Healing Arts Report

Examining Alternatives in Health and Healing — Volume 1, No. 10

Dear Reader,

Why should dying be a topic for integrative medicine? Because dying has for some time been relegated so thoroughly to hospitals and removed from the more natural family setting. Strong emotions and lack of experience in dealing with dying keep it a very awkward topic, even for health professionals. Now, after twenty-five years of the hospice movement, dying is still mostly in the hands of specialists.

I personally am thankful to my mother for choosing hospice care at home. She put her affairs in order while she still had energy. She reminisced and assessed her life while my brother and I listened. In spite of certain disappointments, she concluded that she'd had a full and satisfactory life. Most important, there was the opportunity to exchange tenderness. It wasn't easy for her to show affection or accept help from others. When she had to accept it, she found herself amazed and loving everyone who cared for her. She glowed as she told us she loved us. In spite of it being so close to the end of her life, she was able to have new experiences which touched us deeply.

HEALING ARTS

Dying Can Provide A Healing Experience

Ira Byock, M.D., president of the American Academy of Hospice and Palliative Medicine and author of *Dying Well: The Prospect for Growth at the End of Life* (New York: Riverhead/Putnam, 1997) describes how dying patients and their families can experience growth and healing. Byock compares the tasks of dying to the developmental stages of a child. Quick changes in physical functioning and the way others react can threaten a patient's sense of personhood.

He describes the time of dying as "a dark, foreboding place . . . beyond which lies the unknown." Nevertheless, he says that "the following developmental landmarks can still serve as lampposts to illuminate this frightening terrain, enabling us to achieve a sense of meaning and a new sense of self."

- love of self and others
- the completion of relationships
- acceptance of the finality of one's life as it is

Dying Well

As a physician, when Byock paid more attention to palliative and end-of-life concerns, he found that 'good deaths' were not just works of fiction. In spite of the dying experience being intensely individualized, there are also common features that can be understood and fostered. He prefers the phrase 'dying well' to 'good death' because it better expresses the sense of living and of the sense of process. He says, "Even as they are dying, most people can accomplish meaningful tasks and grow in ways that are important to them and to their families." Health care professionals can play pivotal roles. To accomplish this, the doctor must improve not only his own communication, but

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actively encourage dying patients and their family members to communicate with each other in ways they might not ordinarily try. Byock and the hospice staff use the checklist below to help remind patients and their family members about 'relationship completion':

I forgive you . . . Forgive me . . .
I love you . . . Thank you . . . Goodbye.

How Byock's Awareness Developed

Byock describes how his awareness of end-of-life issues slowly became clearer to him. At first, his involvement was medical and practical in nature -- managing symptoms, procedures and protocol, record-keeping, and economics. Medical training focuses on the relief of physical pain and cure. When cure is not possible, then managing symptoms and prolonging life at whatever cost has become the norm. With all efforts being put toward cure and rehabilitation, little training is given for the personal, rather than the clinical and statistical, nature of dying.

Byock and various members of the hospital staff noticed that lack of coordination of hospital services sometimes left discharged and dying patients with no clear follow-up. Families would not have anyone to whom they could address questions. If families talked with nurses, the nurses might not know which doctor to call on for subscription refills or other information. Social workers were not told what had been communicated to the patient or family.

Concerned staff members began meeting regularly to coordinate services. The program grew as its relevance was proven. Staff became better able to exchange information with each other, some hospital stays were shortened, and crises averted by dealing with problems more quickly.

When Byock diagnosed his own father's terminal illness, he experienced the human side of dying. He asked: What is my role as a family member in the decisions that are made? What is the doctor's role? What does my father want to do? What are the family's needs? In their case, it became important to the family to care for Byock's father at home. A man who ordinarily might have chosen to die in the hospital, instead, he allows his death to become a gift to his wife and children as he lets them care for him at home.

The whole experience opened up new ways for Byock to think about death. In the past, he occasionally heard families describe what had begun as frightening news about their family member's illness turn into the most meaningful time the family had together. Now he understood what they meant. His family had seen happier times, but never had they shared time together so intimately.

Twenty-five Years of Awareness

After years of being hidden, the topic of death and dying first began being aired in public in 1969 with the publication of *On Death and Dying* by Elisabeth Kubler-Ross. In this book, she focuses mostly on the psychological stages a dying patient experiences but also discusses other important issues, such as the roles of culture, medical technology, and religion in the creation of our attitudes toward dying.

