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# Limping, Lethal Medical Systems in the US and Canada, plus a Patient's Perspectives

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## Introduction

I have devoted decades to reading, studying, practicing, and researching wholistic healing (Benor, Ledger, Toussaint, Hett, et al. 2009; Benor, Thornton, Toussaint, 2016) as well as editing articles and books (IJHC, Web ref), and writing books on a broad spectrum of wholistic healing (2009; 2019), and teaching wholistic self-healing in many parts of the world.

Over the years, I have been very disappointed in the conventional medical system, which is acknowledged from research evidence in the US and elsewhere to be the third leading cause of death annually. Only cancer and heart disease cause greater numbers of deaths (Brennan, Troyen A.; Leape, Lucian, et al. 1991; Lazarou & Pomeranz, Corey, 1998; Landrigan, Parry, Bones, Hackbarth, et al. 2010; Null, Dean, Feldman, Rasio, 2005; Starfield, 2000; Thomas JM; Cohen, MR, et al. 2007).

In contrast, complementary and alternative medicine (CAM) therapies are relatively lacking in risks of fatalities. Statistics from New Zealand, comparing deaths from conventional medicine to deaths from complementary/ alternative medicine confirm these findings. An article reviewing and discussing these issues was prepared by Ron Law (2004), former executive director of the New Zealand National Nutritional Foods Association and member of a New Zealand government working group advising on strategies for reducing medical error. The figures from NZ are most telling. The risks of deaths by CAM are so small they cannot be represented on the same chart with those from conventional medicine.

While these statistics have been widely available for decades, relatively little has been done to acknowledge, explore or address them.

I lived much of my life in the US, and from 2006 in Canada, with periods of time in other parts of the world as well. I have been a personal witness to examples of the limitations and flaws in the very different medical systems in each of these countries.

I recently was hospitalized for 5 weeks for severe pneumonia, which followed 4 previous bouts of pneumonia in the preceding year. The infections were caused by an incompetent epiglottis – the flap at the back of the throat that opens and closes access of air to the trachea. It also

prevents breathing in food and fluids when we swallow – which in my case caused the pneumonias. So I also share here some of my personal experiences of medical errors.

I share these observations and suggestions with the hopes that the serious, often fatal flaws in the medical system can be remedied.

*A man's errors are his portals of discovery.*
- James Joyce

**Issues contributing to medical errors**

A broad variety of factors contribute to these medical errors. These range from limitations in financial and human resources to human errors due to a wide variety of issues.

***Financial issues***
In most countries, government allocations to healthcare budgets are not a high priority. On the one hand, people involved in healthcare are unlikely to pursue political careers. On the other hand, the vast majority of politicians represent business and military interests and have relatively little interest in healthcare. Very high proportions of healthcare resources go to administrative costs, rising steadily through the years.

Furthermore, elected politicians cannot be assured they will be re-elected. They need to establish track records of successful achievements during their terms in office. Building healthcare resources requires commitments to long-term investments that exceed the event horizons considered politically advantageous to the vast majority of elected politicians in any single term of office of office. Establishing educational facilities for healthcare personnel, and clinics and hospitals to provide healthcare services are expensive, long-term investments. Politicians prefer to put their energies into investments that show results prior to their next run for re-election. Military and pharmaceutical expenses are very high on the lists of these services.

In the US, the greater number of people rely on private healthcare. People with robust incomes and/or good health insurance can pay for their general healthcare services. But many millions of people with limited means are often left seriously lacking. Even when they have insurance policies, their maximal insurance payments come nowhere near the costs of care for serious illnesses. So on top of all the challenges of dealing with the medical aspects of one's health problems, one may be severely stressed by the overwhelming costs for medical care. And millions of people have no healthcare coverage (L. Thomas, 2017).

