality” (“feelings, thoughts, experiences, and behaviors that arise from a search for that which is generally considered sacred or holy”). Larry Dossey, Samueli Conference on Definitions and Standards in Healing Research: Working Definitions and Terms, 9 Alternative Therapies A10-A12 (May/June 2003).
energy through intentionality or consciousness" may be performed by physicians\(^69\) and allied health professionals, and as well by CAM providers such as acupuncturists and massage therapists, irrespective of religious affiliation of training.\(^70\) Again, theoretically, an atheist, an agnostic, a person of indeterminate religious affiliation, and a person with multiple religious proclivities could offer such practices.

Unlike fields of CAM therapies such as chiropractic and acupuncture—and to a lesser extent, massage therapy\(^71\)—there are no uniform standards for education, training, and practice of energy healing. Energy healing presently lacks a strong, unifying, national body that can translate theory and practice into a health care profession capable of attaining candidacy for licensure in any given state.\(^72\) Therefore, energy healing largely remains a covert element of many professions, and it lacks the support of an independent licensing mechanism for its practitioners.

Furthermore, the training offered to professionals to practice energy healing is not uniform but differs, depending on the school offering the training and its particular philosophy of education. Thus, an individual provider’s training may differ, depending on the practitioner’s appetite for immersion in learning theory, techniques, and practice. For

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69. A separate set of issues arises regarding the ethical implications of clinicians discussing religion with patients as part of medical diagnosis and treatment. These include, for example, questions regarding potential imposition of the provider’s beliefs on the patient, potential coercion, violation of therapeutic boundaries, and management of intraprofessional boundaries. Koenig, supra n. 31, at xiii; see generally Harold G. Koenig, Spiritual in Patient Care: Why, How, When, and What (Templeton Found. Press 2002). Asking patients questions about their spirituality, and taking their responses into account, is “not ‘alternative medicine,’” King, supra n. 31, at 7, and thus differs from using energy healing as a diagnostic or therapeutic modality. Rather, assessing patients’ religious beliefs and practices can help clinicians understand patient interpretation of disease and therapy. Id. at 49. On the other hand, praying with patients may overlap with energy healing practices, since conceptually, energy healing includes accessing nonphysical forces of healing to improve health or wholeness. See Cohen, supra n. 7, at 134-136.

70. Several tools and indices have been adopted to take a patient’s "spiritual history," either as part of a social history or in response to various events in the patient’s medical life and/or the therapeutic relationship. See King, supra n. 31, at 56-62. See Cohen et al., at supra n. 28, at 34-37, (offering guidelines for professional inquiries by physicians regarding patients’ spiritual beliefs). Yet, although such tools may be useful, it must be remembered that medicine “is not a form of religion, and physicians are not priests”; thus, counseling patients inappropriately or invasively concerning spiritual care “opens wide the door to coercion,” and physicians (and other health care providers) must “walk a fine line between the practice of medicine and the practice of religion and between sympathetic response to patients’ spiritual needs and professional coercion.” Id. at 36-37.


72. See generally id. (suggesting importance of strong, national professional organizations for licensure).
example, practitioners can receive certificates in weekend courses or can choose to take much longer programs, such as four-year programs that attempt to integrate energy healing into other professional health care practices. Further, the numerous schools offering energy healing certificates may include a variety of related items within their coursework, including related activities such as spiritual development, “mediation and shamanic journeywork,” hypnotherapy certification, and modalities such as Reiki. As with other CAM professions, counseling the patient appears to be an integral part of many energy healing practices.

Although the experience of energy healing can be individualized, there appear to be common elements, at least as described by patient recipients of energy healing. These can include sensations of warmth, tingling, and caring. For instance, the Chantilly Report describes the experience of energy healing as follows:

[It is] a process during which the practitioner places his or her hands either directly on or very near the physical body of the person being treated . . . [and] engages the perceived biofield from his or her hands with the recipient’s perceived biofield either to promote general health or to treat a specific dysfunction.

Rather than turning to established religions for explanations of healing, practitioners frequently describe the process in terms of the “biofield” or “human energy field” (or “aura”). Such a human energy field is described as surrounding and interpenetrating the human body, and as

73. The Chantilly Report catalogue a variety of modalities, their theory and practice, and their sponsoring, educational institutions. See Chantilly Report, supra n. 11, at 134-142.
74. The above-described training is offered by the High Touch Healing Arts Academy in Huntington Beach, Cal. (information available at <www.schools.naturalhealers.com/hightouch> <spiritnetwork.com/hightouch/healing.html> (accessed July 29, 2003)).
75. The above-described training is offered by North Shore Hypnosis & Reiki, in East Northport, N.Y. (information available at <www.schools.naturalhealers.com/northshore> (accessed July 29, 2003)).
78. Chantilly Report, supra n. 11, at 134. As noted, The Report uses the term “biofield therapeutics,” a term that has not been widely adopted. Interestingly, the Report classified biofield therapeutics as a “manual therapy,” while it puts prayer in another classification (i.e. as a "mind-body" therapy). The typical presence (or absence) of human touch appears to be the reason for these classifications, although the Report does observe that “mental healing, psychic healing, distance healing, nonlocal healing, and absent healing” are part of biofield therapeutics. Id. at 135.
79. See e.g. Brennan, supra n. 76, at 5.
having multiple layers that express different dimensions of human consciousness.\textsuperscript{80} Similarly, rather than turning to concepts within religious traditions, such as “prayer,” “meditation,” or “grace,” practitioners frequently refer to more neutral, secular explanations such as, in Therapeutic Touch, the notion of “centering,” which can involve prayer or meditation but more fundamentally, simply involves “being at a quiet place within ourselves from which we can focus completely on the person before us.”\textsuperscript{81} Likewise, Therapeutic Touch uses the concept of “assessment” to detect imbalances of energies; assessment involves scanning the “energy field” with the hands and locating imbalances of spiritual energy by sensing “tingling, pressure, shock, pulsation, heat, or coolness.”\textsuperscript{82} Modalities such as Therapeutic Touch do not necessarily rely on the notion of “prayer” or of “laying on of hands” in the sense of appealing to God to perform the healing, but rather emphasize a transfer of spiritual energy from (or perhaps, through) practitioner to client.\textsuperscript{83} Indeed, the use of such conceptualizations by practitioners of energy healing—resting, as these explanations often do, outside identifiable religious contexts—can offend religious personnel and believers, and in this sense, are even deemed anti-religious.\textsuperscript{84}

Ironically, there is not yet a scientific consensus for, or validation of, the “spiritual” form of the energy that is presupposed to be transmitted in “energy” healing practices, although NCCAM is sponsoring research projects in this arena of “frontier science,” in an attempt to find mechanistic scientific explanations for, and sound methodological approaches to study, observed phenomena.\textsuperscript{85} In its own way, attempting to bridge beliefs about healing and science, NCCAM has defined the field as follows:

Frontier Medicine can be defined, for purposes of this initiative, as those CAM practices for which there is no plausible biomedical explanation. Examples include bioelectromagnetic therapy, biofield/energy healing, homeopathy and therapeutic

\textsuperscript{80} Id. at 49-54.
\textsuperscript{81} Charlotte A. Wytyas, \textit{Therapeutic Touch in Primary Care}, 5 Nurse Practitioner Forum 91, 93 (June 1994).
\textsuperscript{82} Id. at 93-94.
\textsuperscript{83} In Therapeutic Touch, this step is known as “directing and modulating energy.” Id. at 94.
\textsuperscript{84} See Aldridge, supra n. 19, at 16 (discussing how Larry Dossey has been “criticized by churchgoers for his support of psi phenomena,” and how an English bishop interested in laying-on-of-hands was criticized for importing “Eastern spirituality”).
prayer/spiritual healing. Despite the fact that these therapies are used extensively by the U.S. public, there are very little high-quality data available to elucidate or demonstrate the safety, efficacy, effectiveness and/or mechanisms underlying these approaches.\(^86\)

Notably, the NCCAM definition is for research and not legal purposes, and therefore lumps prayer together with energy healing.\(^87\) The Request for Proposals, however, proposes a more secular purpose for funding. It notes that the Exploratory Program Grants will serve to develop the fields in ways that will increase the likelihood that efficacious therapeutic paradigms will emerge from the existing Frontier Medicine approaches, and thus increase the probability that some of these will become integrated with and will make a contribution to interdisciplinary healthcare.\(^88\)

While scientific consensus around mechanistic explanations is lacking, use of the word “energy” in NCCAM and the research literature does not specifically refer to mechanical notions of energy in physics. Rather, the term “energy” probably has “a broader interpretation in spiritual healing and is likened to organizing principles of vitalism and life force which bring about a harmonizing of the whole person.”\(^89\) In other words, “energy” suggests “dynamic forces that are channelled or set in motion by the healer, or the patient,” to create a transcendent wholeness.\(^90\)

The articulation of energy healing has a secondary import: it also helps describe a subset of CAM therapies, linked by this notion of a unifying, healing spiritual energy: the notion of yin and yang in traditional oriental medicine; the idea of the “innate” in chiropractic; the “spiritual vital essence” (vital force) in homeopathy; and the “prana” in Ayurvedic medicine, all reflect the unifying notion of vital energy.

\(^86\) Id.
\(^87\) NCCAM further defines the program areas within “frontier medicine” as: Bioelectromagnetic Therapy (e.g. diagnostic and therapeutic application of electromagnetic (EM) fields including pulsed EM fields, magnetic fields, Direct Current (DC) fields, artificial light therapy, etc. Note: This category does not include the study of electromagnetic fields as risk factors for disease); Biofield (e.g. energy healing, etc. Note: This category involves systems that use “subtle energy” fields in and around the body for medical purposes. Examples include Therapeutic Touch, Reiki, Huna, laying-on-of-hands, external Qi-Gong, etc.); Homeopathy; or Therapeutic Prayer; Spiritual Healing; Distance Healing; or other examples of prayer and/or spirituality as direct clinical interventions. Id.
\(^88\) Id.
\(^89\) Aldridge, supra n. 19, at 42.
\(^90\) Id.
embedded in consciousness.\textsuperscript{91} Thus, while the term "energy healing" refers in a specific sense to therapies aimed, via physical touch or thought, at transmission of intentionality or consciousness to heal, the term captures,\textsuperscript{92} in a broader sense, the common, vitalistic worldview underlying many CAM therapies.\textsuperscript{93}

In this sense, many CAM therapies share common ground in that they involve spiritual notions of healing that may or may not immediately and directly affect physical health, and thus, in themselves help bridge the present, cultural and ideological chasm between medicine and religion. Perhaps for this reason, their introduction into medical care has been highly controversial,\textsuperscript{94} and has raised issues of power, authority, and legitimacy with respect to who decides what therapies are valid for patient care.\textsuperscript{95}

\section{Regulatory Intervention Into Spiritual Healing}

\subsection{The Constitutional Side (Spiritual Healing and Constitutional Values)}

