A Fresh Look at "Integrative" Medicine:
Merging *Allopathic (M.D.)* and *Osteopathic (D.O.)* Concepts

SALT AND PEPPER TWIN CONTINENTALS

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Powder Blue and Baby Pink. Side by side. Parked behind the office building: twin 1962 Lincoln Continentals. That's one of my fondest memories of seeing Dr. Bill Williams, "my chiropractor" in Waco, Texas. I was a sophomore in high school, complaining of back and neck pains, worrisome to my parents. My father's younger brother – Jim – had long been a chiropractor in Dade City, Florida, so taking me for "non-traditional" evaluation by Dr. Bill was a natural choice. (Sixty years ago, my Uncle Jim was a chiropractor when chiropractic wasn't cool and they often got hauled off to jail![1])

Back and neck x-rays, strange "electric potential" instrument tracing "irritations" up and down my spine, and strong hands finding areas of discomfort along the muscles and bones in my back. In my world, these were reassuring. Then came my adjustments – "manual manipulation," sometimes easy, sometimes rough – and heat packs, ultrasound, "electro-stim" patches to "treat" my muscles, even gentle traction. Each of these made me feel so very much better.

Two or three times a week visits when I started, finally decreasing to once (occasionally twice) a week in the later years of my high schooling. Ahhh, how much I looked forward to these adjustments and treatments. No matter how great I felt when leaving the office – walking past those lovely, elegant blue and pink Continentals – my discomforts managed to return just as before within two or three or four days. Rarely would I "be comfortable" for as long as a ten or twenty days; that just didn't happen. Returning from vacation travels always meant a welcome visit to "my" chiropractor, to get back "in line."

Never once did my parents (who also received their own treatments, though much less often) or I pause to consider that my need for frequent and continuing chiropractic care represented a significant disease pattern. Twenty-five years later, I found out differently. (Simply stated, I have a *genetic* limitation called "hypermobility syndrome," also known as "ligament-laxity syndrome" or "double-jointedness," and this condition

[1] My references to "chiropractors" (as "manual manipulators" – spine adjusters) should be understood in the context that I had never met a manipulating osteopathic physician, I didn't really know anything about them until later in college, when application to medical school included considering a D.O. (osteopathic) education instead of an M.D. (allopathic) one. My uncle wanted me to become a chiropractor (D. C.) – many times I have wondered how my life would have turned out had I listened to him!

means that I more easily injure my connective tissues, and they simply don't heal as well as "other folks." More on this shortly.) *And* I finally found a lasting solution to these lingering and even worsening discomforts in my frame and muscles. *Not* soon enough to save me from the first two of my spinal operations … but certainly in time to make my middle and later aging much, much more comfortable and active.

How might these back and neck discomforts affected my life? The pains and limitations are obvious … I tried to play football in the 8th grade, but I just couldn't tolerate the work-outs (or the brutal contact!) … I tried to run track, but I always suffered shin splints (painful!) and various aches and pains, mostly in my feet and ankles, knees, and hips … I tried to play soccer as a freshman in college; another repeat of my "track experience," but even more physical suffering … I enrolled for karate classes as a sophomore in college; oops, another *real* mistake! … and (slow learner?) I tried ballroom dance class as a college sophomore – fun *but* hip and ankle pains took their toll.

These are "mechanical" perspectives, but bodies are made of "metabolic" processes as well. What is "metabolism"? Simply what you do (chemistry) when your body does ***all*** that it does on the inside. Everything. And that is where a key principle of osteopathic medicine comes into play:

> **WHEN NORMAL ADAPTABILITY IS DISRUPTED OR WHEN THE BODY'S CAPACITY FOR SELF-MAINTENANCE IS OVERWHELMED BY ENVIRONMENTAL CHANGES, DISEASE MAY ENSUE**

So … what kind of "disease" could I be referring to? How about "Chronic Fatigue Syndrome," specifically related (in my case) to a viral infection with "Epstein-Barr Virus" ("EBV") and/or "CytomegaloVirus" ("CMV"). These viruses often are "fellow-travelers," each "showing up" when the other has some forsaken individual in its grasp.

Dr. Paul Cheney, practicing at Lake Tahoe in the mid-1980s, noticed a peculiar constellation of symptoms that he catalogued as "Chronic Fatigue Syndrome" or "CFS." Some of his patients showed a "positive" test for EBV, rather recently discovered and described in the medical literature. Evidence in the scientific reports shows that this symptom pattern has been repeatedly described over many dozens of years, but the descriptions are hidden in medical journals usually read only by the specialists in the intended audiences … such as neurologists, endocrinologists, infectious disease experts. What is even more interesting, though, is that EBV (and sometimes CMV) is often associated with "strep throat" ("positive" throat swab/culture for Streptococcus pharyngitis).

Why is this more interesting? Let's start with my personal history of recurrent strep throat episodes – two to four or more times a year – ever since I was four or five years old. Incidentally, antibiotic treatment for streptococcal bacteria encourages the growth of yeast (most commonly *Candida albicans*), which Alabama internist, C. Orian

Truss, M.D., discovered in the late 1970s[2] to be related to a wide range of human ailments in the "civilized" countries. Tennessee pediatric allergist, William Crook, M.D., popularized these ideas and effective treatments, and his excellent book[3] was followed by mine, **The Yeast Syndrome**[4], which explains a broad range of the metabolic issues involved in many illnesses. Yeast overgrowth has been implicated in an increasing number of puzzling, frustrating, distressing disorders … often the ones that conventional medical specialists consider to be "untreatable."

No doubt the repeated strep throat episodes (along with occasional bronchitis) were "abnormal" (though not uncommon in our "modern" world) and led to an unrecognized "Yeast Syndrome" illness (which I treated in the early 1980s, just after meeting Drs. Crook and Truss). But more fascinating was the strange, powerful malady that struck me over Christmas break of my senior year in high school. I was "down" – feverish, fatigued, absolutely drained – for over three weeks. (Nope, my principal refused to let me delay taking semester finals, the last set of grades to be seen by college admissions committees; thankfully, I "aced" them and spent five wonder-filled years at Stanford.) Okay, so what's "fascinating" about being "ill" then? How about … suffering a similar inexplicable ailment exactly one year later, leading to confinement in the student convalescent center at college. And then a repeat episode two years after that, spending almost another week "in bed" at the center in the spring of my junior year. This final time, Stanford University Medical Center diagnosed me as having "Epstein-Barr Virus" … mono! The test to confirm such an infection had only recently been developed.

Okay, so what? Here's what: how about my *next* episode, during the winter/spring of my sophomore year in medical school? Again, positive testing for EBV. Wow! – what an argument ensued with the treating doctor at the student health service. "Hey, this is the same thing I had as a junior in college." "Not so," said the doc, "you *can't* get it twice." "Well," said I, "then the Case Western Reserve University Hospitals need to argue with the Stanford University Hospitals, because they were definite about diagnosing EBV as a new problem." Yep, I was one of the *first* folks confirmed to have at least two episodes of "acute mono," indicating that I had a version of "*chronic* mono," later one presentation of "chronic fatigue syndrome" ("CFS," now often described as "Chronic Fatigue Immune Deficiency Syndrome"[5] or "CFIDS"), recognized at Lake

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[2] Truss, C. O. **The Missing Diagnosis**. Paperback published 1985 (earlier hardcover no longer available).

[3] Crook, W. **The Yeast Connection: A Medical Breakthrough**. New York: Random House, 1986 (hardcover published 1984 no longer available).

[4] Trowbridge, J. P. and Walker, M. **The Yeast Syndrome: How to Help Your Doctor Identify & Treat the Real Cause of Your Yeast-Related Illness**. New York: Bantam Books, 1986. Now available in electronic format from various booksellers.

[5] Sieverling C. "Dr. Paul Cheney on Mitochondrial Myopathy, MRS Brain Scans and Chronic Fatigue Syndrome." ProHealth enewsletter, January 24, 2001. Available at http://www.prohealth.com/library/showarticle.cfm?id=2966&t=CFIDS_FM, accessed on February 26, 2010.

Tahoe, California, by Paul Cheney, M.D., Ph.D. in 1985.[6] (Only in later years did the thought occur to me that my ailments in my senior year of high school and my freshman year in college were *exactly* the same as those that subsequently were diagnosed as EBV – yep, slow learner!)

I belabor the details of my "chronic fatigue" illnesses because I have had to learn how to treat these effectively in order to stay active and "well" in my adult years. When I look at the correlation of my "mechanical" neck and back problems with the soon-after onset of "metabolic" (viral) ailments, the prospect that my painful distresses have contributed to my immune-system deficiencies seems persuasive. The overlap of symptoms between CFS and CFIDS and fibromyalgia and hypermobility/ligament-laxity syndrome is intriguing and the relationships will be better understood in future years.

My Suffering Turns a New Page

My "mechanical" story became even more interesting as a senior in college, when a friend and I went on a vacation to Mexico. We never made it there. Our motel in San Diego had an inviting pool, and I dove in for a morning swim before checking out. The cold water was beyond chilling … to me, it was paralyzing. My back muscles quickly and severely went into spasm. Fearful of drowning in a *pool* of all things, I struggled with my arms to pull myself forward and to the side, agonizingly dragging my body out. End of vacation but not end of story. My friend drove me the 500 miles back home, moaning in pain and lying as best I could in the back seat of my Volkswagen Beetle.

A long overdue visit was scheduled with an orthopedic surgeon at the Palo Alto Medical Clinic, a premiere facility near Stanford University. A brief visit, then down for x-rays. Lying down, of course, since that's how allopathic ("regular," M.D.) physicians take their pictures.[7] Here's where another principle of osteopathic medicine becomes relevant:

STRUCTURE AND FUNCTION ARE INTER-RELATED

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[6] In various publications and professional lectures, Dr. Paul Cheney has shared his views that this severe fatigue/brain fog/muscle pains symptom cluster has a complex pathophysiology, with more details available at www.cheneyresearch.com. We have reiterated these points in several personal conversations. In Chapter 18 of the New Edition of Dr. Faber's excellent text, **PAIN, PAIN GO AWAY: Free Yourself From Chronic Pain**, we have reviewed the mechanical aspects of ligament laxity syndrome (hypermobility, "double-jointedness"), which shares a number of features with "CFS." Again, genetic and other reasons (including repeated or severe traumas) can cause such laxity.

[7] As a senior medical student, I had the privilege to study radiology at Montefiore Hospital and Medical Center in the Bronx, New York, renowned for its Chair, Harold G. Jacobson, M.D., who – literally – "wrote the book." There, I got to *think* about what x-ray films *meant*, with regard to what was going on inside the living body. No, we took films lying down.

What interrelationship am I referring to? How about something instantly obvious to you, the reader: gravity. People often are more *comfortable* lying down, where the effects of gravity are spread along the length of the body. Many folks are far more *pained* when standing "upright" (as best they can), where the effects of gravity are amassed and pulling from the weight of the head, through the length of the spine, across the hips and all the way down through the legs. Indeed, the "pictures" taken lying down often look much better, because they fail to show the deviations that become apparent (or more significant) only under the influence of gravity.

Osteopathic physicians and chiropractors learn to take almost all of their x-rays in the upright position. Such radiographs ("films") give greater clues to how the body is functioning, at least the muscles (that move the bones) and the ligaments and joint capsules (that restrain the bones within certain limits). "Kinks" in the spinal pattern – or long, sweeping "curves" – can highlight areas of injury, weakness, and/or instability. Since your spinal muscles (as with all others) are expected to be relaxed except for minimal posture adjustments, any backbone deviations from straight lines can indicate areas of excessive muscle stress: ***spasm!***

Muscles chronically "in spasm" are tense and thereby restrict the flow of vital fluids within. This "lymphatic fluid," even along with "blood flow" through tiny vessels, is essential for optimal function. Indeed, the principle is easy to understand: if you need to maintain, improve, assist, or repair any body area, you need to have a continuous supply of fresh supplies. This osteopathic principle is easily understood:

THE MOVEMENT OF BODY FLUIDS IS ESSENTIAL FOR HEALTH

And *that* means easy-flowing circulation, both blood and lymph (the fluid passing within the tissues, between the cells, outside the blood vessels, and returning gradually to the heart to rejoin the circulating blood). When these essential flows are restricted (such as by muscle spasm), essential self-repair and self-adjusting processes are *reduced* or fully *blocked*. This condition violates one of the primary principles of osteopathic medicine:

THE BODY POSSESSES SELF-REGULATORY MECHANISMS

Interruption of the biological processes that internally balance all cells and their functions is a serious early step in the development of more chronic (and more ominous) diseases. Indeed, the true physician, in his role as healer, is always looking for deeper-level interferences to self-repair and self-regulatory mechanisms. The alternative is seen every day in hundreds of thousands of office visits across the country: "reactive" prescribing only in response to being shown a problem and looking only for an easy way to make it disappear (at least become "tolerable").

