Foundations of Naturopathic Medicine Project:

# Codifying our knowledge. *It's time.*

# First International Editors Retreat


## FULL PROCEEDINGS REPORT with Executive Summary

Published by
Foundations of Naturopathic Medicine Project

Executive and Senior Editors
Associate, External and History Editors
Agency Liaisons and Student Consultants
Valerie Campbell & Associates

*All Retreat participants are acknowledged as the co-creators of the First International Editors Retreat results as reported in the Executive Summary and the Full Proceedings. This Report was developed from detailed minutes of each of the presentations, breakout sessions, great speakers, and plenary sessions in extensive on site proceedings documented and reported by Valerie Campbell & Associates (VCA). The Report was edited and revised by the Foundations Senior Editors Team and VCA.*

April 1 – 5, 2007
Skamania Lodge
Stevenson, Washington

ELSEVIER NCNM NATIONAL COLLEGE of NATURAL MEDICINE

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# Retreat Participants on the Steps of Skamania Lodge after the Closing Plenary

Front Row – left to right: Roger Newman Turner, Jared Zeff, Pamela Snider, Stephen Myers, Joseph Pizzorno, Jim Sensenig. Second Row - left to right: Serron Wilkie, William Franklin, Gloria Odiorne, Deborah Epstein, William Keppler, Tom Kruzel, Travis Watrous, Letitia Watrous, Iva Lloyd, Christine Grontkowski, Paul Orrock. 3rd Row – left to right: Sue Yirku, Richard Barrett, Christina Arbogast Woolard, Kavita Sharma, Joe Holcomb, Don Warren, David Odiorne, Cynthia Bye, Kelsi Ervin, Kris Ritchey, Fraser Smith, Louise Edwards, Mitchell Stargrove, Emma Bezy, Erica Oberg. Back Row – left to right: Herb Joiner-Bey, Paul Mittman, Susan Kay Hunter, Priscilla Morehouse, Bruce Milliman, Jay Johnson, Ryan Bradley.

Foundations Project First International Editors Retreat. April 5, 2007

August 2007

Dear Colleagues:

As you will discover reading through this Retreat Report, we are at a most strategic place in the trek to orthodox positioning of our medicine in primary care. Some would say that our history is recent and that we are jumping the gun. We are not, though. The Naturopathic profession, once again, as if for the first time, faces a crossroads of purpose and design. Lindlahr was enthused over eight decades ago about pulling together the best thinking, the best records of clinical practice, the best theorizing and it did not stop there. Dr. Snider and the pioneers at Skamania are continuing that work, and it will not stop there.

This impulse to transform has, in some ways, been in the works since scientific medicine prompted Charles Elliott in 1871 to create the four-year medical education program at Harvard. Twenty years later at Johns Hopkins University under the leadership of William Osler [a Canadian] and William Welch, the model became the platform for the accreditation of medical schools all across North America. By 1918 the educational programs of all but one eclectic school (in Cincinnati) and one homeopathic school (in Philadelphia) were gone. After Flexner, the positioning of naturopathic medicine in primary care in North America was wounded and advocates scattered. However, the enduring power and value of the medicine was kept alive, patient by patient, doctor by doctor, such that its theory and practice survived across several decades of turbulence. And here we are. Rallied. Ready.

By intention or default, the approach to medical education the pioneers of formal naturopathic medical education and clinical practice put together years ago is entirely consistent with the larger paradigm of “professional education” [for lawyers, medical doctors, engineers, etc.], which took shape in the early decades of the last century. In their drive for credibility, rigor and credentialing capacity, they set into motion a curriculum whose form is not unlike mainstream medical schools [basic bio-medical sciences, applied sciences, followed by practical application in a supervised setting], notwithstanding some content differences. Underlying all of these efforts, however, has been the accumulating impulse to codify the knowledge of the profession. The Foundations of Naturopathic Medicine Project is the formal framework for that momentum.

Certain shifts continue to occur in primary healthcare, making patient-centered therapies more important than ever and the need to classify, describe, define and communicate the complexities of the system of knowledge underpinning our medicine. These shifts in primary healthcare include, in summary, altered patterns of types of illness [e.g., increased chronicity, reduced infectious risks], the demographic changes resulting from increased life expectancy, and the challenges for prevention in an environment of risks caused by industrial development. Ironically, this expression of educational values turns out to be a restatement of the same values articulated a half century ago in something called the “Western Reserve” curriculum. That curriculum, in a nutshell, contemplated three major concepts: integration, both among academic disciplines and between preclinical and clinical work; human development; and comprehensive clinical care. Overall, the goal of this curriculum was to repair the dehumanizing effects of scientific specialization, but with retention of the best of science. This is probably what John Bastyr had in mind in the founding philosophy of Bastyr College. This is what the pioneer editors at Skamania had in mind too.

In any case, our strategic planning must reflect an understanding of these phenomena if we are to position the profession what is coming. In practical terms, mainstream medical schools

are failing to provide adequately for personnel who are prepared for the effective delivery of primary care and preventive community-oriented medicine.

Some would say that behind our formal curriculum lies the 'hidden curriculum' of values that are unconsciously or half-consciously passed on from teacher to teacher, practitioner to practitioner, older practitioners to younger ones, and from graduating class to graduating class. It is not surprising, then, that our senior students become increasingly alarmed by the disconnect between a 'technical rationality" (science-based curriculum] focus in the curriculum, and the often confusing and messy problems encountered in day-to-day clinical practice, which embraces among other modalities, botanical medicine, homeopathy, body work, and the spiritual dimensions of healthcare. For example, in measuring competency, why do we insist on quantitative criteria along with the qualitative? The answer is that what is called "normative professional curriculum" has dominated our program in many of the same ways it has the mainstream medical and other professional schools, including chiropractic.

Such a curriculum, alluded to above, teaches students the relevant basic science, followed by the relevant applied science, and finally, a practicum in which they can learn to apply classroom knowledge to the problems of everyday practice. So, our classroom teachers and clinicians get caught in a situation in which they must teach one thing according to the normative curriculum of the school, but often must actually teach something quite different for the real-world demands of practice.

Related to this issue is the constant reminder that we must do "research" if we are to establish the profession's presence in higher education and in the landscape of orthodox medical systems. Grounded in technical rationality, this "need" actually can have the impact of alienating practitioners in the field and confusing our academic leaders about the priorities of our core program. And here is yet another juncture where the FNM Project can and will have a significant, enduring impact.

Technical rationality as the prevailing epistemology for medical schools has fostered a radical separation between research and practice, so much so that the underlying emphasis on research and specialization as a reaction to incorporating modern bio-medical science into medical education has overwhelmed the educational purpose of medical schools all over North America, including our own. Many naturopathic doctors repeatedly call for their colleges to "do research" and do so with little or no formal training or experience in research methodology or design, not to mention an understanding of the resources required to conduct research formally.

Some would say that medical education, the proper preparation of practitioners for the community, has for some institutions become a minor activity of the North American medical school engulfed as it is in the modern research university. While this has not occurred at our schools, we need to choose which road to take and decide which wagons will make the journey. Will it be a teaching wagon loaded with research supplies, the loads equally distributed, or will it be primarily a classroom and clinical education wagon, as is the case now? As we make those decisions and manifest them in the priorities which our operating budgets reflect, year over year, it is the FNM Project which will be a beacon, a consolidating and focusing process critical to the formation of the naturopathic medical profession in North America.

Let's stay the course. Much work ahead. Much accomplished already.

Yours in health,

David John Schleich

David John Schleich, PhD
President, NCNM

August 2007

Dear Foundations Participants,

I respectfully wanted to communicate to the participants of the Foundations of Naturopathic Medicine Project First International Editors Retreat at the beautiful Skamania Lodge in Stevenson, Washington, how much was achieved and accomplished in those power packed days of 1-5 April 2007.

