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Cure of malignant follicular lymphoma (postsurgical recurrent, predominantly small cleaved cell type) through the Gerson diet therapy

Case history and interview with Dr. Allison Sinclair

Compiled and conducted by Gar Hildenbrand

Abstract: *From time to time, this publication reports well documented remissions from presumably incurable advanced disease states, including various cancers, which remissions were probably induced at least in part by the Gerson diet therapy. Because the unique psychosocial makeup and experience of each individual probably played roles in her/his recovery, and perhaps as decisive influences, interviews have been conducted to document the retrospective opinions and impressions of these exceptional people. The Gerson Therapy is a set of integrated medical treatments which has been observed to cure many individual cases of advanced cancer in man. It is a salt and water management which restricts sodium intake and supplements potassium intake. Metabolism and cell energy production are stimulated by thyroid. Hyperalimentation of macro- and micronutrients is achieved by hourly feedings of fresh, raw juices of vegetables and fruits in addition to a basically vegetarian diet. Fat is restricted to lower intake of potential tumor promoters. Temporary protein restriction promotes nonspecific cell mediated immunities. Coffee enemas provide repeatable choleresis and stimulation of bowel and liver transferase enzymes for a kind of dialysis across the gut wall of tumor toxins. Although the mechanisms are not understood, it is probable that the host management of the Gerson Therapy can in some cases induce rejection of tumors.*

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Cure of lymphoma:

Case history and interview with Dr. Allison Sinclair

Case history

This 47-year-old white female, then a Supervisor for the Dallas, TX, Mental Health Clinic, was admitted to the Medical Arts Hospital of Dallas on September 12, 1979. She presented a firm, 2 x 3 cm., ill-defined mass lesion in the left supraclavicular area to the left of the thyroid lobe. Following surgical consultation, biopsy surgery was scheduled for and completed on September 14, 1979. Findings of Dr. M.J. Waldron, Dallas Pathology Associates, on the frozen section were nodular lymphoma, which was confirmed on permanent section. The final reading was nodular lymphoma, lymphocytic type, poorly differentiated. Intravenous pyelogram and liver scans were normal.

Findings were reviewed by Dr. M.A. Luna of M.D. Anderson Hospital and by Dr. Wm. Sheehan of the University of Texas Health Sciences Center of Dallas. In May of 1988, the Gerson Institute submitted Dr. Sinclair's 1979 permanent sections to the Armed Forces Institute of Pathology where they were examined by Pamela Murari, Chairman of the Department of Hematologic and Lymphatic Pathology. Her findings, using current terminology and classifications, were malignant follicular lymphoma, predominantly small cleaved cell type.

Dr. Sinclair noticed the lesion at the make up mirror three days prior to admission. She reported several months of night sweats to be the only possibly related symptom. She was a pack + per day smoker and occasional drinker, but denied lymphatic pain on alcohol consumption.

Family history is significant. At the time of her admission, two of Dr. Sinclair's uncles were alive with cancer of the lymph nodes. Both had lived with the disease for years. According to Dr. Sinclair, one had a "nodular lymphoma" and was alive at age 92. Both a sister and her mother are medicated for hypothyroidism. Her father died at age 36 of myocardial infarction.

Dx: Malignant follicular lymphoma, predominantly small cleaved cell type.

Biopsy surgery was uneventful and recovery rapid. Dr. Sinclair was discharged. Follow up examinations were conducted by Dr. Merrick Reese of the Sammons Cancer Center at Baylor University Medical Center. On first exam, January 9th, 1980, Dr. Merrick noted a 1 x 2 cm. mass which was fixed as though it were part of the surgical scar tissue, and which was definitely tumor. Other nodes were palpable in the left posterior cervical area. He made certain she understood that "if we are convinced that she is having progressive disease, we will need to consider definite chemotherapy at that time."

On subsequent examination, March 11th, 1980, Dr. Merrick noted tumor growth, the large left peritracheal mass measuring 3 x 2.5 cm. Lymphangiogram revealed probable involvement in the upper periaortic region. Dr. Merrick noted that he would like to treat her with CVP chemotherapy for six months. She declined.

Within one month, at an April 4th examination, Dr. Merrick observed an increase of the mass to 4 x 4 cm. At this point, there were other nodes involved. He explained to Dr. Sinclair that the marked overlying swelling was secondary to progression of the disease. He expressed concerns that the tumor w: now quite hard and might be, in fact, a different type of malignancy, and that the changes justified rebiopsy. He also explained that a pregnancy did not seem reasonable when he learned that Dr. Sinclair was pursuing it.

Dr. Sinclair was first seen at the Gerson Therapy Hospital La Gloria on April 28, 1980, and was examined and admitted by Dr. Apodaca who observed the same mass and noted palpable probable metastatic disease in other left cervical nodes and in nodes of the left thoracic channels. Aggressive salt and water management, therapeutic nutrition and other measures of the integrated Gerson cancer management were immediately applied. The patient was discharged on May 12, 1980, in good condition, with instructions to continue the Gerson diet therapy. Lab analyses of May 1st revealed a lactic acid dehydrogenase of 230 (norm 60 - 225), blood urea nitrogen of 8 (norm 1[- 26), cholesterol of 133 (norm 140 - 270) and sodium of 133 (norm 135 - 150). Within the context of the Gerson management, these findings were

I knew — and it must have been an unconscious process — that I had not taken care of my body. There were many reasons why the Gerson therapy worked for me. It was exactly what made sense to me, and what I needed to do, as well as to take care of stress.

— Allison Sinclair

regarded as "within normal limits" and no attempts were made to alter them. The patient experienced gastrointestinal symptoms during hospitalization including fullness and watery movements, but these, too, were interpreted positively. Local edema was seen to recede during hospitalization. Tumor regression occurred gradually during the ensuing months of physician-guided extended care.

erview

Hildenbrand: Gosh, where do I start?

Dr. Sinclair: I just talked to a man who called from Oregon about his grandfather. People do that all the time. They see my name and they call Turtle Creek Psychotherapy Center.

Hildenbrand: I think it's great. If you don't mind, I think it's wonderful. I wonder, you're so far down the pike, do you even remember the onset of the disease?

Dr. Sinclair: Oh yes. How could I forget?

Hildenbrand: When was that, Allison?

Dr. Sinclair: I was diagnosed in September of 1979.

Hildenbrand: What did you feel like before the official diagnosis? What I mean to ask is, why did you go to the doctor?

... Sinclair: Simply speaking, there was a large lump on my neck.

Hildenbrand: Which side?

Dr. Allison Sinclair

*"One thing I want to say, Gar, is I **know** I wouldn't be well without the Gerson Diet."*

—Dr. Sinclair

Dr. Sinclair: My left side. I had not been feeling well. I knew that something was wrong. I was in a very stressful job, experiencing a lot of stressful life changes. And one day, I realized that I had grown this huge lump on my neck.

Hildenbrand: What were you working at then? What was your line of work?

Dr. Sinclair: It was the same, only I was in administration. I was coordinating the Mental Health Screening Center in Dallas which involved a tremendous number of people and staff and locations. It was very stressful.

Hildenbrand: I'm sure of that. How old were you then?

Dr. Sinclair: Let me think, that was in 1979. I think I was 34.

Hildenbrand: Where did you go? Who did you see?

Dr. Sinclair: Well, I went to an internist. Well, first I asked one of the nurses down at the hospital at one of the Mental Health Screening locations, and she said you need to immediately go to a physician. She gave me the name of a doctor, and he immediately sent me for a sonogram and to see a surgeon. I had no idea anything was really wrong. But they had me in the hospital the next day, doing a biopsy, and it immediately turned out to be malignant.

Hildenbrand: Do you recall the hospital setting? Do you remember who told you what it was?

Dr. Sinclair: As I was coming out of anesthesia, the surgeon told me. I remember feeling embarrassed — rather than fearful — embarrassed as if I knew I'd caused it; I'd created the condition.

Hildenbrand: Like you'd done something wrong?

Dr. Sinclair: Yes. I knew I had. I knew that I had not taken care of myself. I knew that I had been overstressed. I knew that I hadn't been eating right. I

knew that I was smoking. And now, I knew I had to turn my life around at that moment. The hospital had wine and cheese trays. It was a very elegant hospital. It was a diagnostic hospital. I immediately started eating fruit. I immediately stopped smoking. I knew I had to do something.

Hildenbrand: What was the name of the physician in charge of your case then?

Dr. Sinclair: Well, I don't remember the surgeon's name. I could look it up. But he immediately referred me to an oncologist, and I despised the man. He was very calm, very clinical. He was not very hopeful, he said, because I was still young. With this kind of cancer, one tended to die faster. He was not very hopeful.

Hildenbrand: One tended to die faster with his help?

Dr. Sinclair: No, with this kind of cancer.

Hildenbrand: It was going to be fast?

Dr. Sinclair: Yes, because this was an old person's cancer.

Hildenbrand: It was a nodular sclerosing lymphoma, wasn't it?

Dr. Sinclair: Yes. He said that old people could live for quite a while with this kind of cancer. He emphasized that younger people tend to die much faster.

Hildenbrand: Did he talk in terms of a time line?

Dr. Sinclair: At that point, he said "under six years". That's what he said. Later on it was "up to two years", according to a second physician.

Hildenbrand: Your prognosis for survival was cut to two years?

Dr. Sinclair: Yes, and it was really scary. Doctors say some insensitive things, I think. I mean, I ask a lot of questions. I probably asked more questions than most people.

Hildenbrand: I understand. Insensitive physicians fail to recognize that people go into a state of shock, of altered consciousness, when they are told that they have cancer. I recently read a paper by Alexander A. Levitan, M.D., which was the keynote address for the 32nd Annual Meeting and Scientific Session of the American Society of Clinical Hypnosis, published in the *American Journal of Clinical Hypnosis* 33(3), Jan. 1991. It was the president's address. Dr. Levitan spoke of increasing attention recently directed to the impact of optimal communication, and to "unintended suggestions made by authority figures to patients in altered states of consciousness".

"I remember feeling embarrassed — rather than fearful — embarrassed as if I knew I'd caused it; I'd created the condition."
— Dr. Sinclair

He said that a new term, "nocebo," has been coined to describe this phenomenon. I quote, "*Nocebo* is intended to be the converse of *placebo*, and was coined to describe the negative effect of an authority person's opinion on a susceptible subject." I'm sure you're familiar with the placebo effect, being, of course, faith, hope, and optimism. The placebo effect has been shown to account for at least a third of all medical efficacy if you can get it to click in. The nocebo is a negative message with, presumably, at least the same potency, which is introduced by an authority figure who predicts death due to disease.

Dr. Sinclair: Embedded in your unconscious.

Hildenbrand: Yes, placed there by someone who is insensitive to the fact that you are in a dissociated trance state that has been caused by the shock of diagnosis.

Dr. Sinclair: Exactly.

Hildenbrand: So you get the word, "you've got cancer". That's the shock. Then you get the word, "you're going to die in six years". That's the *nocebo*.

Dr. Sinclair: I was aware of that, and I just said no.

Hildenbrand: You protected yourself against it.

Dr. Sinclair: Yes. I thought that w... ridiculous, and it just made me more rebellious.

Hildenbrand: Good. Good. How long did it take to find your treatment of choice?

Dr. Sinclair: Gerson?

Hildenbrand: Yes.

Dr. Sinclair: I was so lucky, in that the first tumor was removed, most of it, and the surgeon said he thought he got all of it. You know how that goes. It didn't recur for three months, which gave me three months to think about it. The first month, I was so depressed that I immediately contacted the Simontons and began reading and going to their workshops for professionals. I began to feel very depressed, because I picked up on a "blaming" kind of mindset there. Now, I think they would deny that, professionally. It could have been my own stuff, but, I really felt *more* embarrassed, rather than being able to focu on the fact that I hadn't taken care of my body, which is what I initially felt. In the Simonton program it seemed that I was led to feel more that I must really want to die, that I was really depressed, that I had created this condition. But I really didn't feel that I had.

Hildenbrand: You perceived that there was an undercurrent at those workshops that the reason that you were ill was that you had an internal death message?

Dr. Sinclair: Yes. Exactly.

Hildenbrand: And you didn't feel that you really did.

Dr. Sinclair: No, I didn't feel that I did. I examined that very closely.

Hildenbrand: So did Susan Sontag in her excellent little book. I remember reading it and thinking, "I agree with you, Sontag". She was a breast cancer patient. She said that she wasn't going to tolerate people blaming her for "bringing this on herself" through some abstract corruption of her being; by having some sort of tragic flaw. That

was before the popular trends began to shift emphasis to lifestyle. She was ...ling with the old tuberculosis era ...ndset that "these high strung people bring disease on themselves".

Dr. Sinclair: I do think we bring it on in some ways. But I think we, and only we, can determine that. And I think we have the *right* to determine if it's so, or *not* so.