As suggested, spiritual practices involving healing—on physical and emotional, as well as spiritual levels—are central to a variety of religious traditions. Increasingly, such practices are becoming part of worship services, whether in synagogues and temples, churches, mosques, or other venues for spiritual expression.\textsuperscript{96} Religious pluralism and freedom of religious expression are core values in American society

\begin{thebibliography}
\bibitem{91} Cohen, \textit{supra} n. 67, at 81.
\bibitem{92} \textit{Cf.} Aldridge, \textit{supra} n. 19, at 43 (defining healing as "the intentional influence of one or more persons upon a living system without using known physical means of intervention") (quoting Daniel Benor, \textit{Spiritual Healing in Clinical Practice}, 87 Nurs. Times 9 (1991)).
\bibitem{93} "The names of the energies change—life force, universal innate intelligence, psychic, parapsychological, psi astral, spiritual vital force—but they inevitably elude scientific detection." Kaptchuk & Eisenberg, \textit{supra} n. 56, at 199. The authors offer a taxonomy that distinguishes such "New Age healing" from "mind-body medicine," "religious healing" (use of "religion for salutary effects on ... health"), "folk medicine practices," "ethno-medicine," and categories such as non-normative scientific enterprises, popular health reform, and professional or distinct medical systems.
\bibitem{95} See Kaptchuk, \textit{supra} n. 30, at 821-822 (suggesting that "the question of enhanced placebo effects raises complex ethical questions concerning what is 'legitimate' healing, and what kinds of measurement embody cultural judgment on what is 'correct' healing.").
\end{thebibliography}
and guarantees of religious pluralism and expression are embedded in the First Amendment to the U.S. Constitution. Yet, while the First Amendment protects religious expression, the Tenth Amendment to the Constitution reserves to the states the power to protect citizens' health, safety, and welfare, and thereby to regulate professional health care practices. Under this reserved "police" power, states decide who may practice and who may be excluded from practice of the healing arts.

This power to regulate professional health care practices includes not only medicine and the allied health professions (for example, nursing, dentistry, physical therapy, optometry), but also health care practices historically outside of biomedicine—such as CAM therapies. But CAM therapies are defined to include chiropractic, massage therapy, herbal medicine, acupuncture, and spiritual healing practices, ranging from meditation and prayer to yoga and guided imagery. In other words, irrespective of constitutional protection for "religion," or even for privacy and due process of law, CAM practices are subject to health care regulation; and practices that cross the boundary into "medicine," even if they have religious aspects or infringe on a person's sense of what is best for his or her body, may constitutionally be regulated.

The constitutional collision between individual freedom and the states' rights to regulate pursuant to the Tenth Amendment has received little scholarly attention, largely because in most instances, states' rights have trumped. For example, in a landmark 1905 case, Jacobson v. Massachusetts, the U.S. Supreme Court upheld the state's right to order compulsory vaccination for public schoolchildren, and rejected the argument that vaccination violated the individual's "inherent right of every freeman to care for his own body and health in such way as to him seems best." The court observed that "a community has the right to protect itself against an epidemic of disease which threatens the safety of its members." In Jacobson, the state's obligation to protect its citizens against public health risks was—and since, typically has been—deemed superior to the individual's claim to a right to make autonomous health care choices for his or her own body.

98. Chantilly Report, supra n. 11, at xi-xiii.
100. 197 U.S. 11, 26 (1905).
101. Id. at 27.
Subsequent cases have reaffirmed the principle. Courts have found that the police power outweighed not only the individual’s privacy and liberty interests but also the practitioner’s free speech interests in professional health care practice. Interpreting the practice of “medicine” broadly—as any activity that could be construed as “diagnosis” or “treatment” of human affliction (see infra)—courts have upheld a variety of cases against spiritual healers for practicing “medicine” without a license. For example, in Smith v. People, defendant practiced hands-on healing from his living room and claimed that he merely used his hands to deliver a “gift from the Almighty”; yet, because he purported to cure diseases by laying on hands, his conviction for practicing medicine unlawfully was upheld. Similarly, while courts have found constitutional protection for medical choices such as contraception, abortion, and the right to be disconnected from artificial life support, most courts have refused to recognize a constitutional, privacy-based right to obtain the treatment of one’s choice (for example, acupuncture) against the objections of a state regulatory body (such as a medical licensing board).

Whether or not such decisions are correct as matters of constitutional interpretation, they do suggest an underlying hierarchy of values when it comes to clashes between the personal choices involving the conflux of “religion” and “medicine.” Religious practices involving health are frequently swept into the conceptual category of medicine and its regulation. In this way, the legal system checks individual healing choices, and challenges healing impulses in both medical, as well as religious, personnel that represent potential incursions on state determinations of the legally accepted boundaries of healing. Concomitantly, the medical profession itself has adopted an arguably hegemonic definition of its own scope of practice that sweeps spiritual healing choices under medicine’s rubric.

 Ironically, while the broad, statutory definition of the practice of “medicine”—and its interpretation by courts—appears to include practices intended as religious, the medical profession seems to exclude, rather than embrace, religious healing practices in its diagnostic and

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104. Id. at 22.
105. 117 P. 612 (Colo. 1911).
106. Cohen, supra n. 56, at 81-82 (citing cases).
107. See infra Part IV(A). (Medical Licensure).
therapeutic offerings. As one scholar puts it:

    The [scientific basis of modern medicine] often ignores the
    spiritual factors associated with health. Health invariably becomes
    defined in anatomical or physiological, psychological or social
    terms. Rarely do we find diagnoses that include the relationship
    between the patient and their God.108

And yet, if a nonphysician were to make such a diagnosis—connecting
the patient’s health to the relationship between the patient and his or her
deity, or between the patient and the cosmos, the nonphysician clinician
could, conceivably, be construed as practicing “medicine” unlawfully.109

    This legal opposition between medical healing and spiritual healing
    sets up a contradiction between the legal definition of practice and the
    intended practice of some medical professionals. In fact, it could be
    argued that the actual practice of medicine should—and does—include
    spirituality:

    Patience, grace, prayer, meditation, hope, forgiveness and
    fellowship are as important in many of our health initiatives as
    medication, hospitalization, or surgery . . . . It is in the
    understanding of suffering, the universality of suffering and the
    need for deliverance from it that varying traditions of medicine
    and religion meet.110

    In short, although spiritual healing practices may be an inherent
    part of health care, when they involve “diagnosis” or “treatment” (in the
    broadest conceptualization of these terms), the legal definition of
    medical practice makes such practices inherently criminal—unless they
    are performed by a medical doctor (or, presumably, by another licensed
    provider within the legally authorized scope of practice). This is
    because, as noted, the typical medical licensing statute brings even
    religious practices into the state’s power to sanction unauthorized
    healing conduct.111 Again, the rationale has been protection of public
    health, safety, and welfare, although from an historical perspective, such
    broad interpretation of medical licensing requirements also reflects the
    political and ideological triumph of biomedicine over its rivals and

109. See infra Part IV(A) (Medical Licensure).
110. Supra n. 108.
111. See Cohen, supra n. 56, at 15-23 (citing cases, and observing that “references to
    chiropractic and other modalities as ‘sorcery’ and ‘voodoo’ have continued to find their way into
    biomedical and legal discourse”). See infra Part IV(A). More recently, the increasing prevalence
    of CAM therapies also has resulted in calls for a more “pluralistic system of health-care delivery”
    that includes “spiritual, as well as physical, psychological and social” definitions of illness, health
    and healing. Aldridge, supra n. 19, at 10.
competitors. But as noted, medical practice also has been defined as "the humane action of one human [being] toward another to provide comfort, relief and sometimes to cure"—that is, as sometimes constituting practices involving medical training and skill, and sometimes simply constituting practices involving a healing intention.  

As suggested, the clash in constitutional values should be noted and clarified, but cannot necessarily be resolved, without addressing the larger confusion about what is "medical" and what lies outside the boundaries of medicine; what should be incorporated within medicine and how teams of healing professionals can interact; what are the interlocking layers of "health" and "disease" at all levels of being; what is "physical," versus "mental," "emotional," and "spiritual" (and how these are connected and distinct); which legal rules are anachronistic or the result of historical hegemonies and rivalries, and which legal rules protect patients and further health; and finally, how the complex mix of interlocking aspects of a person's being involving "health" can be understood, and, in some salutary fashion, be regulated.  

For now, it is clear from case law that the state has the right and authority, as part of its police power, to regulate spiritual healing practices as one of many health care services offered by providers. The question is whether exercise of such authority unduly (though not necessarily unconstitutionally) intrudes into a domain of healing considered by many to be "religious" or, at the least, "spiritual," and thereby is beyond the purview and authority of public policy and legal constraint.

B. The Policy Side: Regulation of Spiritual Healing

With many states licensing a variety of CAM providers, it may seem inevitable that new CAM professions, including those based largely on spiritual healing practices, will seek licensure. But in fact, although a current trend is toward increasing licensure of health care providers and toward increasing administrative involvement in the licensing process, licensing is not uniformly favored as a mechanism to control dangerous and deviant practices. The critique of occupational licensure holds that licensure tends to be ineffective and tends to protect

112. Aldridge, supra n. 19, at 30 (citing E. van Leeuwen & G. Ksima, Philosophy of Medical Practice: A Discursive Approach, 18 Theoretical Med. 18, 19-22 (1997)).  
113. See Cohen, supra n. 56, at 15-23.  
114. At least in the arena of CAM therapies, acupuncturists and massage therapists are increasingly finding themselves subject to state licensure. See Eisenberg et al., supra n. 71, at 967, 969.
the entrenched interests of those judging candidates for licensure, rather than the public, therefore by and large failing to serve the interests it portends to present.\textsuperscript{115}

But even if it were effective as a means to control fraud, licensure has other implications in terms of its limits on practitioners’ ability to rely on intuitive aspects of their craft—the so-called dark side of regulation.\textsuperscript{116} Particularly in the case of CAM therapies, licensure presents a potential “dark side” in terms of increased regulatory control and bureaucratic hurdles, and unnecessary intrusion into the therapeutic relationship.\textsuperscript{117} For this reason, many CAM providers fear that the “heart and soul” of their profession will be lost once they are subject to professional regulatory boards.\textsuperscript{118}

If practices involving energy healing remain at the crossroads of touch, intention, therapeutic contact, and caring—that is, they are practiced in good faith, with genuine regard for patient boundaries—then practitioners might have a genuine fear that regulation would be intrusive and have an overall destructive effect on morale in practice. Many providers, in fact, prefer that practices such as energy healing remain unregulated and beyond the requirements of uniform examinations and educational criteria.\textsuperscript{119}

But even in the absence of licensing mechanisms, spiritual healers remain at risk of prosecution when their practices purport to involve (or are understood by the patient to involve) a potential effect on physical health. Once the line between religion and medicine is crossed, the state arguably has the right (and many would argue, the duty) to intervene. Certainly, as noted, the police power pursuant to the Tenth Amendment authorizes such intervention, once practices aim not only at belief, faith, and doctrine, but also at facilitating physical health.\textsuperscript{120} And states, as

\textsuperscript{115} See infra Part IV(A)(1); see Sue A. Blevins, The Medical Monopoly: Protecting Consumers or Limiting Competition?, Policy Analysis No. 246 (Cato Instit. 1995); Edwin A. Locke et al., The Case against Medical Licensing, 8 Medicolegal News 13, 15 (Oct. 1980).