The setting and environment at a spectacular viewpoint overlooking the majestic Columbia River Gorge, plus the many beautiful yellow jonquils, golden daffodils, and many other wild flowers inspired all participants to accomplish this unprecedented opportunity to codify the knowledge of naturopathic medicine.

This momentous event was the brainchild of Dr. Pamela Snider, ND, Executive Editor and the Foundations Senior Team. Without Dr. Pamela Snider's vision, leadership, and organizational skills, the Foundations of Naturopathic Medicine Project and First International Editors Retreat would not have been a reality. The entire naturopathic profession owes a great debt of gratitude to Dr. Pamela Snider, ND for taking on the huge challenge so vital to the acceptance of our medicine in the 21st century.

Dr. Jim Sensenig, ND, Senior Editor, and Dr. Don Warren, ND, Associate Editor and Past President of the Council on Naturopathic Medical Education (CNME), said it best in the Closing Plenary Session on 5 April 2007, "In years to come, this landmark event will likely be cited as the Skamania Breakthrough Convocation."

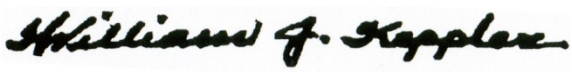
Finally, I wish to acknowledge and thank Dr, Jared Zeff ND and the entire Senior Team, the entire associate editorial team and leads, agency liaisons, student consultants, and volunteers, who all worked so very hard to make the event a success. Their extraordinary contributions were vital to the success of the Retreat and the advancement of the naturopathic medicine profession.

The achievements of the Foundations Project Editors Retreat are now being harvested and distilled into written manuscripts as the book begins to take shape.

Finally, it can be said that the codifying of our knowledge would never have happened without this First International Retreat at Skamania Lodge in early April 2007. I can honestly say it was truly one of the highlights of my nearly five years at the helm of NCNM.

With every good wish.

Gratefully,



William "Bill" J. Keppler, PhD
President Emeritus of NCNM and Professor of Public Health

# Acknowledgements

The Editors and staff of the *Foundations of Naturopathic Medicine Project* are very pleased to report this Executive Summary of the Full Proceedings from our FNM First International Editors Retreat. This event marks the first major international conference dedicated to the articulation of a coherent naturopathic philosophy and development of naturopathic theory in at least 50 years. The conference not only generated the coherence that it was designed to explore and develop, and celebrated naturopathic medicine's rich diversity as essential to its identity and philosophy, but it also generated critical new insights into the core of the medicine that were as unexpected as they were important. **This could not have been done on this scale or this elegance without the very distinct contributions of many people and organizations. We want to warmly acknowledge all of our contributors and supporters here.**

We owe enormous gratitude to our many *Friends of the Foundations of Naturopathic Medicine*, for their corporate and financial support (see Sponsors Pages and Summary Book). Without you, this touchstone would not have been possible! We are indebted to the naturopathic colleges and agencies that provided leadership, significant reflection and direction to the outcomes and practical in kind support; and we thank them for their excellent academic insight, participation, presentations, student consultants, and many contributing editors and authors to bring this dream to reality. Thank you to each of you for your critical contributions: CCNM, UBCNM, BINM, SCNM, Southern Cross University, Research Council for Complementary Medicine, Bastyr University, NUHS, CNME, CAND, NPLEX, AANMC/CCACO, AANP, Naturopathic Society International, and college Naturopathic Societies! Special thanks to the CCACO Group, UBCNM Associate Dean Christina Arbogast Woolard ND, and the all school Delphi Team for their leadership and work on the *Delphi Survey on the Process of Healing*; and to Rich Barrett ND, NCNM Professor for core leadership on the Delphi team and making the survey available online.

The Senior Team deeply respects and is grateful for the unique, essential and remarkable contributions made by each Associate Editor and Lead, and by our extraordinary guest speakers: Iris Bell, PhD, MD; Wayne Jonas, MD, PhD; Mary Koithan, PhD, NR, APRN, CNS; and Ryan Bradley, ND. It is an honour to work among and with each of you. Your tireless leadership and pioneering work at the core of this Project is the heart of our success.

A very special thank you to Sharon Fisher, Valerie Campbell and Vivian Curl of *Valerie Campbell & Associates*, whose effort, resourcefulness, cleverness, fatigue, and brilliance made the Retreat function, provided us with outstanding facilitation and recording, and stellar management. Our student consultants; Serron Wilkie, NCNM Traditional Naturopathic Society; Deborah Epstein, Bastyr University; Brewster Scott, Boucher Institute; and Kelsi Ervin, Bastyr University were our hearts and hands. We thank them for their wisdom and extensive recording of detailed minutes on the proceedings. They will be pleased to know they were well used! Kelsi Ervin is to be commended on her excellent presentation of the *Vis Medicatrix Naturae* research project undertaken with Bastyr University student Kai Yung Chen under the direction of Jane Saxton, Bastyr University's Library Director. Jay Johnson, TreeFarm Communications was warmly welcomed by all, as were his timely and astute observations. We deeply appreciate Emma Bezy, MSW and Louise Edwards, ND, LAc daily bringing a spiritual dimension to our time together. We are grateful to Don Warren, ND, DHANP for his permission to share the report on the Editors Retreat, which he provided to the CNME's Board of Directors.

Finally, we would like to gratefully acknowledge NCNM, our academic home, for its tremendous support and leadership. The NCNM community's extensive involvement and its steadfast, collegial and creative commitment were pivotal to the success of this Retreat. Our heartfelt thanks, warmest appreciation and respect to Dr. David Schleich and Dr. William J. Keppler (President and President Emeritus for NCNM) for their synergy of vision, leadership and support.

Dr Keppler's astute vision, integrity, courage, and wise guidance was essential to our achieving this step; and Dr. David Schleich's long standing vision, dynamic and inspiring leadership, deep scholarship on professional formation, and staunch commitment were vital in advancing through the many joys and challenges of this initiative. We thank Dr. Pauline Baumann and the NCNM Board of Directors for NCNM's warm welcome to our academic home, and Dr. Baumann for her beautiful vision for the medicine; and Nancy Garbett, NCNM's Board of Directors Chair, for her leadership in taking us to the next level; and lastly, our appreciation to Dr. David Odiorne for his savvy Moodle expertise and many hours of essential work on behalf of the FNM; to NCNM CFO Jerry Bores for his astute questions and guidance; to Dr. Rita Bettenburg for being an excellent academic leader and inspiration; to Dr. Richard Barrett for the Delphi Survey and walking our talk; to Teri Davis for navigating and mentoring us through strategic negotiations with the Lodge; and to Susan Hunter, Joey Kerns, Melissa Scholl, April Abernathy, Vanessa Esteves, Kris Ritchey, Kathleen Howlett, Sue Yirku, Kate Williams, Sarah Spring, Kim Eshelman, Steve Dehner, Lindsay Sauve, and Rick Severson for your many vital contributions to the texture and fabric of an exceptional event. Many thanks to Dr. Keppler and Priscilla. Morehouse, who created beautiful memories for us at NCNM's welcome reception. Our editors arriving from around the world truly enjoyed the warm welcome, celebratory atmosphere and delicious food!

## A Tribute to Our Soul Friends

*"There is another dimension of our journey together which we wish to acknowledge. According to Celtic spiritual tradition, the soul shines all around the body like a luminous cloud. When you are very open ~ appreciative and trusting ~ with another person, your two souls flow together. This deeply felt bond with another person means you have found your* anam cara*, or "Soul Friend." Your* anam cara *always beholds your light and beauty and accepts you for who you truly are. In Celtic spirituality, the* anam cara *friendship awakens the fullness and mystery of your life. You are joined in an ancient and eternal union with humanity that cuts across all barriers of time, convention, philosophy, and definition. When you are blessed with an* anam cara*, the Irish believe, you have arrived at that most sacred place."*[1]

At the Retreat, our dear *anam cara*, Dr. William Mitchell was celebrated and felt among us in many ways. Emma Bezy, MSW and Louise Edwards, ND, LAc gracefully and wisely guided us through the spiritual thread of our time together, allowing a gentle space for spirit to be defined and experienced by each of us, from "upward" to "downward" causation and in-between. On June 21, 2007, Emma, founding (former) Chair of Spirituality, Health and Medicine at Bastyr University and Director of the Center for Spirit and Health, passed away after a sudden, rare and intense neurological illness. She follows her close friend and colleague, Bill, across the great mystery. Emma was a true "soul friend," *anam cara*, to many of us, and we celebrate her rich legacy and the many blessings and grace she left on the path behind her. She will be dearly missed.