Hildenbrand: That's the individual with a disease, right? Are you saying, "I, the person with cancer, or person with a disease, am the only person who can make that determination"?

Dr. Sinclair: Yes. There are so many variables, it's presumptuous to say to any one person, "*This* is the reason." And for me, I knew — and it must have been an unconscious process — that I had not taken care of my body. There were many reasons why the Gerson therapy worked for me. It was exactly what made sense to me, and what I needed to do, as well as to take care of stress.

...enbrand: How long did it take you to arrive at the decision? How did you decide on Gerson, and how long did it take?

Dr. Sinclair: It seemed like forever. I began it after I got over being depressed, which was after about a month.

Hildenbrand: You broke depression in a month?

Dr. Sinclair: Well, I would sit around every day and cry and be very anxious. Then I began to get mobilized, and started the imagery.

H: How did you get over the depression?

S: By finding a path.

Hildenbrand: How did you get mobilized? How did you get over the ...ression?

Dr. Sinclair: By finding a path. What really got me over it was Gerson, but in a month I started to do imagery, by the Simonton protocol. I began imagery, but I had a lot of trouble with it — incredible trouble with it — even though I'd read all the books. I have lots of books on imagery. I would practice it three times a day. It was a very weak kind of imagery, and I couldn't make it stronger. I had great difficulty. One day, I did the imagery in which I had these little men in white suits cleaning up the cancer. And they were on strike. They were exhausted and kind of lying down on the job, and I said, "come on guys, go". And they said, "you know, we can't work unless you feed us better and give us more pure water".

Hildenbrand: I love it. Of course I'm going to print it.

Dr. Sinclair: It was very strange. What I did then was turn to diet, and books on diet. That took a long time because people did not respond to me rapidly. I'd write off for information on this or that diet. One of them never did respond. Finally, I just went to a health food store one Saturday and sat down and started going through all the books. As it turned out, there were three references to Gerson. They talked about a saltless vegetarian diet. I knew salt was a problem. I knew I consumed way too much salt. I got really excited and hopeful at the time, but I couldn't find Gerson's book with the results of 50 cases. I found some other references, though, and I began looking for a juicer. Through finding the juicer, I found out about the Gerson Institute and called and made a reservation.

Hildenbrand: You went to the old La Gloria hospital facility?

Dr. Sinclair: Yes.

Hildenbrand: Let's see, who would have been on staff there? Curtis Hesse?

Dr. Sinclair: Uh huh.

Hildenbrand: And Dr. Victor Ortuno.

Dr. Sinclair: Uh huh.

Hildenbrand: And Dr. Alicia Melendez.

Dr. Sinclair: Yes. You know, the juicer had arrived just before I left. I had begun what I *thought* was the diet. You probably have many people say this. I wasn't on anything like the Gerson therapy until I went to the hospital. I'm so glad I went.

Hildenbrand: It's actually very easy to see what the diet is, once it's being given to you. Once it's been delivered to your room several days in a row, with hourly interruptions for the juices, with medical and nursing visits in between, and then the meals, you can see it easily. But trying to piece it together from the pages of books that only make reference to another book that describes the Gerson therapy must be very difficult.

Dr. Sinclair: It was quite an experience.

Hildenbrand: When did you arrive at the hospital?

Dr. Sinclair: It was May of '80.

Hildenbrand: Where were you living then, by the way?

Dr. Sinclair: I was living in Dallas, in the city. Later on I moved out to breathe clean air, but in the beginning I was living in the city. It was the end of April, actually, when I finally got out to the hospital. I was there two weeks into May. As soon as I started the therapy, my body responded beautifully. I don't know if you want to print this — this is really interesting now that I think back on it, now that I understand it better — what happened is that I immediately developed incredible diarrhea. I couldn't even do a coffee enema. I think what happened is my body just started dumping toxins. Rather than stop it, we didn't stop it until I left the hospital. I never had a coffee enema the whole time I was there.

Hildenbrand: You needn't be modest about that. That's exactly the symptom of one of the gross actions of the immune apparatus: the bile mechanism turns on. We've all had that happen with stomach flu. All of us have felt what its like to have our systemic levels of interferon, interleukin, lymphokine, bradykinin and prostaglandin shoot way up. As your immune system turns on, your whole body becomes involved and your intestines reverse

their normal absorption of fluids and out comes all of this bile and fluid from nowhere. I mean, you wonder where the heck could it come from. That's certainly what happened to you. And while it was happening, you were dumping a whale of a lot of sodium. When did that happen? First day?

Dr. Sinclair: Yes, immediately. I had already started at home as best as I could, not with the potassium, but I had already started drinking carrot juice and cutting out all the other stuff.

Hildenbrand: How many days would you say you had been doing that before you arrived?

Dr. Sinclair: The juicer arrived about a week before I went there.

Hildenbrand: You found the book in what, February?

Dr. Sinclair: No. Within three weeks of when I found the diet, I was out there at La Gloria.

Hildenbrand: That was fast. So, one week of juices before arriving.

Dr. Sinclair: And then the full therapy. And immediately, I started having diarrhea which lasted the whole time, and stopped just as I was leaving. It was controllable, you know.

Hildenbrand: Did you have fevers, do you recall?

Dr. Sinclair: No. Little bitty ones. I never had big reactions. I would have long minor ones.

"I wasn't on anything like the Gerson therapy until I went to the hospital. I'm so glad I went." — Dr. Sinclair

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Hildenbrand: What happened to the cervical node, the mass in your neck. How big was it when you came in, by the way? Had it grown from the time of diagnosis?

Dr. Sinclair: Let us go back to that. Remember, the biopsy was in September.

Hildenbrand: That was a resection biopsy in which they took the node, wasn't it?

Dr. Sinclair: Yes. The cancer recurred in January, and it was doubling in size each month. I have the records. It was pretty large. You could really see it when I got to the clinic in May. And then at the clinic, it swelled up. I couldn't wear a certain gold chain I had with me because the tumor swelled with inflammation so that it bulged out over this thing.

Hildenbrand: It's been stated in the literature that the only reliable gauge of prognosis is the rate of tumor doubling. It's been observed that tumors double the same number of times until death, irrespective of treatment and growth. A clear prognosis evolves from your observation that this thing was doubling every month. Were you keeping in contact with the oncologist or the internist?

Dr. Sinclair: At that point, I finally found one that I felt was nice, you know.

Hildenbrand: That matters doesn't it.

Dr. Sinclair: Yes. And he was not very helpful, he was, you know, recommending treatment, and he was concerned that I wasn't doing anything. I never went back to him after I found the diet. I knew what his attitude would be. I had, of course, asked him about diet, and he'd said that it makes no difference at all.

Hildenbrand: When you began the diet therapy at home, you had already been doing positive imagery for at least six weeks.

Dr. Sinclair: No, actually longer. I'd been doing imagery with *no* success from, let's say, October, and I did it throughout the diet. But it became *working* imagery, it became very *powerful* in conjunction with the diet.

Hildenbrand: I'll bet. I loved what you had to say about the little men in white coats demanding better working conditions. What did they feel like after you got the diet going?

Dr. Sinclair: It was no longer little men, it became piranha.

Hildenbrand: Really?

Dr. Sinclair: Oh yes. You know, I ca just look at my immune system in minute in imagery and it's fierce, all these mean looking piranha fish, that would just tear up anything that's not supposed to be in there.

Hildenbrand: You are currently in a line of work that puts you in the catbird seat to observe the effects of the rapidly expanding awareness of the mind/body connection and psychoneuroimmunology. You're actually in a position where you're helping people hook it up.

Dr. Sinclair: I do a lot of work with imagery.

"(Imagery) became very powerful in conjunction with the diet." — Dr. Sinclair

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Hildenbrand: What do you see in your practice, in terms of the effects i people of combination lifestyle changes and psychosocial intervention and adaptation? Have you seen people pull themselves up by the bootstraps at the last minute, before it's too late?

Dr. Sinclair: Oh, yes.

Hildenbrand: I think some people want to desperately so get well that they really respond to encouragement and permission.

Dr. Sinclair: I want to make an observation. When I reached the hospital, I asked Charlotte what she thought my chances were, and she said, oh it's child's play.

Hildenbrand: Nice message.

Dr. Sinclair: She just waved her hand like, oh you're just garden variety.

Hildenbrand: Child's play. Now that's the confidence that her father talked about in his paper "Psychomatic Reactions During the Gerson Therapy". Essentially, Dr. Max said, woe to the physician who doesn't believe with all his heart that his therapy works, because the patients will intuit that. Do

you feel that the process of seeking options, in order to avoid a feeling of 'plessness, can be part of the for-ula for healing?

Dr. Sinclair: Yes. I always felt there was a way out, and I think that's part of what makes one successful that you can figure out — when you find yourself in this kind of trouble — is there a way out?

Hildenbrand: I very much agree. The issue of *Healing* in which this interview will run contains an article about the work of Dr. Ronald Grossarth-Maticek and Dr. Hans Eysenck. They have shown that people can be taught to seek options to correct negative psycho/emotional states, and that these people can derive physical benefits such as lowered risk of disease, and extension of survival in existing diseases. Perhaps you are familiar with Dr. Eysenck, the grand dean of British clinical psychology.

Dr. Sinclair: Yes, of course.

'''ldenbrand: He's behind Grossarth-.ticek's work, standing solidly behind it, co-published with him. He's saying that Maticek's findings reveal that conventional Freudian psychoanalysis is associated not with lower, but with higher risk of cancer and coronary heart disease because, they conjecture, it causes people to focus on the negative and stay focused on the negative. So, what they advocate is a kind of behavior therapy, to train people to seek solutions. They teach people that it is appropriate to regard failure not as a cause for depression, but as a cause to seek a new option.

Dr. Sinclair: A learning process.

Hildenbrand: Yes. As regards the Freudian analysis, I was very surprised. I expected that, at worst, the older modes of psychoanalytic patient/therapist relationships would be less effective. But these results indicate that the longer a person stays in conventional psychoanalysis, the ater the risk of negative physical alth consequences, and that those who break off will lower their risk.

Dr. Sinclair: I absolutely agree with that.

Hildenbrand: The Grossarth-Maticek and Eysenck data also revealed that smoking is a risk for lung cancer in only one specific personality type, the helpless/hopeless individual. Isn't that wild?

"I can just look at my immune system in a minute in imagery and it's fierce, all these mean looking piranha fish." — Dr. Sinclair

Dr. Sinclair: Oh, there's so much we don't know in the mind/body connection; there's so much, our belief systems, our mindset. When I'm working with somebody who is ill, I am *so* respectful of what they believe. It's very important for me to absolutely understand *their* belief system and to work with that.

Hildenbrand: What would be the result if you, as a therapist, tried to superimpose your own template over someone else's belief system?

Dr. Sinclair: I think you can *offer* them other belief systems, but not without first absolutely understanding and respecting the one they arrived with.

Hildenbrand: Do you tell your own story to patients?

Dr. Sinclair: Sometimes. Not always. It depends. And, when I do, it's later on into therapy, at a place where its very pertinent. I don't just start out that way.

Hildenbrand: I have so many questions for you, and I really want to ask them all together at once, to get your overview. I assume you have bipolar patients?

Dr. Sinclair: Oh yes.

Hildenbrand: And single-sided types of affective disorders, and clinical depression?

Dr. Sinclair: Yes.

Hildenbrand: Do you see people in near-psychotic episodes, for whom drugs are not a solution, whether the drugs don't work, or they don't stay on them, or they don't want to take them at all?

Dr. Sinclair: Of course.

Hildenbrand: Do you see an improvement in the success of your therapy if those people change their lifestyles? I know I'm being simplistic, and I'm begging the question actually. Could you make that correlation, or would you?

Dr. Sinclair: I can't. I look at their belief system and try to understand why they think they have a problem, why they're ill. Let's say its bipolar, Let's just take that. What do they think caused it? If they don't know, I might offer them many explanations and see what they choose. When they identify something that seems causal to them, then we work with that. I think it would be presumptuous of me to say, "*this* is what caused it and *that* is what you should do."

Hildenbrand: We share your respect for the limits of human knowledge. I am very cautious when talking about cause and effect. When people ask, "has the Gerson therapy ever cured a case of this specific disease?", I may feel more comfortable saying that there are several people who had that disease who got well while using the Gerson therapy. I'm that unsure of what it is that's actually doing the healing.

"There were many reasons why the Gerson Therapy worked for me: it was exactly what made sense to me, and what I needed to do." — Dr. Sinclair

Dr. Sinclair: I'm much more in awe of what I *don't* know, than what I *do* know. And I've become more and more respectful of the unconscious, just from observing what's happened in myself and in other people.

Hildenbrand: It may be that people who seek and sustain therapy with you, and whose depression lifts con-

current with a lifestyle change, may be getting well and improving their milieu for reasons not related to therapy or lifestyle. It may not be causally related.