> The number of uninsured adults between the ages of 19 and 64 rose to 15.5 percent in March 2018, up from 12.7 percent in 2016. An estimated 4 million people lost individual coverage during that period, while the number of people with employer-sponsored coverage stayed steady.
>
> Adults with lower incomes – about $30,000 for an individual and $61,000 for a family of four – saw a much higher increase: 25.7 percent in March 2018 compared to 20.9 percent in 2016 (Konrad, 2018)

In Canada, with socialized medicine, no one is left without medical care and no one will be devastated by enormous medical costs. That is the good news. The bad news is that there is no financial incentive for prompt services. For surgical referrals from family doctors, wait times can

be in the range of 3-4 weeks. For specialist consultations, wait times can be 40 weeks and longer, depending on the province and the specialty (Fraser, 2017). Growing numbers of Canadians are seeking private healthcare services in the US (Druzin, 2016).

US per capita annual healthcare spending, $10,586, is more than twice the average of other developed countries (Peterson, 2019); Canadian spending is US$4,974.

Total health expenditure in Canada is expected to reach $253.5 billion, or US$ 6,839 per person in 2018. It is anticipated that, overall, health spending will represent 11.3% of Canada's gross domestic product (GDP).

***Pressures of heavy loads of work and limited medical human resources to deal with them***
Though healthcare costs continue to rise steadily, services provided have not improved in line with the greater annual healthcare expenses. In the US, the increases in administrative demands have eaten into the time available to medical personnel for individual patients' visits. In Canada this is less true, but waiting periods for doctors' visits are longer (Fraser, 2017). As mentioned above, patients may wait 40 weeks for appointments with specialists for non-urgent care, such as elective surgeries.

***Limited time allotted to patients' care***
Doctors in the US are often pressured by insurance companies to spend 10 minutes per patient contact, if they are to be paid full rate for their time. On top of that they have 10-20 minutes required for writing prescriptions, record keeping and accounting reports to the insurance companies.

It is no wonder that doctors take notes while speaking to patients, and do not go into great details in taking histories and clarifying the details and extent of the presenting problems. This is a serious setup for missing details that could provide more accurate diagnoses and recommendations for treatments.

For instance, a heart attack (myocardial infarction) presents most often with chest pains. However, it may present with pains in one or both arms, back, neck, jaw or stomach; shortness of breath can occur with or without chest discomfort; or you may break out in a cold sweat, or experience nausea or lightheadedness. In such cases, if you have one of the less common symptoms, the brief period allotted to doctor-patient communications can be a setup for a serious, even fatal, medical error.

At a lesser but still significant degree of danger for medical errors, patients often are put off by not having eye contact with their doctor; being interrupted with questions before they are finished detailing their issues; and not having enough time to fully report all of their problems. They come away feeling they have been railroaded through a processing that does not consider or understand, much less meet their full healthcare needs. This often creates the impression that the patient is just a cog in the healthcare machine rather than a human being.

***Record keeping and reporting***
Record keeping and reporting to the medical employer, insurance companies and tax authorities requires additional administrators to manage the paperwork. This uses up funds that could otherwise be allocated for direct patient care by the doctor.

***Problems of communications between caregivers***
Good medical care requires frequent, detailed, accurate communications between staff involved

with any given patient. Invariably, errors will occur occasionally in this process, because that is the nature of communications.

For example, errors in speaking and hearing clearly and accurately are inherent in spoken language under any circumstances. Who among us has not spoken unclearly, mispronounced words, erred in using the wrong words, or fumbled with language in some other way? A simple game illustrates this. Popular in my childhood, it was called 'whisper down the lane'.

> A half dozen children stand in a line. The first in line whispers a simple sentence to the next child in line, such as "I had porridge, orange juice, toast and milk for breakfast every day this week." This child whispers the message to the third child, at her other side, and so on down the line. Most usually, small errors occur in communication with many, if not all, the repetitions of the message. So the second child may pass on the message as "I had potatoes, orange juice and milk for breakfast this week." And the third as "I had potatoes and orange juice for breakfast today." The fourth, responding to the tone of the message, may pass on "I'm tired of having the same things for breakfast every day." And so on down the chain of communications.