As Foundations Spirituality (Co) Associate Editor, she made landmark contributions to our effort, including her leadership with Louise at the Retreat, and an original and exquisite chapter on the correlations between the roots of naturopathic philosophy and its philosophical roots in world spiritual traditions. As an expert outside of the field, she was deeply recognized within the ND tribe as a respected and trusted scholar, colleague and beloved friend. Emma was uniquely positioned to know the heart and spirit of naturopathic medicine, and to leave a brilliant and original legacy. She elegantly distinguished this terrain for future generations of naturopathic and other students, and fulfilled a long held yearning in our field.

[1] http://www.lifestreamcenter.net/anam_cara.htm

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All Retreat participants are acknowledged as the co-creators of the First International Editors Retreat results as reported in the Executive Summary and the Full Proceedings. This Report was developed from detailed minutes of each of the presentations, breakout sessions, great speakers, and plenary sessions in extensive on site proceedings taken by student consultants, and as documented and reported by Valerie Campbell & Associates (VCA). The Report was edited and revised by the Foundations Senior Editors Team and VCA.

This document is for internal use only by the Foundations Team for their editorial work, and is not for distribution. If at any time in the future, these proceedings are to be published, all participants will have an opportunity to provide further editorial input and participate as co-authors. Errata are invited. Submit to foundationsproject@comcast.net. These will be made available to the editorial team.

This Executive Summary of the proceedings is provided for internal reporting to the agencies. It will be prepared for academic publication and the profession's use in collaboration with the entire team. All participants are invited to co-author this document, and to submit recommended changes for final publication. All participants who wish to be identified as co-authors are encouraged and warmly invited to do so.

[2] The Agency Liaison is a communicating role (rather than a decision making or sponsorship role) to the agencies of the profession through representatives. Having an appointed agency liaison facilitates reports to the Board of Directors, provides collegial input on text matters, Symposium and Project regarding standards, professional positions, competencies, and body of knowledge of naturopathic medicine. Agency liaisons participate on the Symposium Steering Committee. No financial responsibilities are associated with this position. Liaisons may also be Editors; however, these are distinct and separate functions.

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**National College of Natural Medicine** – MOODLE virtual learning environment, fiscal reporting, research, faculty participation, work study support, [3]Retreat volunteers, lodging, recording, and transcription services

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**The Art of Change** – **Rick Kirschner, ND** – strategic consultation

**3rd Rock Data** – relational database design

**Valerie Campbell & Associates** – travel support, strategic consultation and creative design

**Skamania Lodge** – reception refreshments

[3] In-kind Editors Retreat sponsorship

# Table of Contents

## APPENDICES



## CHARTER CORPORATE SPONSORS

# First International Editors Retreat

## EXECUTIVE SUMMARY



# FIRST INTERNATIONAL EDITORS RETREAT REPORT EXECUTIVE SUMMARY

*"In years to come, this landmark event will likely be cited as the Skamania Breakthrough Convocation."* *Closing Plenary, April 5, 2007*

Skamania Lodge, Stevenson, Washington
Sunday, April 1, 2007 – Thursday, April 5, 2007

## Purpose of Executive Summary

This Executive Summary is for internal use as part of the Proceedings Report. It will be revised by participants, submitted for publication, and made available for reference and sharing widely by the profession. It is available to support and facilitate discussion of key ideas and concepts that emerged at the Retreat. The Executive Summary is copyrighted with all participants as co-author, and once revised and published will be available.

The purpose of this executive summary is to provide a brief review of the key ideas and discussion of each session of the editorial Retreat. The participants should find this to be a useful encapsulation of the Retreat. We hope that this document will help ensure a general understanding of the participants' extensive contributions, which are detailed elsewhere. This summary will also assist editors by summarizing the feedback of attendees and new discoveries and insights from the Retreat.

In collaboration with Valerie Campbell & Associates, the FNM Senior Team and staff have also prepared a detailed account of each session for each editor in that section to serve as a reference in their editing process and preparation of their next drafts (Full Proceedings). The detailed account will provide in-depth and verbatim accounts of the discussions behind summary reports.

One of the major goals of the Retreat was to encourage cross-fertilization between the various sections of the text by sharing concepts and models from each of the other sessions. Another goal was to develop a common linguistic framework throughout the text. Ultimately, we hope to strengthen and further develop the conceptual synthesis and coherence between sections of the text.

## Overview of Agenda, Key Deliverables and Goals

The planning team developed three areas of deliverables and goals for the Retreat. These deliverables and goals were developed in close consultation with the entire editorial team, and reflect their sense of what would specifically address their section's needs in integrating and advancing naturopathic theory.

The first key deliverable was defined as "*Proceedings which capture the following for each session and related section of the text:*

**Coherence:** Where is there a convergence of views? Where is concordance?
**Diversity:** Where do we see important and valued diversity?
**Omissions:** Did we forget anything? Is anything missing in this text section?
**Controversy:** Where is there any discord? Is there outright conflict?"

The second set of deliverables and goals were categorized by text section to support each editor's next draft. The final set of goals included those of editor's development, Project management and



policies, and the connecting of each editor's work to the others. Sessions were designed to address these deliverables and goals. The full list of deliverables and goals are in the Proceedings and are available on request. Highlights of key outcomes and ideas are summarized below.

Prior to the Retreat, the Senior Team imagined the Retreat's success. We imagined what would happen at the Retreat. What were the essential deliverables and goals? Among these were: improved thinking on the text; smooth proceedings; unity and effort; good use of time; organized; collegial models emerge; joyful stories; great teams; senior editors mutually effective; speakers great; sponsors excited; notes/recordings of entire proceedings; each editor has improved direction, satisfaction re: understanding of the *Vis Medicatrix Naturae*; motivation for completion of text; systems functioning; growing sponsors; and in-kind support. It is the estimation of the editorial team that these results were well achieved. An evaluation of the Retreat was very positive, exceeding expectations. A SWOT analysis was done and comments are available upon request.

# Proceedings Highlights by Session

## *Inviting Depth Participation - Welcoming Day*

### Welcome Reception at National College of Naturopathic Medicine - Blessing Ceremony at Skamania Lodge

All participants gathered around a memorial table created in honor of Bill Mitchell. A collective blessing was joined by each participant in memory of Bill and regarding the intention of the conference.

### Vision Plenary

Each participant shared his/her response to: "What is your passion for naturopathic medicine, and how do you want to share that jewel with the next generation through this Editors Retreat?" Student consultants captured the key "passion" and "inspiration" words offered by participants. More than 100 words were shared to inspire the Retreat. Comments focused on clarifying and distilling naturopathic wisdom, illustrating its deeper healing/spiritual connections, and sharing it with the world in order for it to have the greatest impact.

## *Deepening Our Common Context – Days 1 and 2*

### The Healing Power of Nature – Towards a Common Understanding and Assessment of the *Vis Medicatrix Nature*

The charge of this session was to review and address the question: what is the *Vis Medicatrix Naturae*, the healing power of nature? Perhaps the most significant task we have is to define and describe in clinical application this phrase: *Vis Medicatrix Naturae*. We consider this the sina qua non, the essential precept of naturopathic medicine, but what is this? How can it be explained within the context of scientific rigor, or can it? To begin this exploration, which is essential to the Textbook, we had an open discussion. *VMN* is a term of totality, a force that cannot be seen, but is observed or experienced, such as gravity. There is a history to this phrase, and an historical definition: "the power inherent in living systems that resists disease and restores health." *VMN* is a



practical thing, of clinical significance, but is steeped in philosophy. We may not be able to define the *VMN*, but only characterize it or provide a range of possibilities. The *VMN* must be connected to naturopathic medicine's unique therapeutic encounter.