Dr. Sinclair: It may be, in fact, because they have come up with their *own* belief, and they have chosen what they are going to do about it. I support and help them in that.

Hildenbrand: Lifestyle change and improvement in depression may be symptomatic of having chosen a path.

Dr. Sinclair: I think so. But, one thing I want to say, Gar, is I *know* I wouldn't be well without the Gerson Diet.

Hildenbrand: In my biased heart, I *love* it when you say that.

Dr. Sinclair: I am absolutely *certain*.

Hildenbrand: Yes, I feel the same way myself. I know how sick I was when I started, and I know how rapidly it worked, despite my reservations.

Dr. Sinclair: I didn't have any reservations. I absolutely knew. I was absolutely certain that this was the right diet.

Hildenbrand: I would love to be so unguarded. I come skeptically to almost everything, which is, I guess, OK, because I avoid a lot of disappointments. But I didn't really expect it to work. I wanted it to work, but I didn't think it would. When it *did*, I was just thrilled. I became enthusiastic, and I had to constantly guard myself against zealotry, against turning conversations in that direction. It's an incredible experience to heal from a serious illness. What about your experience with regression of the lymphoma? How long did it take for the bump to go away?

Dr. Sinclair: The bump — it was so huge — within four months, it was smaller and softer. And within 6 months, it was the size of a pea. From the fourth month to the sixth month, it just went way down. And I went back to La Gloria in December for a rest. After six months on the diet, I was just worn out. I needed someone else to make the juice. I went for a week, and that was really nice. The next spring, I went out to the halfway house for a week. The next year, even though I was off the diet, I went out for a week. It's nice to have someone else take care of you, to do it for you. It was a little treat that I gave myself.

Hildenbrand: Did you stay in touch with your internist during this time?

Dr. Sinclair: No, no I didn't.

Hildenbrand: You dropped out of follow-up there.

Dr. Sinclair: I didn't want any negativity. I just stayed away from anyone that was negative. I just didn't want to deal with them.

Hildenbrand: I don't imagine you ever closed the loop then. Those guys probably don't know you got well.

Dr. Sinclair: No, they don't.

Hildenbrand: Isn't that interesting? And they're still there, in Dallas-Ft. Worth.

Dr. Sinclair: Yes.

Hildenbrand: I'll be darned.

Dr. Sinclair: I probably should let them know.

Hildenbrand: It might be fun. But I certainly understand your avoidance of negativity and the reasons you stayed away from those physicians.

Dr. Sinclair: I think we're all acknowledging that there's more to getting well than the diet alone; it has to do with some mind/body connection that we don't fully understand.

Hildenbrand: I think we have to distance ourselves enough to get an overview, and yet stay in close enough to watch the details. When we become both objective and subjective enough, at the same time, I think we'll understand that it is our entire soup that creates the impression of disease — that we have so many stresses on our intellects and our emotions, negative influences, urgency, for example, from the market place, and pressure from the workplace, a sense of failure or inadequacy in the economy, in addition to horrendous air, water and food pollution problems, the denigration of the nutritional value of the foods, and our genetic predisposition, which depends on how badly damaged our ancestors were. When you try to pick out causes, there are so many potential and interconnected factors that it becomes a game of pick-up-sticks: you try to move the red stick on the bottom and everything else in the pile moves.

Dr. Sinclair: Another consideration is that by the time someone finds out they have cancer — let's say they choose the Gerson therapy — they are depressed, they are beaten down, they are feeling hopeless. The diet therapy alone may be, perhaps, not enough. The other part, the stress of just knowing that you have cancer, has to be addressed.

Hildenbrand: Do you think that it would be appropriate for some, or all, people with cancer who elect this treatment option to engage themselves in some kind of psychosocial intervention?

Dr. Sinclair: Absolutely. If there was some way that you at the Gerson hospital could just make that a part of the treatment, it would be extremely beneficial. That's taking another direction.

"I just stayed away from anyone that was negative."
— Dr. Sinclair

Hildenbrand: We talk about it. We've been talking about it for more than a year. And now, being in the new clinic — actually it's not a clinic anymore, its a hospital, a regular community hospital — we talk about it in terms of *when*, not in terms of *if*. We have a lot of questions about what it is we can offer, because people are here for only such a short time. We have no network of safe therapists to send them to. As with cancer managements, there are numerous and varied psychosocial therapies out there; some of these approaches may be modestly beneficial, some may be very beneficial, and some may be modestly or very deleterious. I'm confident it's safe to say that. I wonder what we could do to

help people to orient themselves to winning strategies.

Sinclair: Develop a network perhaps.

Hildenbrand: Maybe so. Who would you network? Would you network clinical psychologists? Are you a clinical psychologist?

Dr. Sinclair: No, I'm a psychotherapist.

Hildenbrand: A psychotherapist. How did you train for that?

Dr. Sinclair: Well, my training is marriage and family therapy. After I received my degree, I went back and got more training, courses in marriage and family therapy. Yet, this illness has made me go off in other directions as well. It's my opinion that, if you were to network marriage and family therapists, not all of them would deal with these particular issues. I think it would be better to look to people like Joan Borysenko, and what kind of network is being set up in the mind/body connection. Also, I know a lot of people through Eriksonian hypnosis, and it's probably the closest group.

Hildenbrand: We've just recently been in contact with the Eriksonian Institute.

Dr. Sinclair: One of my colleagues is Erikson's daughter. There are institutes all over Texas and other places, too, working a lot with hypnosis and the mind/body connection. I'd be happy to help at the time you all start that, in terms of figuring out what the network is and how you access it.

Hildenbrand: I would love to do that. Rarely has anything in the healing arts surprised me and astonished me as much as the potential immediacy of the answer of hypnotherapy for panic attack disorders and anxiety disorders. I can't believe how rapidly some of those people can be helped.

Dr. Sinclair: As I said, I grow more and more respectful of the unconscious process.

...denbrand: Have to. Have to be. Lord knows what it is, but it is obvious that, when people begin to pay it heed, it can be a tremendous servant for healing rather than a brutal master of illness.

Dr. Sinclair: You know, Gar, if you all move in that direction, let me know, because I would love to help in any way I can.

Hildenbrand: I sure will. I've been reading Spiegel and Sachs and others, who publish on the treatment of dissociative disorders caused by child abuse, child sexual abuse, and I can see that, in the last 10 years, hypnotherapy has gained much validity by tracking its own data and following its own tail, and seeing what it's doing. It's become quite solid once again, and it looks like, to me anyway, this is a strong growth period. There undoubtedly will be a great backlash sometime, but right now it's a growth phase.

Dr. Sinclair: It's respected right now.

Hildenbrand: Yes, it really is. The only naysaying going on right now is in a few of the so called fundamental religious organizations. Some of the fundamentalist groups are equating hypnotherapy with spiritualism or satanism, which I think is dreadfully unfortunate.

Dr. Sinclair: So do I. Gar, my client is here, so we are going to have to wrap this up. Do you want to talk again?

Hildenbrand: I definitely do.

Dr. Sinclair: It occurs to me that we haven't covered what's been happening since I was treated, and keeping up with the diet.

Hildenbrand: Have you?

Dr. Sinclair: Certainly not the whole diet. But I still drink carrot juice, and I really have to discipline myself to do that.

Hildenbrand: Do you ever use the coffees?

Dr. Sinclair: Oh, yes.

Hildenbrand: Me too.

Dr. Sinclair: I think you get addicted to that.

Hildenbrand: They're fabulous. You have a client. I think I have enough here for a good interview, and I have your charts from the hospital here, so I can dig up the early data. I'm delighted our conversation took the direction we headed in, and I am going to call you again.

Dr. Sinclair: Ok. That's it, it's been really fun, Gar.

Hildenbrand: My pleasure.

Dr. Sinclair: Take care.

Hildenbrand: Bye. ■

Short note:

Where are they now?

William Schickle had an exhibition of his artworks at the Cable Gallery of San Diego. The exhibition, entitled "Earth and Sun" ran two months, July and August. Mr. Schickle, in 1952, at the age of 32, was treated for, and cured of, lymphoma by Dr. Max Gerson. His case history is number 18 in *A Cancer Therapy: Results of Fifty Cases* by Max Gerson, M.D./pub. Gerson Institute. ■

Will changing your mind help you heal?

By Gar Hildenbrand
Executive Director
Gerson Institute

It is now generally accepted, at long last, that the mental/emotional status of a patient can affect the outcome of treatment. Research in psychoneuroimmunology has offered many new probable biochemical causes for some of the effects, both positive and negative, of mental/emotional states on health.

It has become increasingly obvious to researchers that mental-emotional states can, in fact, change the levels of many biological variables, such as glucocorticoids (stress hormones), and immunity (lymphocyte activity). Norman Cousins' excellent last book, *Head First*, may serve as a layperson's primer of the scientific bases of psychoneuroimmunology. Readers will be fascinated to learn how many chemical signals emanate from the brain, which is a massive aggregate of glandular tissues.

Brain science now validates what psychologists have long asserted, that what we think and feel absolutely plays a role in, and sometimes completely dominates, our body chemistry.

Blame the victim

Historically, our societies have harbored attitudes unkind to people with tuberculosis, cancer, and other diseases. We have tended to blame the "high strung" or "repressed" personalities of these people, and we have said that they "brought the diseases on themselves."

However, evidence suggests that, in the majority of those so afflicted, disease-causing nervousness and emotional repression did not occur by themselves. In other words, such negative mental/emotional states are not the fault of those who experience them.

Ours is an unpleasant, unhappy, anxious and pushy world. This century has been the bloodiest in history. In the lull between wars, cruel economies control our lives. Regimentation and runaway institutional systems routinely swallow human innovation and independence for the sake of blind productivity. Control-oriented people force performance out of any who will submit, on the job, at play, in the kitchen or the bedroom. Coercion is most frequently practiced with a smile and the admonition, "Have a nice day."

Anger and hopelessness

Anger, frustration, hopelessness and helplessness almost always involve outside objects: e.g., people, goals, jobs, with whom or which our relationships are unsatisfying or painfully unfair (to us). Strategies to deal with self-damaging emotions are many and varied. As awareness grows of the negative physiological effects of the above mental/emotional states, so does the pressing need to identify successful coping strategies and to incorporate them into medical management.

Creative novation

One of the most hotly contested issues in medicine today is *whether* there exists, and if so, *what* is appropriate psychosocial intervention for advanced cancer. We have searched and read the literature, and we have identified a relatively simple behavior therapy for which the data suggest clinical validity. It is called Creative Novation Behavior Therapy, and was developed by Ronald Grossarth-Maticek.

As we considered Dr. Grossarth-Maticek's therapy, we were in communication with Professor Hans Eysenck. Dr. Eysenck is the grand dean of British clinical psychology. Fifty years ago, he introduced clinical psychology into the Department of Psychiatry of the University of London. Dr. Eysenck stands solidly behind the Grossarth-Maticek data, and his support alone carries great weight.

Cancer Maffia

I was stunned when a trusted colleague cautioned me that his acquaintances in Germany had claimed Grossarth-Maticek's data were falsified. They said that Grossarth-Maticek, who is a Yugoslavian oncologist, could not have had access to mortality data in Heidelberg, Germany, because he is not licensed to practice medicine there. I urgently faxed Professor Eysenck. Eysenck's reply was immediate and direct.

He told me that he, too, had heard those criticisms and that he had straightaway contacted the Mayor of Heidelberg. From the Mayor of Heidelberg, Eysenck learned that Grossarth-Maticek and his students had indeed been allowed free access to death certificates from the city. The Mayor himself had granted permission. Grossarth-Maticek's data were real.

Eysenck was matter-of-fact as he explained that Grossarth- Maticek's attackers are part of the "German cancer Maffia", and that they are competitively opposing his research because they are worried about retaining their own financial privileges and access to grants.

CHIPSA Gerson patients

Because of Dr. Eysenck's input, and because we have the courage to trust our own judgment, we have decided to go on record in support of Dr. Grossarth-Maticek, his data and methodology, and his conclusions. And we have decided to encourage patients in the CHIPSA Gerson therapy systems to employ Creative Novation Therapy with the expectation that it will extend survival and improve results of medical treatments.

The areas of cancer medicine potentially affected by Grossarth-Maticek's findings are many. Perhaps the German cancer industry will not be alone when others around the world realize how many apple carts may be jostled his conclusions.

Grossarth-Maticek conducted research over a twenty year period which resulted in the finding that personality types are stronger prognostic indicators than virtually any of the well known environmental challenges associated with cancer.

Think about it.

What if the way we react to our environment is as important, or more important, than the environment itself?

Extended survival

Grossarth-Maticek produced data in a multi-arm long term evaluation which not only documented the tendency of certain personality types to develop disease, but also that a form of behavior therapy called "creative novation" could actually provide people with coping skills necessary to change their basic personality tendencies and prevent disease.

