Commentary

The Medicine We Are Evolving

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While practitioners of the healing arts are schooled in the basic sciences of anatomy, physiology, biochemistry, cell biology, genetics, epidemiology, pathology, and pharmacology—each of which partakes of its own science—no body of knowledge exists within the dominant medical culture that can be construed as "medical science" (note 1). It is our hope that this new publication, *Integrative Medicine: A Clinician's Journal,* will help to evolve the new school of medical practice that appears to be emerging. This school of medicine is based on the following scientific principles:

1. The fundamental subject of medical concern is the human individual;
2. The logic of inquiry as to the health of each individual rests on 2 questions regarding needs:
   a. Does this person have an unmet individual need?
   b. Does this person need to be rid of something toxic, allergic, or infectious?

These principles are antithetical to the implicit, unscientific notions of current mainstream medicine, which are as follows:

1. The fundamental subject of medical concern is disease;
2. The inquiry as to health rests first on the naming of the patient's disease.

Treatment is then prescribed for the disease without rigorous consideration of unique individual needs as reflected in the earlier (a) "get" and (b) "rid" questions. The only exception to this policy is in regard to frank nutritional deficiencies or toxic, allergic, or infectious states.

The legacy and momentum of a focus on acute illness in the past has permitted mainstream medicine to remain disease-focused long after chronic illness replaced acute illness as the dominant problem in our modern, industrialized, hygienic society. The medicine we are developing fixes the following linguistic, statistical, and logical errors of mainstream medicine:

1. The concept that diseases are entities and can cause symptoms is entirely without scientific support. It is a linguistic error that forges a false map in the imagination of professionals and lay people.
2. The idea that each patient's diagnostic and treatment options can be based on determinations of averages is a misuse of statistics when it serves as a diagnostic and therapeutic guide for all individuals.
3. The maxim that assumptions to explain an event should not be multiplied beyond necessity (Occam's razor) is the logical partner of the one-disease, one-treatment approach of mainstream medicine, particularly in the framework of chronic illness. Medicine is the only field claiming a scientific basis in which general systems theory—ie, that everything is interconnected—has not become the acknowledged basis for inquiry. Linear causality remains the accepted basis for etiology.

How do we think differently? The emerging school of thought does not deny the usefulness to the patient and physician of diagnostic groups that allow us the comfort of knowing "what you've got." We are careful to keep in mind that a diagnosis is an idea we form about groups of people and properly belongs to the group, not to an individual. Making a diagnosis in the realm of chronic illness—such as the many conditions of chronic inflammation whose proud names end in "–itis", and autism, schizophrenia, depression, anxiety, cardiovascular disease, and a host of otherwise eponymous, classical, and respectable diseases—is for us not the end of a diagnostic road, but the first step to be followed by the "get" and "rid" questions. These questions are not applied to "curing the disease" but to healing the person. Confronting these 2 questions we encounter their details:

What does the individual need to get? The person may need to add vitamins, minerals, essential amino acids and essential fatty acids, accessory and conditionally essential nutrients, light, love, and rhythmic integration.

What does the individual need to get rid of? The person may need to eliminate toxins (biogenic, elemental, synthetic) and allergens (food, mold, dust, animal products, pollens, chemicals), and microbes.

Questions That Could Cure

Consideration of these details is framed by the focus on individuality in terms of questions beginning with the word *could*: "Could my chronic joint inflammation be caused by something I am eating?" "Could my depression be caused by a lack of something for which I have an unmet need?" Each of these questions defies any notion of averages. The average person with chronic joint pain may respond symptomatically to average doses of anti-inflammatory medicines, but such a remedy is neither humane nor scientific. The average person with depression may respond to average doses of a selective serotonin reuptake inhibitor for a few weeks, but the statistics on which approval of such remedies are based serve us as false guides to an individualized stratagem based on the "get" and "rid" questions. A better guide may be simplified in the Two Tacks Laws:

1. If you are sitting on a tack, it takes a lot of aspirin to make it feel good. (The proper treatment for tack-sitting is tack removal.)
2. If you are sitting on 2 tacks, removing 1 does not result in a 50% improvement. (Chronic illness is, or becomes, multifactorial.)

The bottom line is that patients with many different diseases all have similar imbalances as weighed on the "get" and "rid" scales. The potential for monotony is obviated by the reality that each person represents a different tension on the various strands in the web of implicated factors.

This web is the matrix of factors that express the landscape of each individual's path from genome to disease expression. This path is altered as it traverses the following 8 domains:

- Energy metabolism, or fuel efficiency;
- Synthesis, or growth, regeneration, and repair;
- Detoxification, or waste management; ie, how the body rids itself of used or unwanted substances;
- Message carrying, or the communication systems of hormones and neurotransmitters collectively called informational substances;
- Membranes and boundary issues, or the surfaces on which the body transacts business between different compartments, among which the digestive surface (and its efficiency, integrity, and immunology) is a major focus, and cell membranes are collectively the largest surface;
- Perception, or taking in the world, which embraces the immune and central nervous systems' cellular and molecular signal processing by which the body defines and defends itself;
- Memory, or the biochemistry and immunology of the persistence of self in the central nervous and immune systems;
- Timing, or ways in which harmony is promoted by obeying the imperatives of sequence and rhythmic integration in health.

Each of these vital domains involves biochemical and immunological mechanisms that can be repaired when measurements and interventions are based on the "get" and "rid" questions with the result of tightening the web and improving each patient's health.

Each of these topics will be the subject of a future commentary in this journal.

The New Medicine

This emerging philosophical and scientific approach to healthcare has been referred to by different names, including integrative medicine, collaborative medicine, patient-centered medicine, science-based natural medicine, and functional medicine.

This approach is based on the recognition that individuality is a spiritual as well as a biological foundation in the sense that each of us is a unique creature. Hence our patients are denied dignity when given a group identity (diagnosis) and a group treatment (the "treatment of choice" for that diagnosis). Our personality is collaborative. We aim to form with patients a bond in which the simple logic of our efforts can be grasped equally by practitioner and patient in the process of a leisurely intelligent conversation. The practitioner's expertise is only as good as the detail, accuracy, and structure of the data provided by the patient, who will benefit when the practitioner's recurring question is one I learned in 1959 from my first mentor, Dr Edgar Miller in Kathmandu: "Have we done everything we can for this patient?"

Note

1. I have paraphrased part of the opening of F. G. Crookshank's essay,[1] which I commend to you as a message that is more timely now than when it was first published.

Reference

1. Crookshank FG. The importance of a theory of signs: critique of language in the study of medicine. Supplement II. In: Ogden CK, Richards IA. *The Meaning of Meaning*. New York, NY: Harcourt Brace; 1923.

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