Among the questions considered were the following: Does a rigorous discussion of the *VMN* require a materialistic definition or must it be spiritually imbued? Is there a difference between *VMN* and Vital Force? What is the role of vitality? Is the *VMN* a non-random force? How does the *VMN* function through matter? Is the *VMN* a process that helps to keep the human system "open?"

Is there a 'Divine essence' to the *VMN*? Although the group in general tended towards the spiritual as an integral element in the *VMN*, agreeing to include a spiritual (non religious) aspect in the definition, there is a portion of the profession that does not accept that spiritual implies 'downward causation' or a divine essence, as its origin. This group believes that the *VMN* and what we refer to as spirit, may be an emergent phenomenon of complex natural systems, and is explained by a material theory; and we will include opportunity for a non-spiritual and non –'Divine' explanation and discussion of the VNM.

## Systems Theory – Dynamic Solutions for Complex Problems in Naturopathic Theory and Practice

The charge of the session was to explore and improve conceptual rigor and critical inquiry concerning the foundational concepts of the *Vis Medicatrix Naturae*, spirituality, and the process of healing. Systems Theory offers a modern way to model naturopathic medicine; however, does it provide new insights about naturopathic medicine beyond naturopathic medical training? A major impact would be to teach systems theory to professors who can teach new generations of students the 'classics' of naturopathic medicine within systems theory framework. Complexity theory explains the phenomenon of emergent properties, in which each level of complexity demonstrates properties that were not predictable at the previous level – this is a way to understand the holistic aspect of naturopathic medicine, functioning differently at a different level for whole person treatment than for specific pathological treatment. The profession, in light of systems theory thinking, needs to "update its own language" in order to better align with today's scientific culture, advances and language. We must incorporate naturopathic medicine's rich history and culture in any systems theory applications within the teachings of naturopathic medicine.

Naturopathic medicine is seen as complex and not protocol driven. It was suggested that we must "factor in" individualism, as well as the inherent interrelationship of nature, environment, health, etc. We must collect more data within our research community to provide raw study materials to incorporate within systems theory applications. We should use systems theory to help show how science explains what naturopathic doctors do, the healing power of nature, and the process of healing.

## Spirituality – The *Vis* or More than the *Vis*? This is the Question! Determining the Relationship between Spirit and the *Vis Medicatrix Naturae*

The charge of this session was to explore the inherent definitional challenge of spirituality and its relationship to naturopathic practice and the definition of the healing power of nature: *Vis Medicatrix Naturae*.

There is widespread agreement that a sense of spirit and/or spirituality is part of optimal health. Several concepts were developed in this discussion. Health in and of itself is seen as the goal. Based on Hahnemann's statement in the *Organon*, the purpose and reason for health is to use the reason



gifted mind for the higher purposes of existence. Good health is viewed as a way to realize and express oneself: to live out one's purpose. Health involves an appreciation of one's relationship to the larger whole, the community, the culture, and the universe. Within this consideration is the exploration of the difference between healing and curing, 'spirit,' *Vis Medicatrix Naturae*, and vital force.

A non-mystical approach to spirituality could refer to morality, particularly 'getting along' with other human beings; a sense of service to others to develop gratitude and humility. Optimal health provides the freedom to optimize one's potential – free to be the "person one is meant to be." Part of holism is to focus on the patient's unique spiritual situation. What underlies a person's sense of purpose?

What is the nature of consciousness and spirit? Is consciousness the awareness of mind? The word 'spirit' is difficult to define and is subject to many interpretations. How do we emphasize experience and not belief systems? Is that possible?

The primary problem seems to be one of definition. A secondary problem is the possibility of measurement. Is vital force equivalent to vitality, and can this be measured? Is this related to spiritual health? It may be difficult to define or measure 'spirit,' but perhaps it can be measured indirectly by measuring epiphenomena. Spirituality per se does not equate with good health. It was suggested that the *VMN* "manifests locally in life matter; out of life matter – in consciousness."

We await the chapter submissions on these difficult areas that are generally agreed necessary and intrinsic to the medicine. A further session in this area will be held at the AANP Convention August 23, 2007.

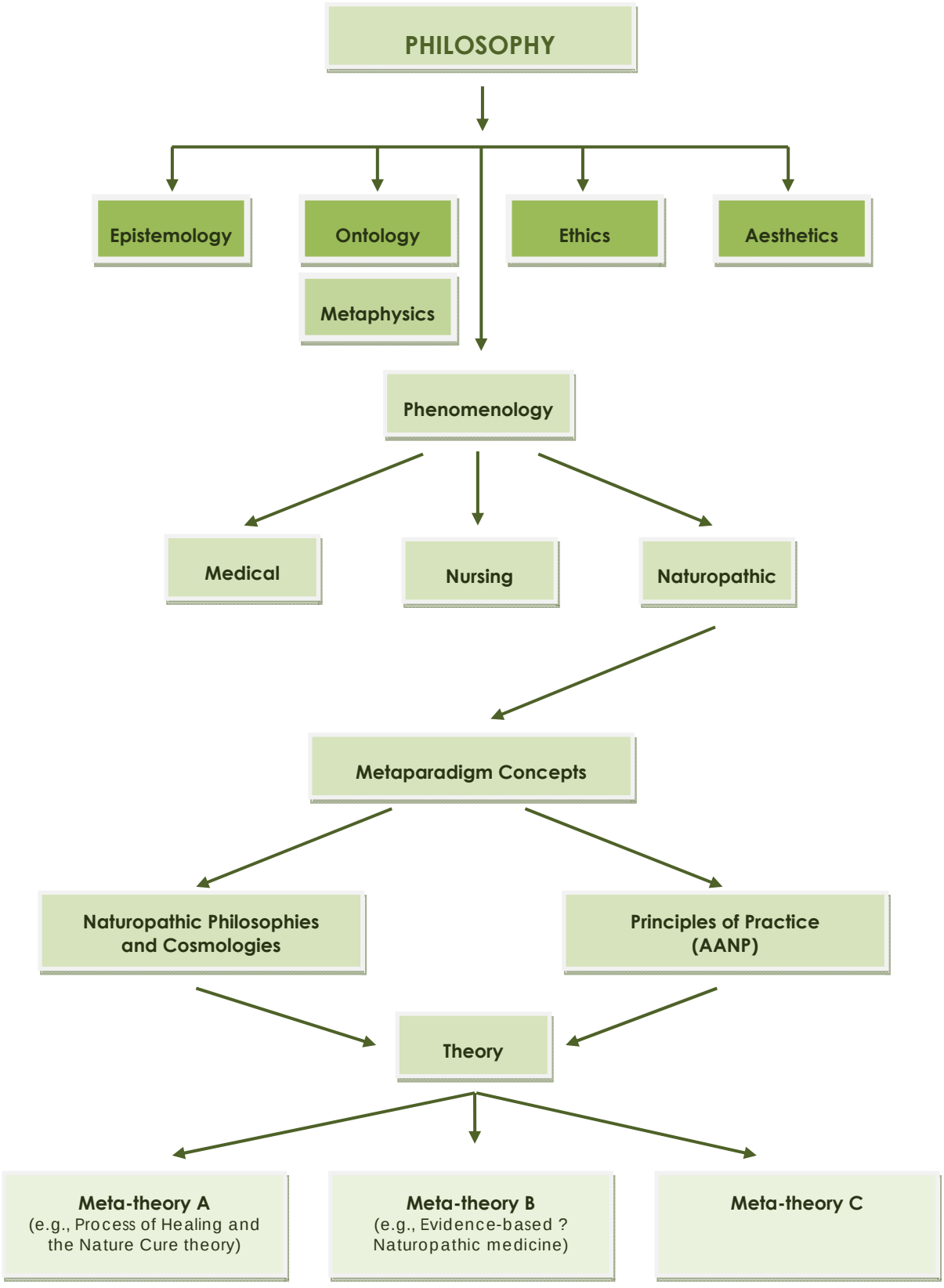
## Epistemology and Medical Phenomenology – A Primer with Implications for Naturopathic Theory and the Foundations' Text

The charge of this session was to assist with editor development and to expand conceptual rigor concerning the foundational concepts of naturopathic philosophy as a whole system in the context of classical epistemology and medical phenomenology.