Not only that, but his research showed that the same "creative novation" tools can, without question, lead to increased survival in cancer patients.

Personality types

Grossarth-Maticek found four dominate personality types.

Type 1 is unable to solve problems in relationships with other persons, situations, and goals. If relationships are sour, circumstances unfavorable, and goals unachievable, Type 1 persons will react by sinking into a depression characterized by feelings of helplessness and hopelessness. They will be unable to alter their negative focus on external objects. This personality type is highly prone to cancer.

Type 2, sharing the same inability to solve problems and alter a negative focus on external objects, reacts with anger and frustration. Type 2 persons are highly prone to heart disease.

Type 3, perhaps the most surprising of the findings, flip flops between helplessness/hopelessness and anger/frustration. Type 3 tends not to get sick.

Type 4 is the healthiest personality. These people are autonomous. They are able to remain self aware and to solve problems in relationships. Groups of type 4 persons have the lowest incidence of disease and deaths due to other causes, such as accidents.

Learned behaviors

As we have examined Grossarth-Maticek's publications, the question arose in our minds whether the above are truly personality types, or whether they are learned behaviors which simply overlay the personality.

It may be that modern Western education, with its well known flaws, has at least prepared us with enough problem solving skills to implement Creative Novation Therapy. The central exercise, which we have repeated since kindergarten, is to recognize a problem and to solve it.

Emotional pain

What we are looking for is emotional pain. If we find our hearts hurting while in a relationship with another person, or with an unfulfilled dream, or our jobs, we must regard the pain as a reason to seek other options. We must remember not to fall into depression, but instead turn our energies to problem solving.

This simple exercise can alter the levels of internally secreted hormones, especially those of the adrenal glands. Reduction of certain stress hormones alone can release a suppressed immune system, speed wound healing, and improve blood sugar levels and cellular metabolism.

Surprising findings

The Grossarth-Maticek findings which have created controversy in the professions are really quite surprising. He found, for example, that people who enter conventional Freudian psychoanalysis, and who stick with it, are *more* likely to become ill than people who drop out of analysis. Could it be that conventional analysis, with its fixation on perceived problems, actually has negative physiological effects?

In the U.S., our National Cancer Institute has placed big money on eradicating cigarette smoking. They claim cigarettes are the single greatest cause of cancer. NCI will not be pleased to learn that the Grossarth-Maticek data clearly suggest that smoking reliably predicts higher cancer rates in only type 1 personalities.

It is, of course, controversial to suggest that behavior modification might extend survival in advanced cancer. But the data strongly suggest that it can, all by itself.

So, how do we do it? How do we go about altering personality traits which are conditioned by a lifetime of interaction with forces which are, no doubt, still at play in our lives? We reprint here the entire text of the Grossarth-Maticek document which was given to patients to help them do just that. Please incorporate it into your Gerson management.

How to achieve emotional independence and a healthy personality

(Text of a document given to therapy patients to help in short-term behavior therapy.)

Reprinted from *Behavior Research and Therapy*, an international, multi-disciplinary journal, Vol. 29(1):1-16, 1991.

Written by Ronald Grossarth-Maticek

Every human being has the ability to alter his behavior, and that of those around him, in such a way that he can attack his problems more successfully, and achieve a complete solution.

I. *How do problems develop which are in part due to your own actions?*

Problems arise because you continue with a certain course of action, or maintain certain views and attitudes, which result in consequences that are negative, harmful, and unpleasant. Possibly you expect positive, pleasant, agreeable consequences, such as the affection or love of somebody who is important to you, and suffer because this acceptable state of affairs is not realized.

II. *What can you do in order to solve the problem and overcome difficulties?*

In principle, there are three things to be done:

1. You can change your behavior in such a way that conditions (e.g. in your interpersonal relations) are changed in such a way that you are placed in a better position (e.g. lose weight, smoke less, improve your interpersonal relations).
2. You withdraw from situations which do nothing for you in the long run, and avoid conditions which are likely to do you harm.
3. Change your mental attitudes and values, and in that way improve your general adjustment.

In these three ways you have a better chance to solve problems which before gave you difficulties.

III. *What are the important variables to consider if you want to change your behavior and your attitudes in order to solve your problems?*

a. You have to observe yourself carefully and try to answer the following questions:
   1. What are the conditions which produce distinctly negative, undesirable effects for you?
   2. Why can't you change these conditions? Is it possible that you may expect positive effects although usually the effects are negative?
   3. What new, alternative activities are there which would enable you to produce more positive consequences, and get rid of the negative ones?

b. The first thing to do is to imagine new, alternative varieties of behavior. These activities may complement your usual type of behavior, or may completely change it. Next go on to try out the consequences of these new activities, both in your thoughts and emotionally. When you anticipate positive consequences from this new type of behavior, try it out in your everyday life.

c. Always try to gain some insight into yourself, remember that your own needs and wishes are important, and that you should not always give way to others in order to preserve the peace.

IV. *What can you do when things do not work out?*

Failure should always be regarded as the reason for trying out new types of behavior and activity. It should never be the cause of depression, but merely serve to enrich your range of experiences. Your principles should be geared to "trial and error": when some new type of activity does not lead to the expected success, abandon it and try something else. In doing so you may of course suffer sadness and despair, and express these emotions, but you should always try to act in such a way that your behavior leads to better and more acceptable consequences.

V. *What can you do when you have no idea what else you can do?*

You can only accept that state of affairs, but continue to observe your own behavior in order to discover the conditions which prevent you from achieving satisfaction and happiness.

VI. *The most important aim of autonomous self-action:*

1. Your aim should always be to produce conditions which make it possible for you to lead a happy and contented life.
2. To increase the positive consequences of your behavior, and to reduce the negative consequences — go for what makes you happy, abandon what makes you unhappy.

VII. *What is the role of other people in helping to solve your problems?*

The aim of autonomy training is not to be a completely independent person, but someone who is able to create the best possible conditions which lead to pleasure and contentment. You will often find that the support and help of other people can be of great assistance. Consequently it is usually important to enlist the help and assistance of other people. When you have a problem, such as giving up alcohol, or reducing weight, then try to enter into a contract with another person who will hold you to your promises. When you cannot solve the problem by yourself, it is very helpful to have an obligation to another person to stand by the rules you have agreed on, such as not to eat more than 1000 calories per day.

VIII. *How do you achieve autonomous self-regulation?*

You are in a state of autonomous self-regulation when you succeed through your own activities, e.g. sport or jogging, refreshing sleep, production of good interpersonal relations, to achieve an inner equilibrium and contentment, and to respond appropriately to deviations from this equilibrium. You will avoid dependence on such things as coffee, alcohol or drugs. It is important to observe your own behavior and mental activity in order to identify those people and objects on which you are too dependent, and which produce undesirable consequences. For instance, you may be drinking too much coffee, which in turn produces great excitement and prevents you from sleeping properly. In such conditions, it is necessary to engage in some alternative form of behavior, such as ceasing to drink coffee, or altering your behavior vis-a-vis a particular person, etc. When through your activities you achieve more autonomous self-regulation, then you will feel that you are very much better off. If this does not happen, you must not despair, but go on looking for an improvement in the situation in which you find yourself. ■

Study finds high worker stress

(Reprinted from *American Medical News*, May 25, 1992.)

MINNEAPOLIS (AP) — The recession has turned companies into "pressure cookers" for about half of American workers who feel they must prove their worth to hang on to their jobs, says a new study.

"Stress is running like a fire through the American workplace and the recession is adding fuel to it," said Peggy Lawless, research project director for Minneapolis-based Northwestern National Life Insurance Co., which conducted the study.

"Over-stressed employees are less able to perform their jobs and more afraid to leave them," she said.

Four out of 10 workers said their jobs are very stressful or extremely stressful, and 39% said they are thinking about quitting, according to the survey of 1,299 employees from randomly selected private-sector companies. Forty-six percent said they worry about their jobs and feel they must prove their worth.

Workplace stress is taking a big toll on workers' health, the study said. Of those who said they were highly stressed, 65% said they suffer from exhaustion, and 45% said they had insomnia. Muscle pain and depression were other commonly reported complaints. Twenty-one percent said they took sick leave in the past month.

Fifty percent of the employees said job stress reduces their productivity. Even though 45% said they must work overtime, 34% said time is still too scarce to get their work done.

At highest risk of job burnout — the extreme consequence of stress — are low-income workers, especially those with college degrees, and single women with children.

Reducing overtime, delegating responsibility and being supportive are effective ways a supervisor can reduce employee stress, the survey said.

The study is part of a two-year research project by the insurance firm. In a study released last year, the company said one in three workers expects to burn out on the job in the near future. The third part of the project, to be released this summer, will include a "self-test" to employers to measure and address stress.

The written survey, which has a margin of error of plus or minus three percentage points, was administered by N.K. Friedrichs & Associates, a Minneapolis marketing research firm. The survey was completed in February and March of this year. ■

Maticek & Me

Editorial

by Christeene Lindsay-Hildenbrand

Gar and I have been presenting the psychosocial intervention of Ronald Grossarth-Maticek (see the article, "Will changing your mind help you heal?", this issue) to the patients at CHIPSA for almost a year. We have received several of letters of concern from members of the psychology and psychiatry professions, and it is in answer to these thoughtful comments that I write today.

We share the work of Grossarth-Maticek, not as authorities on the subject who are insistent that this is the *only* method that will help you, but *as co-patients sharing notes*. We watched this therapy work, in me.

My story

I was a person with lupus for many years (since I was 11). In 1985, when I was 34, my brain began to swell, and I experienced stroke migraines. I used the full Gerson therapeutic diet for 2 years. As my body began to heal, I experienced extreme psychological difficulties. A marvelous psychotherapist came to my aid. With her help, Gar's encouragement, and the nutritional support of the Gerson therapy, I managed to stay on the planet. But I still experienced intense emotional pain, especially if I came in contact with key family members; so I avoided them.

Panic attacks

In August of 1991, I could no longer avoid some of the relationships which caused me such great pain. Circumstances brought us close together against my will. I began to experience panic attacks, *upwards of ten a day*. Coffee enemas and the juices helped, but couldn't stop these rapid-fire explosions of energy which coursed through my entire body, leaving me trembling and, often times, convulsing in agony.

Gar and I went to the Bio-med library and did an in depth search of the literature to find what else could help me. We discovered hypnotherapy, and the work of Grossarth-Maticek. I used the services of a medical hypnoanalyst, and rapidly learned the tools to administer self-hypnosis. The overwhelming series of panic attacks abated. At the same time, I read, and had Gar read to me (while in a very relaxed state), the work of Grossarth-Maticek.

I used the full Gerson therapeutic diet for 2 years. As my body began to heal, I experienced extreme psychological difficulties.

Gar was very excited about this work, but I wasn't. It sounded too simple. And I didn't really believe it. My experience had taught me that emotional pain could not be dealt with. If a situation, or person, in my life caused pain, I would simply have to ride it out. Nothing I could do was going to make any difference. As a matter of fact, it was my opinion that if I tried to do something, it would only make matters worse. My experience said, "avoid the pain, focus on something else," — only now *I couldn't*. The pain was *all I could see;* I couldn't outrun, it no matter how fast I moved.

Type One: Helpless-Hopeless

According to Grossarth-Maticek's work, I had a perfect type 1 personality: helpless and hopeless. But, this is not really a "personality type" but, rather, a *learned pattern of response*. If I had learned this way of responding to things, I could *unlearn* it. I hadn't learned to respond the way I did in a void. I had learned to respond to my life the way I did *because it worked* for me — but it wasn't working now. The conditioned patterns of behavior no longer worked because conditions had changed. I just didn't *know* it yet.

When I started the Gerson therapy, I was emotionally numb. I was ignorant of my own emotional messages. As I healed physically, I found that I began to feel emotions with an intensity I had never known. As my body became hypersensitive to environmental toxins, my emotional being became *that* sensitive to toxic emotional relationships. I think it is all part of the healing. But I didn't have a clue what to do with this newfound knowledge, this emotional awareness. Speaking with other people using the Gerson therapy, I found my observation reconfirmed repeatedly.

The tools outlined in "How to achieve emotional independence and a healthy personality," by Ronald Grossarth-

When I started the Gerson therapy, I was emotionally numb. I was ignorant of my own emotional messages. As I healed physically, I found that I began to feel emotions with an intensity I had never known. As my body became hypersensitive to environmental toxins, my emotional being became that sensitive to toxic emotional relationships. I think it is all part of the healing.

Maticek, provided tools that proved invaluable to me.

Let me put Dr. Grossarth-Maticek into my own words:

#1. Observe & acknowledge your feelings. Don't ignore or try to block emotional pain when it arises. Don't pretend it isn't happening.