\textsuperscript{116} Eisenberg et al., supra n. 71, at 971-972.

\textsuperscript{117} Id.

\textsuperscript{118} Id.

\textsuperscript{119} See Cohen, supra n. 56, at 35.

\textsuperscript{120} Indeed, it has been argued that since the Medicare Act allows Christian Science faith healers to receive Medicare benefits, the patient’s visit to a Christian Science faith healer is “primarily . . . a medical one, not a religious one, or arguably both.” Lauren A. Greenberg, \textit{In God We Trust: Faith Healing Subject to Liability}, 14 J. Contemp. Health L. & Policy 451, 469 (1998). Greenberg argues that Christian Science faith healers therefore should be “held accountable under the medical licensing laws, be regulated under the provisions regarding health care providers, and be liable for medical malpractice for negligence.” Id. Alternatively, she argues, if such faith healers are to be exempt from licensing laws and other regulation, their patient visits should not be covered under Medicare.
noted, have not hesitated to prosecute healers in situations involving the patient’s physical health.

At least one court, in Board of Medical Quality Assurance v. Andrews, has expressly drawn a line between purely “religious” care, and care sufficiently touching medical concerns as to warrant prosecution.121 In Andrews, the minister of a religious organization purported to have special knowledge of body symptoms and needs, diagnosed ailments, and prescribed treatments to his clients. These included severe and prolonged fasts, which apparently endangered the lives of some of the clients. In reviewing his conviction, a California appeals court found the minister to have engaged in the practice of medicine. The court reasoned that the purpose of the fasts and other treatments was therapeutic and not religious.

Andrews suggests that once a religious figure has crossed the line into recommending therapies that aim at physical, as well as spiritual, benefit, a court well may find that the practitioner has crossed the line into practicing medicine. The holding of Andrews is consistent with the tendency by courts to interpret “diagnosis,” “treatment,” and the “practice of medicine” extremely broadly,122 sweeping many different kinds of diagnostic and therapeutic activities—whether or not expressly “medical”—under the medical licensing statute’s rubric. As suggested, historically, such broad interpretation helped to maintain the monopoly by biomedicine over professional healing practices.123 In any event, whether or not spiritual healing practitioners find a way to receive licensure, or to find exemptions thereto,124 their activities will doubtless be seen as affecting physical health, and thereby to cross the line into licensed medical (and other health care) practices.

An interesting arena in which spiritual healing practices are subject to regulatory control involves informed consent. The doctrine of informed consent protects the patient’s bodily integrity by requiring disclosure of information material to patient decision-making. The doctrine does not necessarily provide the patient with a protected interest in access to a variety of therapies.125 Nor have informed consent rules particularly expanded to embrace a patient’s right to be informed

121. 211 Cal. App. 3d 1346, 260 Cal. Rptr. 113 (1989).
122. See infra Part IV(A)(1).
123. Cohen, supra n. 56, at 22-23.
124. See the discussion infra, Part IV(A), of new state laws regulating non-licensed CAM providers.
125. See Marjorie Schultz, From Informed Consent to Patient Choice: A New Protected Interest, 95 Yale L.J. 219 (1985); Cohen, supra n. 56, at 60-61.
concerning CAM therapies. Yet, presumably, there are risks and benefits of practices involving energy healing, even though it might be difficult to frame such disclosure, given the relative paucity of practice standards and scientific evidence concerning results. Policy arguments surrounding regulation of energy healing remain inconclusive and in flux.

III. CONCEPTUALIZING ABUSE

A. Defining “Abuse”

The fiduciary element of the healer-client relationship is ubiquitous, whether that healer is a physician, a mental health care professional, a nurse, or a member of the clergy. Perhaps for this reason, ethical codes among such diverse professions as medicine, chiropractic, and massage therapy contain parallel provisions. Yet, because spiritual healing traditionally has been offered within a religious context, it is also useful to begin by looking at definitions of abuse within the relationship between a member of the clergy and a believer. Further, the spiritual authority of the clergy presents unique challenges in conceptualizing the potential for abuse of that fiduciary relationship.


127. In the faith healing context involving a practitioner of Christian Science, an early case noted that the applicable standard would be the “standard of care, skill and knowledge of the ordinary Christian Scientist, insofar as he confined himself to those methods.” Speak v. Tomlinson, 59 A. 376, 378 (N.H. 1904).

128. Countering the trend toward increasing licensure of health care providers is a movement to reduce the bureaucracy, restrictiveness, and professional turf battles caused by licensure, by creating a new class of “unlicensed” CAM providers that are regulated largely by registration. See infra nns. 184-192 and accompanying text. By creating a large group of providers not subject to the more rigorous criteria for state licensure (as opposed to mere registration), such statutes may counteract a historical trend of using state licensing laws to maintain professional monopolies and exclude undesirable competitors. See Cohen, supra n. 56, at 15-23 (describing use of licensing laws to maintain economic control over professional health care services).

129. See Cohen, supra n. 7, at 72-78. In medicine, physicians:
hold a near monopoly on a sort of power that can make the difference between sickness and health to persons who have been made vulnerable by pain, uncertainty, grief, anxiety, or simply by their dependence on others for care . . . . Fidelity to patients requires that physicians use their power in ways that avoid inadvertent or deliberate coercion.

Cohen et al., supra n. 28, at 36.

While informed consent has been heralded as a limitation on the potential for physician abuse of power, misconduct can infuse more subtle dimensions of the therapeutic relationship, and arguably require vigilance beyond the sanction of legal and ethical rules. See generally Howard Brody, The Healer’s Power (Yale U. Press 1992).
In describing betrayal and infliction of trauma within the setting of the provision of religious services, the term “abuse” has been used almost exclusively to describe sexual abuse between clergy and client. The notion of abuse, however, covers a larger territory, of which sexual misconduct is a subset. More generally, abuse signifies a deviation from the trust and fiduciary responsibility expected by a practitioner of professional health care services. An alternative term in the literature, referring to pastoral care, is “clergy misfeasance”; one current definition is “the exploitation and abuse of a religious group’s believers by trusted elites and leaders of that religion.”131 In legal terms, such misfeasance represents a violation of fiduciary responsibility. Use of the term “clergy misfeasance” recognizes that similar violations also “occur across a broad range of occupations and institutions—for example, in doctors’ and counselors’ offices, in law firms, and on university campuses”—in short, in other contexts presenting “hierarchies of unequal power.”132 In this usage, clergy misfeasance has been conceptualized as a subset of “elite deviance,” broadly defined as “illegal and unethical acts committed by persons in the highest corporate and political strata of society,” who “run relatively little risk of apprehension or serious punishment.”133 Examples include manufacturer distribution of dangerous products and political and corporate corruption.134

Unlike perpetrators of “secular” elite deviance, whose misconduct frequently is motivated by desire to further organizational goals, perpetrators of clergy misfeasance frequently are motivated by “lust, greed, or personal problems.”135 Again, however, the common element is violation of a fiduciary relationship—betrayal of trust in an expert professional to whom the client “has turned for services and assistance and thereby revealed vulnerability.”136

130. “Over the past decade clergy misfeasance has been discussed largely within a narrow sexual paradigm—the sexual exploitation of youth by pedophiles or of vulnerable females by male clerics.” Anson Shupe, The Dynamics of Clergy Misfeasance, in Wolves Within the Fold: Religious Leadership and Abuses of Power 1, 2 (Anson Shupe ed., Rutgers U. Press 1998).
131. Id. at 1.
132. Id. at 1-2.
133. Id. at 3 (citing David R. Simon & Stanley Eitzen, Elite Deviance (Allyn & Bacon 1990)).
134. Id.
135. Id. at 4. Psychotherapists who violate sexual space with clients tend to have unmanageable levels of personal vulnerability, fear of intimacy, crises in personal relationships, feelings of failure, low self-esteem, poor impulse control, professional isolation, and depression. Cohen, supra n. 7, at 175-180 (citing Patricia Keith-Spiegel & Gerald P. Koocher, Ethics in Psychology: Professional Standards and Cases 256 (Random House 1985)).
136. Shupe, supra n. 130, at 4.
Clergy malfeasance, as previously defined, takes at least three forms of deviance: sexual, economic, and authoritative. Sexual deviance includes seduction, rape, and pedophilia. Economic malfeasance includes con schemes and diversion of funds for personal enrichment. Familiar examples include economic fraud by televangelists, and resemble white-collar crime, with an added overlay of religious manipulation.

Authoritative malfeasance (or “abuse of authority” by a spiritual figure) includes “excessive monitoring and controlling of members’ livelihoods, resources, and lifestyles to enrich” the spiritual figure. Basically, authoritative malfeasance (deviance) means “abuse of authority by a religious leader,” and covers a gray zone or continuum of behaviors, from those acceptable (e.g. “shepherding” others) to those clearly identifiable as wrongful (e.g. micromanaging every aspect of followers’ lives). A popular term used for this kind of abuse from the perspective of the victim is “toxic faith,” defined by one author as “a destructive and dangerous involvement in a religion that allows the religion, not a relationship with God, to control a person’s life.” Notably, the term “spirituality” could equally be substituted for “religion,” and a generic term such as “one’s spiritual center” could be substituted for the more religiously oriented term, “God.” The principle remains the same: ceding personal power and enabling

137. Id. at 5.
138. Id.
139. Id. at 6.
140. Anson Shupe, Economic Fraud and Christian Leaders in the United States, in Shupe, Wolves, supra n. 130, at 49-64.
141. Id.
142. Shupe, Dynamics, supra n. 130, at 7.
143. Id.
144. Id. at 7.
145. Stephen Arterburn & Jack Felton, Toxic Faith: Experiencing Healing From Painful Spiritual Abuse 19 (WaterBrook Press 2001). The authors, like Booth, agree that “[p]eople broken by various experiences, people from dysfunctional families, people with unrealistic expectations, and people out for their own gain or comfort seem especially prone to ... abusive and manipulative and ... addictive” involvement with spirituality. Id. The authors list four common characteristics of “religious addicts”: having had rigid parents, having a deep wound from a major disappointment, feeling low self-worth, and being a victim of abuse. Id. at 20. They include as forms and variations of toxic faith: compulsive religious activity, laziness, giving to get, self-obsession, extreme intolerance, and addiction to a religious high. Id. at 24-31. Ironically, they argue, “toxic faith” erects barriers between individuals and genuine spiritual growth. Id. at 20.
146. Id. The book’s title, which refers to “Spiritual Abuse,” implies as much. Since autonomy is voluntarily relinquished, however, and not invaded, legal rules such as those governing informed disclosure arguably are inapplicable.