Back to the orthopedic surgeon, an allopathic doctor through-and-through. He put the x-ray films up on the viewer and then called me over. "These are your pictures," he said. Never having seen any x-rays "up close," I must have looked quizzically at him.

"They look much more like those of a seventy-year-old man, not someone twenty-one like you." Ton of bricks!! I hadn't expected to hear that sentence to a lifetime of crippled discomfort, especially since I had continued frequent chiropractic adjustments throughout my college years (at least, whenever my pains had worsened).

Facing down this sobering conclusion wasn't really "happy" in my world. I was too young to consider a lifetime of limitations. (Giving up sports was easy, I'd already done it; giving up "usual" activities and shuffling around hunched over like an old man was much harder to swallow.) And swallow I did: the muscle spasm relaxing medications, arthritis pain relief medications, and actual pain pills, all prescribed by my orthopedic surgeon. You might guess, of course, that I was reluctant to give up my motorcycle, a Suzuki X-6 nicely customized for high-speed highway commuting. Well, anti-spasm drugs can be wonderful – and stupid! – to cover up the discomfort of back muscles rebelling from the stress of a longer ride. The bike finally got sold.

In the winter of my fifth-year-senior term, I was working on a class paper. I had laid out various notes, arrayed in front and around me as I knelt on the carpet. I reached over for a pencil … and white lightning pain ***shot*** through my low back. Tears welled up as I found literally ***any*** movement brought severe, disabling agony. Again, more muscle spasm pills, more anti-inflammatory arthritis pills, more "real" pain pills. I was "down" for three weeks – *a hard way to get through school!* – and that's when I learned that whiskey really made the other pills much more effective. WOW! Talk about having to face a real test of self-will, realizing that the path of drugs and alcohol can be a one-way street.

With careful attention to activities, especially lifting with proper mechanics, I managed fairly well over the next three years. Then, late in my first year of medical school at Case Western Reserve University in Cleveland, Ohio, a major tragedy occurred. Coming home from a long day of studies, I was confronted by trash from my garbage can strewn across my driveway. My next-door neighbor disliked the side of my driveway where I put my trash can. His solution was to spread my rubbish in such a way that I couldn't drive in. As I was bent over in the rain to clean up the mess, his fist was in my face. "Gentleman boxer" that he was, he proceeded to pummel my face for the next several minutes, in my own front yard. Three squad cars arrived, they took him away in handcuffs. The prosecutor refused to prefer charges: "this is just a domestic squabble." I wore a neck collar for the next several months. In fact, I've never fully recovered from this battery in 1973. Over the next several years, more prescriptions for spasm, pain, and "arthritis" discomforts.

The Spider Takes On the Texas Ranger

One of the problems with "conventional" or "usual" care – whether allopathic (M.D.) or osteopathic (D.O.) – is what I call the **Texas Ranger Theory of Medicine**. The story is told from the late 1800s that the town was experiencing a riot, so they cabled to Austin to send the Rangers. The message returned: "MEET TOMORROW AFTERNOONS TRAIN." The good townsfolk gathered at the train station. The train

pulled to a stop as the mayor rushed over. A tall Ranger stepped onto the platform, dusted off his hat, and adjusted his gun belt. The mayor was excited: "Where are the others?" "What others?" replied the Ranger. "We have a riot, we asked for the Rangers." Calmly the lawman reassured, "*One* riot, *one* Ranger." In the world of medicine, doctors look to peg a name on your condition … that makes treatment relatively simple: *one* disease, *one* drug.

Taping a diagnostic label to your forehead might be convenient, sometimes even easy – but *jamming* "you" into a labeled cubbyhole defeats the whole purpose of treating you as a whole person. The premise of "wholistic medicine" is to review and understand how the "totality of you" figures into your illness and injury problems ("mechanical" [structure] and "metabolic" [function] issues) and how treatment strategies can be most successful by supporting your weaknesses and playing into your strengths. I call this the **Spider Web Theory of Medicine**: pull on *any* part of the web, the *whole* web jiggles. Treatment planning needs to take into account "all" of you, not just your muscle spasms (anti-spasm drugs), not just your pains (pain drugs), not just your arthritis changes (anti-inflammatory drugs). The key is to find all the relevant strategies to support your natural healing, your body's capacity to repair itself, since many factors will encourage rebalancing and resumption of more normal functions. This brings to mind one of the other osteopathic principles:

THE BODY IS A UNIT

Never once did the orthopedic specialist, or later clinic GPs, or any of my chiropractors ever mention that their treatments were simply *reactive*, just based on treating my complaints when offered. Never once did any of them suggest that I might have fundamental problems with my ligaments and other supporting tissues. Never once did they suggest any treatment other than putting fancy band-aids (whether drugs or manipulations and massage) on my grumbles and whines.

Long and late hours training in surgery aggravated my neck and back discomforts and triggered new complaints in my shoulders. During my surgical internship at the Mt. Zion Hospital and Medical Center in San Francisco, California, I was privileged to have one of the earliest "TENS"[8] units, whereby a small electric current delivered through patches applied near the spine helps to block pain signals coming from further down in the body. Another "Texas Ranger" approach, but often successful and with fewer "side effects" than with drugs.

As an aside, let me offer that drugs have NO ***side*** effects, absolutely ***NONE***. You might argue, but you'd be wrong. Drugs ONLY ***have*** effects, all the changes that they "make" inside your biochemistry when they are given to you. The desired effects that you *want* are called "therapeutic effects." For example, if you take the common anti-histamine, Benadryl®, in order to control itching or nose congestion, that's the intended

[8] "TENS" means "**T**ranscutaneous [across the skin] **E**lectrical **N**erve **S**timulation," which uses the "gate theory of pain," similar to acupuncture.

benefit. But Benadryl® can also make you sedated, sleepy – that's a *side* effect … unless, of course, you're using the drug specifically to help you sleep! If your "sleep drug" gives you uncomfortable nose dryness, then you would call *that* a side effect. *All* drugs work this way: they simply have *effects*, sometimes lots of them, and you hope for more of the desirable ones and fewer of the uncomfortable ones.

Begging for *The Knife*

My first year in practice, in Humble, Texas – a Houston suburb – began with an unexpected interruption. While hauling some bricks (to make a mailbox for my new tract house), I managed to "spring" my neck the wrong way. Over the next several weeks, a gnawing, boring pain developed in my left arm. Finally I got to the point where I could put my hand on a door handle but I couldn't squeeze my fingers to turn it. At *that* time, I knew I was really in trouble. Some two weeks in the hospital, stretched in traction for most of every day, failed to provide other than minimal improvement. What happened next is stunning: I had neck surgery.

The several "pins 'n' needles" "EMG / NCT"[9] tests were painful "to the max." Then came the myelogram, where contrast dye is injected into the spinal canal to outline the nerves, looking for any bulges that indicate rupturing disks or arthritis spurring or any other compression, such as from a tumor. Oops! The disk bulge ("herniation") was located one level *lower* than suggested by the EMG/NCT tests. The operation *had* been planned to be from the front, with placement of a bone plug between the two neck spinal bones where the disk was collapsing. However, a "Cloward" procedure from the front carries a much higher risk of paralyzing one of my vocal cords when a lower disk is involved. I'm a speaker. My patients, friends, and family know that I talk *a lot!* So the neurosurgeon and I agreed that an approach from the rear would be more ideal, despite the fact that it might not produce ideal results.

As an aside, another osteopathic medical principle comes into play at this juncture of my story:

> **THE NERVES PLAY A CRUCIAL ROLE IN CONTROLLING THE MOVEMENT OF BODY FLUIDS**

"Pinching" a nerve is understood as a reason for "nerve pain" ("dysesthesias") or altered sensations ("paresthesias"). What isn't always clear is that *any* irritation or pressure on a spinal (or other) nerve can cause major changes in the tissues "innervated" by ("plugged into") that nerve. The closer the nerve is to the spine, the broader an area of tissues and organs can be affected. The closer the nerve is to the brain, the larger an area can be affected. "Affected" means *bad* things. Nerves that are free to "do their thing" will send

[9] "EMG" means "**E**lectro-**M**yo-**G**ram," needles measuring the electrical current in muscles to be sure that their nerve *supply* has not been compromised; "NCT" means "**N**erve **C**onduction **T**ests," needles evaluating whether nerve signals are being conducted *normally* to and from the brain and spinal cord.

signals to tissues to balance their functions and will send status reports back to the brain. Nerves that are being pressured or pinched can send altered signals at best. One of the alterations in tissues is the accumulation of fluid – lymph and blood, as discussed earlier with regard to muscle spasms – and that "swelling" interferes with normal function and metabolic (biochemical) balance. Even the blood vessels themselves (and the heart, as the pump) respond to nerve signals that can indirectly alter fluid balance and metabolism in distant tissues and organs.

Back to my neck operation: July 19, 1979. *Another* awful *week* in the hospital, suffering terribly with "post-op" pain, hour by hour, day by day. Finally I was able to return to work, literally starting anew in my general practice of medicine, still wearing a supportive neck collar for months, returning home each evening to spend time in traction, searching for relief from the spasms and pains and headaches, since I refused to take the drugs (yes, the *same kinds* as from 1969, when I first saw the orthopedic surgeon) while seeing patients during the day.

Surgery was "successful" in reducing a fair amount of my discomfort, but the seeds of future failure were sewn during this operation. A major bone spur (the result of earlier injuries) was located in *front* of the nerve, toward the front of my neck. From the rear, the only approach available was to pull the nerve aside in order to cut off the spur. But every time the neurosurgeon "retracted" the nerve, it blanched (became pale, its blood supply compromised). Two problems: first, you can't cut off blood supply to a nerve for more than just a few minutes, otherwise it will wither and die (*bad* news for a neck nerve coming off the spine, remember?); second, you can't "let go" of the nerve until you completely remove the spur, otherwise you risk slicing the nerve on sharp edges not yet smoothed off. The decision was made to simply remove more bone *behind* the nerve, carving a wide area for it to "float" away from the front spur. More on this situation later. Meanwhile, this circumstance meant that I remained with a "low" level of discomfort – and numbness down my left arm, to my little and ring fingers, along with moderate weakness – for years to come.

Nevertheless, I managed. [People "learn to live with their pain"; what they want is to live *without* it.) My neck and back and "arthritis" pains were continuing complaints, but I was able to minimize prescription drugs to just an episode of distress here and there. As a younger then middle-aged adult, I was "on the sidelines," politely declining requests to participate in picnic sports, unable to pursue exercise programs beyond minimal stress. Yes, I continued chiropractic care. A couple of osteopathic physicians had joined our medical staff, but they were "drug and surgery docs," just like my fellow allopathic physicians, and they did little or no manipulation. Certainly I hadn't heard of any way that they might help me. But a couple of talented chiropractors "kept me going" (as best they could), sometimes treating me twice a day, often staying "after hours" for me to arrive (slowly!) after a day of seeing patients in *my* office. I'll forever be grateful for all their help in reducing my suffering over the years.

The Slow Learner Gets Another Faster Education

My first daughter was born in 1988. What a lovely little six-pound fourteen-ounce "football." Then we made the mistake of feeding her. She grew and grew – and loved being held. Over time, her increasing weight (and wriggling) simply overloaded my low back (and neck) again and again. Over Thanksgiving, we were visiting family and decided to go bowling. *[Note to self: when bowling, release the ball; do NOT hold on to it, it **will** drag you down the lane.]* Sure enough, I managed to embarrass myself quite thoroughly by lofting not only the ball but my entire body, which crashed onto the lane about a dozen feet past the line. Whoa, just a bit sore there in my low back. I was "finished" bowling for the evening. I didn't realize that I was "finished" for the next 15 years!

The next morning, my back pains and spasms became more and more repressive. By the first week in December, I was suffering terribly. I called my friendly neurosurgeon; get x-rays, he advised. That was Tuesday. I saw him Friday late afternoon. "Stand straight," he instructed. "I can't, this is it": I was hunched far forward, balancing on my left toes because I *couldn't* straighten my left leg. The next morning, a "myelogram-CT scan"[10] showed a catastrophe. I had fractured the disk between lumbar levels four and five (the weakest one in the low back group). Pieces had broken off and floated back into the spinal canal, pressing on nerves at *two* levels on the left, causing the excruciating pain and weakness in my left leg. As my neurosurgeon professor said, "I like having my residents see patients like you – real pathology instead of merely 'bulging' disks that hardly qualify for operation." That said, my emergency surgery that evening, December 10, 1988, was a blessing.

Once again, I avoided having bones of my spine fused to one another. "Fusion" surgery is thought – by the general public and by *many* (or even most?) physicians and surgeons – to create greater strength for the area where a disk has collapsed or disintegrated. This view, however, ignores the functional issues that are fundamental to understanding how the spine actually works. You have 7 neck ("cervical") spine bones, twelve chest-rib ("thoracic") spine bones, and four or five or six low back ("lumbar") spine bones. (When the number is more or less than five, you have developmental abnormalities that can weaken the lower back structure.) This harkens back to one of the key principles in osteopathic medicine:

STRUCTURE AND FUNCTION ARE INTER-RELATED

Fusion surgery is a major change because it upsets the natural flow and capacity of "functional units" of the spine.