#2. Identify the immediate source* of the pain. To me, this means using pain as a tool to locate the immediate source. It has been my experience that there is always an immediate trigger, something that causes the pain just now. Ask, "why am I hurting?" *(This step terrified me. The basic tool I had used to survive pain was to ignore it; now he was saying to walk right into the middle of it. I worried that I wouldn't survive the pain if I had to look at it. — I survived!)*

#3. Change the relationship. But HOW? You've already started by recognizing that there is a problem. Your intention to change the problem is another change. You are already heading into

#4. Look for options. Just looking for options will raise your immunity and change the relationship. The path itself is part of the cure.

#5. Repeat number 4 as many times as necessary, until the pain stops. To me, this was one of the most important steps. I knew my pain VERY well by this time, but I didn't think I could change it, because I was locked into a very narrow pattern of behavior; I had very few options. This work helped give me permission to "try something else", and to try again if that didn't work. I was no longer allowed to tell myself, "that didn't work, I've failed"; instead, I would say, "that didn't work, let's look for something else."

Our conditions change continually, what worked last time might not work next time. But our options are wide open... and... if someone closes a door, we can try out the windows!

There were two basic benefits that I gained using this strategy. *I listened to my own pain.* I acknowledged that I hurt. I could now seek options. I had a problem to solve (my emotional pain) and *I was allowed to look for alternative ways of dealing with things.* I used the pain itself as my guide. When the pain stopped, I knew I had succeeded. This strategy also encouraged me to keep trying when the first attempt didn't work. Looking for alternatives became a game.

I didn't trust the work of Ronald Grossarth-Maticek. I didn't think it would work. I felt like he "blamed the victim" inside of me, and that his suggestion that *problems develop which are in part due to (my) actions* was mocking my pain. I didn't cause this.

But, I found that his suggestions did work. I didn't cause my disease, but I could do *something* about it. I took Grossarth-Maticek's work and I ran with it. I didn't stop with his simple article, but I followed its advice. And I will continue to do so. Let me encourage you to look twice at his work. I'm thankful Gar convinced me to read it again.

Our conditions change continually, what worked last time might not work next time. But our options are wide open... and... if someone closes a door, we can try out the windows! ■

* **Note:** I use the phrase *immediate source* because I have come to recognize that the *identified source* of pain, for), is usually a catalyst, or key that activates an old behavior-template which, when followed to its source, usually reveals *patterning* set in place during my childhood. I am finding that I am capable of *changing my relationship* with the *identified immediate source* using a systematic technique devised by Konrad Stettbacher and outlined in his book, *Making sense of suffering.* (Hoffmann & Campe, Hamburg, Germany, 1990).

Mammography Radiates Doubts

By Samuel S. Epstein

(Reprinted from the *Los Angeles Times*, January 28, 1992.)

An activist coalition fighting breast cancer needs to question the line doled out by the cancer Establishment.

It has been widely (and with reason) charged that the makers and marketers of silicone breast implants, and self-interested plastic surgeons, made women their guinea pigs. But what of that other, and greater, scourge of women, breast cancer? There is reason to believe that women are equally ill-served by the cancer Establishment, especially in its unrelenting promotion of mammography.

Breast cancer now strikes one in nine women, a dramatic increase from the one in 20 measured in 1950. This year, 180,000 new cases and 46,000 deaths are expected. Hearings scheduled February 5 in Washington by the Breast Cancer Coalition, an advocacy group loosely modeled on AIDS activists, could not seem more timely.

The coalition wants more federal funding for the National Cancer Institute (NCI) to increase its research into the causes and treatment of breast cancer, and to improve delivery of breast health care — including diagnostic screening. In pursuing these goals, the coalition has been co-opted into supporting the policies of the cancer Establishment — NCI and the American Cancer Society — which is fixated on basic research, diagnosis and treatment. Cancer prevention receives only an estimated 5% of the annual $1.8 billion NCI budget.

Breast cancer is not the only cancer on the rise. While its incidence has increased 57% since 1950, overall cancer has increased 44%, now striking one in three people and killing one in four. Male colon cancer is up 60%, testis, prostate and kidney cancer up 100%, and other cancers, such as malignant melanoma and multiple myeloma, more than 100%. The cancer Establishment trivializes evidence linking these increasing rates with avoidable exposure to cancer-causing industrial chemicals and radiation that permeate our environment — food, water, air and workplace.

"The cancer Establishment trivializes evidence linking these increasing rates with avoidable exposure to cancer-causing industrial chemicals and radiation that permeate our environment — food, water, air and workplace."

The cancer Establishment maintains, on tenuous evidence, that a fatty diet itself is a major cause of breast cancer, while ignoring contaminants in fat. Carcinogenic pesticides, such as the highly persistent chlordane and dieldrin, which concentrate in animal fats, are known to cause breast cancer in rodents. Elevated levels of DDT and PCBs are found in human breast cancers. An Israeli study found that breast cancer deaths in younger women recently dropped by 30%, despite a substantial increase in consumption of animal fat. This drop followed, and seems linked to, regulations that reduced previously high levels of DDT and related pesticides in dairy products. These pesticides act by mimicking the action of estrogens or by increasing estrogen production in the body, which in turn increases the risk of breast cancer. A related concern is lifelong exposure of all women to estrogenic contaminants in animal fat, because c their unregulated use as growth-promoting additives in cattle feed.

In 1977, NCI's director of endocrinology, Dr. Roy Hertz, warned, without effect, of breast cancer risks from these contaminants.

More ominous is the enthusiastic endorsement by the cancer Establishment of massive nationwide expansion of X-ray mammography, including routine annual screening. While there is general consensus that mammography improves early cancer detection and survival in postmenopausal women, no such benefit is demonstrable for younger women.

Furthermore, there is clear evidence that the breast, particularly in premenopausal women, is highly sensitive to radiation, with estimates of increased risk of breast cancer of up to 1% for every rad (radiation absorbed dose) unit of X-ray exposure. This projects up to a 20% increased cancer risk for a woman who, in the 1970s, received .10 annual mammograms of an average two rads each. In spite of this, up to 40% of

A large Canadian study conducted from 1980 to 1988 found a 52% increase in early breast cancer deaths in women aged 40 to 50 who had 10 annual mammograms, compared to women given just physical examinations. More recent concern comes from evidence that 1% of women carry a gene that increases their breast cancer risk from radiation four-fold.

— Samual Epstein

women over 40 have had mammograms since the mid-1960s, some annually and some with exposures of 5 to 10 rads in a single screening from older, high-dose equipment.

Significant studies on radiation risks to the breast have been well known since the late 1960s, including evidences that mammography, especially in younger women, was likely to cause more cancers than could be detected.

confidential memo by Dr. Nathaniel erlin, a senior NCI physician in charge of large-scale mammography screening in 1973, may explain why women were not warned of this risk: "Both the [American Cancer Society] and NCI will gain a great deal of favorable publicity [from screening, and]... this will assist in obtaining more research funds for basic and clinical research which is sorely needed."

Thus, once again, suspect technology was applied to women on a large scale, in spite of clear warning signals and with insufficient knowledge of the likely consequences. (On a smaller scale, but even more ethically appalling, was the use until last April of industrial polyurethane foam to coat silicone breast inserts, despite clear evidence that its manufacturing contaminants and breakdown products were carcinogenic. As with mammography, no serious studies have been launched to find out what happened to women in whom the foam was implanted, or indeed to women carrying any type of silicone implant.)

The risks of mammography, especially for premenopausal women, persist with the lower radiation doses (about one-half rad per screening) found in modern facilities with dedicated equipment and licensed operators. A large Canadian study conducted from 1980 to 1988 found a 52% increase in early breast cancer deaths in women aged 40 to 50 who had 10 annual mammograms, compared to women given just physical examinations. More recent concern comes from evidence that 1% of women carry a gene that increases their breast cancer risk from radiation four-fold.

The coalition should insist that the NCI and American Cancer Society initiate an immediate, large-scale, well publicized study to further investigate the role of past mammography in increasing breast cancer rates, and to investigate future cancer risk from mammography as currently conducted under widely varying conditions. Women should also be informed of their X-ray exposure and individual and cumulative risks each time they undergo mammography. The coalition should demand an immediate ban on obsolete high-dose X-ray equipment, and the abandonment of routine mammograms on premenopausal women.

The coalition should also encourage a crash program to develop and make available safe alternatives to mammography, apart from physical examination. Two that show the most promise are magnetic resonance imaging and transillumination with infrared light. The expansion of mammography should be put on hold, especially in view of the 1991 conclusion of the General Accounting Office that "there are more than enough machines to meet the screening needs of American women".

The Breast Cancer coalition represents a welcome trend toward active grass-roots involvement in public health. However, its current goals are too narrowly defined within the context of existing perspectives and institutional policies. The coalition needs broader and more radical strategies if it is to reverse the modern epidemic of breast cancer. ■

Dr. Samuel S. Epstein is professor of environmental and occupational medicine, School of Public Health, University of Illinois at Chicago, and the author of "The Politics of Cancer".

Water

By Gar Hildenbrand
Executive Director
Gerson Institute

Gerson patients need pure water, especially for coffee enemas. Most cities have bottled water businesses which deliver purified and distilled water to homes.

Water can also be purified at home with reasonably priced equipment which may be purchased or rented.

Water purification equipment is everywhere now. You can get reverse osmosis units, distillers, carbon filters and more from just about anyone. People go door to door selling all sorts, sizes and combinations.

Hardball sales pitch

Maybe you've seen the guy who takes a glass of your regular tap water and tests it with a "special chemical" which causes gobs of white grungy looking stuff to appear and settle to the bottom. Now he informs you that you can get all that poison out with a carbon filter, and he proves it by filtering your water and repeating the test. Voila! No grunge.

In a well researched article in their *Consumer Reports: 1992 Buying Guide Issue*, Consumers Union (CU) staff members explained that the "special chemical" is doubtless a flocculating agent which causes harmless minerals in water to precipitate. Unscrupulous sellers use this bogus water test to convince potential buyers of the unpotability of tap water in their homes.

Unsafe tap water

In fact, your tap water may be teeming with hazards, none of which would be recognized by such a "test". According to CU writers, there are more than 70,000 recognized water contaminants ranging from industrial or agricultural wastes to heavy metals and radon. Microbes are also known to flow from the household tap.

Labs that test water

For the Gerson household, it is probably unnecessary to carry out lab tests for contaminants because of the demand for really pure water. However, friends and relatives interested in water quality issues may wish to use one of these CU listed labs:

Water Test
33 South Commercial St.
Manchester, NH 03101
Tel. 800-426-8378

National Testing Laboratories
6151 Wilson Mills Rd.
Cleveland, OH 44143
Tel. 800-458-3330

Water Testing Laboratories
4600 Kutztown Rd.
Temple, PA 19560
Tel. 800-433-6595

These tests are expensive, ranging easily up to $200.

CU writers were most concerned about lead, radon, and nitrate as water contaminants. There are good reasons to remove added fluorides and chlorine, as well.

No machine does it all

The big surprise is that *no single form of water purification tested by CU was able to remove all contaminants; not distillers; not reverse osmosis units; and not carbon filters.*

In order to get really pure water, it's necessary to COMBINE techniques. You have two choices:

1. Carbon filtration with reverse osmosis
2. Carbon filtration with distillation

Strengths and weaknesses

For practical purposes, distillers are better at organic health hazards than reverse osmosis units, but they miss the volatile ones like benzene, carbon tetrachloride and trichloroethylene. These minor differences disappear when either type of water purification is coupled with carbon filtration.

Only carbon filtration is able to remove chlorine, benzene, carbon tetrachloride, trichloroethylene, and radon. Carbon filters sound pretty good so far, but they fall apart when they get to the inorganic health hazards.

Only distillers *or* reverse osmosis units will take out arsenic, barium, cadmium, chromium, fluoride, lead, nitrate, and selenium.

Buy or rent?

If you are in a locale which is not serviced by a reputable water company, e.g.: Culligan, you may have to purchase equipment. Your costs may run

No single form of water purification is able to remove all contaminants. In order to get really pure water, it's necessary to COMBINE techniques. You have two choices:
1. Carbon filtration with reverse osmosis.
2. Carbon filtration with distillation.

from $500 to $1,400 for either of the effective combinations. Also, *bear in mind that your costs won't end with your purchase.*

Distillers typically draw 1,500 Watts, and electricity is expensive. Extrapolating CU writers' numbers, it looks like five gallons of water will cost $1.50 on the utility bill. For patients, the *electricity cost alone may run approximately $30 per month.*

Carbon filters are replaced frequently, on the order of every six months for high volume usage. *Replacement costs run from $5 to $100.*

Reverse osmosis units allow up to 80% of water to flow by the membrane and down the drain. *When it's time to replace the membrane, usually once a year, costs range from $45 to $234.*

We chose to rent

If, after reading the above, you still want to own your own gear, we recommend that you use the CU ratings guide to make good choices within a reasonable budget.