Errors in pronunciation, mis-hearing, mis-remembering and responding to nuances of emotions included in the message quickly accumulate with this process, not just among children. This general problem will occur at times in medical communications as well. Occasional misreadings and misunderstandings of questions, explanations, instructions and orders are impossible to avoid.

Similarly, a frequent problem is the assumption that the person you are speaking with understands what you are talking about.

> I recently had a PET scan to clarify the possibility of a newly identified lesion (by X-ray and needle biopsy) of the Adenoid Cystic Carcinoma (ACC) in my neck. As I left the medical imaging center, the technician handed me a CD, saying, "Here is your copy of the scan". I assumed this was for my personal records. She added, "In a few days we'll have a written report and evaluation from the radiologist." Checking with the office of the referring ENT specialist, I was surprised to discover that the CD handed to me was meant to be brought by me to the ENT specialist. The technician knew about this and assumed that I did too, but I had never been informed of this.

In addition, under pressures of time constraints, in situations of heavy caseloads, with multiple, urgent patients' needs and demands, there must invariably be increases in the likelihood of mispronouncing or mishearing details urgency in clarifying situations where assessments and interventions are required, and assuring that proper treatments are prescribed and delivered.

***Arrogant ignorance***

Ignorance is grossly rampant in medical care, despite the prevalent doctors' arrogant beliefs and attitudes that they are at the pinnacle of medical knowledge, methodologies and skills for assessments, diagnosis, and currently accepted interventions.

True, it cannot be denied that doctors graduate from their training programs with vast knowledge and skills in deciding upon diagnoses and direct interventions, including giving medications, surgery and other caregiver duties. The most challenging part of this is that doctors and nurses are almost always ignorant about their ignorance in aspects of these

matters, while being dismissive of other practitioners' comments, assessments, experience, research and recommendations.

Despite medical practitioners' enormous healing knowledge and skills, there is an over-confidence in the accuracy and efficacy of assessments and accurate prescriptions for treatments and cures. This incudes

- A gross over-focus on medical and surgical interventions, and ignoring of other aspects of the human condition that contribute to illness, including issues of emotions, mind, relationships and spirit
- A grossly limited scope of knowledge of the human condition, particularly regarding non-physical contributors to most conditions
- Frequent disparaging and dismissive attitudes about the observations of other medical staff's inputs about clinical situations

> Some of the saddest, most extreme examples of these sorts of ignorance are from wrong limb amputations. At times, operating room personnel were aware this was happening but made no comment to the surgeon, out of habits and fears of never questioning or contradicting that surgeon (Joint Commission, Web ref.; Lowenthal, Abrams, Web ref.).

Nurses often are miles ahead of the doctors in listening to patients. In part this is because nurses' duties include more contact with patients, with direct administration of treatments and assessments plus charting of treatment results. This also used to be due to greater lengths of time nurses spent with patients. Sadly, this advantage has been eroded for similar reasons of requiring more detailed record keeping and requiring that nurses attend to larger numbers of patients per unit time, under pressures similar to those experienced by doctors.

***Reluctance and refusal to share or challenge opinions and knowledge suggesting that current, prevalent opinions on cancer remissions may in some cases be inadequate or wrong***

Doctors will not publicly express views, opinions, and knowledge from their direct observations or patient reports that contradict current, generally accepted medical opinions.

Reviewing and analyzing cancer remission reports 1900-1987, Challis and Stam (1990) report that "no physician was willing to risk his/her reputation by reporting a case of spontaneous regression s/he felt was due to a psychological method..." No other non-conventional mechanisms to cause these remissions are considered.

Let me digress here to consider some of the reasons for this (from Benor, 2004). Tilden Everson and Warren Cole reviewed the medical literature on cancer from 1800, and identified 176 cases of spontaneous remission. They suggest that modern isolated "cures" of cancer via unorthodox therapeutic measures might actually be spontaneous regressions of cancer. That is, the natural progression of the disease in some instances might include remissions that could be unrelated to therapeutic interventions. They propose that the following factors might contribute to such remissions: endocrine influences; fever and infection; allergic or immune reactions; disruption of the nutrition of the cancer; removal of the carcinogenic agent; unusual sensitivity to therapy that is normally inadequate; complete surgical removal of the cancer (where it had been presumed that the removal was incomplete); and incorrect histologic (microscopic pathology) diagnosis of malignancy.