While the general view is that each spinal bone (known as a "vertebra," one member of the long "vertebral" column) is a *separate* soldier, this is patently naïve. The

[10] Myelogram contrast dye is injected into the spinal canal, x-rays are taken to be sure it has covered the area of interest, then the patient is sent for a "CT" ("**C**omputerized **T**ransverse") scan to give fine detail pictures of the spinal nerves as they exit through the spaces between the vertebral bones.

"vertebral functional unit" is a ***set*** of ***three*** soldiers, one "on the top," one "in the middle," and one "on the bottom." Wherever you start, you can envision that each soldier is an interlocking member of up to three sets: the **one** "on the bottom" of *set 1* is also "in the middle" of *set 2* and, at the same time, is "on the top" of *set 3*. You can easily imagine that the stresses and loads are slightly different across each bone, depending on whether it is functioning foremost as a "topper," "middler," or a "bottomer" at any particular time. The disks in between, the capsules around the disks, and the muscles and ligaments attached to the bones are responsible for *each* of these interconnected sets-of-three acting as a *functional* unit. In your mind, imagine the beautifully fluid motion of hands on the keyboard of a piano, gently pressing each key in a long string of blending tones as the player's hands wander up or down the ivories. The bones of your spine bend and twist and turn with similar inter-related elegance.

Fusion changes everything. The procedure is explained simply as locking two bones together, usually with a bone "plug" (such as taken from the "wing" of your pelvis-hip bone) but sometimes with metal plates and screws or even with "donor bone" from a "bone bank" of tissues harvested from someone who died. This explanation, though, is *overly*-simplistic. Assume that you fuse just two vertebral bodies: you have affected ***each one*** in its role in *three sets*, as a "topper," "middler," or "bottomer." So the *one* fusion between *two* neighboring bones actually affects the stresses across *four* vertebral sets. The bones don't exist in isolation; they are pillars of support and attachment points for ligaments (bone-to-bone), tendons (muscle-to-bone), and capsules (wrappers around joints). In addition, their various muscle attachments allow for the movement and "dynamic stresses" present every time we walk, turn, sit, lift, lie down … basically *every* action and position.

Fusion is serious business: because of the interruption to the vertebral functional units, those people who have *one* fusion many times end up with a *second*, then even a *third* – often sooner rather than later. Perhaps an easy way to envision this continual "losing" process after "winning" surgery is provided by your foot and ankle. If you were to fuse bones in your foot or your ankle, you could no longer flex, rotate and roll, or wiggle your foot. Whenever you walked, you would be more "peg-legged" on that foot. Imagine for a moment how different stresses would be transferred to your knee, your hip, and so on. The same illustration would hold for fusing bones in your wrist or your elbow, your knee or your shoulder: altered dynamics would stress other joints, sometimes dramatically. Why, then, do surgeons seem to presume and reassure that fusing bones in your spine has only *minimal* effects for your future neck and back motion?

The December 1988 low back operation was a breeze. "Microsurgery" left me with a short band-aid scar, far smaller than the three inches for my neck operation almost ten years earlier. Operated on Saturday evening, I left the hospital on Monday morning; I took my last pain pill on Wednesday and I had already returned to work in my medical office. The crippling pains down my left leg were down to a dull discomfort and the altered sensations were decreasing and easily bearable. As they used to say in the South, I was feeling so good that I was in "high cotton."

When Surgery Won't Work … Then What?

Texas is home to the Fat Stock (now "Livestock") Show and Rodeo – often called Rodeo-Houston – and attending the year's richest-purse scheduled cowboy show-off is even more of an event than the Kentucky Derby. And the show goes on for twenty days! Early in March of 1979, I felt fine as I was "dressin' up" to take in the rodeo. Cowboy boots have pull-up loops on either side to help slide your feet through the narrows at the ankle. I'd never had problems before, so I wasn't prepared for what came next: while pushing my foot down and pulling up on the loops, I felt agonizing white lightning pains as something went "sproing" in my low back. "Dear God," I feared, "I've ruptured another disk."

Happily, that was *not* the case. But then … what can be done for an extremely painful low back where surgery isn't going to help? You guessed it: more anti-spasm drugs, more pain drugs, more anti-inflammatory arthritis drugs. Remember, the medical paradigm – in both allopathic and osteopathic medical fields – is "drugs and surgery; then … *more* drugs and *more* surgery." Your very next question should be this: if the pains from my low back shot all the way down my leg and "out" through my toes, how could that ***not*** be a ruptured disk? Simply stated, tearing ligaments (or other connective/supporting tissues) away from their attachments to bones can cause pains that seem to mimic those expected with a disk injury.[11] A specialist in Reconstructive Therapy, well trained and experienced, can distinguish between the two … an important step, since the treatments are vastly different.

So I suffered on through, taking care of patients during the weekdays, using medications and ice and heat and rest during the evenings and weekends. Some nights were so unbearable that I would get pillows from the couch (since they can't be compressed as much as bed pillows) and place them on my bed, then place bed pillows over them, then lie face down on this small mountain, with a large cool-pack (blue-ice type) on my back. This might *sound* uncomfortable, but I would rarely change position – and I would awaken able to see patients without taking drugs. I would cinch tight a "lumbar (low back) corset" before hobbling to my car to drive to the office; when I arrived, the nurses would place a large cool-pack on my low back and we would cinch tight *another* lumbar corset to hold me firmly in place. At lunchtime, we would swap out the cool-pack for another semi-frozen one, to assist me numbly through the afternoon. As I later learned, anyone who is helped at all by "**outside** support" (corset, cane, crutch, or other bracing) is in *dire need* of treatment to restore "**inside** (around the joints) support." More on this soon.

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[11] In the introductory chapters to Dr. Faber's excellent text, **PAIN, PAIN GO AWAY: Free Yourself From Chronic Pain**, he clearly explains how these "ligament" strain pains develop – and why they *cannot* be effectively treated by surgery. In fact, spinal and other joint surgery can, indeed, *create* such lingering and sometimes devastating pains.

"The good ol' times," though, rarely last. Finally, my daughter was a two-year old who weighed twenty-two pounds dripping wet. Every time I picked her up – even while sitting in a chair – I suffered shooting pains down through my leg to my toes. I managed, but not so well. One summer evening in 1990, I reached forward to lift her onto my lap and the pain exploded like a lightning bolt through my left leg and "out" my toes. *This* time, I was *sure* that I had ruptured another disk. Again, not so. My treatment plan: I reached for the telephone. I called my friend, Bill Faber – an osteopath.

I had interviewed Dr. Faber several weeks earlier on my nationally-syndicated AM radio show – "*Finally Feeling Better, with Dr. John Trowbridge*" – when his book, **PAIN, PAIN GO AWAY** had been published. Great interview, lots of fun reading his book and preparing for our program, BUT … just as with many people who first hear about his remarkable Reconstructive Therapy treatment program … it sounded great for ***others*** but probably wouldn't help ***me***. OR … sure, that might have helped me *years ago*, but I've already (done so much damage) (had two spinal operations) (just fill in the blank with whatever excuse ***YOU*** want to use) that my chances of really getting better ***now*** probably aren't worth it. AND ANYWAY … I certainly can't afford to travel far (insert your distance – mine was from Houston to Milwaukee) and can't afford a hotel and meals and such, let alone paying for treatments, so it's not even worth my while to look into this approach.

What's the approach? The name chosen by Dr. Faber is "Reconstructive Therapy" – "RT" for short. "His" changes are many, since he was first trained in "prolotherapy," the name by which this connective tissue proliferation treatment method is often called. (In the "old" days, the term "sclerotherapy" was inaccurately used, suggesting that new "scar" was being created as a strong patch for an area of prior injury; in fact, the tissues appear to be restored or *naturally reconstructed* more normally.) Understanding this approach is simple: a tiny injection of a mildly irritating fluid is made at certain points of prior injury, to stimulate (promote) a proliferation (growth of new tissue) to strengthen the damaged zone. Since joints often survive injury without fractures because their supporting tissues (ligaments, tendons, capsules, as reviewed earlier) "collapse" (stretch and tear) first, **reconstructing** those tissues is the primary goal of treatment. Hence: "RT."[12]

Well, my first few injection sets with RT were nothing short of spectacular. My pains and limitations were resolving steadily and my optimism was higher than ever.

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[12] A much more elegant explanation is available – along with detailed reviews of how RT works for *each* joint area (accidents, sports injuries, arthritis) – in Dr. Faber's excellent text, **PAIN, PAIN GO AWAY: Free Yourself From Chronic Pain**, available from amazon.com; be sure your copy *is* the "New Edition," published in September, 2007, which includes Chapter 18, the one I was invited to write: "Fibromyalgia / Hypermobility Syndrome: A Hidden Cause of Unresolved Pain and Disability." Also available for purchase in our office from www.milwaukeepainclinic.com. Also available on DVD from our office is a splendid slide-show lecture by Dr. Faber, which he kindly presented at one of our community educational seminars.

And that includes neck, low back, shoulders, knees, elbows, basically all of my joints. (Of course, I'm a "wuss" when it comes to volunteering to experience any pain or any more discomfort, so we did only a few areas on each treatment day.) Over the next several years, I gained dramatically in strength and comfort. Five years later, when doing spring cleaning on my closet, I discovered the low back corsets I had relied on for several years. (Remember, when the pain episodes were worse, I used to put one on at home and drive to the office, then wear two with a "blue ice" pack in between in order to get through the day.) Sit down and buckle up: after my early RT treatments, I even returned to playing a halfway decent game of picnic volleyball. And I tooled around the local lakes on jet skis, tolerating the sudden bumps, the twists, the turns quite handily. Dumb? Probably yes. Fun? Absolutely yes!

Learning How to Help Ninety Percent of My Patients

I was so thrilled with my first RT treatments that I quickly signed up for Dr. Faber's preceptor training course, to learn how to offer this remarkable approach to my own patients. My "personal interest" certainly contributed a lot of motivation to become smooth and steady with the treatments. Perhaps most valuable, though, was my own experience with pains and limitations in virtually all the joints of my body over the previous thirty years. Given that background, I could decipher the struggling words of patients and readily show that – *finally! this* time! – someone actually understood what they were going through.

Remember, many of the pains shooting down arms and legs are ***not*** "pinched nerve pains" but are triggered instead by injured capsules and stretched or torn ligament and muscle attachments to bones. Surgery is rarely (if ever?) the best treatment for such structural damage, because operations tend to (scrape/cut/drill) remove *more* of the already weakened tissues rather than strengthening them. RT has a remarkable record – not only is it incredibly safe in trained and experienced hands – but also this treatment program helps over ninety per cent of those people who are accepted for care. *Regardless* of the original pattern of joint injury. *Regardless* of how long the discomforts have been present.[13]

Incidentally, "treatment" with RT is more than just hearing your story, doing an exam, getting x-rays, and then placing injections. The whole plan behind Reconstructive Therapy is to entice and encourage your body to heal an area that has ***not*** healed despite its earlier best efforts. This is a major task – otherwise, you would have already become strong, vigorous, and pain-free months or years ago. RT means coaxing your body to heal even in the face of most other illness problems. Some exceptions are worth noting: rheumatoid arthritis poses risks of unpleasant side effects; a history of spider, tick, scorpion, or snake bite sometimes can delay healing patterns and requires special

[13] The only real exception is with hip arthritis changes, where patients need to be evaluated carefully and where treatment needs to be pursued aggressively and several dozens of times; even then, "satisfactory" improvement approaches only seventy-five or eighty per cent of patients.

expertise to assist your body; other illness history – such as syphilis, vague or deep-seated infections (bacterial, viral, parasitic, especially "odd" ones), hormone deficiencies, and such – add further levels of complexity and require a more detailed approach by the treating doctor.

Long-term or current use of steroids ("corticosteroids," cortisone compounds) can slow or even prevent healing, but our experience has, for many, been very positive. Further, patient cooperation with other aspects of the RT program can help to encourage healing to proceed steadily, even faster than expected.[14] In this regard, another osteopathic principle has sway, and physician and patient are duty-bound to adhere to its requirements:

THE BODY HAS THE INHERENT CAPACITY TO DEFEND AND REPAIR

The beauty of RT is how it invites the body to heal – to "do its thing" – *naturally*, with coaxing and suggestion, rather than imposing a final result by using screws and rods and plates and pins (or even *worse!*). Since your body performs an actual tissue repair, you return to much more normal strength and function, often dramatically relieved of pain and limitation. Just the way your body heals a surgical incision or an accidental wound, the tissues are strong and secure and your personal repair lasts for years and years.

So – time went by, I enjoyed my life even more as the RT helped my body to become stronger and feel better. Chiropractic treatments here and there took out any kinks I managed to "throw" in my way (remember the watercraft and volleyball?). (Why not "osteopathic manipulation"? Again, I didn't know of any "manipulators" in the area – and my chiropractic adjustments worked just great.) Then came the rain.