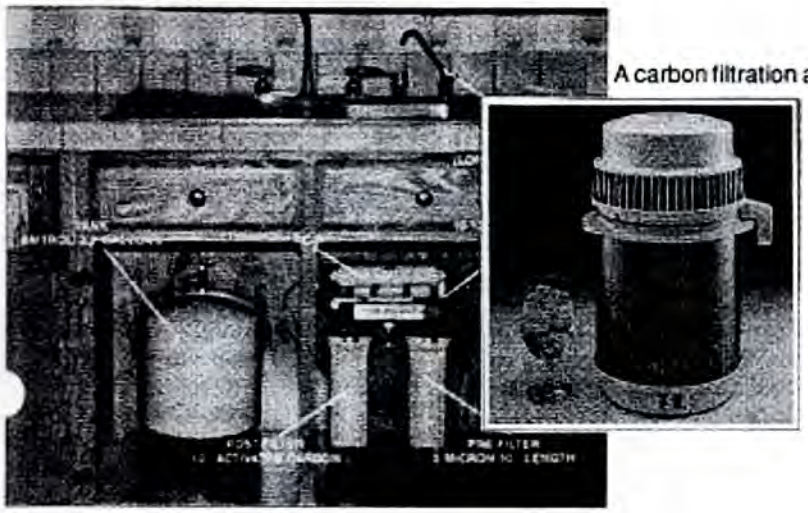
On the other hand, you may choose to rent. We did. Christeene and I pay *$18 per month rent for an under-the-sink combination reverse osmosis and carbon filtration unit* which is maintained by the company. We pay *no replacement costs* for filters or membranes. A test light signals when the unit needs servicing. The unit makes plenty of water, allowing us up to five gallons per day when needed.

Finding a vendor

We found our Arrowhead dealer offering special deals at a trade booth in the Del Mar Fair. They're also listed in the Yellow Pages, along with a bunch of other water companies who offer similar services.

Arrowhead is a company that started with spring water and distilled water deliveries around San Diego County. They saw a good market opening up in equipment rentals, they snagged good technology, and they marketed it competitively. Lots of companies are doing this. It's a buyers' and renters' market. Look in your Yellow Pages.

The quality of tap water mostly everywhere is less than the best. Fortunately, purification units are available, affordable, and effective. ■



A carbon filtration and reverse osmosis system (left) manufactured by Kiss, International and an example of a countertop distiller (inset) manufactured by Waterwise, Inc.

The Gerson Institute recommends no specific brand of water purification equipment. The models shown here are representative who what is available but their depiction here is not a product endorsement.

Office of Alternative Medicine opens new era for NIH

Healing editor Hildenbrand appointed to NIH advisory panel

by Gar Hildenbrand

I found myself telling Canadian Broadcast Corporation (CBC) reporter Sonya Wallace, "We were higher than kites for days, and then it sank in, how incredibly enormous was the task before us." Just home from a week in Washington, DC, and Bethesda, MD, Christeene and I realized in stages the enormity of the U.S. health policy changes of which we had been privileged to be a part.

The National Institutes of Health (NIH) have a new Office of Alternative Medicine. Its first meeting, a public forum, was held on the NIH campus June 17th and 18th, 1992. I am one of nineteen advisors selected to guide the formation of the office.

We were higher than kites for days, and then it sank in, how incredibly enormous was the task before us.

In this issue of *Healing*, and elsewhere, you will read the impressions of professional journalists, their sense of the historical significance of the opening of a new office chartered to "fully investigate and validate" promising alternatives in medicine. Balanced, and some even hopeful, articles about the office and its first meeting, a two day public forum, have appeared in *The Lancet, Nature, The Medical Tribune, The Journal of the American Medical Association, The NIH Register, Newsweek, The Washington Post, USA Today*, and other publications.

Failure of the marketplace

Why? Why does this new office attract so much attention? Because, I believe, our health care crisis has reached critical mass in the sense that we are near either a meltdown or an explosion. Public and governmental confidence in the established order is almost completely gone now.

In the face of failure of the marketplace to provide appropriate, affordable and sustainable healthcare, Senator Tom Harkin, powerful Chairman of the Senate Appropriations Committee for Labor, Health and Human Services, and Education, has told NIH to have an open mind about the alternatives.

Miracle

Like Moses parting the Red Sea, Tom Harkin has done what no man before him could do. He gave permission to NIH to open the doors and windows of research. Moses parted the sea, and the children walked on dry land, a wall of water on the left and a wall of water on the right. Scientists came out of the woodwork, eager to participate. The rigid hierarchy of NIH, which mirrors Food and Drug Administration (FDA) policies, had been parted. It was a miracle.

There was no legislation to create this new office; according to Senate Appropriations Committee Chief of Staff Mike Hall, "we told them to."

Former U.S. Representative Berkley Bedell deserves credit for giving Senator Harkin the strategic idea. Senator Harkin was the one who saw the need for oversight and mandated one of the strongest advisory panels ever, one which will select alternative treatments for evaluation and prescribe the methodology by which they are to be evaluated.

Our health care crisis has reached critical mass in the sense that we are near either a meltdown or an explosion.

Battle raging

Actually, the battle has been raging for decades for recognition of promising alternative medical treatments, which I often refer to as the marginalized industries of medicine. Most recently, constituent pressures resulted in a Congressionally mandated Office of Technology Assessment (OTA) evaluation of "Unconventional Cancer Treatments".

OTA Deputy Director, former Sloan Kettering vice president, Dr. Roger Herdman went before the retrograde U.S. National Cancer Advisory Board (NCAB) in 1990 to tell them, "The people have spoken, Congress has heard the people, and now *you* must listen. You must pay thoughtful attention to the alternatives."

"We don't feel sick"

hardened by decades of trade ...rs which were fueled by top flight propaganda, the NCAB was unmoved. A key member leaned back in his chair, sneering this riposte; "Dr. Herdman, we hear you saying we've got some kind of disease, but we don't *feel* sick."

*The people have spoken, Congress has heard the people, and now **you** must listen.*
— OTA's Assoc. Dir. Roger Herdman to the National Cancer Advisory Board

Congress was stumped. Even after House of Representatives Energy and Commerce Committee Chairman John Dingell told the Associated Press that the OTA study showed that some of ... evaluated treatments had both ...ysiological and psychological benefits which physicians should not ignore, NCI and NCAB had no intention of looking at the alternatives.

Harkin not pleased

Frank Wiewel had been talking with Senator Harkin for years about the OTA study. Wiewel was the man most responsible for focusing efforts to compel OTA to look at the alternatives. He told me that Harkin was not pleased with NCI, and that he was looking for a way out of the deadlock.

I wrote a strong letter to Senator Harkin and copied the full House and Senate *(see box this page)*.

Harkin boiling

Wiewel contacted me to tell me that Senator Harkin was holding hearings with NCI, and that he wanted People Against Cancer to develop questions for NCI Chief Samuel Broder. We did. ...arkin was not satisfied with the answers.

Shortly thereafter, Berkley Bedell got in touch with Harkin to urge him to do something to help the legitimate alternatives. He had, himself, suffered prostate cancer which, he felt, was arrested by the treatments of Canadian homeopath and microscopist Gaston Naessens.

Harkin had reached the boiling point, and he was fed up with NCI. He wrote in the appropriations bill, signed into law November 22, 1991, by President Bush:

"The Committee is not satisfied that the conventional medical community as symbolized by NIH has fully explored the potential that exists in unconventional medical practices. Many routine and effective medical procedures now considered commonplace were once considered unconventional and counter indicated. Cancer radiation therapy is such a procedure that is now commonplace but once was considered to be quackery. In order to

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Dear Senator Harkin: March 4, 1991

CONGRESS RECOMMENDED the National Cancer Institute (NCI) go out to look at **"Unconventional Cancer Treatments"** (see **OTA-H-405**).

NCI WON'T GO. I know. I have ***twice invited*** NCI to send an observer. NCI has ***twice refused*** (**1983** Schepartz, **1991** Hawkins).

FOREIGN DOCTORS VISIT our Mexican hospital and write about it. **England** (*Lancet* Sept.15, 1990 "Juices, coffee enemas, & cancer"). **Austria** (*Aktuelle Ernährungs-Medizin*, April 1990 "Results of diet therapy in surgical oncology"). Other countries like **Germany, Japan, the Netherlands...**

BUT NOT NCI. Why? Too busy? Not enough people suffering? **CANCER KILLS AN AMERICAN A MINUTE.** More than **1,400 deaths a day.**

The **"WAR ON CANCER"** turns 20 this year. **20 YEARS OF BIG SPENDING.** Pie in the sky promises. Rising incidence. Soaring mortality. **THE BODY COUNT NEARS 10 MILLION.** On our side.

Today, a leading German cancer statistician says that NCI's best-**CHEMOTHERAPY DOES NOT EXTEND SURVIVAL.** The same **TOP EXPERT SAYS CHEMOTHERAPY DOES NOT IMPROVE QUALITY OF LIFE.** This expert says **NO OBJECTIVE EVIDENCE** supports NCI's claims. Not in cancers most folks get. [***Chemotherapy of Advanced Epithelial Cancers***, Abel (German Federal Cancer Research Center). Published by Hippokrates Verlag, Stuttgart, 1990. 92 pgs. Available through **PEOPLE AGAINST CANCER** (515) 972-4444. **GET IT AND READ IT.**]

CANCER HURTS BAD. REAL BAD. Maybe numb NCI bureaucrats can sleep with these death rates. This knowledge of suffering. But **THOUSANDS OF ORGANIZED,** networking, frightened and angry **AMERICANS DON'T WANT TO DIE LIKE THAT.** They hate the status quo. They want you to **DO SOMETHING!**

Honorable Senator, **NCI IS YOUR AGENCY.** It doesn't want to get off its butt. **YOU MUST KICK NCI OUT THE DOOR.** *Make it go look.* At every independent, innovative cancer management. The more unusual, the more different from current treatments the better. **SAY ONLY ONE TREATMENT IS FOUND TO REDUCE HUMAN SUFFERING A BIT. GOD KNOWS, THAT ALONE WILL JUSTIFY YOUR SEARCH.**

Sincerely,
Gar Hildenbrand

Executive Director
Advisor to OTA-H-405

cc: the Senate
the House of Representatives

more adequately explore these unconventional medical practices the Committee requests that NIH establish within the Office of the Director an office to fully investigate and validate these practices. The Committee further directs that the NIH convene and establish an advisory panel to screen and select the procedures for investigation and to recommend a research program to fully test the most promising unconventional medical practices. The Committee has added $2,000,000 for this purpose and asks for a report by the end of January 1992 on progress made to establish this office."

No game plan

On May 12th, I got the call from Steve Groft, acting director of the new office, who formally invited me to join the Advisory Panel and to plan on a two day public forum at the NIH campus in about a month, on the 17th and 18th of June. Dr. Groft is a fascinating man, a doctorate holding pharmacologist who has been executive director of an FDA Commission on Orphan Drugs, an "inside outsider".

There was no game plan for getting the word out about the forum.

I stayed in touch with Groft over the next two weeks regarding details of the meeting and travel arrangements. On May 26th, we had a frank conversation about the fact that he had no secretarial help as yet, and that there was no game plan for getting the word out about the forum, with the exception of an announcement to be printed in the *Federal Register*.

Networking the invitation

In fact, the language of the announcement had gone up to the desk of NIH Director Bernadine Healy just that day. She would sign it that day, and it would be printed shortly. I asked Groft if he would like help networking the invitation. He said yes. The next day, the 27th, he faxed me the invitation with Dr. Healy's signature. I quickly created a one page summary of the news of the office and the invitation. I fashioned a joint Gerson Institute, People Against Cancer announcement and got Frank Wiewel's signature. Then I handed it to Christeene.

Christeene fed the network and I answered phone calls for the next five days. By the 15th of June, as I called Groft from the Capitol Hill Hotel in Washington, DC, he reported that there were more than seventy speakers coming into Bethesda. He remarked that he was going to make me listen to all of them. I laughed.

Christeene fed the network and I answered phone calls for the next five days. By the 15th of June, as I called Groft from the Capitol Hill Hotel in Washington, DC, he reported that there were more than seventy speakers coming into Bethesda.

Marathon

I wasn't prepared for the marathon. Over two extraordinary days, more than twenty hours of testimony was rendered by approximately ninety Americans who had come on their own nickel, representing practitioners, treatments, consumer groups, and themselves as researchers or healers. Scientists who were part of the system, including NIH staff, spoke of the failure of peer review and the elimination of alternative expertise.

Dr. Dan E. Rogers of CHIPSA delivered an understated assessment of the results of salt and water/nutritional management of cancer patients and issued an invitation to NIH to send an observer. He noted that similar invitations had been declined by the National Cancer Institute in 1983 and again in 1991.