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dysfunctional control in the name of higher ideals.  

Ultimately, all these forms of misconduct are, in a psychological sense, boundary violations—distortions of the accepted and healthy boundaries of the therapeutic relationship between the spiritual caregiver and the recipient of spiritual care. Boundary violations are a common ethical concern in psychotherapy, and indeed, the mental health professions offer an additional model for exploring the potential for abuse between the practitioner of spiritual healing and client. As a baseline, issues of sexual boundaries between therapist and patient and their potential exploration are of deep concern. But in addition, the profession has sufficiently evolved to generate a complex set of definitions and rules governing many different kinds of potential abuse between psychotherapist and client.

Arguably, ethical rules governing mental health counseling provide a particularly useful analogue for practices involving spiritual healing, because of the attention paid to the therapist’s own psychological state (e.g. awareness of transference and counter transference) and the need to respect the client’s emotional boundaries as part of the therapeutic process. Furthermore, the ethics of mental health counseling emphasize a holistic view of personal development as a paramount treatment goal. Finally, psychotherapy emphasizes the patient’s

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147. As suggested, it is not simply the attribution of physical illness to religious compliance (or lack thereof) that is abusive, but rather the control and manipulation of individuals’ expectations, beliefs, and conduct, in order to achieve submission to the authority of individual human personalities or to the authority of designated organizations. The religious affiliation, thus, becomes a dangerous and destructive involvement that controls the subject’s life, rather than enhancing welfare. See id.

148. See generally Marilyn R. Peterson, At Personal Risk: Boundary Violations in Professional-Client Relationships (W.W. Norton & Co. 1992); cf. Martin H. Williams, Boundary Violations: Do Some Contended Standards of Care Fail to Encompass Commonplace Procedures of Humanistic, Behavioral and Eclectic Psychotherapies? 34 Psychoth. 238, 238 (1997) (arguing that although [h]ugging, dining with, self-disclosing to, or making house calls to patients are among behaviors which have been termed ‘boundary violations’ in psychotherapy . . . some of the activities in question are consistent with the ethical practice of humanistic and behavioral psychotherapies, as well as with eclectic approaches deriving from those schools.)


151. Id.
vulnerability and emotional dependence on the therapist.\textsuperscript{152}

Although some connections between ethical issues in the practice of psychotherapy and practices involving spiritual healing have been preliminarily explored,\textsuperscript{153} further research is necessary to explore the intersection of thought (i.e. intention), behavior (e.g. touch), nuances of emotion (e.g. healthy and healing, or pathological and abusive), and the extent to which the profession of psychotherapy can or even should, from an ethical perspective, embrace spiritual healing,\textsuperscript{154} or alternatively, intensify the psychic boundaries between therapist and patient.\textsuperscript{155} In any event, malfeasance in psychotherapy offers a potentially parallel research ground for exploring issues of abusive conduct by health care providers offering spiritual healing.

B. Abuse of Authority in Spiritual Healing

Practices involving spiritual healing provide a particularly rich arena for exploring the definitions of abuse in clergy malfeasance, because spiritual healing purports to embrace the whole person—that is, not only the physical and emotional, but also the spiritual. In fact, spiritual healing in the health care context purports to mediate the client's physical, mental, and emotional issues, with the spiritual realm,\textsuperscript{156} with claimed benefits ranging from curing on the physical level to the broader notion of healing (a sense of spiritual redemption or reclaimed wholeness).\textsuperscript{157}

The healer acts not only as a confidant and therapist, but also as a medium through whom the energies of healing are purported to flow. The relationship between healer and client thus involves an expanded realm of interaction, bridging the physical, mental, emotional, and spiritual realms of being. In other words, the relationship involves not

\textsuperscript{152} Id.

\textsuperscript{153} Id. at chs. 5-6. The closest the American Psychological Association comes to defining abuse of authority as described in this article is Standard 1.15, \textit{Misuse of Psychologists' Influence}, which states: "Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence." Am. Psychol. Assn., Code 1992, \textit{supra} n. 149.


\textsuperscript{155} Freud apparently initiated the debate about appropriate use of touch in mental health care, and raised "questions that still cannot be definitively answered: Where is the line that demarcates non-erotic touching from erotic contact or sexual intimacy?" See Cohen, \textit{supra} n. 7, at 176 (quoting Patricia Keith-Spiegel & Gerald P. Koocher, \textit{Ethics in Psychology: Professional Standards and Cases} 253 (McGraw-Hill, Inc. 1985)).

\textsuperscript{156} See Cohen, \textit{supra} n. 7, at 137-142 (citing sources).

\textsuperscript{157} Chantilly Report, \textit{supra} n. 11, at ix.
only the client’s trust, vulnerability, and surrender to the healer’s care, but also the perception of a flow, or exchange, of spiritual energy. The healer anchors himself or herself in the sacred, and thereby literally claims to draw on a universal field of spiritual energy to charge himself or herself and transmit the resulting “voltage” to the patient. The healer can be viewed as a shaman—bridging worlds, helping individuals transcend their normal, ordinary definition of reality, by moving easily between ordinary and nonordinary states of consciousness.

Further, the healer ostensibly is empowered with spiritual gifts to which the client presumably lacks access. These are self-reported, among some healers, to include from among the following: clairvoyance (the ability to access information through visual means), clairaudience (auditory access), clairsentience (access through sensing or feeling), long-distance perception, and direct access and precognition (ability to predict possible futures). Given such claims, the “unequal power” thus includes “claims to possess disproportionate spiritual wisdom, experience, or charisma of office,” as well as “theological authority.” This very imbalance of power—of stated ability in the arena of spiritual access and discernment—creates a potential for abuse of authority.

158. This is what Krieger calls “centering.” See generally Krieger, supra n. 4.

159. Brennan, supra n. 76, at 185. According to Brennan, healing occurs through “harmonic induction”: As long as the healer’s voltage is higher than the patient’s, the healing energy flows from the healer to the patient; but if the healer is tired, weak, and unhealthy, the healer could pick up the patient’s negativities, or, presumably, drain the patient. Id.


161. See Brennan, supra n. 76, at 153-156. See generally Roslyn L. Bruyere, Wheels of Light: A Study of the Chakras vol. I (Bon Productions 1991); Jack Schwartz, Human Energy Systems: A Way of Good Health (Penguin Books 1980). Some would critique the assertion of such powers as exercises in “magical thinking,” a category of pathological delusion articulated in DSM-IV. Cf. Booth, supra n. 27, at 35-36 (describing the abuse of power by Jimmy Swaggart), though this also may reflect negative bias against religious proclivities. See Cohen, supra n. 7, at 295-296. Interestingly, some place “messages from God” in the category of delusional or pathological behavior, Booth, supra n. 27, at 45; yet, energy healers frequently rely on intuitive sources of information to locate sources of imbalance and attempt to bring healing. The controversy over the epistemological legitimacy of intuition and other such “spiritual gifts,” including “messages” from another source, is beyond the scope of this article, although it mirrors attempts to distinguish “faith and fanaticism, healthy religiosity and addiction.” Id. at 57. Notably, the conflict has been played out historically, perhaps most visibly in the Inquisition’s trial of Joan of Arc. See Cohen, supra n. 67, at 76.

162. Theresa Krebs, Church Structures That Facilitate Pedophilia Among Roman Catholic Clergy, in Shupe, supra n. 130, at 15, 17. Although Krebs is discussing how institutional structures in the Roman Catholic Church facilitate sexual malfeasance, this paper extends a part of that analysis to spiritual healing in the secular arena.

163. In the religious context, “the local authority of individual clergy is an extension of a
Therefore, while both sexual and economic deviance may be possible in the realm of spiritual healing, this article focuses on the category of authoritative abuse. Given the above claims of spiritual power by healers, the exchange between healer and client arguably is just as heightened and intensified, and the client is just as vulnerable and dependent, as in the clergy-confidant relationship. Yet, the healer’s role purports to bridge that of physician and clerical counselor: to mediate physical and spiritual; to make the unmanifest manifest, and thereby bring gifts from divine realms—or at least the most sublime dimensions of human awareness—into the human condition.

Thus, whereas in the context of pastoral care, authoritative abuse may involve controlling recipients of care (e.g. through micromanaging, or manipulating behavior through expressions of spiritual dogma), the potential authoritative abuse in spiritual healing is likely to involve abuse of the healer’s position of authority by virtue of claimed access to specialized, intuitive information—that is, access to the shamanic worlds of non-ordinary consciousness that give the healer a privileged glimpse into the client’s condition and potential mechanisms to resolve the client’s health care issues or crisis.

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bureaucratic authority that legitimates it.” Id. (citing Anson Shupe, Opportunity Structures, Trusted Hierarchies, and Religious Deviance: A Conflict Theory Approach 19 (Paper presented at annual meeting of the Society for the Scientific Study of Religion, Raleigh, N.C. 1993)). When spiritual healing is presented in a secular context—such as the hospital—the local authority of the individual practitioner could be viewed as an extension of the profession as a whole (e.g. nursing) that sanctions the technique (e.g. Therapeutic Touch) and/or the institutional bureaucracy (e.g. hospital credentialing committee) that authorizes its use.

164. Again, the potential for the “dark side” presumably is analogous in the physician-patient relationship. See generally Brody, supra n. 129.

165. See e.g. Myss & Shealy, at 72-76. Powers may include “the ability to prophesy, see and hear at great distances, bend the flame of a candle at will, transmit his emotions to others, change the weather, and heal sickness.” Robert Kisala, The AUM Spiritual Truth Church in Japan, in Shupe, supra n. 130, at 33, 36 (providing description of claims of the founder of AUM Shinrikyo). In the case of destructive religious groups, promises may be made that the client (or follower) will attain the psychic powers the leader already has attained by following the leader’s training. Id.

166. Interestingly, in assessing why followers have joined destructive religious groups to the point of engaging in criminal activity, some have rejected theories based on claims of social tension and/or mind control. Id. at 34. Indeed, “techniques of psychological manipulation,” such as fasting, sleep deprivation, isolation, and image training, are “not unique to destructive religious groups and have been found useful in presumably healthy contexts,” such as meditation by mainstream religious groups and training by athletes. Id. at 42. Instead, it has been argued, “ultimately the dynamics of religious faith, supported by elements” within a nation’s indigenous religious and cultural heritage, motivate the criminal activity. Id. at 34. Thus, for example, AUM Shinrikyo was founded by an acupuncturist and masseur who was convicted of manufacturing and selling harmful and deceptive remedies for various ailments; “[I]n the wake of his conviction his business went bankrupt, and he apparently turned to religion.” Id. at 35.
the abuse involves deception, a transfer of authority to the healer, and the potential for physical (and emotional) injury arising from relinquishing appropriate self-care. The very same instrument of healing—the human form, with its consciousness of caring, loving intentionality, and sacred touch—also can be used for destructive exploitation. In short, the potential for abuse of authority in spiritual healing presents unique conceptual challenges, precisely because it is potentially ubiquitous among spiritual health care providers, and simultaneously, promises to bridge medicine and religion.