Although estimates of the frequency of spontaneous regression of serious illnesses are greatly speculative, all sources agree that it is extremely rare, possibly in the range of one case per 80,000 to 100,000.

Brendan O'Regan and Caryl Hirshberg, with the advantage of computer-assisted library searches, undertook the Herculean task of reviewing 3,500 case reports of *spontaneous remission,* many from more recent years. About three-quarters of these remissions were from various types of cancers. They point out that spontaneous remissions may occur without allopathic treatment; may be associated with treatments by allopathic or complementary therapies; or may be associated with spiritual cures – sometimes labeled as *miracle cures*. They most often occur gradually, over days or months, but may also occur rapidly, within minutes or hours.

> *You see things; and you say "Why?" But I dream things that never were; and I say "Why not?"*
>
> – George Bernard Shaw (1921*)*

According to O'Regan and Hirshberg, spontaneous remission has been largely overlooked by medical science for several reasons:

1. remissions are usually identified after the fact, which makes the processes involved in these unusual cures difficult to study;
2. quality of reports varies in so many respects that it is difficult to assess their frequency or accuracy;
3. doctors suspect that there must have been errors in the initial diagnosis;
4. clinicians are reluctant to report such remissions – wary of skepticism, and afraid of being criticized for poor initial diagnosis or other similar errors;
5. clinicians treating physical conditions often omit details of patients' personal histories, and clinicians addressing psychological aspects of illness rarely include documentation about the physical conditions; and
6. skeptics suspect that all such remissions will be temporary.

O'Regan and Hirshberg's survey is a monumental work. However, it focuses heavily on remissions of physical illnesses, with minimal consideration of psychological aspects of remission. The next reference amply redresses this deficit.

Caryl Hirshberg and Marc Ian Barasch reviewed *remarkable recoveries* from a broad spectrum of illnesses. Great attention was given to people's descriptions of their beliefs about illness, how they received their treatments – both conventional and complementary – and how they understood their transformations. I have selected a few examples from among their many helpful observations. The study contains numerous other discussions and fascinating individual accounts of personal health challenges that were met with courage, and were dealt with through a spectrum of wholistic healing approaches.

Hirshberg and Barasch noted that certain characteristics appeared frequently among the large number of people they interviewed:

1. They had a strong sense of their *selfhood*.
2. They demonstrated qualities of *congruence*, being true to themselves in the emotional, cognitive, and behavioral aspects of their lives.
3. They did not cluster in particular personality styles. "[I]t may be more a matter of finding an individual 'right path' than having the 'right stuff.'" (p.152)
4. They were *determined to improve*, and *assertive* in exploring therapeutic alternatives and implementing them.

5. They refused to accept dire prognoses from doctors, sometimes even deciding to fight their illnesses to spite their doctors' predictions. Such *constructive denial* might even include refusal to equate a serious diagnosis, like cancer, with death.
6. They developed reasons to live and to enjoy life.
7. They had spiritual experiences, often associated with profound personality changes, as a result of their illnesses.

So we can see there are many reasons people may experience self-healing

***Beliefs of medical staff (based on inadequate information) that they, as experts, know and understand best the patients' issues and needs, and what to do for them***
While medical staff have specialized knowledge and expertise for dealing with health issues, there are times when their general knowledge may not be adequate, relevant or applicable in a particular person or situation.

I personally encountered an unfortunate and unhappy example of this issue. I had a stomach tube, to avoid pneumonias from aspiration of swallowed fluids and foods. This was caused by an incompetent epiglottis (mentioned above). I was therefore on permanent stomach tube feedings. The nutritionist prescribed four cans of tube feeding daily, a standard amount for a person of my weight. On this diet, I lost 4.5 pounds in my first week of hospitalization. My wife and I told the nutritionist that I always ate more than other people and that the hospital diet prescribed was inadequate for my needs. Our requests for increased feeding were repeatedly denied, on the basis that this might lead to vomiting and aspiration. I continued to lose weight at that rate of feeding over the 5 weeks of my hospitalization, dropping from 137 lbs. on admission to 118 lbs. on discharge. No amount of discussion or argument on my part made any difference, and the doctors deferred to the nutritionist, assuming my weight loss was due to my pneumonia.