Overhaul peer review

Carlton F. Hazlewood of Bay' University, a professor of medicin and an adjunct professor of physics, cautioned, "I have used the system, and I have been abused by the system." He said the NIH peer review process must be overhauled, quoting Fleck, "Once a structurally complete and closed system of opinions consisting of many details and relations has been formed, it offers enduring resistance to anything that contradicts it." He told us, "It is believed by many that it should be formally recognized that sound scientific inquiries and medical therapeutics out of the mainstream of thinking will most likely meet with resistance. Therefore, formal mechanisms should be developed to provide fair and equitable evaluation of these new "out of the mainstream" proposals. If such mechanisms were carefully and thoughtfully put into place, it would soon promote an environment supportive of innovation, shorten the time between discovery and the delivery of technology to th public, and promote more efficient use of public funds."

I have used the system, and I have been abused by the system.
— Carlton F. Hazlewood

Can peer review be rebuilt? Probably so. The Berlin wall fell.

Just the beginning

Some are concerned that the $2 million budget of the office is far too small for meaningful change to take place, but take heart. Key members of Congress ardently support this project. Multiple, sequentially increasing budgets and many years of hard work have been foreseen and planned by those key members, and the upcoming change of administration will not derail the train. We are reminded that a similar budget was allotted to womens' health studies only several years ago, and the current budget exceeds $200 million.

What a wonderful and terrifying time to be alive, let alone to be involved in a at social revolution in medicine. Dan Glick, writing on the new NIH office for *Newsweek*, July 13, 1992 ("New Age Meets Hippocrates" pg. 58) offered this bottom line, "the search may unearth a truly radical cure — keeping people healthier and lowering the bill at the same time."

The excitement is felt by everyone involved with the new office, and those who come into contact with it.

Looking ahead

NIH advisor Frank Wiewel, director of People Against Cancer, summarized the meeting, "The panel heard testimony as to the benefits of scores of alternative treatments which have been overlooked by the medical establishment. Many of these treatments hold great promise as safe, effective and economical alternatives to conventional medicine."

Many of these treatments hold great promise as safe, effective and economical alternatives to conventional medicine. — Wiewel

My own impressions of the first session at NIH, outside of a feeling of awe that it was happening at all, are as follows: The panel, participants and onlookers were introduced to a tremendous number and type of medical alternatives which are not currently part of the financial reimbursement patterns of government and industry. Any of these, if established as meaningful and accessible treatments covered by health cost reimbursement strategies, could conceivably contribute to better health for individuals and lowered overall costs for the Nation.

We, the Advisory Panel, did not choose treatments for evaluation during the first round. The Senate Appropriations Committee specifically said that job is to be done by the Advisory Panel. I guess we will have to do it one of these days real soon, to avoid angering Senator Harkin, and to prove that we can do something simple in a straightforward and uncomplicated way.

As soon as we have identified a few treatments for the first round of evaluations, we have to decide how they are to be evaluated. The Committee said we have to come up with the methodology. That's a pretty tall order.

I say that, not because it is inherently difficult to look for and measure effectiveness, but because nearly the whole scientific medical community is hung up on an excessively expensive and time consuming, hairsplitting type of evaluation called the Randomized Clinical Trial (RCT). Even though RCTs are not going to be necessary for the first several hundred rounds of investigation, we have already seen a number of advisors pay verbal homage to them. RCTs have wasted the Advisory Panel's time already, and we're not even involved in doing one.

Shoulder to the boulder

We'll meet again in September. We who are dedicated to moving this project quickly toward fulfillment of the goals set forth by the brilliant Senator Harkin will no doubt have to keep a shoulder to the boulder. It is certainly not an Instant Pudding (just add water and stir). But, I too believe that we must look to the alternatives if we are to find viable solutions to our towering National problems of disease, disability, and runaway costs. And, I believe that we, and therefore our Nation, will discover quite a few before we're through. ■

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A taste of history

Wednesday, June 17, 1992,
Building C,
National Institutes of Health, Bethesda, Maryland

Steve Groft: I'd like to introduce myself, I'm Steve Groft. I'm the coordinator and the acting director of the Office of Unconventional Medical Practices here at the NIH. I'd like to say that we've been somewhat overwhelmed at the response to the Federal Register announcement and, probably more importantly, the "network" of getting the information out to the public.

I'm very, very impressed and I thank you all for attending this session. I think many of you have come from quite a distance and at considerable expense to join us. We think that we will be preparing a strategic plan to think about for unconventional medical practices, or at least a plan to begin to evaluate alternative medical practices or unconventional medical practices.

We've got a very, very busy schedule the next two days, including approximately seventy-two individuals who have elected, have requested time, to make a presentation on issues that we identified in the Federal Register. So, please bear with us. It's going to be a very grueling two days. I know that several of you have sat through public forums and public hearings, and you know what it's like as you get through. We're going to have a number of breaks to sort of keep us fresh. If we appear bleary eyed, we'll be back.

So, thank you very much, and I'd like to thank the panel members, particularly, for being willing to come back here and join us for what we hope is going to be a very, very productive two days, and a continuation of this activity into the Fall, and for a long time into the future. So thank you very much.

I'd like to...let me first go around the table and have the individuals at the table introduce themselves, and then I will ask Dr. Jay Moskowitz, the assistant director for Science Policy and Legislation here at NIH, to give us a welcome to the NIH. Michael, would you start?

I'd like to say that we've been somewhat overwhelmed at the response.
— Groft

Michael Balick: Sure, I'm Michael Balick of the New York Botanical Gardens.

Jennifer Jacobs: I'm Jennifer Jacobs from the University of Washington.

Brian Berman: I'm Brian Berman from the University of Maryland.

Carola Burroughs: Carola Burroughs, Brooklyn AIDS Task Force.

Berkley Bedell: I'm Berkley Bedell, former member of Congress.

Dean Ornish: I'm Dean Ornish of the Preventive Medicine Research Institute of the University of California, San Francisco.

Karen Olness: Karen Olness, Case Western Reserve University.

Frank Wiewel: I'm Frank Wiewel, founder and director of People Against Cancer.

Deepak Chopra: I'm Deepak Chopra, founding president of the American Association of Ayurvedic Medicine.

David Larson: I'm Dave Larson. I'm in the office of the Secretary of HHS (Health and Human Services) and the Assistant Secretary of Planning at NIH.

Peter Rheinstein: Peter Rheinstein, director of the medicine staff of the Office of Health Affairs, the Food and Drug Administration.

Lana Skirboll: Lana Skirboll, associate administrator for science of the Alcohol, Drug Abuse and Mental Health Administration.

Gar Hildenbrand: Gar Hildenbrand, executive director of the Gerson Institute, California.

Joseph Helms: Joseph Helms, president of the American Academy of Medical Acupuncture, and director of physician education in acupuncture at the University of California, Los Angeles.

David Eisenberg: I'm David Eisenberg, Harvard Medical School.

In order to give you a tiny taste of the events in Bethesda, we give you here the introductory comments of acting director Steve Groft, and Office of Science Policy and Legislation associate director Jay Moskowitz. A full transcript of the two day forum is being prepared by NIH.

Leanna Standish: My name is Leanna Standish. I'm the research director at Bastyr College.

Barrie Cassileth: Barrie Cassileth, Chapel Hill, North Carolina.

(Also named as advisors, but not present, were Michael Lerner, Laura Nader, Beverly Rubik, Bernie Siegle, and Jeremy Waletzky.)

Steve Groft: Thank you very much. Jay?

Jay Moskowitz: Right at the top of my formal remarks, I want to publicly thank Steve Groft for all that he has done in putting together this meeting and, in fact, working since the legislation came from the Congress to develop what he described as a long range program for NIH. Steve has been in my office for a number of years and has been a very committed individual to everything he does, and I think that he is very committed to this new and very important task for NIH. At the same time, there have been a number of people that have been working with Steve and, not to leave out anyone, I do want to mention four who have spent a lot of time in advising us from within the NIH, Ms. Anita Pikus, Dr. Philip Chen, Andy Parfitt and Margaret Easter. These people have really been very important to us at NIH in the development of this program.

On behalf of Dr. Bernadine Healy, the Director of NIH, I am also pleased to welcome you today, and I personally appreciate your willingness, as does everyone here at NIH, to lend your expertise and your experience as we launch what I consider a very important and exciting initiative. Through it, we will provide opportunities for an expanded research effort that will add to the armamentarium of vital new therapies and treatments that will ultimately improve the health and the quality of life of every man, woman and child in this country. I want to emphasize that this meeting is just the first step in a partnership which we hope to build with you as members of the research community.

This office will have the responsibility of working with the constituency represented in this room, and some not yet in this room, to set an agenda and to begin, as Steve has mentioned, a strategic planning process that will guide the evaluation of unconventional or alternative medical practices.
— Moskowitz

Through our investigator-initiated research, through our clinical trials, and through our demonstration projects, NIH has always encouraged pursuit of novel ideas and new therapeutic approaches. This expanded venture will permit us to capitalize further on the creativity and innovative thinking of individuals both inside and outside the realm of what is called conventional medicine while adhering to the principles of science and of sound scientific evaluation.

As many of you know, NIH has been working with the biomedical research community to develop its first strategic plan, which will create a sense of a common mission and common goals, and articulate the vital areas of science and science policy which the whole of NIH must address. Our mission, our draft mission is simply stated, and I'll read it for you: "Science in pursuit of fundamental knowledge and its application to extend healthy life and reduce the burdens of illness and disability."

As part of our plan, we've established clear goals which are realistic and sensitive to changing public health needs. The first of these goals, as written in our draft strategic plan, is to foster innovative research strategies designed to advance significantly the Nation's capability to improve health. Clearly, we are gathered here to examine ways to meet this noble goal.

Now, the entire United States Congress, and members who were in the

Congress, with the strong support and leadership of Senator Tom Harkin of Iowa, has historically committed itself to the ideals of the NIH mission. It has, this year, provided us with an impetus in the 1992 appropriations for the support of studies for unconventional medical practices as part of our mission. As a demonstration of our commitment to this effort, we have expanded upon this directive by creating an office for the study of unconventional medical practices within the immediate Office of the Director of NIH.

(Some misunderstandings apparently exist in NIH regarding whose idea it was to form the new office. Here, Dr. Moskowitz has suggested that formation of the new office constitutes an expansion on the Senate Committee's directive to do so. Actually, it is merely an act of compliance. The Committee clearly directed NIH to create the new office with this language, "the Committee requests that NIH establish within the Office of the Director an office to fully investigate and validate these practices." The new office most certainly is not an NIH innovation. It is not clear at this time why Dr. Moskowitz thinks that it is. — ed.)

NIH will offer technical assistance and financial assistance for the rigorous scientific evaluation of claims made about alternative medical practices. Research exploring the mechanisms by which some of these practices work is a major area of potential study.

— Moskowitz

This office will have the responsibility of working with the constituency represented in this room, and some not yet in this room, to set an agenda and to begin, as Steve has mentioned, a strategic planning process that will guide the evaluation of unconventional or alternative medical practices. We have convened this *ad hoc* group, this *ad hoc* advisory panel of distinguished members, to begin the process, and to provide a thorough, thoughtful consideration of all the issues surrounding these practices.

Throughout the history of medicine, many great discoveries were made based on theories that were ridiculed early in their use because they were viewed as radical for conventional thinking of the day.

— Moskowitz

During the last few years, there has been increasing recognition of the use of unconventional medical practices for the diagnosis and treatment of various disease conditions that you will all tell us about during the meeting, and I'm not going to pick out a few. For the purposes of this meeting, we have defined unconventional medical practices — and that is something that we can discuss, if that is the proper word, the proper name for the activities which we are pursuing — as a diagnostic or therapeutic technique that is presently considered "outside" the mainstream of scientific research. *(Heated debate began well before the first meeting regarding the name of the office. Wiewel pointed out that if we are to use the term "unconventional", we may as well call ourselves the Office of Weird Medicine. Here, Moskowitz has acknowledged the controversy. — ed.)* Now, we intend, as an organization, through this structured process, to learn more about these areas.

Often, the scientific database that can be readily analyzed is not readily available, or does not exist, for some of these practices. In 1990, the Office of Technology Assessment, the research office of Congress, published a report, as many of you are aware, called *Unconventional Cancer Treatments.* One of the concerns expressed in that report, and again from the Senate Committee on Appropriations' report accompanying our 1992 appropriations, is the need to test the validity of these alternative practices.

The availability of specific information and data useful to practicing physicians and other health care providers on the safety and the effectiveness of any particular therapy, regimen, and practice will, of course, determine the speed of its transition from alternative or unconventional medicine to conventional medicine. Therefore, consistent with its goals and its role of biomedical research enterprise, NIH will offer technical assistance and financial assistance for the rigorous scientific evaluation of claims made about alternative medical practices. Research exploring the mechanisms by which some of these practices work is a major area of potential study. In addition, scientists may be interested in developing special instrumentation or techniques for measurement to be used to quantify or interpret changes in the systems or functions with which any particular alternative modality interacts. It must be recognized, however, that not all alternative medical practices are amenable to traditional scientific evaluation, and that some of them may require deliberation, and possibly special consideration in establishing methods to measure their efficacy.