Slipping on the Banana Peel

The rain? Does that have something to do with the "Salt and Pepper Twin Continentals"? No – but more on *them* later. In January of 1997, I was leaving work to pick up my two daughters at their Montessori school. The rain was light, but it had made the roads "just slick enough." I was stopped at an intersection, waiting for crossing traffic, looking left – remember, that side is where the bone spur is, in my neck. Did I mention that there's a bar nearby? The *Blue Angel*. Two very nice young fellows had stopped in for a few beers after *their* workday ended. As they approached my stopped car, the driver put on his brakes – and slid hard into my back bumper. Were they going too fast? Stopping too late? Sliding on a water-coated oily pavement? I'll never know. BUT the rain was getting heavier, I was getting later, and the bumper and trunk didn't have any damage. We parted with a "Be careful!" each to the other (why to me???), and

[14] Many of these details are reviewed in a delightful book by Dr. Faber and me, **DO WHAT YOU WANT TO DO: Get Pain Relief Now**, published in 1996, and available for purchase on amazon.com or through our office or www.milwaukeepainclinic.com.

I drove on to the school to retrieve my waiting children. A couple of days later, I awoke with excruciating pains down my left arm … and it got ***worse*** from *there!*

You might have heard that cortisone has all sorts of side effects.[15] Well, it *does*. (Remember, NO drug as ANY "*side*" effects, just "effects.") But … cortisone (along with "the usual" – muscle spasm drugs, pain drugs, arthritis drugs) helped "get me better" quickly.

"Get me better" is a misnomer (read: "white lie") that I fell into because of wishful thinking. After all, I remembered how much my left arm had hurt before my *first* neck operation. Ooops – I just gave away the punchline. Well … the rest of the story. Remember that I'm not quite too bright … so after I was "feeling better," I went on a roller coaster ride at Busch Gardens during a trip to Florida a next few weeks later. My neck did ***NOT*** like the stresses. (Great ride, though, except for trying to brace my head against the padded brackets as we swooped and soared.) The pains worsened – and I mean worsened ***LOTS***.

Next thing I knew, I was "mainlining" the incredibly potent cortisone, prednisone, praying to reduce the excruciating pains in my neck and down my left arm. I laid for days in neck traction, at the highest weight limit I could tolerate – it felt like I was trying to pull my head off. Incredible spasm in my neck and upper back muscles kept my head *on*. My family and I had traveled to Palm Springs to see my two widowed aunts for a week. How I made that trip is a mystery to me, the pain was so overwhelming. The sad truth is that I spent hardly any time seeing my mother's sisters during those days.

During the next three or so weeks, my neck nerve finally released its death-grip on my body. When "the boys" had slid into my car, I had been looking to the left; their sudden collision jolted my car and jerked my body. Remember that "spur" that couldn't be removed at my neck operation in 1979? The nerve lying over the spur could not have been more squarely placed at just the moment of impact – and it was brutally sliced as my head and neck bounced back and forth. This brings to mind another guiding principle of osteopathic medicine:

> **THERE ARE SOMATIC COMPONENTS TO DISEASE THAT ARE NOT ONLY MANIFESTATIONS OF DISEASE BUT ALSO ARE FACTORS THAT CONTRIBUTE TO THE MAINTENANCE OF THE DISEASE STATE.**

The spur that couldn't be removed 19 years earlier was still lurking in the shadows, ready to do massively greater damage under just exactly the right circumstances. This "somatic (body) component" had contributed to maintenance of my discomfort over the years by causing odd and uncomfortable numbness and pains and weakness down my left arm and

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[15] See Chapter 16 in Dr. Faber's excellent text, **PAIN, PAIN GO AWAY: Free Yourself From Chronic Pain**, for a frightful review of how cortisone can twist your life like a tornado.

hand ever since the first operation. And then, acting just as an axe poised and ready to fall given just the "right" situation, the spur insured that I would be disabled during the accident impact, by slicing into my nerve root.

Prednisone seemed like a godsend – to me, the same as to almost all other patients in similar circumstances – because it held out the prospect of being able to "wait it out," to avoid another operation. But my dosages were massive: 80 mg daily, then down to 40, the finally 20 … still a huge amount. By December, I was down to 10 mg a day – even then a considerable amount of drug – and the changes in my body were becoming worrisome. Whenever I walked up stairs or for any distance, I felt "tissue changes" rather like I was pulling apart inside, all over. Indeed, powerful cortisone drugs *do*, literally, *melt* your structural materials, namely ligaments, tendons, capsules, disks, and so on. Nevertheless, the aching, gnawing discomforts in my neck and left arm (all the way to the tips of my fingers) drove me "to the (prednisone) bottle" despite my best exercise of willpower.

Finally, I called my neurosurgeon, the university professor who had performed my splendid low back disk operation in 1988. I had seen him soon after my injury, and we had agreed to try to "get through" without surgery, because I had seen such excellent benefits from RT treatments since 1990. By the summer of 1998 – almost 18 months after my "rainy day" injury – I could no longer stand the changes in my body, the pains in my arm and neck, the headaches, the muscle spasms, the loss of sleep … especially the pains. Despite the drugs, despite the fancy prednisone that I could never get away from.

Even though the neurosurgeon and I had discussed waiting until the Christmas holidays, when I could more easily endure the economics of losing workdays in order to recover from surgery, I told him that I could no longer wait. I was growing crazy with the unrelenting discomforts. Choosing to have surgery was a major step: in my experience from 19 years earlier, I looked forward to the prospect of spending another painful and limited week in the hospital and another half-dozen weeks slowed and hurting.

Patients who think that my practice of Reconstructive Therapy, as an "alternative" to surgery, means that I don't *like* or *recommend* surgery. They're wrong. Remember, I *trained* in surgery after graduating from medical school. Surgery has its place – especially for injuries and catastrophes, also when non-surgical approaches haven't been tried, haven't been effective, or are no longer successful. The problem is that "conventional" doctors look only to drugs as the "non-surgical approaches," rather than learning about *all* of the many incredible "complementary" health-promoting/healing technologies that are now available.

My surgeon's office called on Tuesday: "You haven't had your pre-op physical yet!" "That's okay," I reassured them, "Doc can check me on Friday morning before the operation." Yep, I showed up as instructed, on Wednesday in his office for an after-lunch exam. "So," said he, "you're just having problems on the left side, correct?" "Yes, and we're operating *just* for the pain, not for any muscle weakness like I experienced in 1979,

which led to my first neck operation." During the exam: "Okay, spread your left hand fingers, while I try to hold them closed." I couldn't. I "flunked" *all* of the muscle-strength exams on my left arm, wrist, and hand. How could that be, you might ask? I had unknowingly learned to live within my limitations, as the loss of muscle function happened so gradually over many months. (Sound like you, too?)

Friday morning of surgery, 6:00 am: check-in for surgery. Gowned, iv line in place, on the gurney, ready to be out of pain. "You can take me in to the OR and get me ready for anesthesia." "Your surgeon won't permit us to move you until he talks with you again." A few minutes after 8:00 am: "Show me which arm gives you the pain." He marks a huge "X" on my left shoulder. "Do you have any pains or problems on the right side that we should be concerned about?" "No." "Good – see you after surgery."

Some two hours later, I awoke in the recovery room. Confused but awake. As with my prior operations, I wiggled fingers and toes and felt an immense relief: I was going to be okay. What I didn't really know was what was coming my way later that day: my favorite, lobster bisque. Noon came and went, I felt pretty good, minimal pain (thanks to those wonderful medications.) Later, the nurses offered ice chips then water. Oh, yes! Then a bit of clear broth. Great! My surgeon stopped by, did a quick check, and surprised me: time to get dressed and go home, get your pain prescriptions filled on the way. *What??!!* Once again, microsurgery to the rescue! Rather than riding home during the Houston rush hour, we stopped at a lovely restaurant for a lazy supper.

I had scheduled to be off for ten days, to make a full recovery without having the risk of needing pain medications during patient care hours. I took full advantage of the long rest. And I had my office nurses come over daily to start a "chelation therapy" iv treatment, to remove swelling from surgery and to promote more rapid healing. When I returned to office hours the next Monday, I felt great. Only occasionally did I need the soft foam neck collar, when my muscles seemed tired and aching. My left arm quickly recovered strength and lost most of the disturbing pains and altered sensations.

Helping me to regain function and comfort was, *of course*, more RT treatments to my neck. This scenario illustrates the highest art form of complementary medicine, where specialist physicians who have "conventional" training (whether at an M.D. or D.O. school) combine their medical expertise with sophisticated "health-promoting" ("alternative") strategies, designed to achieve the best patient results. Both technologies can contribute to a better outcome: "drugs and surgery" along with "alternatives" in healthcare. "Complementary" medicine, as a term, has yielded more recently to the name "integrative" medicine. Indeed, the specialists in "advanced medicine" do learn to integrate advances in nutritional science, physiology, and biochemistry, weaving these into their traditional understandings of how to treat diseases and injuries. In the case of RT, creating a healing pattern also involves a more detailed study of physics, structural design and balance, and patterns of mechanical injury that affect bones and connective tissues as well as nerves … along with an intimate awareness of biochemistry and physiology of tissue repair. While I am a physician *offering* RT, I am also a patient whose life has been *saved* by RT.

And Life Goes On

The past twelve years have been mostly uneventful. I've continued to recover more function and comfort as I steadily grow older (is there any *other* way?), thanks to continuing RT and rare chiropractic adjustments. You might ask: why have I continued to need episodic Reconstructive Therapy? Remember the "ligament laxity syndrome" ("double-jointedness")? You will have a better idea of just why Dr. Faber invited me to write the "hypermobility" (another name for "ligament laxity") chapter when you read those forty pages in his New Edition of **PAIN, PAIN GO AWAY: Free Yourself From Chronic Pain**. Just the way many people need to continue wearing eyeglasses to help their vision, some patients need to continue having RT because their healing patterns are *genetically* (or otherwise[16]) impaired … like mine. This disturbance to tissue structure means weakened support tissues, even under the best of circumstances. *That* is why I have had so many problems, as described in this chapter. Tremendous advances in eye surgery – such as LASIK and other cornea-altering procedures – have meant that some people have been able to put down their glasses. Even then, there are some for whom surgery cannot correct the underlying vision problems. For the fore-"see"-able future, surgery will ***not*** be able to correct the connective tissue problems that are best treated by RT.

While supporting tissues – ligaments and such – might have *genetic* limitations on healing in a person such as me, greater comfort and function (often approaching normal) certainly are achievable. What is even more rewarding, though, has been the continuing reduction of "nerve irritation" in my left arm. Remember the neck spur that couldn't be removed in the 1979 operation and then finally was "ground down" in the 1998 microsurgery? I suffered 24/7 altered nerve sensations – some of them *very* painful – along my left arm, especially from my left elbow, along my forearm, down into my ring finger and little finger. After the first year (1980), I had given up on expecting any further nerve pain improvements; that's what we're taught in medical school and residency. Then, when I started RT with Dr. Faber in 1990, a remarkable change began … slowly but steadily, I became more comfortable. Recall these critical osteopathic principles:

> **WHEN NORMAL ADAPTABILITY IS DISRUPTED OR WHEN THE BODY'S CAPACITY FOR SELF-MAINTENANCE IS OVERWHELMED BY ENVIRONMENTAL CHANGES, DISEASE MAY ENSUE**

[16] Other "reasons" for ligament laxity include trauma (being stretched, even torn, as you are thrown about or "crash-land," extreme exercises (yoga, ballet), excessive athletics (gymnastics, cheer, others). These non-genetic reasons hold the prospect of healing more easily and completely (even beyond "normal" strength), because they lack the genetic limitations on tissue repair patterns. For those who are curious, Ehlers-Danlos Syndrome is an extreme form of genetic ligament laxity.

… but, when insults are removed or reduced,

THE BODY HAS THE INHERENT CAPACITY TO DEFEND AND REPAIR

The "boys from the *Blue Angel*" episode starting in 1997 was quite a setback. (Think: take a sledgehammer or dagger to a nerve slowly recovering from years of being clobbered by a *rubber* mallet.) After repeat neck surgery in 1998, resumption of RT treatments (to *stabilize* my neck again!) happily has led to further reduction in nerve discomfort and "sensations."

In all fairness to people who might think that Reconstructive Therapy is the "be-all and end-all," another healing technology has complemented RT in achieving the benefits that I have enjoyed. The nickname for this other one is "NT," for "Neural Therapy" (just remember it as "Nerve Therapy").[17] Simply stated, this is a way to reduce the "irritation" found in scars (or injuries) when the skin and underlying tissues have been damaged but having recovered to fully normal condition. You've probably seen some scars that are barely visible, smooth, and soft, while others are humpy-lumpy, thickened, and discolored. The pink or reddish ones, especially when more dense or looking like deformed skin, are more irritated and, therefore, "electrically active." Read for this: distressing, even painful.