IV. REGULATION OF ABUSE IN DELIVERY OF HEALTH CARE SERVICES

A. Legal Rules Regulating Potential Abuse

Legal rules governing (and attempting to control) potential abuse of authority by health care professionals are extensive. They are subsumed under five categories: (1) medical licensure; (2) scope of practice; (3) professional discipline; (4) malpractice; and (5) fraud. These legal rules operate together as a complex of limitations on potential abuse of authority by a variety of health care professionals. This Part describes these rules and their application to spiritual healing.

167. It has been argued that both parties—healer and client—can share some responsibility in abusive situations that occur on a mass scale. See e.g. Dushkin v. Desai, 18 F. Supp. 2d 117 (D. Mass. 1998). In Dushkin, the court granted motions by defendant, a yoga teacher, spiritual healer, and leader of a spiritual community, to dismiss claims for intentional infliction of emotional distress, breach of fiduciary duty, and breach of contract.

168. In another sense, abuse of religious authority parallels abuse in other contexts—and similarly, it has been argued, "religious addiction" parallels addiction to mood-altering behaviors and substances. See e.g. Booth, supra n. 27, at 2. Religious addiction is defined as using God, a religion, or a belief system as a means both to escape or avoid painful feelings and to seek self-esteem. It involves adopting a rigid belief system that specifies only one right way, which you feel you must force onto others by means of guilt, shame, fear, brain-washing, and elitism.

Id. 169. A contractual relationship between healing professional and patient also may be possible, triggering contract, rather than tort, obligations and potential liabilities. Contracting principles may be especially appropriate when healing practices rely on consensus and mutual responsibility. Cohen, supra n. 15, at 152 (citing Heidi Rian, An Alternative Contractual Approach to Holistic Health Care, 44 Ohio St. L.J. 185, 187 (1983)).

There are limits, however, as to what rights courts will permit patients to contract away, and negligence principles may still apply if practices are below prevailing standards of care. Such cases further blur the borderland between contract and tort. See Michael H. Cohen, Reconstructing Breach of the IMPLIED Covenant of Good Faith and Fair Dealing as a Tort, 73 Cal. L. Rev. 1291 (1985) (proposing tort remedies, or at the least, expanded contractual remedies, for bad faith and unreasonable breaches involving denial of the existence of a contract, and other situations involving obstruction of the injured party’s interest in securing the compensatory value of the agreement).
in the clinical arena.

1. Medical Licensure

Medical licensure is one of the earliest forms of regulation recognizing professional delivery of health care services, and subjecting the conduct of health care professionals to statutory proscriptions. Medical licensure originated in New York in 1760 as a means to prevent "ignorant and unskillful persons" from "endangering the lives and limbs of their patients, and many poor and ignorant persons, who have been persuaded to become their patients." Thus, medical licensure neatly fits the police power rationale, articulated in Part II(A), of protecting public health, safety, and welfare.

By requiring a license to practice "medicine," and defining the practice of medicine in its broadest sense—as any act constituting "diagnosis" or "treatment" for any disease or ailment, medical licensing laws—as interpreted by courts—resulted in convictions of chiropractors, naturopaths, massage therapists, hypnotists, nutritional counselors, and spiritual healers for unlicensed medical practice. Thus, although they were initially weakly enforced, by the late nineteenth century, medical licensing laws had become a powerful tool for enforcing dominant medical paradigms. Medical licensure had evolved from the attempt to control lay practitioners of the healing arts into the consolidation of a medical establishment, with extensive political and economic control, and the ability to condemn anyone who opposed dominant medical perspectives as "an 'enemy of physic and all learning.'" While medical licensure has been variously criticized as self-serving, ineffective, and tending to incite litigation over practice boundaries, its ostensible purpose—to protect the public from

170. See Cohen, supra n. 56, at 29.
171. Id. at 15 (quoting T. Romeyn Beck, A Sketch of the Legislative Provision of the Colony and State of New-York, Respecting the Practice of Physic and Surgery, N.Y. J. Med. 139 (1822)).
172. Id. at 22 (citing cases). The statutory definition of practicing medicine varies by state, but typically includes: (1) diagnosing, preventing, treating, and curing disease; (2) holding oneself out to the public as able to perform the above; (3) intending to receive a gift, fee, or compensation for the above; (4) attaching such titles as M.D. to one's name; (5) maintaining an office for reception, examination, and treatment; (6) performing surgery; and (7) using, administering, or prescribing "drugs" or medicinal preparations. Id. at 26-29 (citing cases). The third element, involving receipt of compensation for the healing service, is not a necessary element in all states. Id.
173. Id. at 15.
174. Id. at 17, 34-35.
175. Id. at 17 (quoting Richard H. Shryock, Medical Licensing in America, 1650-1965 (Johns Hopkins Press 1967)).
176. Id. at 34-35 (citing sources). For a seminal critique of licensure, see Walter Gelhorn, The
unscrupulous and untrained providers—arguably deters those who “practice medicine” under the statutory definitions from delivering health care services that could injure the public. Medical licensure thus serves the regulatory goal of fraud control.¹⁷⁷

Courts have followed legislatures in conceptualizing the practice of “medicine” broadly, so as to include many different kinds of practitioners and practices within the proscription against practicing “medicine” without a license.¹⁷⁸ This interpretation has resulted in litigation involving allied health providers—such as psychologists, physician assistants, and nurse practitioners—as well as osteopaths, midwives, and other providers of therapies outside conventional medicine (including lay practitioners of spiritual healing).¹⁷⁹ Criminal convictions of spiritual healers in the past have shown courts’ willingness to construe “diagnosis” and “treatment” sufficiently broadly to cover laying-on-of-hands, particularly in cases where healers have purported to use their spiritual gifts to cure disease, as well as to bring spiritual wholeness.¹⁸⁰

Notably, most state medical licensing laws typically contain an exemption for spiritual healers. These healers, however, typically are exempt from medical practice acts so long as they limit their activities to “praying” over their clients or to delivering their services in a religious context.¹⁸¹ This is because treatment by prayer alone has been held to constitute religion, and not medicine.¹⁸² Since energy healing often purports to operate in a secular context—and often involves “centering,” “mindfulness,” or similar techniques, without necessarily invoking “prayer” to “God”—the statutory exemption for religious healers arguably is unavailable, or at the least, as a matter of policy,

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Abuse of Occupational Licensing, 44 U. Chi. L. Rev. 6 (1976).

¹⁷⁷. See Cohen, supra n. 7, at 86-87.

¹⁷⁸. See Cohen, supra n. 56, at 35 (citing cases).

¹⁷⁹. Id.

¹⁸⁰. See Cohen, supra n. 15, at 117, n. 272 (citing cases); see discussion of People v. Smith, infra.

¹⁸¹. See Barry Nobel, Religious Healing in the Courts: The Liberties and Liabilities of Patients, Parents, and Healers, 16 U. Puget Sound L. Rev. 599 (1993); see D.C. Code § 3-1201.03 (2002) (exempting any minister, priest, rabbi, officer, or agent of any religious body or any practitioner of any religious belief engaging in prayer or any other religious practice or nursing practiced solely in accordance with the religious tenets of any church for the purpose of fostering the physical, mental, or spiritual well-being of any person).

¹⁸². Greenberg, supra n. 120, at 457, (citing Crane v. Johnson, 242 U.S. 339 (1917)). Thus, a faith healer who also prescribed herbal medicine and applied a personally patented medication was held liable for practicing medicine unlawfully, since the healer arguably had exceeded the bounds of religious practice. Id. at 458 (citing People v. Vogelgesang, 221 N.Y. 290 (1917)).
inappropriate.\textsuperscript{183}

Parenthetically, because medical licensing laws have resulted in convictions of spiritual healers and other providers for unlicensed practice of medicine, grassroots movements have grown in a number of states, seeking to free such providers from the threat of prosecution for unlicensed medical practice. For example, at least three states, California, Minnesota, and Rhode Island, have enacted legislation permitting (with specified limitations) practice of health care by persons who are not licensed by the state.\textsuperscript{184} Rhode Island, for example, defines “unlicensed health care practices” as:

the broad domain of unlicensed healing methods and treatments, including, but not limited to: (i) acupressure; (ii) Alexander technique; (iii) aroma therapy; (iv) ayurveda; (v) cranial sacral therapy; (vi) crystal therapy; (vii) detoxification practices and therapies; (viii) energetic healing; (ix) rolfing; (x) Gerson therapy and colostrum therapy; (xi) therapeutic touch; (xii) herbology or herbalism; (xiii) polarity therapy; (xiv) homeopathy; (xv) nondiagnostic iridology; (xvi) body work; (xvii) reiki; (xviii) mind-body healing practices; (ixx) naturopathy; and (xx) Qi Gong energy healing.\textsuperscript{185}

The legislation provides that subject to certain restrictions, persons in Rhode Island “are authorized to practice as unlicensed health care practitioners and receive remuneration for their services.”\textsuperscript{186} Restrictions include a posting that the state has not adopted any educational and training standards for unlicensed health care

\textsuperscript{183} Cohen, \textit{supra} n. 67, at 78-79. Presumably, however, the Native American medicine man and Christian faith healer would retain the exemption, since they purport to practice within a religious tradition. \textit{Id.}

\textsuperscript{184} See \textit{e.g.} 2002 Cal. Stat. 820, enacting Cal. Bus. & Prof. Code §§ 2053.5, 2053.6 (also stating the purpose of the legislation). The legislation provides that a person is not in violation of specified provisions of the Medical Practice Act that prohibit the practice of medicine without being licensed as a physician, as long as the person does not engage in specified acts, and also makes specified disclosures to each client, for which the client must acknowledge receipt in writing.

\textsuperscript{185} R.I. Gen. Laws § 23-74-1(3). The statute provides that “unlicensed health care practices” do not include:

- surgery, x-ray radiation, prescribing, administering, or dispensing legend drugs and controlled substances, practices that invade the human body by puncture of the skin, setting fractures, any practice included in the practice of dentistry, the manipulation or adjustment of articulations of joints, or the spine, also known as chiropractic medicine . . . , the healing art of acupuncture . . . , or practices that are permitted under [two other, specific statutes].

\textit{Id.}

\textsuperscript{186} \textit{Id.} at § 23-74-1(4)(d).
practitioners.  

The registration requirements provided by such laws, aimed in large part to protect such providers from unlicensed medical practice, may still leave them vulnerable to claims of exceeding competence and thereby crossing the line into unlicensed medical practice, if courts continue the historical tendency to interpret medical licensing statutes and the concepts of “diagnosis” and “treatment” broadly. Further, such laws allow providers to be prosecuted if they commit fraudulent acts, or are found to be engaging in contact that “may be reasonably interpreted by a client as . . . engaging in sexual exploitation,” or are shown unable “to engage in unlicensed health care practices with reasonable safety to . . . clients.” Providers also may not offer a medical diagnosis, although that term, while it is more specific than simply “diagnosis,” is not given further definition.