This was extra uncomfortable because I ended up losing my fat pads in my body, making it painful to lie in bed or sit in any one position for more than a brief period. I also had to struggle to avoid bedsores.

At home It took me 8 weeks of 7-8 cans of tube feeding daily to restore my lost weight. Needless to say, this was a very weakening, frustrating and tedious experience!

The dismissiveness of the medical profession regarding healthcare options outside the standard, narrowly focused care provided by conventional medical care is appalling. Let's consider a few particular areas where this is glaringly evident.

***Ignorance of the medical profession about complementary/ alternative medicine (CAM)***
Much more pervasive and limiting is the ignorance in the medical profession about availability and benefits of CAM. There is a wealth of information, including substantial scientific research, available in journals and on line, confirming non-medical approaches that are highly effective for a very broad spectrum of health problems. See lists of these at the end of this article.

Why this willful ignorance? First and foremost are the deficits in these areas in medical school training. I believe these are due in part to habitual tunnel vision, but in even greater extent to the reliance on medications as the primary tool for medical interventions. Not having been trained in medical school to know about CAM therapies, much less nutrition, doctors simply dismiss these as irrelevant. As an example, I had a 1 hour lecture on nutrition in my 4 years of medical

training. I've spoken with younger doctors recently and can report that the situation is little improved, unless you want to compliment them that they now have a 400% increase in lecture time on nutrition, with an anemic 4 hours in their entire training total about this vitally important factor.

And it is not just an issue of over-focus on using medications as the primary medical intervention. As mentioned from the start of this discussion, money speaks. That is the bottom line. The profits of the pharmaceutical companies are exorbitant. They invest heavily in advertising to promote their products. The US has more than 45% of the of the worldwide pharmaceutical market, earning 446 billion dollars in 2016, with 6 of the leading global 10 pharma companies located in the US. (NIH, Web ref.).

**In summary: Factors contributing to medical errors**

A variety of errors are inevitable in speaking and hearing what is said. But beyond these, there are rampant, willful, dismissive ignorance among medical doctors that is contemptible. One of the saddest aspects of this is that this places patients at significant risk because of the lethality of the medical errors. As noted above, the minute numbers of fatalities attributed to CAM cannot be compared on the scale of lethal effects found in conventional medical care.

**My personal experience with medical errors**

I'm an MD and psychiatrist. I trained in the US in the days when psychiatry was mostly about psychotherapy and very minimally about drug therapies. I refused to shift with the tide of pharmaceutical focus into practicing the almost exclusive prescription of medications. Over the years, I have actually found it increasingly difficult to communicate with my psychiatric colleagues – many of whom have no training and little understanding of psychodynamics and psychotherapy. In many psychiatric training programs, psychotherapy is an elective, and it is common for half the psychiatric students to give this a pass. They treat bodies, not people.

My practice is largely focused on teaching people self-healing methods for dealing with their problems. Almost without exception, they find it easy to relieve and eliminate many of their own problems when they use these methods, by focusing on every aspect of their being: body, emotions, mind, relationships and their personal spiritual awarenesses. In many cases they find their problems clear completely without medical interventions.