(In case you're wondering: these scars can come from ALL injuries and operations, and treating each of them is quite easy, with wonderful results.)

Sometimes the pains coming "from" scars and/or areas of injury are felt a distance away. For example, you might notice "left-overs" from an appendix or gallbladder or hysterectomy or breast operation in your shoulder or elsewhere. The first problem, of course, is recognizing that an "old" scar might be a problem. Injury areas cause similar tissue changes due to stretching, twisting, or compression during the "accident." This means that any fall, sports contact (even dozens of years ago), or auto accident could lead to puzzling pains or problems elsewhere, with which you could suffer for years. The difficulty in diagnosing these issues is obvious, since conventional doctors are not trained in this NT technology. Simply stated, this means that a *zillion* dollars can be spent on x-rays, MRIs, CT scans, bone scans, and blood tests – not to mention the risks of dozens of drugs, even "exploratory" (or "specific") operations that fail to help at all but create new scars and "injury" areas as well!

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[17] For complete details, you'll enjoy one of the best books on this topic by Dr. Faber (with Morton Walker, D.P.M.): **INSTANT PAIN RELIEF: Immediate Resolution of Pain and Dysfunction**, published in 1991, second edition in 2003, Milwaukee, Wisconsin: Biological Publications. Available for purchase on amazon.com or through www.milwaukeepainclinic.com.

Many women rightly have a cosmetic purpose in mind: this-or-that scar is unsightly or uncomfortable, especially during summer activities or sports or with evening wear. NT has a remarkable "smoothing" capability, sometimes making "ugly" scars barely visible after just a half-dozen or dozen treatments. But this therapy is far more powerful in some situations. Headaches, for example, can be what doctors call a "diagnostic dilemma": the answers simply aren't obvious. RT can help in startling ways, since many people never trace back to a head or neck injury, fall, rear-ender or other accident, sports injury, but stabilizing your neck can produce miraculous relief. NT, on the other hand, can be just as surprising in its results. A "tight" scalp can result from coming up under a shelf, turning into a door jamb, falling backwards hitting your skull, or myriad other head injury circumstances (many of them often from *early* childhood!). NT to scalp tissues – and especially to any deep dents or cuts or operation scars – sometimes makes headaches, head "pressure," "brain fog," and other weird but real complaints simply fade away.

Dr. Faber has done extensive NT treatments to my various scars, especially on my neck, from my first operation. The combination of RT and NT can produce results that few people would believe, especially conventional physicians who "know" that these treatments "can't work"! Guess I forgot to mention the two-inch gash at my left forehead hairline. Eleven years old, messing around being stupid in a gym (waiting to watch the next boxing event), tripped while running on a wrestling floor mat and fell face first – my forehead caught the lower wooden frame of some odd structure we were jumping up onto. My Dad had to take me for stitches (lotsa bleeding!). Picture this: him trying to explain this bandaged event to Mom when we arrived home. The day after stitches were removed, a friend and I wheeled around into each other, realizing we were about to miss the school bus. Busted open. *This* time, no longer eligible for sutures. Steri-strip tapes just don't produce as smooth a scar. Solution: NT thirty years later.

Guess I forgot to mention jumping (like on a trampoline) on my parents' bed, four years old. Flopping back made for a good bounce, then start over jumping. "Stop that, John!" I still hear Mom's voice echoing in the distant past. Pretty remarkable that I even have that memory: it was quite a concussion when I slammed the back of my head onto the square iron bed frame at the foot of the bed. I was frightfully close to having become quadriplegic without ever sensing the danger. To this day, a quarter-inch "dent" stretches across the back of my skull, about an inch "up" from the bottom. This injury makes "tissue compression" *easy* to understand! Solution: NT some forty years later.

Guess I forgot to mention that "There *is* a Superman!" Or so I announced at age six, when I left home, headed for the playground. We had a twelve-foot high slide/swing set, an ideal launching point for my flight. Bravely I stood there, ready to soar. My red cape fluttered above me during the fall, conferring no powers of flight. I still have vivid memories of slamming into the unwelcome earth. Guess I forgot to mention fast-pitch softball at that very playground. I was playing catcher (*not* a good position for the knees and ankles of someone with ligament-laxity syndrome, but I was dozens of years away from a diagnosis). A "fast one" got away from the pitcher, tipped the *top* of my mitt, and slammed into my forehead. Yep, another concussion.

These stories are (almost) typical of the childhood misadventures of many folks. Sadly, I didn't have the cool experiences of Tom Sawyer or Huck Finn, but I sure amassed a collection of injuries. Each of the several described above led to neck (and back) problems where ***the*** later solution has been RT. Each also led to skin and scalp injuries (or later surgery for same) where the later solution has been NT. I share these details because your past experiences largely determines your future suffering. Even when you don't recall or don't appreciate that these injuries have "set the stage" for suffering, you might end up presenting your complaints to dozens of doctors over dozens of years, *never* finding an answer that produces lasting relief. Unfortunately, very few doctors are trained, skilled, and long experienced in RT and NT technologies.

Fighting Disease – *or* Helping People

One fascinating observation I have made over the past thirty years has been that allopathic (M.D.) doctors in the society outnumber osteopathic (D.O.) ones by almost ten-to-one. But membership in our "complementary" or "integrative" medicine professional organizations shows a *far* greater number of osteopaths than would be expected by these lop-sided percentages – in many cases, there are an equal number of M.D.s and D.O.s as members. I pondered over this for several years until I reached a workable conclusion. I think it's a basic personality "bent," further refined by their training experiences. People go to *allopathic* (M.D.) schools to "fight disease," and they learn these skills very well. (Not very effectively for chronic degenerative diseases in my humble opinion, but they nevertheless put forth a valiant effort.) Others go to osteopathic (D.O.) schools to learn how to "help people who are suffering." They come out with a *different* kind of curiosity, a mind much more open to exploring treatments that seem to help folks even though they might look a bit odd at first. Many of the integrative medicine technologies have been discovered or developed by doctors in solo practice, not by teams hidden in research labs in the major medical centers. Research teams and stellar professors successfully play the "grant game," getting tens of millions of dollars to study their newest drugs and to publish hundreds of articles. Solo docs simply go to meetings and share their successful experiences with others interested in learning "a neat new way" of helping their patients right now, next week, back in the office.

"I'll look into that when there are more studies that show it could work." *That* one phrase kept being repeated to me almost nine years ago, by attendees at a continuing medical education seminar in San Francisco. The California legislature required twelve hours of "pain management" and/or "end of life care" to maintain your medical license. Several hundred of us were meeting that requirement, listening to professors sharing the ins-and-outs of maintaining patients on Percodan®, Oxycontin®, morphine and the like. At the snack and lunch breaks, I would casually comment to whoever was nearby, "Interesting ideas, but I don't ever need to prescribe these drugs because I fix over ninety percent of the folks who come to me with neck and back and joint pains and such." "How's that?" would come the curious reply. "I inject them to rebuild the injured tissue." Their reply: "No, cortisone is just a quick fix that doesn't really repair the injury." My response: "I don't use cortisone or other steroids, I use a mild natural

irritant to instruct the body to heal this area or that." *Almost to a person*, the response would come, "I think I've heard of that … sclerotherapy, right?" "That's the old style; a newer name is prolotherapy – the advanced technique I use is called Reconstructive Therapy." And *every single doctor* ended our brief exchange with something like this: "Well, I'd need to see a lot more evidence that it might work before I'd be willing to try something like *that*."

I traveled back to Houston with a sad realization: none of these conventional physicians would *ever* be my "competition" for the remaining thirty-plus years of my professional practice. How many tens of thousands of people would suffer needlessly, simply because their doctors chose to be closed-minded in the face of my bold claim suggesting that I "fix" over ninety percent of people accepted for care. I used to think that we went to college to learn "basic knowledge" and how to study, then we went to medical school to put on blinders that allowed us to focus especially on the science of healing human illness, then on to graduate residency training to sharpen our skills and knowledge in a specific area of illness or injury, much like seeing those problems in the greater detail found through a microscope. Then I learned that specialty training wasn't much like using a microscope but rather like putting on a blindfold: *don't* confuse me with the facts, I know all there is to know about *my* specialty.

Osteopathic (D.O.) physicians, as a whole, "enjoy" the same training experiences as their allopathic (M.D.) counterparts. But remember my conclusion, that many more of *them* went to medical school to learn how to "help people" rather than primarily to "fight disease." Thus, in their practice lives, they remain a slight bit more open to different ways of treating problems … so more of them end up as colleagues of mine, each of us learning novel technologies that work, that work well, that work safely. Safety is *always* the first consideration for an integrative medicine physician, as it should be for all doctors. Next should come effectiveness – if it isn't likely to work, why do it? After these two key concerns come all the others, such as comfort, ease of compliance, cost, and so on. In our modern world of "Well, my insurance will cover this but not that," patients have mistakenly placed cost as the number one factor. Some of them lose their lives, many of them *lose their comfort* for their remaining years, in making this error.

Hark back to the first day of medical school, where we are cautioned, "First, do no harm."[18] Patients are very trusting when they come to their doctors. We learn about "transference," a powerful psychological process by which a person must suspend his mistrust or skepticism and place full confidence in the physician he has chosen, because

[18] Attributed to the First Physician, Hippocrates, in his **Epidemics**: "The physician must be able to tell the antecedents, know the present, and foretell the future - must mediate these things, and have two special objects in view with regard to disease, namely, **to do good or to do no harm**. The art consists in three things - the disease, the patient, and the physician. The physician is the servant of the art, and the patient must combat the disease along with the physician." Available at http://ancienthistory.about.com/od/greekmedicine/f/HippocraticOath.htm, accessed on March 7, 2010.

the patient lacks the technical knowledge or experience to make "the best choice" for his treatment. So here's an interesting point: in the first year of medical school, we learn how the body works "normally"; in the second year, we learn how it "malfunctions." In classic textbook used by most practicing physicians today, Robbin's **Pathologic Basis of Disease** (available at amazon.com and elsewhere), we learned that inflammation is the very ***first*** step in healing and repair. In the third and fourth years – our practical "clinical" training "on the wards" – we learn how to prescribe ***anti***-inflammatory medications. These provide immediate and long-term *comfort* (relief of swelling and pain) *but* they remarkably slow (and even block) the process of *healing*.

When taken daily – as done by many people with injuries or arthritis discomforts – ***anti***-inflammatories (aspirin, ibuprofen, others) can guarantee that healing will *never* be completed. (With injuries to connective tissue, reduced blood flow in such "tensile" structures already guarantees that healing will be less than complete in the *best* of circumstances – that's why RT is designed to "turn on" the repair processes again, and structures can be strengthened up to forty percent stronger than their "normal.") Cortisone is a major ***anti***-inflammatory drug, again often given after surgery and major injuries (recall my prednisone history after "the boys from the *Blue Angel*" accident). Aspirin is the easiest one to take, preferred by millions of people. Hundreds of people die each year in the United States from bleeding in their gut, caused by aspirin. Several thousand similarly die from bleeding caused by innocently-sounding "NSAIDS," "Non-Steroidal Anti-Inflammatory Drugs."

NSAIDs include aspirin, ibuprofen, naproxen, and other prescription *and* over-the-counter "pain" relief drugs. Reportedly over thirty million Americans take an NSAID daily for a quick "feel-better," whether for headaches or pains or even to help sleep. (Remember, we're largely a sit-down society, so activities such as yard work, baseball, and water sports can be "taxing" on our soft muscles and stiffened joints!) Almost half of those asked say that they ***take "more"*** than the recommended dosage. NSAIDs might be the leading cause of non-infectious ulcers and gut bleeding, resulting in over 100,000 hospitalizations each year … and almost *20,000 deaths*. You might be less tempted to casually pass of these numbers – until you realize that these "harmless" drugs kill more Americans each year than AIDS … and *four times more* than cervical cancer.

Perhaps more alarming is that no "test" can tell who might suffer bleeding more than someone else. And gut hemorrhage can start suddenly, without *any* warning signs. Older folks are more at risk, as are those who believe that it's safe to combine prescription pain medications with over-the-counter NSAIDs. Those who have had ulcers in the past, or who have "needed" these drugs for extended periods, or those who are also taking blood thinners (much more common now, given our predominant heart and blood vessel disease treatments) or cortisone/steroid medications are at higher risk.[19]

[19] These data were presented at the 2004 meeting of the American Gastroenterological Association, summarized on the internet on May 24, 2004, and available at

There, But For the Grace of God, Go I

When you read about "side effects," especially dangerous[20] and life-threatening ones, it is oh-so-easy to dismiss them as unlikely, even rare. After all, you have been reasonably healthy – or lucky – or blessed – or whatever through your whole life to this point. Please resist the temptation to be lulled into a false sense of security. My career in integrative medicine began the day I pronounced a patient dead in the intensive care unit. In my first year of general practice, a man in his early fifties came in complaining of arthritis pains. Naprosyn® was a reasonably new drug and caused far less gut distress than our earlier prescription drugs. In his eyes, I was a hero: he felt great and tolerated the medication quite well. Until he bled to death without warning. We couldn't pump blood into him fast enough to stabilize his blood pressure, to take him into surgery just eighty feet down the hall. I left the ICU clearly crushed, having lost my first patient. In the kindest way I knew, I told his wife that he had died. "Why?" she asked, "What happened?" I described what we thought had caused his death, bleeding due to the arthritis medication. I comforted her with an arm around her shoulders as she cried in quiet desperation, now alone in her world.