Twenty-five years of attempting to bring the topic of death into public awareness is reflected now mostly in the growing hospice movement. Hospices help patients and families make choices about dying beyond hospital walls. It is still a rare experience, however, to hear family members speak about the subject of death. Also, unsatisfactory communication with physicians is still a complaint.

The Double-Bind of Communicating

Physicians often find themselves in a double-bind. They want to be honest and tell patients the bad news about their prognosis in order to give them the opportunity to put their affairs in order. On the other hand, they understand that their words can take away all hope.

An elderly woman tells of accompanying her ill friend to hear the results of tests for colon cancer. The doctor opens his report to the patient by stating, "Well, go home and get your papers in order."

The accompanying friend is so shocked by his directness that she exclaims, "Isn't there anything you can do to help?"

He answers, "I wasn't talking to you." The patient goes downhill quickly and the neighbor blames it forever on the doctor. It is difficult to say whether the neighbor's assessment is correct or not, but clearly, communication was not made in a manner that offered hope.

When Lewis Mehl-Madrona, M.D., author of *Coyote Medicine*, spoke with doctors at the Winchester Medical Center in Virginia in July, he described it as arrogant and discouraging when doctors tell patients how much time they have to live. If patients ask directly about whether they are dying, Mehl-Madrona believes a physician can be honest about what he has seen without causing hopelessness. "It is a question of how information is conveyed that can make the difference." He adds, "After all, people do beat the odds."

Studies Shows Lack of Understanding

A recent study concluded that among seriously-ill hospitalized adults, communication about preferences for cardiopulmonary resuscitation (CPR) is uncommon.[1] Neither physicians nor one-year interns accurately understood whether their patients wanted to undergo CPR, nor could they accurately tell what their patients' end-of-life treatment preferences were.

The study's lead author, Dr. Ira Wilson, of the New England Medical Center, stated that the length of time a doctor knew the patient did not translate into having better responses for their critically-ill patients. "Physicians often are vague and euphemistic in their discussion of CPR, for example. Therefore, some patients are unaware that the physicians felt they had talked about CPR," he said.

Other findings showed that doctors as well as interns overestimated patients' willingness to receive lifelong tube feedings or to live in a nursing home. Lack of communication puts patients at higher risk of receiving unwanted procedures.[2] Forty-nine percent of attending physicians had known their patients for more than six months. Even those who had known patients for longer did not understand patient experiences and preferences better.

"We should worry about this," Wilson said, "because if experience means anything, surely it should correlate with more commitment to talking with patients and more skill in doing so." Little is known about how physicians' level of training or experience relates to their ability to assess patient preferences.[3]

Learning to Speak About Death

When a topic is avoided, as the topic of death is in our culture, we become fearful of it. We must introduce it into our sphere of vocabulary and experience. This process is referred to as de-sensitization. One of the easiest ways to begin is by reading good books or articles on the topic. They often contain uplifting stories which dispel cultural superstitions that keep one from thinking about dying.

Begin with material that treats death from an angle that is interesting to you. A scientific yet moving approach is offered by Sherwin B. Nuland in *How We Die.* He describes the physiological process of how the body shuts down from different conditions and diseases, including AIDS, cancer, heart disease, Alzheimer's, accident, suicide, euthanasia, and murder. The emotional and psychological issues are approached in the now classic half-dozen or so books by Elisabeth Kubler-Ross, M.D. Stephen Levine combines the personal with the compassionate, calm, and philosophical in *Who Dies?* For an unusual, serious, humorous, yet respectful view of life, death, love, and grief, read *The Undertaking: Life Studies from the Dismal Trade* by undertaker Thomas Lynch.

Comfort at the End

Regarding end-of-life care, Byock makes one point very clear -- there is no reason for the patient to experience physical agony. The variety of drugs and even surgical procedures that are available can keep the patient alert and pain free. He believes there would be fewer advocates for assisted suicide if patients and doctors understood better how pain could be relieved. He makes clear distinctions between assisted suicide and allowing for the natural process of death to occur. If there is any lack of clarity, he brings the question to the local ethics committee so that nothing is happening in secret. Everyone involved, including the patient, can feel they made the best decisions. Most important, he explains to patients what their options are. For example, if applicable, he might describe what death is like for those who long ago lost their appetite or ability to eat and now choose not to take nourishment.

Byock asserts that death in the hospital can become a 'macabre' event when extreme life-prolonging treatments are imposed, even when a person is expected to die shortly. Patient

concerns about their own pain and dignity are often not given consideration in spite of widespread cancer; end-stage heart, kidney, or liver failure; or when they see their natural death as final relief from physical debility and suffering.