One guiding principle in looking at alternative medical practices acknowledges that treatments or diagnostic procedures considered

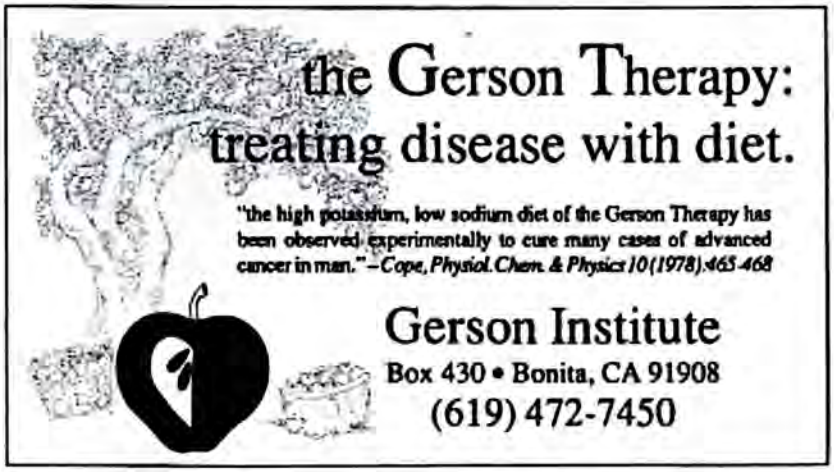
unconventional today may gain acceptance and become conventional in the future. Throughout the history of medicine, many great discoveries were made based on theories that were ridiculed early in their use because they were viewed as radical for conventional thinking of the day, and there are many examples of the emergence of widely accepted therapies from what were previously considered unconventional.

The National Cancer Institute (NCI) has taken a number of steps to better integrate the evaluation of unconventional therapies into existing procedures. NCI has long encouraged investigators to submit novel compounds for evaluation in our screening programs for cancer and, more recently, for AIDS. The staff of NCI's Investigational Drug Branch has been assigned to evaluate data submitted to the NCI by scientists exploring alternative therapies. This approach has already resulted in the initiation of clinical trials for two therapies (Hydrazine Sulfate and Visualization/Psychotherapy) and is likely to result in the NCI filing for an Investigational New Drug (license) for a third (Antineoplastons). Regardless of the source, NCI remains committed to identifying novel approaches to the treatment of cancer, and is eager to guide investigators in obtaining and preparing interpretable data, and to review promising results. I hope that this initiative will increase the ongoing commitment by many of the other Institutes as well as NCI.

For example, another important activity currently being coordinated by the Fogarty International Center, one of our twenty Institutes, is the issuance of a request for applications for the establishment of International Cooperative Biodiversity Groups. The purpose of these groups will be to address issues of biodiversity conservation, and sustained economic growth, but it's also quite relevant to our mission in terms of human health and drug discovery for many diseases, including cancer and infectious diseases. Fogarty's other activities include the sponsoring of a symposium or workshop to discuss the interface between natural products and folk medicine. They are also in the process of development of a ten year plan to fund ethnobotanists to conduct a worldwide screen of possible treatments using natural products.

I only pick these as an example. All the other Institutes have similar programs which Dr. Groft, in the early part of his activities, did collect all the data from these Institutes and can provide that to you.

In ending, I would like to paraphrase from a recent speech by Dr. Healy, who said, historically, great breakthroughs have come from those who eschewed conventions and orthodoxies. American Historians, such as Gerald Holton, have commented that, "America's great contribution to science in the Twentieth Century was the entrepreneur, the enterprising scientist not willing to wait for the consensus." An innovative scientist is a risk taker, a speculator in the commerce of ideas. I believe it is essential that each of you and your colleagues here today, in collaboration with your other partners in the biomedical research community, strive to work together toward NIH's goal: the improvement of health and the extension of the quality and well-being of human life. I thank you very much. ■



Health Quest

Exploring Unconventional Medical Therapies

By Margaret Mason

Special to The Washington Post
Reprinted from *The Washington Post*, week of June 29, 1992

Something wonderful happened — and a quiet grass-roots revolution in health care was officially recognized — last week on the sixth floor of government Building C in Bethesda.

The something wonderful was the atmosphere of respect and affection accorded about 90 spokesmen for "unconventional therapies" invited to present their treatments to an unusually eclectic ad hoc panel convened by the National Institutes of Health.

Few people in the packed hearing room could have missed the momentousness of the occasion; more than one called it "historic", and no one dozed over two days and 20 hours of eloquent, sometimes dazzling, testimony and discussion.

NIH's very invitation to practitioners of so-called alternative (and controversial) medicine was in itself validating, and everyone knew it. Men and women physicians and healers came from all over the country to get their word in on virtually everything under the unconventional treatment sun: Acupuncture, homeopathy, ayurvedic medicine, naturopathy, biofeedback, oxygen therapy, Chinese herbs, flower therapy, hands-on healing, meditation, visualization, intravenous Vitamin C, holistic dentistry, to name a few.

The emphasis, from different directions, was clearly on the need to integrate mind, body and spirit for both healing and prevention. And you could sense a movement among the most avant-garde toward the melding of Eastern and Western medical practices, ancient and new. There were pleas from outside and inside the panel to remember that sometimes what counts can't be counted, and to dare to believe the unbelievable.

"I must admit, I was somewhat overwhelmed by the response", said Steve Groft, 47, the enthusiastic and imperturbable acting director of the newly established NIH Office of Unconventional Medical Practices. He has no secretary, answers his own phone and typically works 10 and 12-hour days. He got a standing ovation after the two-day session.

"Exciting" is a word Groft and others use often in talking about the NIH initiative.

"There is a generosity of spirit manifested here", said James S. Gordon, a psychiatrist and clinical professor involved in mind/body research at Georgetown University School of Medicine. "We must continue to learn from each other."

In the midst of the optimism and good will, however, was an undercurrent of anger and distrust. There were frequent mentions of unnamed individuals practicing controversial and allegedly successful therapies who didn't dare appear for fear of losing their licenses. Indeed, one of the panelists was a representative of the FDA which didn't always get positive reviews for its policing of treatments. In some cases the FDA suddenly has halted purported life-saving, or at least life-enhancing, therapies because they had not been scrutinized scientifically enough.

"One would have to be made of stone not to recognize the importance [of the NIH invitation]," said New York health and science writer Ralph W. Moss, "Yet we have to pinch ourselves — to stop and ask, 'What exactly is going on here?'".

The most simple explanation of what was going on — forgetting for a moment other politics and pressures in the health-care industry — was this:

The Senate Appropriations Commi tee, headed by Sen. Tom Harkin (D-Iowa), had issued this mandate to NIH:

"The Committee is not satisfied that the conventional medical community as symbolized by NIH has fully explored the potential that exists in unconventional medical practices... In order to more adequately explore these unconventional medical practices, the Committee requests that NIH establish within the office of the director an office to fully investigate and validate these practices. The Committee further directs that the NIH convene and establish an advisory panel to screen and select the procedures for investigation and to recommend a research program to fully test the most promising unconventional medical practices...

And how did Sen. Harkin come to be so savvy about the need for a closer look at "unconventional medical practices"? Two fellow Iowans (both now NIH panel members): former Democratic representative Berkley Bedell and Frank Wiewel, executive director of People Against Cancer based in Otho, Iowa. They told him about the growing number

of Americans who are fed up with not only the outrageous cost, but the ity, anti-humanness and sometimes ineffectiveness of the surgery/drug/technology emphasis of mainstream medicine. People are looking for more to maintain and heal body, mind and spirit.

Bedell, 71, something of a star people's advocate on the NIH panel, had surgery and radiation for prostate cancer four years ago. Two years later, "There were indications that the malignancy was coming back", he said in a separate interview.

After a good deal of research and reading on his own, along with tapping into the very active underground cancer network, Bedell underwent an unorthodox treatment in Canada. "I believe", he says, "it has controlled my malignancy".

Bedell told his good friend Harkin "what had happened to me. And I told him it's a shame that more people don't know about what's available out there".

And what's available out there — as demonstrated at NIH last week — is considerable. Also considerable are the tasks confronting the panel. The two major challenges, as Groft sees it, will be to:

1) Integrate the alternative and mainstream communities.

2) Come up with methodologies to expeditiously — and without great cost — evaluate alternative practices.

A multitude of other challenges — from getting insurance to pay for preventive care to circumventing the old-boy networks — were mentioned by the 18 panelists present last week. A brilliantly conceived representation of the bureaucracy and establishment and non-establishment medicine (even including a botanist working with medicine men in the bush of Central and South America), they seemed, with a few exceptions, most concerned about the patient.

The patient who, as Mescalero Apache "traditional medicine man" (and NIH panelist) Anthony P. Ortega put it, is his own healer. "People will tell you where they hurt and why and they will tell you how to cure it if you listen. We must listen to the people because people have their own answers".

And from moderator Steve Groft, after the long line of speakers had finished at about 6:30 p.m. on Thursday:

"The hard part starts now, and it's going to be difficult, very difficult, to convince some parts of the establishment. But we have to: the people are telling us there's more to it. There's more to learn". ■

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Thoughts on visiting patients at CHIPSA

by Charlotte Gerson

Once in a while, nurses or other medical professionals ask me, "It must be so depressing to work with almost exclusively terminal cancer patients. How can you stand it?" This question was answered yesterday.

I had the opportunity to take a doctor along on rounds at CHIPSA, the Gerson Hospital in Mexico. We visited about twenty-two patients. One patient, suffering from an advanced renal cell cancer, displaying a huge tumor on her knee, showed us how much smaller it had become, how it had folds in it, how soft it was, and how the whole leg was taking shape again, losing its tremendous swelling.

Another patient, suffering from pancreatic cancer with liver metastases, told us how her appetite had returned, her color improved, her energy was back, and she was raring to go home.

A third patient, suffering from metastasized breast cancer which had spread into her lungs, reported that prior to arriving at CHIPSA, she needed to have fluid withdrawn from her lungs every five to six days in order to be able to breathe. After four weeks on the Gerson therapy, and only one more 'tapping', her lungs were clearing, her breathing improved, and her energy much better.

And so it went for one after the other — joyous returns toward health, wellbeing, and faith in the future.

At lunchtime, I suggested to the visiting physician that he listen a moment to the general sounds in the dining room: laughter, joking, happy chatter — no suggestion of cancer, despair, pain or death.

So, my answer to the above question is: it is the most exciting thing to be able to do; to see people overcoming their pain, their tumors, their despair, and to send them back to life and living. Instead of depression, I derive joy and new energy from my visits at CHIPSA.

Two exceptional patients

About three months ago, a lady brought her little five-year-old son in a wheelchair. He had been diagnosed at home with neuroblastoma, which had spread to his long bones (arms and legs), and he had a large tumor in his liver. The local physicians didn't even want to treat him with chemotherapy, he was too far advanced toward death. They just gave him liquid morphine to help to alleviate his pain. He was unable to walk, had a swollen belly, was extremely pale, and had large, dark circles under his eyes.

After twenty-four hours on the Gerson therapy, his pain was gone and he did not need any more morphine. In three days, he was able to take some wobbly steps. Another three days, he was walking normally, and then he started to run. He was able to eat, and his weight had gone up from forty-one pounds to forty-six pounds (and that is without fats, meat, animal proteins, desserts, cakes, etc., on only the strict Gerson foods). His dark circles were almost gone, and his pale cheeks were showing some color. He was playing and acting quite normally.

Another case was exceptionally dramatic, a 31-year-old lady who had been diagnosed with melanoma some time ago. About five months before she arrived at CHIPSA, her doctors noted from a scan that about 75% of her liver had become involved and was tumorous. By the time she left home to come to Mexico, her doctors called her family together at the bedside to say goodbye to her, because they would not see her again.

When she arrived at CHIPSA, her abdomen measured 100 cm., a full meter around, swollen with ascites. It was so firmly bloated that she was unable to bend at the hips to sit, nor could she bend to dress herself. After only days on the Gerson cancer therapy, her ascites started to come down; her abdomen now measured 95 cm., then 92 cm. In the meantime, she found she could sit, bend, pull on her clothes, and walk around. By the end of her third week of treatment, she was able to arrange a birthday party for a CHIPSA staff member, and she gave a little concert, singing and *dancing* four traditional Japanese songs.

To our great delight, her blood count came up from 5% lymphocytes, at first to 10%, and now it's 15%. She is improving daily, and is confident and forward looking. Her smile lights up the dining and meeting rooms and cheers everybody. ■