2. Scope of Practice Rules

Scope of practice rules refer to services that licensed nonphysicians (as opposed to physicians or laypersons) are authorized to provide pursuant to their own licensing statutes; such services typically are defined more narrowly than the broad authority granted to physicians to “diagnose” and “treat” disease. For example, in the allied health professions, licensure to practice psychology or physical therapy does

187. Id. at § 23-74-1(4).
188. See Cohen, supra n. 56, at 29-31 (citing cases, describing legal action against the non-licensed CAM provider), and id. at 47-55 (citing cases, describing legal action against the licensed CAM provider).

189. California’s legislation allows prosecution if the provider:
(1) Conducts surgery or any other procedure on another person that punctures the skin or harmfully invades the body. (2) Administers or prescribes x-ray radiation to another person. (3) Prescribes or administers legend drugs or controlled substances to another person. (4) Recommends the discontinuance of legend drugs or controlled substances prescribed by an appropriately licensed practitioner. (5) Willfully diagnoses and treats a physical or mental condition of any person under circumstances or conditions that cause or create a risk of great bodily harm, serious physical or mental illness, or death. . . . (8) Holds out, states, indicates, advertises, or implies to a client or prospective client that he or she is a physician, a surgeon, or a physician and surgeon.


190. R.I. Gen. Laws § 23-74-4(2). When therapies necessarily involve healing touch, such contact may be more ambiguous than the present statutory language allows. See Cohen supra n. 7, at 167-211.
191. Id. at § 23-74-4(6).
192. See supra n. 188.
not authorize the licensee to diagnose and treat in the medical sense.

As an example that may be relevant to the limits of healing by CAM providers, licensed chiropractors typically are authorized to use spinal manipulation and adjustment to readjust the flow of "nerve energy" in their patients; licensed acupuncturists, to use techniques of traditional oriental medicine to help adjust the "flow and balance of energy in the body"; and licensed massage therapists to use "rubbing, stroking, kneading, or tapping" the muscles to promote relaxation and affect well-being.\(^{194}\)

None of these providers are authorized to diagnose and treat disease in the medical sense. For this reason, frequently, the licensing statutes delineating scope of practice provisions for nonphysicians include an express prohibition against the unlicensed practice of medicine.\(^{195}\) Indeed, such providers often have a duty to refer the patient to a physician whenever the patient’s condition exceeds the scope of their training, education, and competence; and violation of the duty can lead to malpractice liability.\(^{196}\)

Despite these statutory attempts to draw distinctions, the line between authorized practice of a nonmedical profession (e.g. chiropractic) and unauthorized medical practice, can be difficult to draw. For example, chiropractors who have offered nutritional advice have been prosecuted for practicing medicine unlawfully, despite the argument that nutritional care is part of chiropractic education and training.\(^{197}\) Courts have tended to interpret scope of practice narrowly, in the same way they have tended to interpret the practice of "medicine" broadly and inclusively.\(^{198}\)

In addition to the rationale of preserving public health, safety and welfare, one reason for this blurring of lines is that any distinction between a holistic notion of wellness care (adopted by many CAM providers) and the actual "diagnosis" and "treatment" of a "disease" is difficult to conceptualize. The difficulty increases when the latter terms are taken in their broadest sense to incorporate any and all attempts to help patients heal.\(^{199}\) In either case, many modalities such as nutritional

\(^{194}\) Id. at 40-44 (citing statutes).

\(^{195}\) Id. at 39.

\(^{196}\) Id. at 68-69 (citing cases).

\(^{197}\) Id. at 47-49 (citing Matter of Stockwell, 622 P.2d 910 (Wash. App. 1981); Foster v. Georgia Bd. of Chiropractic Examiners, 359 S.E.2d 877 (Ga. 1987)).

\(^{198}\) See id.

\(^{199}\) Again, the medical licensing statutes do not seem to make a distinction between the narrower notion of "curing," and the broader realm of "healing" (the latter implying a restored psychosocial and spiritual wholeness).
care occupy the borderline between the two poles of "wellness care" and "disease care." A further problem is that scope of practice rules reflect the notion that the enterprise of healing can be carved into neatly severable and licensable blocks," whereas many CAM practices aim to be holistic—to address the whole person, and not simply an afflicted body part.  

One implication of these definitional conundrums is that, to the extent that licensed health professionals are using spiritual healing as part of professional care, they may offer such services only if acting within their legally authorized scope of practice. Thus, for example, nursing professionals would have to ensure that Therapeutic Touch is within the scope of nursing practice authorized by the licensing statute within their state.

A further complexity arises since spiritual healing services may be provided by any number of health professionals—physicians and allied conventional health professionals (such as nurses and dentists), as well as CAM providers (such as chiropractors, acupuncturists, and massage therapists). Scope of practice thus may overlap. Yet, state licensing statutes do not always expressly state whether spiritual healing can be offered. Sometimes, regulations by the relevant state professional board may delineate what the licensing statute omits. For example, in Massachusetts, the Board of Registration in Nursing has provided that it is within the scope of R.N. or L.P.N. practice to employ complementary therapies including "Massage, Therapeutic touch, Reiki, Reflexology, Imagery, Hypnosis, Music therapy, Shiatsu, and Aromatherapy," as "part of an overall plan of [nursing] care for which clients have granted informed consent." In the absence of such regulation, providers may argue that spiritual healing, if not expressly prohibited in the statute, is permitted (so long as part of their education and skill set); while the

200. A similar issue arises in trying to conceptualize distinctions between "structure-function" claims, which are permissible for dietary supplement labels under the Dietary Supplements Health Education Act of 1994, and "disease claims," which are impermissible, and bring the supplement in question within the definition of a "drug." See Cohen, supra n. 56, at 81 (citing sources); Cohen, supra n. 67, at 114-115. Structure-function claims describe the role of a nutrient or dietary ingredient intended to affect the structure and function in human beings (for example, "saw palmetto maintains prostate health"); whereas disease claims link the dietary supplement to the diagnosis, mitigation, cure, or treatment of a disease (for example, "saw palmetto cures prostate cancer"). Cohen, supra n. 67, at 114.


state may argue just the opposite—namely, that what the statute fails to expressly authorize, it prohibits.

3. Professional Discipline

Licensing statutes for health care professionals typically include a set of provisions specifying under what circumstances the licensed professional may be disciplined, with sanctions ranging from fines to loss of licensure. Unprofessional conduct (also known as professional misconduct) that provides a basis for such discipline typically includes such acts as obtaining the license fraudulently, practicing the profession fraudulently, practicing with gross incompetence or gross negligence, practicing while impaired by drugs or alcohol, permitting or aiding an unlicensed person to practice unlawfully, or failing to comply with relevant rules and regulations. 204

Presently, no independent licensure exists for practitioners of spiritual healing. 205 As a result, in most states, health care providers arguably must seek licensure in another category or profession (such as nursing or chiropractic) that incorporates modalities such as Healing Touch or Reiki into its regimen. In such cases, these providers are bound by the provisions governing professional discipline that are contained in their respective licensing statutes.

Presumably, for example, a nurse practicing Therapeutic Touch in an extremely unskillful manner conceivably could be considered to be practicing with "gross incompetence," and thereby be subject to professional discipline. However, it may be difficult to define what constitutes "gross incompetence" to the extent that the profession itself may have failed to establish practice standards for the modality in question (e.g. Therapeutic Touch).

And even if the profession has set such standards, they may be less tangible than parallel standards for a medical or nursing procedure, since such acts as "centering," "assessing," and "directing energy"—even if taught as part of the nursing school curriculum and applied in a hospital setting—inherently cross the boundary between medicine and religion,

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204. Cohen, supra n. 56, at 87 (citing statutes).

205. One could consider the case of states such as California, Minnesota, and Rhode Island, as an exception; as noted, these states recently have enacted statutes allowing a broad range of CAM providers to offer services, without requiring them to obtain licensure, but requiring them to register with a state agency that can receive consumer complaints. See e.g. Minn. Stat. § 146A (2002). Conceptually, however, the distinction between "licensure" and simple "registration" of the unlicensed may be one of degree and not substance. See Cohen, supra n. 56, at 35-37 (discussing differences between mandatory licensure, permissive certification, and registration).
and perhaps suggest untested (or untestable) metaphysical propositions. In other words, without the existence of objective criteria to measure whether a practitioner has met the standard, it may remain difficult to interpret and enforce the norms contained in professional discipline provisions of the licensing statute.

Notably, in recent years a number of states have enacted statutes, protecting health care providers—particularly physicians—from professional discipline based on therapeutic recommendations involving CAM therapies. For example, Alaska’s statute, enacted in 1990, states that the medical board “may not base a finding of professional incompetence solely on the basis that a licensee’s practice is unconventional or experimental in the absence of demonstrable physical harm to a patient.”206 Similarly, Colorado’s statute provides: “The board shall not take disciplinary action against a [physician] solely on the grounds that such a [physician] practices alternative medicine.”207 The language contained in these statutes varies by state.208 In most states, it remains to be seen whether such language would, in fact, protect providers incorporating controversial therapies considered by a given regulatory board to be within a domain that is beyond testing, or in the minds of some, beyond plausibility.209

4. Malpractice

Malpractice liability rules protect patients against negligence by health care providers. Negligent practice is defined as practicing below the standard of care, which conduct injures the patient. Since CAM therapies historically have been defined as outside conventional

208. See Cohen, supra n. 56, at 92-95 (discussing some differences among statutes).
209. New guidelines by the Federation of State Medical Boards concerning physician use of CAM therapies provide that in considering professional discipline, the medical board should evaluate whether the physician is using a treatment that is:
- effective and safe? (having adequate scientific evidence of efficacy and/or safety or greater safety than other established treatment models for the same condition)
- effective, but with some real or potential danger? (having evidence of efficacy, but also of adverse side effects)
- inadequately studied, but safe? (having insufficient evidence of clinical efficacy, but reasonable evidence to suggest relative safety)
- ineffective and dangerous? (proven to be ineffective or unsafe through controlled trials or documented evidence or as measured by a risk/benefit assessment)
standards of care, the potential arises for courts to label use of such therapies as malpractice *per se*—that is, irrespective of any wrongdoing.\textsuperscript{210}

At least one court, in *Charell v. Gonzales*, has articulated the proposition that a physician’s inclusion of CAM therapies conceivably could itself be negligent, given the current definition of CAM therapies.\textsuperscript{211} The danger increases with a therapy such as energy healing, which has theoretical underpinnings about which many similarly situated providers would be skeptical. Thus, an expert witness from the defendant’s profession might be able to persuade the jury, as in *Charell*, that the defendant’s use of the modality in question was “bogus” and “of no value.”\textsuperscript{212}

Several defenses to medical malpractice might be available to the provider who uses a CAM therapy, even though the therapy has not been adopted as part of the standard of care within the jurisdiction. These defenses include, the “respectable minority” defense—the idea that a significant segment within the profession accepts the modality—and assumption of risk, the notion that the patient knowingly, voluntarily, and intelligently assumed a risk of injury from the chosen therapy.\textsuperscript{213}

The respectable minority defense, however, is especially complicated in regard to use of CAM therapies, since it may be difficult to determine what constitutes the requisite quantity of providers, and what level of evidence of safety and/or efficacy would make them sufficiently “respectable” to trigger the defense. Similarly, the assumption of risk defense does not allow providers to act negligently—in other words, there are some risks that courts will not allow patients to assume. This caveat to the defense triggers a circular argument as to what is negligent, and whether, in cases involving novel and controversial therapies, negligence can, like “fraud,” simply become a label that is applied based on a bias view of those therapies.