> 'Sue' (assumed name), a middle level executive, came to me because she suffered from chronic stomach pains that were not responding to any of the medications her doctor prescribed. Even worse, she was suffering varieties of side effects from the medications. When I saw her, her pains were at a level of 7 out of 10 (the worst they could be).
>
> I asked her whether it might be possible that her body was wanting to alert her to know something about her life. She paused for a thoughtful moment, and responded (in her words) that she was swallowing down resentments over being passed over for promotion, despite many years of dedicated and increasingly skilled work in her position. To her great surprise, when we checked on how strong her pains were, they had gone down by half.
>
> Asking next what her pains might suggest she should do differently in her life, Sue thoughtfully responded, in some detail, about her chronic feelings of being unappreciated and undervalued by her boss. And this resonated as well with her feelings in childhood of being undervalued compared to her younger brother, who was favored by her parents as the

son and future heir to the family name and business. Again, Sue was surprised to find her pains going down to a 2.

I invited Sue to ask what she could promise herself to do – in response to what she had heard from her pains. After a modest period of reflection, she said she might think of looking elsewhere for a more challenging job. This time, her pain increased to 3. I asked her whether she was committing to looking for a new job, or just saying that tentatively – because her pain didn't seem to believe her. She paused, thoughtfully, and said in a much firmer voice that she was really going to do that. To her great surprise, her pain went down to a 0.5. I suggested she might thank her pain for helping her in so many ways! She smiled, and did so. And she added that she was thanking her pain for lingering just enough to remind her of her resolution to do better for herself.

Sue contacted me several weeks later to share her good news that on the day she found a new job her pain completely cleared!

I can't emphasize this enough. While the conventional medical, psychiatric and psychological therapy communities almost always take pain to be a sign of something seriously wrong with the physical body, this is actually only true some of the time. Sue's response is very typical of people's experiences when they seek out the underlying meanings and messages associated with their pains. And once they have listened to what their inner selves are alerting them to through their symptoms, the symptoms most often disappear.

Pain serves many functions.

- Warning of tiredness and over-use in muscle and joints
- Alerting us to attend to physical strains and injuries
- Indicating presence of infections or other causes of tissue swelling and malfunctions
- Responding to toxins or allergies in foods or in the environment.

While these are the causes of pains most commonly acknowledged in conventional medicine, they are not the sole contributors to causing pains. They are also not the most common causes for worsening of chronic pains. Stresses due to emotional, mental, relational, and spiritual issues are the most frequent causes pains.

- Anxieties are probably the most frequent causes for headaches, backaches, stomachaches and pains in any other muscles and joints
- Any other emotion may do the same, such as worries, disappointments, regrets, guilts, angers and other negative feelings may lead us to tense our muscles and joints till they express in our physical self the issues that we are not addressing and that are leading us to build up tensions in our body to the point that we feel pain.
- Unconscious issues with tensions in our relationships that are outside our everyday awareness often call our attention to these interpersonal issues through pains. (These are commonly acknowledged in our language as issues that are "a pain in the ___" and which can clearly manifest as actual pains in those parts of our body.)

And again, for the record, I emphasize that these assertions are based on clinical evidence that is easily validated in the personal experiences of those suffering from pains. My observations on non-physical causes for pains and other symptoms are not based on my professional preferences for engaging people on every level of their being – due to my training in a broad spectrum of complementary and alternative approaches to care, on top of specializing in psychology and psychiatry. They are based on people's abilities to rapidly and permanently

clear their symptoms when underlying wholistic contributors to the pains are identified and addressed.

Three simple questions almost always cut right to the chase regarding the causes for pains:

Q1. What does your pain want you to know about your life?

Q2. What does your pain want you to do differently in your life?

Q3. What do you promise faithfully you will do in response to what your pain has just told you?

These questions elicit transformative responses. Pains are immediately reduced significantly. I invite you to check these out with yourself and others.

**Some of my personal experiences with pains**

***My own discomforts and pains***

Let me share the context in which I learned about pains. My own journey through life was challenging in several ways. My mother was my sole caregiver in the earliest years of my life. She came to New York City in 1940 for training in Occupational Therapy and Rehabilitation. The way she told it, I was the reason she was seasick on the boat from Palestine to New York. We were forced to remain in New York till the end of World War II.

We moved to Palestine in 1945, at the end of WW II. There I had a four-year taste of very different cultures. I met my father for the first time at that time. My mother had a very strong personality and he was very passive. Though he was quite intelligent, with great integrity, he was not very insightful psychologically.