Byock's gift as a physician is his ability to listen to what his patients want and to help them achieve it when they themselves don't know how. Byock suggests two questions to help begin this journey: (1) What would be left undone if I were to die today? and (2) How can I live most fully in whatever time is left? These are two questions we can all benefit from at any time in our lives.

The American Academy of Hospice and Palliative Medicine is an international organization of physicians dedicated to the advancement of hospice and palliative medicine in the management of the terminally ill. Their website is http://www.aahpm.org.

Choice in Dying is a nonprofit organization for consumers and professionals. It offers services dedicated to fostering communication about complex end-of-life decisions. Their video Before I Die *has been shown on public television. Phone 212-366-5540 or see website at http://www.choices.org.*

The Hospice Foundation of America can be reached at 800-854-3402 or by fax at 305-538-0092. Their website provides explanation of hospice and other information including how to locate a hospice. Web address is http://www.hospicefoundation.org.

HEALING CONCEPTS

What is Holistic about Traditional Chinese Medicine?

"Talking with my sickly father over twenty years ago, I gazed unthinkingly as he sorted out his eighteen bottles of medicine. Half of them were for symptoms in various parts of his body. The other half were prescribed to counter their side-effects. In addition, they had been prescribed by several different doctors. Then it hit me -- the medical profession seemed to have divided him up into territories, which they called 'specialties'. They created boundaries where there were none. It just seemed naive." This is a description given by one of the almost 33 percent of American patients who seek alternative health care. Their reasons for seeking alternatives often go back to unpleasant earlier family experiences which they want to avoid in their own health care future.

The Mechanistic View

The scene described above is the result of a mechanistic view of the body, it's relationship to itself and to the world. It is a view that has dominated Western medicine since the time of Descartes, when scientists agreed to attend only to physical concerns, leaving emotions and other intangibles to the church. This attitude has been most prevalent in this century and it is this model which is now being challenged.

The West has typically seen the body as a machine with parts that can be dismantled, 'fixed,' or replaced. The analogy has served a purpose in helping scientists understand the functions of particular systems and discriminate their material constituents. David Lorimer, director of the Scientific and Medical Network, explains that after inventing machines, we then used them as a model for human functioning and began to put aside any observations that did not fit the model.

This reductive thinking has certain assumptions. Humans are seen as separate from nature. All matter is quantified and seen as the result of cause and effect. The human being is lost to the focus on pathogenic agents or mechanical failures. Average parameters are considered standard for everyone. Knowledge is 'objective.' Health means fitting within the parameters of objective measurements and qualities which are not measurable are ignored.

Human Beings Are Like Gardens

In Chinese medicine, according to authors Harriet Beinfield and Efren Korngold in their book *Between Heaven and Earth: A Guide to Chinese Medicine*, people are seen as a microcosm of nature and as part of a unified whole. Each human being is unique, while remaining part of the pattern, rhythms, and cycles of life. The doctor's role is a partnership with the patient to help increase patients' abilities to contribute to their own state of health.

In Traditional Chinese Medicine (TCM), the body is compared to a garden. The functions are seen as networks relating to each other

as well as to external influences. Health is reflected in the ability to function mentally and emotionally as well as physically. The qualities of health include being adaptable and feeling integrated and fulfilled, rather than fitting measurable parameters.

This concept of wholeness is reflected in author/physicist Fritjof Capra's comments about the new science paradigm. In *The Tao of Physics* (Boston: Shambhala Publications,1991) he states, "Gradually, physicists began to realize that nature, at the atomic level, does not appear as a mechanical universe composed of fundamental building blocks, but rather as a network of relations and that, ultimately, there are no parts at all in this interconnected web."

In *The Web That Has No Weaver*, author Ted J. Kaptchuk, O.M.D. (New York: Congdon & Weed, Inc., 1983) discusses the history of early Greek medicine. The earlier qualitative stream of Greek thought, like TCM, had certain similarities to the practice of Arab physicians and to Hindu Ayurvedic systems. "Health and illness," he says, "were usually defined in terms of balance." In the other quantitative stream, opposing elements are seen as building blocks of the body which need adjusting in their portions. Eventually, "images of quality are left behind for precise units of quantity . . . ."

TCM Practice

TCM treatment combines acupuncture, diet, herbs, massage, and exercise, such as qigong. It is not something that is done only after the diagnosis of a disease is made. Symptoms often develop long before an illness can be diagnosed. The traditional Chinese doctor sees his job as educating the patient to make changes in his lifestyle. It is assumed that the patient is responsible for his health.