There is general agreement that we must apply the existing disciplines of epistemology and medical phenomenology to our work. To accomplish this, we need research, curriculum development, and formal teaching to develop the connections between naturopathic medicine, science, medical philosophy, and traditional phenomenology. We agree that understanding mind-body medicine and homeopathy is a moment of revelation to traditional medical science and has the potential to create a revolution in medicine. In naturopathic medicine, it is understood that there is more inductive thinking in medical assessment and decision making. Listening has a great value in the naturopathic profession. Conventional medicine is based upon seventeenth century rationalism, wherein a preconceived understanding is imposed on nature. Naturopathic medicine takes a different approach, developed through this cultural tradition, but driven more empirically, allowing nature to reveal itself. This results in a different understanding of the task of the physician. For example, the internal debate of healing versus curing, and the place of death in medicine. Research in phenomenology includes qualitative and quantitative methods to explore and examine the full scope of evidence to be evidence-based medicine. The *Vis Medicatrix Naturae* could be brought into the naturopathic ontology and phenomenology by coalescing the different aspects of the *VMN* into one definition.

The following diagram was created to express how naturopathic theory would fit into a larger philosophical metric:




PHILOSOPHY
Epistemology
Ontology
Ethics
Aesthetics
Metaphysics
Phenomenology
Medical
Nursing
Naturopathic
Metaparadigm Concepts
Naturopathic Philosophies and Cosmologies
Principles of Practice (AANP)
Theory
Meta-theory A (e.g., Process of Healing and the Nature Cure theory)
Meta-theory B (e.g., Evidence-based ? Naturopathic medicine)
Meta-theory C



## The Process of Healing – Reflective Voices Towards A Unified Theory and Special Session on the Metaparadigm

The session was formulated as an in-depth panel discussion, developed to address emerging constructs in naturopathic clinical theory and philosophy, which express naturopathic physicians' world view, understanding of the process of healing, how disease or illness develops, what creates, sustains, and supports health and vitality, and what disturbs or obstructs it.

Special guest and panel member, Mary Koithan RN, PhD, who was instrumental in developing modern nursing philosophy and clinical theory, addressed the development of concepts for a naturopathic 'Metaparadigm' as part of The Process of Healing panel, which could then be applied by the Editors to refine and enhance rigor in the text. The metaparadigm and meta-theory constructs introduced by Dr. Koithan created an understandable construct for organizing both coherence and diversity taxonomically throughout the text.

It was understood and celebrated by participants, that such a construct provides the editors and the profession with a recognized model for the unity and diversity extant in the profession. The metaparadigm and meta-theory taxonomy provides a dynamic and inclusive container for the orderly evolution of clinical theory, principles and the philosophy of naturopathic medicine. Participants were enlivened by Dr. Koithan's presentation, and agreed to make changes to the agenda in order to provide time for participants to hold a full session on this, to better understand the constructs, and to apply and develop them for the text. The Process of Healing Session was redesigned spontaneously to include an emphasis on this new area of dialogue. A Special Session Report in the Full Proceedings captures this new session, its findings, session outcomes, and discussion.

Instead of the planned smaller breakout groups to create visual models of the process of healing, the group worked as a whole to identify the key constructs to include in a naturopathic metaparadigm. A metaparadigm must be a thing, characterized by a noun (not in relationship to something else), necessary to the profession, that cannot be argued, but presented in simple abstract. We should be able to characterize the medicine with five to seven, perhaps more, such nouns. Breakout groups then formed to identify key constructs to coalesce into a more unified metaparadigm at a later point.

The group also considered, in similar fashion, the developing concept of 'therapeutic order,' the three part clinical model that forms a core theoretical construct of the text. They created a detailed model of the process of healing.

Although there is a high degree of agreement regarding the central place of this theoretical construct as a representative theory of naturopathic medicine, there are areas of controversy and disagreement, and some who completely disagree with this theoretical model. These were considered, and the models were reconsidered in subsequent breakout sessions. This resulted in several variations to the original, and some significant progress was made in exploring agreement in this area.

Three areas of primary concern were the place of physical medicine or structural integrity, the need to represent individualization and the dynamic nature of healing order, and the addition of a specific naturopathic assessment directive in the therapeutic order.

Outcomes on the process of healing then emerged 'organically' throughout the Retreat, and are documented in the full proceedings report. These include a new synthesis of the process of healing theory, involving submissions from 40 contributors; the addition of naturopathic assessment order; naturopathic considerations; process of disease; results of the Delphi Survey; a case management model inclusive of the therapeutic and assessment order; and naturopathic considerations; therapeutic order as holarchy; an algorithmic model; and a several models of the process of healing and therapeutic order constructs and concepts.



## Special Development and Report in The Process of Healing Discussion: Metaparadigm

Based on Mary Koithan's presentation, "Researching Nursing Theory: How We Did It: A Matrix Analysis of Lindlahr's *Nature Cure*," participants returned to the topic of The Process of Healing on Day 3 (Wednesday, April 4). The group continued to nurture the development of the expression of the 'metaparadigm.' Breakout groups considered and developed lists of metaparadigm words/concepts describing naturopathic medicine, and then regrouped as a whole to present their findings, and evaluate correlations between the groups' findings. These lists will be further considered by the editors and the profession, and continue to be developed through the construction of the textbook.

Additional concepts proposed by the participants, metaparadigm breakout reports and detailed discussion are reported in the **Special Session Report on Metaparadigm** in the full proceedings. Further to the development of the Metaparadigm construct, a graphic was created to express the relationship between epistemology, phenomenology, naturopathic theory, and principles for further discussion, revision and integration with the Metaparadigm and meta-theory constructs and model (see above).

## Education: Making Naturopathic Education More Naturopathic World Café: Visioning an Ideal Naturopathic Graduate and Implications for Skills, Transformation and Applied Philosophy

The charge of the session was to develop a vision for future naturopathic graduates, and determine how such a vision might influence the future evolution of naturopathic medical education.

It was well recognized that our education is outmoded in certain respects. Our students are overworked, and there may be significant redundancy or excessive detail in our curriculum that overburdens our students unnecessarily. We developed our curriculum, in part, to satisfy the concerns of external agencies that we be adequately educated in the standard medical model. In accomplishing this goal, did we lose something? It is time to reconsider our curriculum in terms of what would make the best naturopathic physician, rather than what would best satisfy the concerns of external agencies. Through breakout and discussion, the participants developed a series of lists of attitudes and attributes we want in our students, and specific elements of knowledge, skills, and values. Most of the participants are directly involved in naturopathic education as teachers, administrators, or evaluators. The sessions concluded with two summary statements:

"Naturopathic doctors are compassionate, patient-centered leaders who act as revolutionary change agents (including in the sciences), are competent and safe primary care providers, care for individuals, community, and the eco-system, and exemplify the philosophy in personal and professional life as they provide excellent care."

"Naturopathic physicians are compassionate, successful, prosperous change agents practicing from a combination of knowledge, skills, and personal experience … Naturopathic physicians help patients to understand why they are sick and how to become healthy."

The writers will focus in part upon the development of competencies that would accomplish the goal of generating the best naturopathic physicians, regardless of the traditions or concerns of external agencies who do not necessarily share this primary concern. The vision and implications findings of this lively World Café session were captured in detail and summary in the full proceedings for the Naturopathic Education section of the text.