Without knowing it at the time, I absorbed a lot about living in a culture very different from that of my early upbringing America. This included an appreciation of Arab as well as of Jewish ways of negotiating one's way through life – since my father had been born in Cairo and worked as an administrator for Arab education. This taught me that there isn't one, single way of living that is THE right and best one – as many people who have not been exposed in their early years to multi-cultural life experiences tend to believe.

I lived four years in Palestine, which became Israel after a scary war. My most vivid memories are of our retreating to the cellar for safety from the frequent shellings and bombings, day and night. Occasionally the ground shook with explosions nearby. Food was rationed and sometimes scarce, and my mother actually lost weight during her pregnancy with my younger brother. A fond, family memory was of an Occupational Therapy student of my mother who lived on a Moshav (a collective farm) bringing us a chicken from a barn that had been shelled. Not only were we delighted by the meat, but we discovered it brought with it several eggs in various stages of maturation. We hadn't seen eggs in many months!

I returned with my mother and brother to live in New York, and only learned a year later that my parents had been divorced at that time. And the cultural differences from the perspective of an eight year-old were quite different from those of my peers. To some extent, this was due to my innate emotional awareness, with an early maturity developed by having lived in a war zone, where life and death were immediate and real.

- I could not participate in my friends' games of cowboys and Indians, because for me this was not something taken lightly – a make-believe experience, as it was for them. "Bang, you're dead!" brought back memories of family friends who had lost their lives in the war of Palestine being divided into Israel and Jordan.
- And I was horrified by the amount of food that was thrown away at the end of the school lunches.
- Nor could I bring myself to participate in an egg-throwing and catching contest at a school fair in the park.

In high school I was fascinated to read about psychosomatic problems, and early on came to feel that psychology was going to be my major focus in university. I never regretted that decision. After completing my BA in psychology, I decided to pursue studies in medicine and psychiatry. In the 1960's, psychiatry was primarily focused on psychotherapy, and I went through medical school and then psychiatric training in pursuit of the broadest and deepest understandings I felt I could achieve academically in these areas.

I was fortunate to enjoy pretty good health for the first 70 years of my life. I weathered bilateral inguinal hernia repairs and corneal transplants due to cataracts without problems. The last 8 years, however, I've been challenged with

- Vocal cord paralysis on the left since 2013, and on the right since 2018, severely limiting my ability to speak above a whisper
- 5 bouts of pneumonia 2018-9, with the last requiring a 5 week hospitalization, caused by malfunction of my epiglottis (the flap at the top of my larynx) that fails to protect me from food and drink dribbling into my lungs
- A lump in my neck on the left side of my larynx, identified in May, 2019 by needle biopsy as an Adenoid Cystic Carcinoma (ACC), which is generally a very slow growing cancer that often grows along the nerves
- The last two are requiring surgical removal of my larynx and creation of a stoma (hole) in my throat in August of this year
- Benign prostatic hypertrophy requiring an indwelling catheter, awaiting surgery till after my surgery for the ACC that will require removal of my larynx and creation of the stoma
- A recurrent hernia

***My professional experiences with discomforts and pains***

For several years I was very pleased with my course of study and my psychiatric practice. But I was soon very disappointed when the new range of psychoactive medications became the treatments of choice of most of my psychiatry colleagues.

I persisted in pursuing psychotherapy as my primary intervention in helping people. Life circumstances continued to bring me varied experiences in different social, medical and academic cultures, including:

- 1963-4 National Institutes of Mental Health Research Fellowship at the Neuropsychiatric Institute, University of California, Los Angeles
- 1968-70 US Air Force Medical Corps during the Viet Nam War, in Wichita Falls, Texas
- 1973-1979 Private practice Ashkelon and Jerusalem, Israel
- 1979-1987 in Philadelphia
- 1987-1997 in England
- 1998-2006 in New Jersey, where my interests in CAM therapies blossomed
- 2006-present in Guelph, ON, Canada

Doctor-patient relationships were fairly similar in various locations in the US, but varied somewhat between countries, mainly in the degrees to which doctors listened to patients rather than just dictating their recommendations.