A second theory supporting malpractice liability is the failure to provide adequate informed consent. To date, no patient has successfully argued that a provider’s failure to disclose the possibility of using a CAM therapy, instead of a biomedical therapy, caused injury and constituted malpractice. At least one court has, however, observed that

\textsuperscript{210} See Cohen, *supra* n. 67, at 23-26.

\textsuperscript{211} 660 N.Y.S.2d 665, 668 (N.Y. Sup. 1997).

\textsuperscript{212} *Id*. The decision was affirmed, but modified on appeal to vacate the punitive damages award, 673 N.Y.S.2d 685 (App Div. 1998).

\textsuperscript{213} See Cohen, *supra* n. 56, at 58-59, 62-62 (citing cases, and discussing the potential application of these defenses to use of CAM therapies).
such an argument would succeed if the therapy in question had a sufficient level of professional acceptance.214

The implication is that if energy healing were to gain significant acceptance within a given profession—say, nursing—then failure to disclose its availability to a patient if the patient were thereby injured, would constitute an actionable violation of informed consent and allow the patient to recover for malpractice. On the other side, an energy healer who fails to inform the patient concerning material, medical alternatives to energy healing probably would have violated the duty of informed consent and—particularly if such alternatives are within the provider's legally authorized scope of practice (e.g. medicine or nursing)—thereby be liable in malpractice.

5. Fraud

The tort of fraud is triggered when a health care provider deceives the patient and does so with the intent to so deceive.215 To the extent the provider offering spiritual healing intentionally deceives the patient into expecting a result that lacks sufficient scientific evidence, the prosecution would have a viable argument that fraud has occurred if that result is not achieved. The deception would have to be intentional and not simply negligent or the result of an honest mistake.

Providers of spiritual healing face arguably less legal risk if they describe potential results in spiritual rather than physical terms—alluding, again, to the distinction between healing and curing. The argument is that the description of healing work as spiritual helps deflect perception that the conduct falls within diagnosis and treatment of disease. On the other hand, this definitional strategy again dichotomizes medicine and religion—the physical and the metaphysical—and eviscerates the notion of a borderland between the two. As noted, spiritual healing practices are incorporated in a variety of clinical settings by various practitioners, often with the intent to produce more than relaxation, palliation, or spiritual comfort.

Ultimately, the language of fraud may be inadequate to the task, except under egregious circumstances meeting the requisite legal definitions. The law, perhaps, has not yet adequately learned to address the uncomfortable borderland between science and faith, medicine and

religion—between accounts of the world considered objective and those by and large regarded as subjective. By definition, energy healing, when it is practiced in good faith—with the intent to heal, not to dupe—makes a charge of “fraud” appear as an ideological label, rather than as a conclusion of law. Again, fraud, an intentional tort, is among the most extreme forms of the abuse and potentially the most difficult to prove, since a distinct mental state must be alleged and proved. This is particularly ironic since, as noted, spiritual healing purports to draw on a clear and healing intentionality (i.e. a positive and beneficial mental state) on the part of the practitioner.

B. Conceptualization and Categorization of Potential Abuse

As suggested above, legal rules that would apply to the practice of spiritual healing within a secular context, such as the modern medical center, are extensive, even if not explicitly directed at spiritual healing practices. Whether such rules are in fact effective is an empirical question, requiring data beyond the scope of this article. What this article can suggest, however, is that these rules, taken as a whole, help conceptualize abuse of authority (as defined and described in Part 3) and thus create a preliminary, conceptual web that helps curb potential abuse by providing legal sanction for specific kinds of violations. For illustration, consider the following hypothetical scenarios:

1. D, who lacks any health care licensure but has several certificates from various schools teaching certain CAM modalities, offers energy healing to individuals, purporting to cure various ailments.

2. D, who is a licensed nurse, offers energy healing to individuals, purporting to cure various ailments.

3. D, a licensed family physician, offers energy healing to help a patient access his or her own inner resources for smoking cessation.

4. D, a licensed family physician, offers energy healing to a cancer patient, and, making the assumption that these methods will help shrink a tumor, neglects to perform or recommend accepted mainstream treatment.

5. D, a licensed family physician, offers energy healing to a cancer

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216. A related question is how to assess spiritual groups and determine when healthy religiosity crosses the line and becomes religious addiction. Cf. Arterburn & Felton, supra n. 145, at 137-159 (listing the characteristics of a toxic-faith system, including a claim that its members have “special” character, abilities or knowledge; authoritarian leadership; oppositional status toward the world; a punitive nature; demands of members to give overwhelming service; lack of objective accountability; and use of labeling to discount those who oppose the beliefs of the group).
patient, and, assuring her that these methods will help shrink a tumor, neglects to perform or recommend accepted mainstream treatment.

These hypothetical situations respectively illustrate major potential arenas of abuse of authority in healing as follows: scenario (1) lack of professional competence; scenario (2) exceeding professional competence; scenario (3) exceeding professional boundaries; scenario (4) professional negligence; and scenario (5) intentional deception (including exaggeration of claims, and diversion from conventional care). This is not an exclusive and comprehensive, nor even systematic, map of potential areas of abuse, but it does provide a working framework for assessing the extent to which legal rules capture and address abuse of spiritual authority.

In this light, one can draw a parallel between the major legal rules governing delivery of healing services, identified above, and the potential arenas of abuse just mentioned. In the first scenario, D lacks the education and professional training necessary to cure various ailments. Because D arguably holds himself or herself out as being able to diagnose and cure disease, D could be criminally liable for practicing medicine without a license. Perhaps for this reason, hospitals may rely on licensed providers (e.g. licensed nurses or massage therapists, if massage therapy is licensed within the state) rather than unlicensed personnel (e.g. lay practitioners trained in Reiki) to offer energy healing services.

In the second hypothetical, D, in some (but not all) jurisdictions (particularly those with officials adverse to energy healing), might be considered to be exceeding professional competence, and thus the scope of practice authorized in the licensing statute. This would subject D to

217. To some extent, all these forms of abuse overlap and intersect; they have been separated for clarification. Legal rules such as malpractice and professional discipline similarly overlap, in that an act of gross negligence, for example, can subject the perpetrator to potential malpractice liability as well as professional discipline, resulting in monetary payment to a civil plaintiff as well as loss of licensure to the state.

218. See Cohen, supra n. 67, at 62-64 (discussing credentialing mechanisms to ensure provider competence). Assuming the unlicensed provider, even if within the hospital, works closely with medical staff, the hospital arguably could help immunize itself from claims of aiding and abetting unlicensed medical practice. Thus, the location of the provider offering energy healing—i.e. living room, vs. community center, church basement, or hospital or clinic—could make a difference.

219. As noted earlier, though, nursing regulations in some states—such as Massachusetts—would authorize CAM practices in general, or even specific modalities such as Therapeutic Touch. Interestingly, the suggestion has been raised that distance healing (or non-local healing)—the application of energy healing through intentionality at a distance, as opposed to through touch and contact—might raise regulatory issues similar to the telemedicine and/or practice of law at a distance (i.e. via Internet). Personal Correspondence to Kathi Kemper (2002). From a regulatory perspective, however, the above discussion suggests that the issues raised by energy healing have
criminal charges of practicing medicine without a license.

The third hypothetical presents a situation in which a licensed physician employs energy healing. Since physicians typically are said to have an "unlimited" scope of practice to diagnose and treat disease—as opposed to the more limited scope of practice allocated to allied health professionals and CAM providers—the issue is not one of legal authority over practice, but rather of professional boundaries. In other words, the relevant professional regulatory board (i.e. medical board) could argue that physicians should not include energy healing in clinical practice, because energy healing lacks a sufficient evidentiary base. The physician's claim about energy healing (e.g. for cure, support, stress reduction) could be relevant to the board’s ultimate response, however, especially if the physician continued to offer conventional care, since the physician then could not be accused of foregoing necessary medical care for untested alternatives.

In the fourth scenario, the physician neglects necessary conventional care, and thus is negligent in failing to meet the standard of care, and commits malpractice. The fifth hypothetical presents the case of an unwarranted claim that deceives the patient. If the deception has been intentional, then the patient can sue for fraud and potentially criminal fraud charges can be brought as well.

The noted correspondence between forms of abuse and applicable legal rules can be summarized as follows:

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less to do within physical distance and more to do with questions of competence, professional boundaries, and standard of care.

220. Cohen, supra n. 56, at 40.


Form of Abuse | Corresponding Legal Rule:
---|---
(1) Lack of competence exceeding professional competence | Licensure
(2) Exceeding professional competence | Scope of Practice
(3) Misconduct | Professional discipline
(4) Negligence | Malpractice
(5) Deception | Fraud

The correspondence could also be expressed by putting the second column first. This formulation illuminates how legal rules are intended to address (or have the actual effect of addressing) abuse in various, specific forms:

Legal Rule | Intended to Address Abuse in the Form of:
---|---
(1) Licensure | Lack of competence
(2) Scope of practice | Exceeding professional competence
(3) Professional discipline | Misconduct
(4) Malpractice | Negligence
(5) Fraud | Deception

In short, such rules—whether or not directed in a comprehensive, rational manner toward such practices—do provide a preliminary conceptual map for major arenas of dysfunction. Whether or not completely adequate to the task, when taken together, legal rules governing licensing, scope of practice, professional discipline, malpractice, and fraud, do constrain the practitioner and begin to address major arenas in potential abuse of authority. Questions remain, however, as to how deeply these rules—historically rooted in the biomedical health professions—penetrate into future problems likely to arise from increasing use of spiritual healing in mainstream health care settings.

C. Future Regulation of Potential Abuse

Historically, of the above categories, the label of fraud has been
most commonly ascribed to CAM therapies, and perhaps most strongly resonates with impressions of energy healing for many in the scientific and medical communities. Fraud, however, requires a mental state—an intention to deceive—as well as deception itself, and therefore should not be used as a conclusory label for liability.

As CAM providers increasingly receive licensure, scope of practice becomes an area of increasing legal attention. In cases of energy healing, this could result, for example, in attendant debates over whether Therapeutic Touch is properly within the scope of nursing, whether such therapies as network chiropractic are appropriate for professional practice in integrative care settings in hospitals, and the extent to which "noncontact touch" therapies are within the legally authorized scope of practice for some massage therapists.