The TCM practitioner depends on non-invasive observations and listening skills to make diagnoses. Along with medical history, listening to the patient describe complaints and treatments, as well as life style, the doctor makes observations about:

- the way the person carries himself
- the tone and strength of voice
- the appearance of complexion and tongue
- the strength, rhythm, and other qualities of the pulse
- the odor of the body, breath, and other excretions

A patient might be prescribed a combination of weekly acupuncture treatments and daily herbal extracts. Another may also be given qigong exercises and dietary recommendations.

As more Western practitioners are studying Chinese medicine, they are incorporating TCM concepts into their practices. Although the philosophical perceptions and explanations are very different, they are able to measure the results of treatment by Western standards, such as blood chemistry. Anxiety attacks, chronic fatigue, high blood pressure, and arthritic pain have all been shown to be amenable to Chinese medicine.[4]

Call The American Association of Acupuncture and Oriental Medicine in Pennsylvania at 610-433-2448 for more information or doctor referrals.

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SCIENCE REPORT

Grass Roots Research

In spite of many alternative therapies being older than conventional practice, they are continually challenged by mainstream medicine, insurance, and drug companies as unproven. Conventional researchers may dispute the efficacy of Therapeutic Touch, for example, because there is no proof that an energy field exists around a patient which the practitioner is affecting by 'smoothing it out'.

Some groups are taking integrative medical research into their own hands, hoping to provide pilot studies that later could be expanded into full research projects if they prove promising. The Baltimore School of Massage, for example, developed a non-profit arm called the Institute of Creative Studies (ICS).

ICS is run by volunteers and at least part of the funding is raised by the organization itself. Volunteer Mary Cox describes it as a grass roots effort. "We're doing it because we believe it needs to be done," she explained in a recent phone interview. "We've raised money by selling health food and a class of students has even made a donation."

Barrie Cassileth, outgoing Alternative Medical Program Advisory Council member from the National Institutes of Health (NIH) Office of Alternative Medicine (OAM), has been advising ICS on how to set up pilot studies. The validity of their pilot studies will provide a base from which to apply for grants in the future. Many organizations are not familiar with research protocols and may be doing studies that will be viewed as unacceptable. The OAM can provide advice.

ICS is conducting three pilot studies. Patients are being recruited for these studies with the cooperation of patients' physicians. The first study seeks to document the effect of massage therapy on non-insulin dependent diabetes mellitus. The second study involves the efficacy of massage in HIV-infected patients. The third is being conducted to show the effect of massage on patients with peripheral vascular disease. ICS recently had an article accepted by *Cancer Prevention International* documenting the effects of massage therapy on cancer patients.

Obstacles and Needs for Research

In the world of complementary and alternative medicine (CAM), researchers face a number of obstacles in addition to the usual shortage of funds. There is little machinery developed to instigate research and a great deal of machinery already in action to prevent it. CAM researchers haven't been developed in colleges where research programs are funded by conventional sponsors, such as drug companies, who can earn back costs spent on the studies. National headquarters for alternative therapies, if they exist at all, usually survive through membership fees, often barely enough to support a coordinating office. Even if members could agree to support research projects, financial demands on the organizations would be greater.

There are research issues which are very significant in the alternative spectrum and which have no precedent in traditional research. These include: "effects on therapeutic outcome of patients' choice of treatment; participation by patients in their own care; and the relationship between the expectations of patients, cultural context, and lifestyle activities."[5]

Researchers trained in the biomedical model need to work with an expert in the specific alternative therapy in order to design effective and valid research protocols.[6] An example of this problem is described in Vol. 1, No. 8 of *Healing Arts Report*. It described the faulty research of a specific homeopathic remedy being given to everyone with a particular diagnosis. In homeopathy, different remedies are given according to the types and qualities of an individual's symptoms, not according to conventional diagnoses.

The OAM provides extensive technical assistance to complementary and alternative medicine practitioners and researchers in the areas of research methods, protocol development, grant proposal development, and practice assessments. In addition, the OAM Intramural Research Training Program is under development. This program may provide some training in NIH laboratories, educational materials, a scientific seminar series on CAM research topics at NIH, and presentations of research results at an annual meeting.[7]

Send contributions to the Institute of Creative Studies at the Baltimore School of Massage, 6401

Dogwood Road, Baltimore, MD 21207. Phone 410-944-8855.

The Office of Alternative Medicine's mission is to identify and evaluate unconventional health care practices and support research training. For more information, phone 888-644-6226 or fax 301-495-4957.