It was in 1998 that I began to develop my current approaches of integrating body-mind therapies with psychotherapy. I call my approach WHEE: Wholistic Hybrid derived from EMDR (Eye Movement Desensitization and Reprocessing) and EFT (Emotional Freedom Techniques); AKA TWR: (Transformative Wholistic Reintegration) – a new alternative name for those who were uncomfortable with "WHEE" because it sounds trivial to them or might be confused with the video game called 'wii' (Benor, Web Refs).

It has been in my practice of psychotherapy that I found my best teachers. These teachers were my clients, who showed me how much innate wisdom they have about their own conditions. Most were completely unaware of this inner knowledge, and have often been more surprised than I was at their abilities to release their symptoms very quickly, even when they had been present for years.

Interestingly, people frequently find that specific, precise wordings are crucial to describe their symptoms and feelings in order to achieve maximal benefits. Their initial wording may be only partially or not at all effective in releasing their symptoms with TWR/ WHEE. The unconscious mind may be extremely specific and literal in responding to the affirmations selected.

For instance, Albert started with:

> "Even though I feel very sad and depressed over the loss of my wife…"

His level of distress only decreased from 8 to 7.5 and wouldn't go down any further. Changing his wording to

> "Even though I feel utterly devastated that my wife left me after we were together for six years…" brought it down on the next round of tapping to a 5.

By searching for alternative wordings for a situation in which the intensity of the description is not decreasing in a round of tapping, it is often possible to achieve complete releases of symptoms when the terms are identified that precisely fit the situation for that individual. This can be very subtle, with minor changes in terms bringing about major shifts in responses.

> "Even though I feel upset/ angry/ devastated/ etc. over being told I have cancer/ losing my leg in the car crash/ etc…"

Judith Swack, PhD, developer of HBLU (Healing from the Body Level Up), has been focusing on specificity of terms in self-healing affirmations. She has an extensive, extremely helpful collection of terms and issues to check out in regards to your health conditions, whatever they are (Swack, 2002; 2012). Even more amazing, she has methods for clearing each issue very quickly. I have personally found her approaches extremely helpful – not just in clearing issues, but in confirming how literal our inner selves are in identifying issues (Swack website).

**In summary**

It has been acknowledged for decades that conventional medicine is the 3rd leading cause of

death in the US and elsewhere. It is a sad and despairing situation that at the same time, costs for medical are rising.

Healthcare consumers must be aware and alert to check that medications prescribed and administered properly.

BUYERS BEWARE!

At the same time, CAM therapies are associated with next to no serious dangers.

BUYERS REJOICE!

**CAM Research Resources**

Cochrane Collaboration Complementary Medicine Reviews — plain-language summaries and abstracts of research on complementary health approaches.

NCCIH-funded studies in PubMed — a pre-designated search of all published, NCCIH-funded research to date.

CAM on PubMed® — citations to journal articles on complementary health approaches—from acupuncture, to herbs, to traditional Oriental medicine.

PubMed Dietary Supplement Subset — access to citations and abstracts from research on dietary supplements. (Office of Dietary Supplements)

Annual Bibliography of Significant Advances in Dietary Supplement Research — bibliographies of significant dietary supplement research from 1999–2007. (Office of Dietary Supplements)

Statistics on Complementary and Integrative Health Approaches

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Similar statistics from New Zealand, also comparing to deaths from complementay/ alternative medicine:
Law, Ron. Relative risks of hospital care, pharmaceutical drugs, traffic accidents, foods and dietary supplements New
Zealand www.laleva.cc/petizione/ronlaw/relative_risks_bubbles3.pdf
*This article was prepared by Ron Law, former executive director of the New Zealand National Nutritional Foods Association and member of a New Zealand government working*

*group advising on strategies for reducing medical error*
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*The figure from NZ is most telling. The risks of deaths by CAM are so small they cannot be represented on the same chart with those from conventional medicine.*
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