# *Creating Coherent Clinical Applications – Days 3 and 4*

## Critical Information Session – Text Structure, Milestones, Timeline and International

The charge of this session was to provide Project management and policy overview and the opportunity for questions, problem solving on deadline management, clarifications, changes, and other technical or structural problems.

This session had mostly to do with the structure and timeline of the text. A number of specific details were brought up, including ease of access, the need for some sort of key to using the text for its various purposes, the desirability for chapter summaries, the essential need for a glossary, the use of sidebars to allow for divergent opinions, the potential for CD and DVD texts, etc.

On subject matter and diversity, we need to illustrate diversity of clinical theories, differences and applications. Do we have more than one clinical theory? We should provide a section on diagnosis, including training, and the difference between what is proven (evidence-based) and what is unproven (explaining that it can take 50 to 100 years to create evidence-based material). It was discussed that there are different levels of evidence, and that clinical anecdote is a form of evidence. There were other such concerns expressed, and a discussion ensued regarding the need to discuss economic impact and cost effectiveness of naturopathic medicine. NPLEX Executive Director Christa Louise provided guidance from the NPLEX perspective on what would serve this agency's needs in such a textbook.

International variations in scope and linguistic framework were presented, and editorial attention committed to these important distinctions. Associate Editors Stephen Myers, ND, BMed, PhD (Australia); Roger Newman Turner ND, DO (UK); and Don Warren, ND, DHANP (Canada) were welcomed to the senior team, enhancing the international leadership of the text.

The problem with the writers' contracts was brought up and discussed, and the changing timeline for manuscripts. By October 31, 2007 all submissions should be in to Senior Editors.

## Nature Cure: Honoring the Heart of Naturopathic Medicine

The charge of session A was to present a summary of the authors' perspectives on and definition of Nature Cure in naturopathic medicine, yesterday, today and tomorrow.

Following the presentation on Nature Cure by Cathy Rogers and Letitia Watrous, there was widespread agreement with the fundamentals reviewed in this session, so much so, that the breakout group plan was re-choreographed to permit the large group to discuss its metaparadigm on "the process of healing." In particular, there was support for the Nature Cure group's discussion on the *Vis Medicatrix Naturae*, vital force and the therapeutic order in nature cure. Also, the history of naturopathic medicine was referenced to European and other spa and/or water therapies.

A discussion among the large group ensued following the presentation. There was a discussion about the use of the word 'nature cure' and whether it is accurate. The group discussed the need for care in the use of naturopathic language and the problem of language in general, as most of the extant language in the field is based upon standard medical concepts. Reference was made to Dr. Dick's classic quote and admonition to "treat the hole in the middle – the emunctories –" as the starting point of the therapeutic order, and for re-establishing the basis of health. As such, it is non-



linear, and works from the center in a 'sphere of influences.' This is a core teaching and understanding of naturopathic medicine and its unique approach to healthcare.

It was agreed that naturopathic doctors do not 'manage' disease like standard physicians, and that these thoughts go to the heart of naturopathic medicine, and that participants wish this to be referenced in the text.

Discussion continued regarding the availability and ability of coding of such services, using a medical model and integrating as such within mainstream healthcare delivery. There was also agreement that participants would like to see the profession organize an in-patient facility that was affordable or free to lower socioeconomic communities. This would provide needed care, offer invaluable training for College residents, and enable critical research opportunities to demonstrate the efficacy of Nature Cure using evidence-based and science-based modalities.

## Naturopathic Medicine Modalities: Evolving with the Progress of Knowledge and Voices of the Elders

The charge of Session B was to provide feedback to enable the Modalities chapters to produce the first definitional statements of naturopathic modalities in the context of naturopathic philosophy and theory; and to represent the full range of expression extant among naturopathic doctors whose practice and jurisdictional scope vary.

As with the nature cure session, the Modalities session was released from the planned breakout group encounter in order to create time and space for the process of healing metaparadigm discussion. The panel, Stephen Myers and Jim Sensenig, answered questions following their abbreviated presentation.

The group discussed defining modalities, the clarification that naturopathic medicine is a complete system, and that there are modalities clusters within that system. It was agreed; however, that rather than clustering these modalities, the book should allow each equal space and acknowledge the clustering, for example, graphically. A lively discussion ensued in open plenary regarding the use of drugs, and the philosophy behind the use of various modalities.

## The Elements of Naturopathic Primary Care: Evaluation, Management, and the Ecology of Healing

The charge of Session A was to present a synthesis of definitional work on the elements of modern Naturopathic Primary Care in the context of naturopathic philosophy, traditional naturopathic practice, and the classic principles of primary care evaluation and management.

In open plenary and breakout, participants generally agreed that a primary care provider is defined as the caregiver that the patient goes to first for healthcare, within the legal jurisdiction of the geographical area of practice. She coordinates the patient's care (e.g. consults, co-manages and refers) and has greatest responsibility for the patient's care. Naturopathic Doctors are generalists in whole person primary care, and legally defined as primary care physicians or providers in many jurisdictions.

Key elements of naturopathic primary care were identified. Naturopathic primary care uses the 'least force model.' Naturopathic interventions are consistent with its philosophy, and are not inherently harmful. Naturopathic care is premised on empowering patients to take control of their health. Naturopathic doctors regularly assess and monitor the parameters of health. The philosophy is towards cure or healing, by supporting the body's innate healing process. Evaluative techniques



focus on patterns of causation and their complex interconnections, including obstacles to cure, and evaluative elements are more subtle, more functional, and often pre-pathological.

Naturopathic primary care includes a wide array of interventions: physiologic, pathologic, pharmacologic, and subtle interventions such as energetic, homeopathic and spiritual.

Naturopathic primary care shares understanding of pathologic diagnosis and pathologic intervention with standard physicians, along with a shared level of basic training (breadth and depth of basic medical sciences).

Issues of accessibility, efficacy and effectiveness were discussed. The importance of naturopathic primary care in underserved populations and community health was passionately confirmed, and participants agreed that naturopathic philosophy can be applied in all populations by meeting patients where their needs are greatest, an important aspect of naturopathic philosophy. The transformative potential of naturopathic care to re-orient the dominant healthcare system from a disease-centered to a health restoration model exists. So also does the shift in emphasis from fear about disease (germs, bacteria and viruses) towards an awareness of personal health cultivation.

Finally, the necessity of including a section or chapter on naturopathic standards of care (AANP) was endorsed.

## Application of Naturopathic Theory to Population Groups and Clinical Specialties: A Naturopathic Approach to Whole Person Practice, the Whole Person, and the Ecology of Healing

The charge of session B was to review this section's structure, and develop an innovative section design and internal chapter framework, which reflects the heart of naturopathic medicine, yet is recognizable to conventional providers; in effect, creating an accessible framework for presenting the full scope and context of naturopathic clinical medicine, as described in naturopathic principles and theory.

The group supported the strategy of utilizing a chief health complaint and searching for "cues" into other systems in the body. The purpose of the chapters is to articulate how naturopathic doctors think. Case examples will be used for illustration. The language should reflect the interrelatedness and thinking of 'systems' and the unity of disease rather than 'specialties.'

Key contents and chapter layout recommendations included revising and lengthening the opening chapter to "Introduction: The Naturopathic Approach." The content for this chapter was developed in breakouts and reported in plenary. Naturopathic doctors are acknowledged as primary care, whole person generalists, addressing the unity of disease. There will be an introduction developing overarching systems themes and philosophy, complex systems, the 'process of healing' concept, and using the 'therapeutic order' as a basic approach to case management. A systems approach will be emphasized, utilizing a problem solving and case based approach. Systems to be included will be in two categories: systems and subsystems, and include a section on populations' health

It was recognized that such an approach will require excellent case illustration of this unique approach to clinical areas typically divided in the conventional framework, and recognized in naturopathic practice as functionally significantly interrelated both for assessment, treatment and monitoring purposes. The group felt that this was a very exciting breakthrough, and this section of the text would support modelling naturopathic thinking in didactic and clinical teaching with such tools.