My depression lasted for many months. Even though gut bleeding was a known risk of the NSAIDs, and I could hardly be accused of failure to practice "good medicine," I was crushed. It was *my* name on the prescription – and *his* name on the gravestone. In my world, that was completely out of bounds. I thought about leaving private practice and going to law school or business school, so I could go into administrative medicine, where I wouldn't have to face the prospect of feeling this devastation again. When I was a senior medical student on externship at the National Institutes of Health (NIH), I had interviewed with the deputy assistant secretary for health, regarding the prospect of future employment with the NIH or the Centers for Disease Control (CDC). As my depression lingered, the prospect of government service in research or administration seemed much more appealing. Incidentally, Naprosyn® must be "much more safe" now, since they

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http://www.aphroditewomenshealth.com/news/20040424000521_health_news.shtml, accessed March 7, 2010.

[20] While you *assume* that the Food and Drug Administration – charged with determining that drugs are ***safe*** *and* ***effective*** – is making sure to reduce risks to your future, you need to realize that several drugs are withdrawn (or have serious warnings added to their "inserts" [instruction sets]) each year. Pfizer continued to market Celebrex® (its best-selling arthritis treatment, a fancy NSAID) with warnings in 2004, after discovery that heart attack and stroke risk was doubled by the drug. An FDA review specialist estimated 55,000+ trusting patients died early, preventable deaths or suffered the debilitating effects of strokes at younger-than-expected ages. Merck had to recall its successful arthritis drug, Vioxx® (another NSAID), for similar reasons and deaths – the largest drug withdrawal in history. Any number of law firms are listed on the internet to assist families losing loved ones to "approved" drugs. You'd best take the sidelines on the next *huge* class action lawsuit coming, which I think will be regarding the Crestor®/Lipitor®/Mevacor® class of "cholesterol" drugs!

promote it on TV as a *safe* and *wonderful* relief … marketed in half-strength as Aleve®. *Still* deadly? Just take double the recommended dosage, up to the prescription dosage level, and **you** decide.

How did this unfortunate patient death lead me along the path to integrative medicine? (Back in the early 1980s, this was called "alternative" medicine; my dear friend Bob Atkins offered the term "complementary" medicine.[21] More recently, the name "integrative" medicine has taken hold, encompassing what we learn in *conventional* medical schooling and training and "integrating" *that* knowledge base with older knowledge [acupuncture, herbs] and newer discoveries in physiology and biochemistry [nutrition, metabolism, genetics].) I was very well trained in conventional medicine at Stanford and Case Western Reserve, then in surgery at Mt. Zion Hospital and Medical Center (now part of the University of California/San Francisco) and the University of Texas Health Sciences Center at Houston's pace-setting Texas Medical Center. None of *that* background satisfied my need for change after my patient's tragic death. One day while I was on hospital rounds, a lab tech at the hospital randomly asked what I knew about "laser acupuncture." "Nothing," I answered.

Our discussions led to our purchasing a "cold laser" (not "cutting," as in James Bond 007 movies – and it cost more than a new car), *his* getting trained in doing acupuncture without needles, and *me* learning a great deal about pain management. "Blown away" is an understatement to describe my amazement at seeing disabling migraine headaches literally gone within twenty minutes – no drugs, no needles, no nothing except the laser light. Since acupuncture had "been around" for over 4,000 years, traced back to almost the Stone Age in China – but I had never learned about its powerful effects in medical school.

Crossing the Rubicon – I Can't Look Back

"What else," I pondered, "did they *not* teach me in medical school?" Nutrition was the next obvious topic to study. I traveled around the country to study from experts who knew how to take care of people in ways that produce "nutritional healing" I had never before imagined possible. In 1985, I completed a master's degree program in nutrition and physiology, through the Florida Institute of Technology Medical Research Institute at Melbourne. From the time I became first aware of "alternatives" that could make people's lives and health tremendously better, I have since explored ever more exciting avenues. I have been blessed to reach vantage points from which I have never looked back. In many conversations, I've described my situation as having "crossed the Rubicon"[22] – there is *no* way that I could return to the practice of conventional medicine.

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[21] Atkins, R. C. **Dr. Atkins' New Health Revolution: How Complementary Medicine Can Extend Your Life**. New York: Bantam Books, 1990.

[22] "Cross the Rubicon": "a boundary or limit, which when crossed commits a person irrevocably. In 49 B. C., Julius Caesar led his army to the banks of the Rubicon, a small river that marked the boundary between Italy and Gaul [France] and which the Roman Senate had forbidden him to cross. 'The die is cast,' said Caesar, wading in, knowing full

Indeed, my sharing with prospective patients the *evidence* from scientific studies – or various wonderful success stories – has met with intense prosecution (persecution?) by Texas State Medical Board.[23]

The political climate in medicine is exemplified by *dozens* of years of the continuing prosecutions of physicians who choose to offer safe and effective "alternatives" to the usual conventional practice of medicine, whether M.D.s or D.O.s. In one recent administrative trial, I served as a medical expert for one of my colleagues in an eastern seaboard state. He was being prosecuted for various aggressive complementary therapies that have been *helping* patients suffering with disastrous illnesses. The exchange would have been hilarious but for the fact that the prosecutor was deadly serious in his ineptitude. The following is excerpted from a pre-publication article that I recently submitted to *The Townsend Letter*:

> At a recent trial, where I was serving as an expert witness for the defense, the state medical board attorney noted that "Since EDTA and other chelation medications are approved by the FDA for removal of toxic metals, then really their use is 'conventional' medicine practice, not 'alternative' or 'integrative,' right?" My reply: "Well, yes, *except* for one teeny-tiny technicality." "What's that?" asked the prosecutor. "The State Medical Boards." "Why do you say *that?*" he asked, surprised. "Isn't that why we're in *this* trial? All of the medical boards *ignore* approval by the FDA, *ignore* the clear evidence found in the medical literature, and *ignore* the overwhelming reports of patient benefits from chelation – and they *prosecute* the doctors offering the treatment, just as *you* are today."

The only reason that I could keep from laughing is because my friend's medical license was "on the line." And this *defective* reasoning was the *best* they could offer in their attempt to destroy his medical career and to deprive thousands of future patients of his services and discoveries? The political power behind this convoluted thinking is, sadly, as powerful in restricting future choices for you as the sly suggestions you might have heard from "real" doctors that the kinds of services that "integrative" doctors offer "might work for some people, but the results aren't lasting – and they can be risky – and they aren't proven." *Ask them* simply: exactly ***what*** have you ***read*** to reach these conclusions?

The economic climate in medicine also serves to discourage physicians from offering sound, scientific alternatives to the conventional care options of drugs and

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well that this step would mean civil war." On the internet at *The Phrase Finder*, available at http://www.phrases.org.uk/bulletin_board/7/messages/311.html, accessed on March 7, 2010.

[23] A *few* of these experiences were documented by Tulane University Professor James Carter, M.D., D.P.H., in **Racketeering in Medicine: The Suppression of Alternatives**. Norfolk, Virginia: Hampton Roads Publishing Company, 1992, available on amazon.com.

surgery. "But my insurance pays for (drugs) (surgery) (more drugs) (more surgery) (physical therapy) (my wheel chair) (nursing home care)." Just fill in the blank. Patients have come to rely on insurance ***not*** for *assistance* with major medical expenses but instead for "guidance" regarding ***all*** of their choices in health care. What puzzles me is the ease with which patients will agree to be put to "sleep," to have major surgery performed for joint problems where Reconstructive Therapy has a long track-record of *dramatic* successes.[24] The benefits of surgery are obvious – and very *similar* to those available through natural healing, through Reconstructive Therapy. Operations often proceed smoothly and with minimal unexpected problems. However, the risks of surgery, particularly of the neck, back, and joints, *can* be ominous.[25] I cannot fathom why an informed patient would, literally, put their future and health on the line without first trying a *non*-surgical alternative that has a high-probability of wonderful healing.

The economics play out in different ways, particularly because insurance reimbursement programs, as part of their design, restrict access to various treatments that are "unconventional." (The typical terminology is to deem something as "experimental" or "not usual, customary, and reasonable" with regard to charges or services.) For example, I heard third-hand about twenty years ago, that the Houston refineries had **excluded** coverage for "chelation therapy" for their workers. Chelation is the *only* treatment available in modern medicine to remove toxic heavy metals after exposure and concentration into body tissues. (As such, chelation drugs are ***approved*** for *that* use by the United States Food and Drug Administration – the FDA.) In case you don't know, certain aviation fuels still have lead as an additive. Putting two and two together, you quickly realize that they put the lead *into* the gasoline … *at* the refineries. *Those* are the workers who may be most exposed to toxic lead! So … there must be an economic policy being enforced, when the very workers who unsuspectingly are likely to get "the most sick" are the ones to whom the *only* available treatment would be denied by their insurance coverage.

Change You'd Better Believe In!

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[24] For over fifty years, the American Osteopathic Association (AOA) has been the umbrella organization for the American College of Osteopathic Sclerotherapeutic Pain Management, where "sclerotherapy" and the later advances in "prolotherapy" have been taught in twice-yearly didactic and practical hands-on training seminars. A name change is in place, the "American Osteopathic Association of Prolotherapy Regenerative Medicine."

[25] Take note that Solange Magnano, a former Miss Argentina, recently died from complications of plastic surgery – see "Model's death highlights plastic surgery risks," reporting on this tragic episode is available at http://www.cnn.com/2009/HEALTH/12/02/model.death.surgery.risk/index.html; also see "Risks and Complications of Surgery," available at http://generalmedicine.suite101.com/article.cfm/risks_and_complications_of_surgery; also see "Understanding the Risks Involved When Having Surgery," available at http://surgery.about.com/od/beforesurgery/a/RisksSurgery.htm; all these accessed on March 7, 2010.

"Coverage" concerns bring up the whole question of "Health Care Reform." This hot-topic issue has gone through a variety of rewordings, to see how best to "sell" it to the general public. In fact, my viewpoint is very simple: there are four issues to resolve – **insurance *coverage***, **insurance *cost***, **care *quality***, and **care *cost***. Each of these is separate, although they are distinctly interrelated.

Care cost is a function of care quality. When "conventional" medical treatment is offered, the cost can be three to ten times ***higher*** than the cost to produce similar (even better) results with "integrative" care alternatives. For example, MRI and CT scans are often used by conventional orthopedic[26] specialists and general doctors, to "diagnose" neck, back, and joint pain problems. These extremely costly tests are rarely used by integrative specialists using Reconstructive Therapy (or prolotherapy).

Another example comes with "scope and scrape" (arthroscopic) surgery for knee arthritis or injuries – the orthopedic surgeon might spend thirty or forty minutes in the operating room, billing a fee of $4 – 5+ thousand for physician services, to which you must add operating room, anesthesia, and recovery room fees, as well as lab tests. A specialist in RT might treat a knee two dozen times, billing the same amount for physician services, but spending six hours carefully doing the treatments and customizing the approach as the patient's complaints are changing during healing. These cost examples are not limited to structural complaint treatments. One of my cardiologist friends charges $285 for a visit that can be as short as less than *three* minutes. That's *my* fee for spending *twenty*-some minutes with a "heart" patient.

Turning our attention to care quality, the issues are just as clear. Many people have the idea that "most doctors are just in it for the money" … except, of course, for the doctor *they* see. Then they brag about how busy their doctor is, since *everyone* wants to get in – and how they're hesitant to ask questions because he/she *really doesn't have the time* to answer, since they're so busy taking care of patients. Sounds to me more like veterinary medicine: "No need to hear from the 'patient,' just do whatever you think needs to be done."[27] Besides these concerns, which *patient* really knows whether an MRI

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[26] "Orthopedic specialist" simply means a bone-and-joint surgeon, not an "osteopathic" physician – both M.D.s *and* D.O.s can be orthopedists.