Similar debates are likely to erupt in the arena of professional discipline, as emerging uses of energy healing—like earlier debates concerning use of homeopathy by physicians—challenge political structures within each profession. Indeed, such debates already have erupted within institutions, for example, attempting to draw policies determining which providers can lawfully practice energy healing and under what circumstances. In addition, debates may erupt as to what constitutes "efficacy," given that spiritual healers may be competent in their own terms while failing to meet a biomedical paradigm of effectiveness.

225. See Cohen, supra n. 15, at 134-157 (applying tort elements to specific scenarios involving CAM practices).
226. See Cohen, supra n. 56, at 110 (suggesting that legislative scope of practice for emerging providers challenges the drafter to be specific enough to cover areas of potential ambiguity, yet broad enough to support holistic practice).
227. See e.g. Guess, 393 S.E.2d at 833.
228. Yet another arena of sensitivity is how to approach patients who have suffered from religious abuse, as they "may react strongly to having chaplains, ministers, nuns," Booth, supra n. 27, at 254—or, presumably, to medical personnel querying them as to whether they object to receiving energy healing.
229. See Cohen, supra n. 7, at 55-57 (proposing to distinguish "spiritual" from "physical" notions of efficacy). One also could consider the various levels of "efficacy" yet another way to understand the distinction articulated between healing and curing—sometimes a patient may be cured, without being healed, and sometimes the reverse may occur. From another vantage, Eliade describes the "effectiveness" of a medicinal plant as containing the "threelfold effectiveness of the moon, the waters, and vegetation," each of which works on multiple levels (vegetation, for instance, implying "notions of death and rebirth, of light and darkness ... of fecundity and abundance, and so on"). Eliade, Sky, Moon, and Egg, in Eliade, supra n. 32, at 45, 55-56, whereas modern pharmacology would only consider the effectiveness of the medicinal plant in terms of the effect of its identified, active ingredient. Thus, from a mythological perspective, "e]verything hangs together, everything is connected, and makes up a cosmic whole." Id. at 56; there is no differentiation of efficacy into separate, component parts. The drive to chronicle the world, and
Finally, ethical codes within a healing profession may help delineate gray zones of conduct, where legal rules fail to reach. These might include, for example, referring patients to chaplains or other ministers when significant spiritual needs are identified, and ensuring that patients can exercise the right to refuse spiritual healing, counseling, or inquiry.

One arena that the above scenarios fail to address is the abuse of power that results in emotional injury, but without any physical consequences. For example, consider the following scenario:

P, a thirty year-old woman, inexplicably grows deaf in one ear. Her physician has no explanation other than reporting that some people grow prematurely deaf. P visits an “intuitive helper” who says she is “learning a lesson on a soul level: you haven’t been listening to God,” and advises her that “with prayer, meditation, and opening your heart to God’s wisdom, the deafness will heal.” P leaves the session, feeling bewildered, guilty, and morally imperiled, as well as frightened by her new physical status. She visits her physician who reassures her that all standard diagnostic and therapeutic procedures have been performed.

In one sense, the dogmatic “black-and-white” thinking articulated by the healer in this scenario, combined with the ascription of a physical condition as punishment from God, exemplifies the notion of “religious abuse”—of “adopting a rigid belief system that specifies only one right way, which you feel you must force onto others by means of guilt, shame, fear, brain-washing, and elitism.” An individual who buys into such abuse may have a “toxic belief”—for example, that she is being punished for failing to listen to God, or that if she has real faith, a cure is guaranteed. On the other hand, one need not label the

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\text{what happens in one's own soul, is, according to Eliade, a need organic to the human condition. Eliade, Literary Imagination and Religious Structure, in Eliade, supra n. 32, at 17, 21-22.}
\]

\[230. \text{See e.g. NFSH, National Federation of Spiritual Healers Code of Conduct (Sunbury on Thames, NFSH).}
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\[231. \text{King, supra n. 31, at 69 (referring to prayer and spiritual ministry).}
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\[232. \text{The hypothetical comes from Cohen, supra n. 7, at 165. Admittedly, by using the word “God,” the hypothetical suggests religion, rather than the broader notion of spirituality as earlier defined; one could easily, however, substitute the notion of turning to one’s innate wisdom, and the principle would be the same: “Depending on the manner in which this information (or opinion) was conveyed, it may have been helpful or hurtful, inspiring or intrusive.” Id.}
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\[233. \text{Booth, supra n. 27, at 2 quoted supra, Part III(A); see Jeanne M. Miller, The Moral Bankruptcy of Institutionalized Religion, in Shupe, supra n. 130, at 152-172 (describing experiences with sexual abuse and its later denial by church members and officials). As suggested, this is a variation on the definition of “abuse of authority” offered in Part II(A).}
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\[234. \text{See Arterburn & Felton, supra n. 145, at 39-42 & 49-50 (2001) (listing 21 typical “toxic beliefs” held by religious addicts, including, “If I have real faith, God will heal me or someone I know,” and “Problems in my life result from some particular sin”).}
\]
individual who is prey to the healer’s misconduct a spiritual “addict” in order to understand the heightened vulnerability, propensity for dependence, and intense trust such a person may come to have in the healer.

Legal rules would address a physical injury, if the healer were to make a recommendation to ignore or neglect medical advice, or to substitute spiritual advice for medical diagnosis and treatment. But legal rules may incompletely address the explicitly emotional aspect of malfeasance by spiritual healers. Historically, the tort of negligent infliction of emotional distress could be met only when physical injury was shown; although more recently, the requirement has been relaxed so long as plaintiff can show that the defendant has breached some other duty recognized by law as being owed to the plaintiff.235 Thus, abuse of trust, without more, might not be actionable, particularly if the relationship was based on spiritual care-giving and advice, the healer steered away from giving an opinion on medical problems or issues concerning physical health, and there were no agreed standards of professional conduct in such a relationship (making negligence difficult to show). If, on the other hand, the healer, as suggested, were to advise P to disregard her physician’s advice and to substitute a prescribed, ritualized regimen for healing, issues of scope of practice, malpractice, professional discipline, and fraud doubtless would arise.236

The lacuna between spiritual and physical injury—between infliction of a wound to the heart and soul of the patient, and injury that can be concretized in material terms—raises novel policy issues. It may well be that the law, having opened up through licensing and other rules the possibility of allowing health care professionals to deliver exclusively spiritual (and not physical healing) to patients, has failed to recognize legal harm consisting exclusively of spiritual (and not physical) injury. Of course, it is debatable whether this has do with evolution in consciousness among those who give and interpret the law,237 or whether it is simply difficult to concretize spiritual injury

236. Most likely, the healer would be held criminally liable for practicing “medicine” without a license—or, if a physician, would be held negligent and likely would receive professional discipline. In the arena of parental care for children, abuse and neglect laws likely would be triggered.
237. Cf. Aldridge, supra n. 19, at 13 (“I am not arguing for idealism but a transformation of consciousness, which will demand a compassionate acceptance of the material world as it relates to an understanding of the spiritual.”).
sufficiently to make such injury comprehensible to a jury, and thereby compensable. At the very least, the thrust of modalities historically considered religious, into realms historically considered scientific, medical, and outside the purview of religion, may augur reconsideration of fundamental assumptions about what sorts of conduct are comprehensible as forbidden, socially condemnable, and monetarily compensable.

V. CONCLUSION

The presence of spiritual healing in clinical care centers, within a secular (and frequently medical context) challenges the legal boundaries of professional health care practice. More specifically, energy healing therapies, whether they are practiced by physicians, nurses, or other licensed health care providers such as (in many states) massage therapists, are subject to an array of legal rules.

Such rules proscribe (and ideally constrain) certain, specified categories of professional misconduct, and simultaneously circumscribe attempts by providers to portray diagnostic and therapeutic practices as “religious,” rather than as “medical.” More importantly, such rules attempt to delineate the major categories of potential abuse of power in the relationship between the energy healer and the patient.

Perhaps most significantly, in considering such rules, and their impact on conceptualizing malfeasance, policymakers confront practices that occupy the borderland between regulatory categories. In other words, energy healing therapies, like other CAM therapies, can blur the distinction between realms considered by many to be distinct as religion and medicine, and thus force a reconceptualization of legal categories previously thought to be less permeable.

Finally, although present legal rules address issues of abuse of power in the practice of energy healing, the practices themselves may lead to profound rethinking of fundamental legal principles. As one example, one of the exceptions to the informed consent doctrine—the therapeutic privilege—protects the physician from liability for failure to disclose to the patient information that could result in the patient’s suffering physical or emotional harm.238 Yet, some forms of energy healing assert that consciousness is non-local (i.e. not limited to the body and mind of a particular individual), thereby permitting providers who are appropriately trained to gain intuitive access to information

238. Karpman, supra n. 126, at 939 (citing sources).
concerning patients’ health and prognosis. The suggestion is that in the future, some healing professionals will have intuitive diagnostic, as well as therapeutic, tools of consciousness (rather than medical or scientific instruments) at their disposal that may enable them to reach information not available to the patient in question. Thus, the reach and extent of therapeutic privilege may need to be reconsidered, should physicians be able to access information intuitively and have to wrestle with legal and ethical obligations surrounding such knowledge.

In similar fashion, theories of malpractice liability may need to take into account the provider’s mental, emotional, and spiritual effect on the patient—as well as physical injury; and likewise, in conceptualizing battery, questions may arise as to what constitutes impermissible “touch” in a world where individuals are conscious not only of the physical body and a zone of privacy around it but also of threads of spiritual energies connecting persons. In other words, if safety, efficacy, and mechanisms of energy healing ultimately receive sufficient scientific proof to garner general medical acceptance, expanded use of these controversial therapies in clinical care may suggest the need to extend legal paradigms to include expanded ideas, not only about different therapeutic modalities and domains of training and knowledge, but also about the nature of healing and human consciousness.

In sum, spiritual healing touches the boundary between medicine and religion, science and faith, intellect and uncertainty. Legal rules, in addition to safeguarding the public health, also codify political attempts to preserve professional monopolies. In so doing, such rules crystallize cultural belief systems about what professional healers can or should be able to do. Thus, it is increasingly important to explore the nexus between legal rules, ethical codes, religious values, and medical culture. Probing the regulatory edges of abuse of power at the borderland of religion and medicine begins to tease out unstated assumptions about the ultimate meaning of human affliction and the health care professional’s role in the process of healing.

239. See e.g. Dean Radin, The Conscious Universe: The Scientific Truth of Psychic Phenomena 159 (HarperCollins 1997) (arguing that “the idea of field consciousness suggests a continuum of nonlocal intelligence, permeating space and time”); see David Bohm, Wholeness and the Implicate Order (Routledge 1993).

240. See generally Brennan, supra n. 76; Shealy & Myss, supra n. 2.

241. See Cohen, supra n. 67, at 166.

242. See generally Jonas & Crawford, supra n. 39.