## Naturopathic Case Analysis and Management – Towards a Model of Naturopathic Case Management: A Light for Our Path

The charge of session A was to address the question: what is a model for naturopathic case management that explicitly applies naturopathic philosophy, principles and theory to practice?

A groundbreaking basic model for Naturopathic Case Analysis and Management was presented and discussed. There were many points of agreement among them: Assessment should include a physical and pathological understanding of the patient as an individual. It should utilize empirical knowledge. It should assess causal factors, with reference to disturbances to the 'determinants of health.' It should recognize multiple places in the spectrum between wellness and disease. Using the therapeutic order, assessment could include: current level of health of patient; determinants of health; pathology and severity of pathology, and physiological function disease/diagnosis before applying treatment.

A complete case management model was developed further in the breakouts defining a number of features and constructs, including 'center of gravity' of illness (physical, mental, emotional); genetic propensity (including family history) versus environmental factors; time allowances available for intervention; level of vitality of patient and assessment of life force, and many other factors organized in several models presented to the group and case management editors for their further development.

A detailed discussion of case management and standards of care occurred, which focused on maintaining naturopathic individuality while providing general guidelines for good management. How do we establish a general agreement about standards of care in a system in which so much individuality occurs, which has historically been seen as valuable. How do we preserve the historic individuality of the medicine, which is generally considered valuable, and yet create standards? The solution seems to reside in generalities of process as opposed to specific requirements of procedure.

## Clinical Algorithms and Guidelines – Our Philosophy in Action

The charge of session B was to illustrate the overall thought process by which naturopathic physicians inquire, perceive, ponder, and intervene in the health of the individual patient expressed visually through clinical algorithms.

The session developed a series of recommendations. The first was to include the "therapeutic order" definition, which is seen as a continuum of therapeutic intervention from least force to greater force. It was suggested and strongly agreed that we describe elements of the therapeutic encounter, not the disease, and associate the algorithms initiation with specific findings in systems rather than disease entities, e.g., breathing problems instead of asthma. Asthma, for example, would be part of the algorithm but further along. It was suggested that as much as possible this algorithm should be case based. Include examples of algorithms also as cases. Participants felt that we should delete the word 'allopathic from the lexicon; and replace it with 'conventional' or 'standard' medicine. Consider that the therapeutic order is not the basis for the algorithm. It informs the algorithm. It is absolutely critical that naturopathic algorithms teach people how naturopathic doctors think rather than setting up rigid formulas for how to treat patients.



## Closing Plenary

Kate Williams, MA of WordTurners, attended the Retreat and the Closing Plenary. She summarized the closing eloquently in September 2007 NDNR article[4] reporting on the Retreat:

"In the end participants had collective breakthroughs reaching elements of a coherent definition of the *Vis Medicatrix Naturae*, and drafting core concepts of a naturopathic metaparadigm. With nearly a hundred years of fierce independence and struggle to survive as a medical discipline behind them, the multi-generational clan present at the end of the day felt the peace and coherence that emerge with personal and professional maturity in the classic process of professional formation.

A collective vision for a contemporary foundation of naturopathic medicine was experienced because independent minds united with a shared heart, honoring the spirit of the late and beloved Dr. William Mitchell's 'listening medicine,' invoked at the conference opening. The FNM team is forging the way to making naturopathic medicine a coherent and complete system of medical theory and practice ready to meet the needs of physicians, patients, colleges, and their students.

Acknowledgments abounded as participants expressed their awe in the Retreat's outcomes. Don Warren, ND shared, "It was a peak experience . . . in an atmosphere of expectation, respectfulness, love of our profession, and a great desire to contribute in a thoughtful, reflective manner to the evolution of naturopathic medicine." Holding the talking stick, Mitchell Stargrove, ND, L*Ac*, history editor, offered, "I am impressed by our ability to look at what we are doing and aspire to articulate it." Finally, senior editor, James Sensenig, ND, having participated in other significant naturopathic gatherings over the years, proposed that the Retreat "be forever thought of as the Skamania Breakthrough Convocation."[4]

## Conclusion

We are very pleased to report the successful completion of and outstanding results from the First International Editors Retreat**.** In the words of participants, "It was an historic, landmark event and exceeded our wildest expectations!" The Retreat was held at beautiful Skamania Lodge in Stevenson, Washington, April 1st to the 5th. It was attended by 45 participants representing the United States, Canada, Australia, and the United Kingdom; all 7 Canadian and US naturopathic colleges; several colleges in the UK and Australia; 7 naturopathic agencies; 5 student consultant/volunteers, naturopathic faculty, deans, clinicians, scientists; and experts from other disciplines. Several guest observers joined the meeting throughout the week. Evaluation of the Retreat was very positive, exceeding expectations. A SWOT analysis was done, and both survey and comments are available upon request.

Skamania Lodge provided a beautiful natural setting and an outstanding venue for the dialogue. It is anticipated that the results of these collective discussions will be useful, and make a significant contribution to naturopathic scholarship. These results have been captured in detailed full proceedings to be distributed to the editorial team and co-leads. The proceedings will undoubtedly assist the editors tremendously, and will have a decided and dramatic effect on the final quality of the Foundations Textbook to be published by Elsevier in 2009.

A critical aim of the planning team achieved at the Retreat was participation by all colleges and key agencies within naturopathic medicine. This included a passionate group of naturopathic medical students from 4 colleges who functioned as consultants and volunteer staff. These students

[4] Naturopathic Doctors News and Reviews; September 2007, www.foundationsproject.com): "The Foundations Project International Editors Retreat Catapults the Profession Forward: Welcome Aboard, Buckle Up."



represented the Traditional Naturopathic Society (NCNM); the Nature Cure Club (Bastyr); and the Naturopathic Societies (SCNM and UBCNM). Their hearts, minds and hands were deeply appreciated.

Participants uniformly expressed a desire to hold a larger *International Clinical Integration Symposium* open to all contributing authors and the profession. *The International Clinical Integration Symposium* will provide an opportunity to strengthen, deepen, unify, and communicate the work of modern naturopathic physicians into clinical and other educational settings, and will provide a lively forum for sharing new models and tools, and advancing and debating naturopathic theory and its application. Such a Symposium will provide an opportunity to strengthen emerging coherence and celebrate our diversity in a rigorous and collegial atmosphere of critical inquiry.

To accomplish this unity and acknowledge diversity, and to remain a dynamic field of healthcare, naturopathic clinical theory must be collectively developed, advanced and vetted by the broader naturopathic medicine communities from agencies to students, faculty, clinicians, researchers, and international thought leaders. Educational models and curricula must also be supported and created to ensure that the principles, philosophy and clinical theory can be practically applied with each patient encountered in our colleges' clinics. This Symposium will provide a forum for this to take place with broad representation and participation from across the naturopathic profession.

To honor the intergenerational and collegial intention and mission of the Foundations Project, the FNM team has invited agency liaisons, Gathering and Naturopathic Societies, and FNM international editors to co-chair this Symposium, planned for 2010 to follow the book's publication. The FNM team has invited the Gathering to host continued discussion on the metaparadigm through 2009 in collaboration with the FNM.

# First International Editors Retreat

## REPORT ON PROCEEDINGS:

### OUTCOMES OF EACH SECTION OF THE RETREAT AGENDA



# *Welcoming Day – Inviting Depth Participation*

## Welcome Reception Hosted by National College of Natural Medicine

The First International Foundations of Naturopathic Medicine Editors Retreat was launched at National College of Natural Medicine, Academic Home to the Foundations of Naturopathic Medicine Project. Participants welcomed their international colleagues, visited with College faculty, staff, students, and volunteers, and networked with editorial team members. There was an air of celebration as all participants came together for the first time after two years of previous work in four countries on planning, organizing, and writing early drafts of key sections of the Foundations of Naturopathic Medicine text. Dialogue was lively in anticipation of advancing the work to its next critical stage of evolution in the following four days of presentations, deliberations, questions, challenges, and determination of priorities.