[27] I cannot conclude this chapter without sharing with you a brief account of the "quality" care received by one of my patients, recently hospitalized for a painful foreleg fracture. I'll call her "Jackie O," because I like the name. Plain film x-rays taken after a bad fall showed a break in the fibula, the thinner "outside" bone of the leg, as well as a crack in tibia (thick shin bone). I sent her to the ER for a posterior leg splint. They admitted Jackie O, insisting that surgery would be needed for screws and pins across her "severe" fractures. The orthopedic specialist did not even appear for almost 24 hours; he had already concluded that all she needed was a knee brace and "send her home." He never touched her. By that, I mean that his "exam" was a visual inspection; he never laid a finger on her. The admitting family doctor did an exam limited to listening to her heart;

is necessary or whether "plain x-rays" (drastically less costly) will provide more than enough information for treatment planning? Another example: which *patient* knows whether "lying down" x-rays are better/worse than "standing up" pictures? (Hint: standing x-rays, when able to be done, show the effects of gravity pulling down on joints and spine, helping to guide RT and other "healing" treatments to be even more effective and provide better pain relief.) The list of questions is endless. Most *patients* **never** know whether their expensive "annual physical" blood tests really show much worth finding out. (Hint: most of the "usual" tests are severely limited in their "prediction ability" with regard to developing critical illness – including the ever-present cholesterol studies … just ask for our perspectives.) These observations should raise more questions in your mind – most patients are simply too passive, too accepting, too trusting that they are getting the very "best care" possible. Thanks to books such as those written by Dr. Faber and me and others, learning more of the answers is easier than ever before.

So what about the insurance coverage issues? Here's where "Health Care Reform" really rings true for most people. Does it make sense for you to have a job and have insurance for twenty years, where you're "fully covered" and then change to another job where you cannot get any coverage for a "*pre*-existing" illness … one that *was* covered by insurance through your first job? A lot of people have struggled with that quirk in their policies. Does it make sense that the state where you ***work*** might have more *limited* coverage than that available from other companies … in the state where you ***live***, just a few miles across the state line? Restrictions on which companies can "write" coverage in each state is another issue with which many people have struggled. Several *auto* insurers offer a number of "options" where you can "customize" the coverage you want (thus, the premiums you want to pay) … doesn't that seem to make better sense for *medical* coverage as well? These and a dozen other "coverage" issues are complex – the real question comes down to whether the "free market" will be allowed to adjust to needs in a more open economy or whether the governments will impose a "one-size-fits-***none***" approach.

The final concern is for insurance *cost*. Here's where care *quality* and care *costs* converge and drive the premiums even higher. As more studies are completed, the early conclusions are that more expensive hospital stays do **not**, by definition, have better patient outcomes. But patients often labor under the (*unfounded?*) belief that bigger hospitals, larger clinics, fancier office buildings, larger office staffs, even legions of younger doctors "in tow" mean that the care quality is somehow smarter, better, more effective, more efficient. (Remember that many practitioners of "unconventional"

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he "deferred" the remaining examination to the specialist. Here's the glitch: Jackie O suffered polio as a child and her fractured leg was a flail extremity with a floppy foot. Every time her foot dangled, her pains were excruciating. The "specialist" refused to visit her again. A second orthopedist was called, and he advised … *(yes!)* a posterior leg splint. Her excruciating leg pains were suddenly better, as I had anticipated three days *earlier*. No surgery needed, not even a hospitalization. She spent five days there. **How Doctors Think** has become a popular book by Jerome E. Groopman, M.D. *I* have seriously considered writing a "sequel," to be titled **Why Doctors *Won't* Think**.

integrative approaches practice solo in small suburban or rural offices; their "appearances" are less imposing … and their fees are often far more reasonable!) The costs for insurance coverage, however, are based upon "loss-experience." In other words, how many dollars did the insurance company "pay out" in claims during the prior year. Expecting the trend to continue, they need to charge higher premiums *this* year just to keep paying such ever-more-expensive claims *next* year.

The Dirty Little Secret

But there's a little twist that you might not *ever* see: insurance companies are regulated just like public utilities. They are expected to be able to make a reasonable return on their dollars required to "do business." For sake of discussion, let's assume that a company can make a "ten percent return" on the costs, and their total expenses amount to $10 million. Their "ten percent" amounts to just $1 million. But … if their expenses (claims paid, salaries, rents, utilities, benefits and retirements, even advertising – all of those) amount to $100 million, then their "ten percent" cut amounts to $10 million – quite a handsome sum greater. Patients are always surprised to find that insurance carriers have little or ***no*** interest in finding less costly medical treatments, especially compared to surgery. Then they become aware of this formula, where higher claims paid out justifies higher premiums charged, and more expenses actually translates into greater profits for the company … and for the doctors and hospitals and drug companies, all the way around. (Do you **use** your phone because billboards and TV ads *invite* you call everyone … or just because you *need* to talk to the other person; these ads have a *wonderful* side-effect – raising telephone company advertising costs also [remember the "10 percent rule] raises their profits! Go figure!) Why should any public utility that is still collecting ever-higher fees want seek cost-saving "alternatives" that would, in fact, lower their own *profits?*

The need for "Health Care Reform" is obvious – we simply can't go on paying five times more per person than any other country and still being "sicker" than two dozen others on the planet. Yes, on various health surveys, we don't even come close to being in the Top Three or even the Top Ten. The issues, however, are complex and every proposed change has its own champions and defenders, each seeking to influence the political process. To accomplish an **effective** revision of the system by a two- or three-thousand page bill *never read* by the Members of Congress who voted for it seems an exercise in idiocy not intellect. We haven't even addressed cost-raising issues of malpractice claims, abuse of the legal system by frivolous lawsuits leading to mega-millions "jackpots" won by a few plaintiffs here and there. You see, the discussion gets ever more complicated.

What happened to the possibility of allowing the "free market" to address many of these questions? The term often used is "fairness" or a "level playing field"; in other words, each team has an equal opportunity to score, neither has an advantage of always running downhill while the other is always running up. When we talk of political or economic influences, we're protesting that The Establishment has set the conditions where the "playing field" (the market of patients needing and paying for care) has been

tilted on purpose. When insurance policies pay for *conventional* care (drugs and surgery) but **not** *integrative* treatments (such as Reconstructive Therapy), the playing field is tilted in favor of "usual" doctors. When allopathic or osteopathic physicians are brought up on charges before the state medical boards for offering integrative "alternatives" to usual drugs and surgery, the playing field is more than just tilted – doctors sometimes lose their license (and their livelihood, sometimes their families) when *not **one** single patient* has complained. (Hint: that means that "the competition" complained, or an insurance carrier notified the medical board that they are worried that "fraud" might be happening, where the doctor is doing nothing less than dramatically helping patients who have failed to improve with "usual" care.[28]) Sadly, integrative physicians are targeted with regularity, because they aim for results rather than for complying with rigid "checklists" (called "protocols") favored by the other doctors who already *haven't been able to **help*** the patient.

So what would be an "ideal" playing field? Many people say that "insurance should cover everything, usual care and alternatives as well." That would, of course, defeat the political agenda of minimizing the use of unconventional, integrative approaches. The Establishment is unlikely to let that happen. In one recent scenario, chiropractors were able to achieve coverage for services under the Medicare program, and an interesting backfire occurred. Rather than being able to deliver the adjustments and physical therapy that the doctor feels is needed for a particular patient's condition, the coverage is limited to an arbitrary limited number of sessions. Does the patient "*have* coverage"? "Yes." Does the coverage "take care of his/her *needs*"? Often *not*.

I have long proposed a more novel approach – a *completely level* playing field. Let's have **major** medical coverage, for serious illnesses and tragic accidents. Let's have a large deductible, say $20+ thousand each year, where **any** dollars spent for medical **or** health care (yes, there is a *major* difference!) are fully tax-deductible, dollar-for-dollar against your total income earned. (The details aren't important; look closely at the concept.) If you could get your neck or back or knee treated with Reconstructive Therapy, while you continue working and increasing your activities, where you need

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[28] HIPAA – The Health Insurance Portability and Accountability Act of 1996 provided for insurance carriers to withhold payments and instead to complain of "possible fraud," so that the machinery of government can grind away at any doctor so targeted. Doctors who haven't helped the patient have their often exorbitant billings paid (including for operations, hospital care, physical therapy, drugs, home nursing, and so on). Meanwhile, the doctor who has finally *helped* the patient scrambles to save his license – and the insurance executives can sit back with a hearty laugh and a bigger bonus. This relatively short (two hundred-plus page bill) has created massive problems for M.D.s and D.O.s around the country. All but three Members of Congress voted *for* the bill. Did *anyone* read it and realize the implications? HIPAA does nothing to insure patient privacy, despite what you sign before receiving care. Once "personal information" leaves the hospital or office records, you have absolutely **NO** recourse under law if it widely publicized on the internet or elsewhere. HIPAA is a microcosm of how government-regulated health care could become a fiasco.

fewer and fewer drugs to control your discomforts, where your fees might be just $4 or 6 thousand this year, would this be appealing? Or you could choose to have surgery, where your fees could be $10 to 50 thousand or more, where you might have a lengthy recovery with further expenses for frequent physical therapy, where you might need another operation in the future? ***YOU*** get to decide what for ***YOU*** would be "usual, customary, and reasonable" care and charges – neither the government nor insurance company bureaucrats could restrict your options. The choice, in each case, would be yours – but the "unconventional" non-surgical approach would seem for many patients (especially earlier on) to have fewer risks and offers several important benefits. In the "olde days," before "Ye Newe Blue Cross" arose in 1929, this was pretty much the situation, where *you* paid for care that *you* needed. A great deal of charity care made sure that many problems were adequately handled.[29] People tend to lead their lives in a more responsible manner when the costs for their care come out of their own pocket.

What about insurance offered by the employer. Well, the deductible amounts could be covered to various levels, with more profitable companies giving a higher "coverage" of the first dollars spent. Then, companies could purchase "major medical insurance" covering all of the remaining expenses anticipated, since very few employees are likely to seek services costing more than the high deductible. The details are unimportant – the idea is simply that we ***could*** have a better system without ruining almost everything for almost everyone. Doctors sometimes deliberate in committees regarding the best care options for a particularly complex patient (such as cancer, where many times the treatment options are simply lousy). The Congress used to have a policy of referring bills to various committees, each of which would hold hearings with experts regarding their particular expertise … finance, administration, tax implications, and so on. Maybe we could *hope* that – **unlike** the Affordable Care Act (the ObamaCare program) – Congress could return to the idea of holding hearings, listening for the best ideas in the conflicting testimony presented by the public as well as by lobbyists, so that even better ideas could emerge compared to those from locked closed-door sessions by party leaders.

Vive la différence!

Since osteopathic (D.O.) physicians have, in my view, a stronger inclination to listen to their patients, they have the chance to provide better explanations of problems, diagnoses, and treatment plans than do allopathic (M.D.) physicians. Such dialogue can markedly increase patient compliance – and more successful treatments certainly lead to greater patient satisfaction. In a society where the internet, newsletters, talking heads on TV, internet advertising "articles," and third-class brochures in the mail have all become "experts" in the fields of medical and health care, having a skilled and caring physician

[29] Medicare is hardly a "model program" for "Health Care Reform." Ever since the government meddling began in 1966, the costs doubled every four years through 1980. Early expense predictions of $12 billion for 1990 had mushroomed to $120 billion, under the careful scrutiny of bureaucratic administrators. Medicare and Medicaid have shattered **all** budget projections at *every* turn.

"sort out" your questions and concerns is almost essential. The more that *your* osteopath (D.O.) or allopath (M.D.) is prone to *consider* "alternatives," the more reliable answers you will be able to obtain.

Integrative physicians tend to be more advisory and less authoritative; they tend to review choices with you, to recommend readings (or, in our case, DVD videos and CD audios and various brochures and books) to help build your understanding, and then to discuss your proposed decisions in more detail. One problem encountered here – as in any technical field – is that "newbies" attend a weekend physician workshop and arrive back in the office on Monday feeling that they are now an "expert" able to handle any problems coming their way. After all, they have a binder filled with brochures to copy, advertisements to place, questionnaires for patients to complete, lists of lab tests to be performed, and a "decoding list" showing the recipes to follow depending on the patient's responses and results. Simply stated, there is no substitute for thorough training, tempered expertise, and *years* of doing it "right." One saying I have heard: "A novice practices until he gets it right; an expert practices until he can't get it wrong." While there are *no guarantees* in medical and health care, those who have spent years researching, writing, lecturing, and teaching others are more likely to **be** … the experts.

As the television advertisements suggest, "Ask your doctor if [**X**] is right for you!" Odd thought but … don't you think that, if **X** *is* right for me, then he/she might have *already* come up with that idea? Don't I "pay my doctor" to be thinking ahead of my problems, not behind the curve? One of the major concerns is that patients look *trustingly* to their "usual" doctors, *assuming* that they know what should be known about "alternatives": "Could I try Reconstructive Therapy before considering an operation on my [xyz]?" "Well, that might be helpful briefly for some people – but in your case, you really need the operation." "Oh, okay – *thanks, doctor*." Once again, another opinion offered because that's what doctors **do**, *not* because he or she has any *actual* knowledge. If your doctor leans away from "alternatives," you'll likely never find out how much you might have been able to be helped without daily drugs, without surgery. And remember, those "conventional" options are **always** available for you, should "unconventional" care fail to meet your expectations within a reasonable number of treatments.