HEALING ARTS

Chelation Therapy: Clearing Toxins

Derrick Lonsdale, M.D., a physician specializing in nutritional therapy and author of *Why I Left Orthodox Medicine: Healing for the 21st Century*, believes that chelation "improves energy metabolism, the root cause of every chronic disease . . . . It is an extension of the nutrition principle." He adds that it "is a lot better than most of the pharmaceuticals on the market. It has no dangers if used properly . . . (and) is a kind, non-aggressive treatment that works in 80-85 percent of people."

Chelation therapy refers to a series of intravenous administrations of EDTA (ethylenediaminetetraacetic acid) combined with several nutrients. The injection can take from two to four hours, depending on what rate of speed the doctor assesses will be comfortable for the reclining patient. The EDTA binds with toxic metals and carries them out of the body through natural bodily processes. Although the Food and Drug Administration has not yet approved EDTA for anything but heavy metal toxicity, it can be used legally for other conditions at the discretion of the physician.

Chelation has been shown to reverse arteriosclerosis blockages by combining with and carrying away the plaque that accumulates in arteries. It has worked even in cases that ordinarily would have required bypass surgery. Other ailments which are responsive to chelation are extreme angina, leg cramps, and threatening gangrene. It also is used to reduce internal inflammation caused by free radicals which can then ease discomfort from arthritic scleroderma and lupus. Lonsdale, who is also editor of the *Journal for Advancement in Medicine*, says that some practitioners have been experimenting with oral chelation using EDTA as well as other substances. He has not, however, seen any hard scientific evidence proving its effectiveness.

Chelation seems to exemplify the ambiguous problem of being a new therapy for which many studies have been done. Conventional medical paper publishers refuse to publish these studies because they are unwilling to publish subjects which are still controversial. This situation might be more acceptable if the journals who do publish holistic and alternative findings were indexed in the study references of medical libraries.

Safe and Effective

Chelation is very safe when administered according to the protocol established by the American Board of Chelation Therapy. In terms of current drug safety standards, aspirin is considered to be approximately three-and-a-half times more toxic than EDTA. Chelation has been used by over 500,000 patients over the last forty years.

When choosing a doctor, find one who uses the American Board's protocol, has several years of experience, and has completed training conducted by The American College of Advancement in Medicine (ACAM). ACAM has workshops to train physicians twice a year.

Heart patient Jack Bellingham believes he wouldn't be alive today, twenty years after having bypass surgery, if it weren't for chelation. "I've read that people who have had bypass often have to go back for bypass two and three times and I haven't had to do that." Bellingham had what his doctor thought was a heart attack about ten years ago. A relative who survived cervical cancer using alternative therapies told him about chelation and begged him to try it.

According to Lonsdale, the initial cost of 26 treatments over a period of three months is about $3,000. Bellingham keeps up a maintenance program of ten treatments a year at $75 per session. Although most insurance companies don't cover it, some are beginning to look at it. Bellingham remarks, "Why insurance companies aren't jumping at it is beyond me. Compare it to $40,000 for surgery." Bellingham recommends the book *Bypassing Bypass* by Dr. Elmer Cranton, which is also on ACAM's recommended reading list.

Bellingham tells the story about how his

own doctor, Harold Huffman, M.D., in Harrisonburg, Virginia, came to use chelation. Huffman's father had already lost one leg because of diabetes and he was developing gangrene in the other one. They decided to try chelation and it kept him from losing the other one. He lived into his 90s. Although Bellingham finds the three-to-four-hour treatments tedious, benefits include having a special day out with his wife and meeting interesting people receiving treatment at the same time.

"I've watched many people improve," says Bellingham. One woman who had a stroke needed two people to help her sit down and get up. The next time I saw her she was using a walker. The next time, a cane. Another patient came in with a terrible looking gangrenous foot. Several months later we met him again and his foot was normal! He didn't take care of himself, didn't eat very well, so it had to have been the chelation. We've met people recovering from strokes, lead poisoning, and gangrene and seen the results with our own eyes."

Jack Hank at The American Board of Chelation Therapy in Chicago will provide the names of board-certified physicians. Phone 800-356-2228.

The American College of Advancement in Medicine provides chelation protocol, member physician referral, and their recommended reading list. Send a 55-cent stamped, self-addressed envelope to P.O. Box 3427, Laguna Hills, CA 92654. Phone 714-583-7666, 800-992-8350.

Derrick Lonsdale, M.D., can be contacted at 216-835-0104.

Best wishes,

Barbara June Appelgren

Barbara June Appelgren

END NOTES

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