Perhaps a food example could make things more clear. In some "fast food" places, you place your order and they take the next wrapped one off the already-prepared tray, bag it, and you're on your way. At others, they actually cook "everything to order." In most restaurants, your meals are prepared only to order, but soups and salads might have been made ahead. In fine dining establishments – especially those with four- and five-star ratings – virtually *every* part of your meal is prepared specifically to your requests. Such personal attention, of course, is more expensive as you "move up the list" as shown here. Nevertheless, people do appreciate quality and fine dining becomes a tradition, with the most elegant restaurants thriving for dozens of years. The same can be said of other finer encounters in life. An automobile can be purchased for $8 thousand; a BMW or Mercedes luxury sedan or sports car might be ten or even twenty times that amount. A tractor can be purchased for $15 thousand; a John Deere, the recognized pacesetter, might cost several times that amount. Replacement parts for more expensive

equipment are likewise more expensive. But many years of dependable, satisfying performance are the hallmark of expert design, manufacture, and service.

In the medical care arena, the so-called "doc-in-a-box" urgent care clinics offer very basic care for very basic illnesses and injuries. A physician assistant or nurse practitioner might offer similar basic care, or slightly more advanced "management" under the direction of your regular doctor. Your doctor in his office can provide treatment for many daily concerns, and in the hospital setting, he can marshal even more resources during your in-patient stay. Emergency rooms can be well equipped and staffed, but only a few of those qualify for regional Trauma Level I classification, where surgeons and support personnel and equipment and facilities are on-site and can respond immediately to the most serious catastrophes. Again, more comprehensive services are more customized, more personalized to meet your specific needs, and the fees and charges rise accordingly.

A similar situation exists where a physician has undergone "usual doctor" training (whether M.D. or D.O.) and later has devoted perhaps dozens of years of his/her time to study various "unconventional" approaches. Depending on his or her interest, such studies might have been very intensive and extended, sometimes resulting in one or more classic books explaining various topics to public or professional audiences. (I have heard the saying, "A few *write* books, some others *read* books, still more have heard that there *are* books, and *most* are completely clueless.") When your doctor has spent years attending far more continuing education classes than are expected by the state medical board, he/she might be able to offer better care for many more of your health concerns during your office visits. As expected, more time will be involved to deliver this personalized (and, often, "multi-specialty") care, and the fees will be higher. When your doctor has refined certain skills – such as with Reconstructive Therapy and Neural Therapy – your fees for these particular services will be higher as well.

The ABCD's of Medical (or Health) Care

Another way of looking at why America's "system" for medical and health care[30] delivery has "broken down" (and will *stay* that way!) is by review of the ABCD's involved. Read this section carefully, to the point where you feel comfortable repeating these ideas with a friend or family member; your effort might help to save their life one day. The lesson here: each of us is totally different. Not partly. **Totally**. Think of 300 million closets in America, one for each person above the age of one or two. Here's the challenge: can you ever find TWO closets that have exactly the same clothes in them.

[30] Think of "medical" care as that special attention expected from a physician for a disturbance of "usual" function, whether from illness or injury or toxic exposure or genetic limitations or other causes. Think of "health" care as the use of nutritional supplements, dietary changes, exercise programs, and other "no drugs, no surgery" approaches that can powerfully improve, enhance, even **optimize** body functioning. In many cases, "health" care technologies can prevent or correct "medical" issues to the point that they no longer require drugs or surgery to achieve desired improvements.

You can't. Period. End of story. We are different people, we have different preferences, we have different sizes – and what we choose for our clothes are as individual as what we deserve for our medical and health care!

Ramming all of us into a "One-Size-Fits-***None***" system is doomed to failure. The situation is just like trying to ram a round peg into a square hole (or the other way around!). You might believe otherwise; you would be wrong. Pay close attention.

A and B: Patient A is totally *different* from Patient B. You are a special person, with your own genetics, your own past events and concerns, your own food choices, and so on. In your experience, can you persuade anyone that *everyone* in the "medical care system" looks at ***you*** as a unique individual? As one whose personal history and examination means that *different* evaluations might be essential? (Or at least desirable?)

C and D: Disease C is *different* from Disease D. Many illness problems or injuries might look *similar* in different people – such as pneumonia or joint pains or high blood pressure. In your experience, can you persuade anyone that ***your*** infection or ***your*** pains or ***your*** blood pressure or ***your*** anxiety are actually a bit more complicated than those with which your neighbor or friend might be suffering?

E and F: Doctor E is *different* from Doctor F. In *Yellow Pages* listings, the same degrees appear, D.O. or M.D. You might even assume "the same" specialty training, if the names appear under the same heading. Do you know … that students with the highest *and lowest* passing grades **each** get their same degree, M.D. or D.O.? Medical school courses can be taught by young instructors or by Nobel Prize-winning scientists and physicians, by assistant professors or by National Academy of Sciences members. Internship and residency experiences vary widely, especially depending on the academic interests of the "clinical faculty."

After their internship, some doctors go directly into practice; others go on for specialty training. Later post-graduate experiences and continuing education can be spectacular … or merely mundane, more of a rehash of prior training. Still, all doctors receive an equivalent license (as a "Physician and Surgeon"), often proudly posted on their office wall. During years of professional practice, doctors *might* have read widely, written books, become broadly respected throughout their professional circles, searched for deeper explanations for patient problems … ***or not***. Still, they *all* keep their doors open and their schedules full. And these points have overlooked perhaps the most important personal traits of all: ***compassion*** and ***caring***, demonstrated as a devotion to *solving problems* not just getting on to the next patient and the next and the one after that. In your experience, can you persuade anyone that *any* doctor – or *any* particular specialist – will actually take the ***time*** and *also* will have the ***skill*** and ***expertise*** to evaluate ***you*** and ***your*** problems thoroughly and effectively?

G and H: Treatment G is *different* from Treatment H. Medical knowledge is exploding, with an incredible number of new approaches and options emerging each

month. Some are based on treatments used for other problems, while others are completely novel. Some work exceptionally well, others are less effective. If patients were treated *only* with what doctors had learned early in medical school or post-graduate training, then we would *never* have any newer or better ways. If older treatments that work well are abandoned, we can be left stranded, *hoping* that newer drugs and surgery will soon be coming along that will work at least as well as those long before. Surprisingly, physicians – whether osteopaths or allopaths – who introduce different ways of treating patients – such as Reconstructive Therapy – are often severely *criticized* by their peers and even *ostracized* from their professional community. The greatest punishment, however, is when jealous doctor-competitors turn such progressive doctors into the state medical board for "discipline," merely for making more advanced treatments available in their community. In your experience, can you persuade anyone that *every* treatment that *any* doctor proposes is the ***safest***, most ***effective***, most ***appropriate*** one for you as an individual, for ***your*** particular problem?

Some have said that whenever you choose your physician "by random chance" – through the Yellow Pages or internet ads or by referral from someone who really knows little about the quality of care but feels "the doctor is so very nice" – you might be just settling for "pot-luck" for you and your family. Whenever possible, ask a physician whom you trust (because your evaluations and treatments have, for the most part, been "spot-on") for referral to the next physician you might need. In the Health Care Reform planned for America, such necessary personal choice might not be possible … not because you will be denied the opportunity but rather because such physicians might be "outside" the system and their services might be "booked up" months in advance. These comments, of course, apply as well to those who provide nutritional and other specialty services in their advanced practice of medical and health care.

"Vote With Your *Feet!*"

Despite all this "talk" about integrative medicine, despite my belief that osteopathic doctors are more inclined to learn and offer integrative medicine technologies, I am very slightly optimistic about the future. Economic downturns – especially recessions and depressions, as we are experiencing now – dramatically reduce the willingness of people to spend their personal funds for their personal *health* care. Instead, many will choose to undergo drugs and surgery[31], more drugs and surgery, more

[31] Most patients assume that the "risks" of surgery – especially common procedures – are minimal and unlikely, especially in *their* world. One of my patients (successfully treated over the years with Reconstructive Therapy for severe ligament laxity and post-polio syndrome) insisted that her friend's husband travel to see me for shoulder treatments. "But insurance doesn't cover it, and his doctor said the surgery is really what he needs and he'll be just like new.") So, he stayed in his hometown, for arthroscopic surgery. During the procedure, the surgeon accidentally poked through the shoulder capsule and cut a major vein. The patient bled to death on the operating table, while the anesthesiologist struggled to maintain blood pressure so that his life could be saved. In ***retrospect***, RT looks much more simple, more effective – and certainly *safer!*

and more (you know the drill), until the deductibles and the "non-covered" drugs and other expenses have drained them dry. That point is that the wrong time to expect that integrative approaches might be right for you … is after you've already made sure that The Establishment has scooped up all the dollars it can from your "care" and has retained the political and economic clout to repress physicians whose joy is offering "alternatives" to improve your health. Over time, the number of physicians offering effective integrative care could be dramatically reduced, not increased.

"Vote with your feet!" has long been my counsel: so long as you walk into hospitals and "usual" doctors offices, they will continue to have the resources to control the decisions for your future. Which decisions? How about … which services will be "covered" by insurance policies. Or which drugs or products will be approved by the FDA. Or whether nutritional supplements will be highly regulated despite dozens of years of exceptional safety … or even banned altogether. If you want a different world for *your* future or for your *children* and *grandchildren*, then walk *instead* into the offices of integrative physicians. Our task is to help your body to recover and maintain as much structure, function, and comfort as is possible. When our integrative treatments are successful, then you need less doctoring, fewer drugs, and fewer operations. Until millions more prospective patients "vote" by choosing integrative medicine "alternatives," these choices will become fewer not more, farther not closer, more costly not less. Could I be wrong? Of course. But I don't make a habit of it.

"Health Care Reform," when it finally arrives and under whatever guise it takes, will change the whole equation. My concern is that the Congress will fail us in its obligation to stay within Constitutional bounds and will fail us by attempting to over-reach, gulping in too much too fast and without reflective consideration of how their new "laws" could reduce our access to care. Are you worried that your choices could become fewer and fewer, simply because of rules set by some bureaucratic agency. Over a *hundred* new federal agencies are contemplated, probably several thousand new State agencies to interact with their new federal counterparts. While the current legislative and judicial effort might appear to be reasonable in some ways, I am alarmed in many more. Trowbridge's Rule is simple to grasp: "Inside every small problem is a larger problem struggling to get out."[32] A "let's wait and see" attitude about the new "Reform" might be the biggest mistake that we could ever make! One defense that you have, personally and with your family, is to seek out a practitioner (whether a D.O. or an M.D.!) who respects and follows the basic principles of osteopathic medicine, as we have explored in this chapter.

I'm Confused About the Salt and Pepper Twin Continentals …

Our daily lives are filled with mundane details – getting up, finding matching socks or shoes, eating breakfast, making calls, remembering to pick up the laundry, getting everything needed at the supermarket, getting the car safety inspection, and so on.

[32] My rule has been documented elsewhere as "The Schainker Converse to Hoare's Law of Large Problems" – but what did *they* know?

Day in and day out, these demand our attention, though they matter little in "the big picture" of our lives. In the hallowed halls of the hospital, the *dramatic* events occur – birth, suffering, surgery, death. In between these extraordinary episodes, certain occasions stand out: graduation, marriage, birth of your child, promotions, retirement, whatever. But *health* is a special affair, especially when pain and limitation are involved. Illness and injury, clear changes in our health, often sharpen our focus, draw and keep our attention. The oddest mental pictures can etch themselves in the memories of the moments of our lives.

My neck and back (and other) problems (due to hypermobility syndrome) became obvious – both painful and limiting – when I was a young teenager. My chiropractor, Dr. Bill Williams, helped me "get through" what was unknowingly the *introduction* to a life punctuated by even greater suffering and heartache. And what mental picture do I *remember most vividly* from those early times? Walking out to his parking lot, through the back door of his office, past his and his wife's Powder Blue and Baby Pink twin Continentals.

In Summary, the Eight Major Principles of Osteopathy:

THE BODY IS A UNIT

STRUCTURE AND FUNCTION ARE INTER-RELATED

THE BODY POSSESSES SELF-REGULATORY MECHANISMS

THE BODY HAS THE INHERENT CAPACITY TO DEFEND AND REPAIR

WHEN NORMAL ADAPTABILITY IS DISRUPTED OR WHEN THE BODY'S CAPACITY FOR SELF-MAINTENANCE IS OVERWHELMED BY ENVIRONMENTAL CHANGES, DISEASE MAY ENSUE

THE MOVEMENT OF BODY FLUIDS IS ESSENTIAL FOR HEALTH

THE NERVES PLAY A CRUCIAL ROLE IN CONTROLLING THE MOVEMENT OF BODY FLUIDS

THERE ARE SOMATIC COMPONENTS TO DISEASE THAT ARE NOT ONLY MANIFESTATIONS OF DISEASE BUT ALSO ARE FACTORS THAT CONTRIBUTE TO THE MAINTENANCE OF THE DISEASE STATE

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