Dr. William Keppler and Pamela Snider with Senior Editors: Jim Sensenig, Jared Zeff, Stephen Myers, and Joseph Pizzorno

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Collective intention toward the Retreat's goals and common ground was established during the Welcome Reception. Following the Welcome Reception, participants arrived at Skamania Lodge to begin the onsite Editors Retreat.

## Blessing Ceremony

An altar was created outside Skamania Lodge, overlooking the Columbia Gorge, in honor of Associate Editor, Dr. Bill Mitchell, beloved mentor, friend, teacher, physician, and fellow Foundations of Naturopathic Medicine leader and contributor.

Participants pictured at left are from back row – left to right: Bruce Milliman, Christine Grontkowski, Christa Louise, Patricia Herman, Christina Arbogast Woolard, Fraser Smith, Stephen Myers, Joseph Pizzorno, Leanna Standish, Mitchell Stargrove, Valerie Campbell, William Franklin, Herb Joiner-Bey, Jared Zeff, Roger Newman Turner, Jim Sensenig, Serron Wilkie; far back row – left to right: David Odiorne, Bill Keppler, Don Warren, Thomas Kruzel; front row – left to right: Vivian Curl, Sharon Fisher, Pamela Snider, Emma Bezy, Louise Edwards, Paul Orrock, Iva Lloyd, Kelsi Ervin, Joe Holcomb, Letitia Watrous, Rita Bettenburg, Deborah Epstein, Brewster Scott.

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All gathered around the altar to offer their blessings to Bill. Each person was asked to personalize their blessing for Bill by adding their own unique experience in the context of the following statement:

*"Bill I honor and thank you for the gift of …"*

The following blessings were offered with love:

- ✓ *Teaching*
- ✓ *Passionate spontaneous teaching*
- ✓ *Science, magic smile compassion*
- ✓ *Communication*
- ✓ *Shining smile, depth of healing*
- ✓ *Generosity, passion for naturopathic medicine*
- ✓ *Natural life*
- ✓ *Impact of life and community*
- ✓ *Your wisdom*
- ✓ *Physician is a modality*
- ✓ *Your wisdom*
- ✓ *Energy of universe*
- ✓ *Teaching me and smiling*
- ✓ *Imaginative and creative thinking*
- ✓ *Spirit and success of this event*
- ✓ *Responsibility and education*
- ✓ *Impact of life and community*
- ✓ *Your wisdom*
- ✓ *Continence and courage of institution*
- ✓ *Your presence will energize the Retreat*
- ✓ *Beauty of eye*
- ✓ *Do not hurry*
- ✓ *Voluminous emails, wise words*
- ✓ *Humble loving essence, peace love and humor*
- ✓ *Resonance*
- ✓ *Fully present*
- ✓ *Recognize and articulate what we do*
- ✓ *Sharing and willingness to learn*
- ✓ *Clarity*
- ✓ *Style*
- ✓ *Seeing our past*
- ✓ *Producing best darn textbook*
- ✓ *Great spirit*
- ✓ *Legacy, commemorate to next generation*
- ✓ *Being present*
- ✓ *Listen, love, learn, grow*
- ✓ *Step back before moving forward*
- ✓ *Respective*
- ✓ *Grow and evolve*
- ✓ *Inspired greatest vision*
- ✓ *Tangible way*
- ✓ *Capacity*

# Vision Plenary

Participants returned to the Lodge to set their intention for the Editors Retreat on an individual and a collective basis. Using Bill Mitchell's Talking Stick,[5] each person was invited to share their passion for naturopathic medicine and vision for the Editors Retreat.

Responses were offered to the following statement:

*What is your passion for naturopathic medicine, and how do you want to share that jewel with the next generation through this Editors Retreat?*

Student consultants captured the key "passion" and "inspiration" words offered by participants. These words were then attached to Tibetan prayer flags, which were hung throughout the main meeting room to sustain the sense of passion and inspiration created during this first day throughout the working agenda.

Participants input from the Vision Plenary hung in the meeting room as a reminder of the vision of the participants. Several are shown here while Jared Zeff presents.

Photo courtesy of Sarah Spring, NCNM 2007 ©

The following statements offered the seeds to crystallize and energize the entire Editors Retreat:

- Flower that is yet to bloom
- A path for divine healing
- Advancement beyond the founders
- Healing the delusion that heaven and earth are separate
- Producing the best damn textbook
- The hand can reach higher than the heart
- The truth of the medicine

| | | |
|---|---|---|
| Agreement | Ancestors | Articulate the Vision |
| Awakening | Backbone | Being present |
| Beyond saying | Carry the torch | Clarity |
| Clarity and presence | Communications | Community |
| Connection to roots | Courage | Create coherence |
| Critical place | Deepening common context | Defining words |
| Discover | Discover and articulate | Distill our wisdom |
| Divine illumination | Ebb and flow | Educator |

[5] NOTE: Dr. Mitchell's altar was transported into the main Editors Retreat Mt. Adams meeting room, just off the side of the main meeting area. His picture was placed with his shoes, in a chair set aside for him, and his talking stick remained on the plenary and panel table throughout the week's presentations. From this time onward, Bill was recognized as an honorary participant in the Editors Retreat.

| | | |
|---|---|---|
| Elders | Energy of universe | Excitement |
| Expectation | Experience | Faith |
| Fire | Forum | Fully present |
| Gaia | Gather | Generosity |
| Great spirit | Grow and evolve | Healing spa |
| Health | Heart | Hope |
| Integrity | Least force | Legacy |
| Listen | Listening medicine | Magic |
| Main morality is love | Medicine is not science | Miracles |
| Objectivity | Organic | Passion |
| Patience with the process | Pattern recognition | Philosophy |
| Powerful | Processing | Productive |
| Progress | Re-articulate | Re-enchantment |
| Remember | Resonance | Respectful |
| Self healing | Sense of well-being | Sharing of expertise |
| Sharing | Simple truth | Smile |
| Spirit | Spirit and success of this event | Spontaneity |
| Stepping stones | Structure | Style |
| Tangible | Teaching | The love within |
| Therapeutic | Transformative | Understanding |
| Unifying theory | Unity | VIS |
| VMN | Wildest dreams | Willingness |
| World | | |

Photo shows some of the Tibetan prayer flags with words of inspiration from the Vision Plenary on the flags in the corners of the meeting room. Picture left to right, Front Row: Mitchell Stargrove, Christina Arbogast Woolard, Fraser Smith. Middle row: Iva Lloyd, Don Warren, Gannady Raskin. Back row: Christine Grontkowski, Patricia Herman, Roger Newman Turner, Deborah Epstein, Serron Wilkie.



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## *Deepening our Common Context – Days 1 and 2*

# Opening Plenary
# Setting the Stage and the Path for the Retreat

The purpose of Days 1 and Day 2 was to *deepen the common editorial context* for the textbook, by engaging in a series of presentations, discussions, syntheses, and debates regarding and advancing the coherence and rigor of the core philosophy and elements of naturopathic medicine.

The agenda for the first two days was designed to incorporate editors' development through interacting with presenters in areas to define the core tenets of naturopathic medicine: the *Vis Medicatrix Naturae*, operationalizing concepts for research, systems theory, complex systems and naturopathic concepts; the definition challenge of spirituality and naturopathic medicine; epistemology; the role, format, development, and clinical application of theories of healing in a profession; the relationship between scientific research and philosophy/theory concepts; emerging perspectives and new synthesis of the process of healing theory; and visioning future naturopathic physician graduates.

This foundational strategy would set the stage for tactical discussions and synthesis *creating coherent clinical applications* and new models during days 3 and 4. Days 3 and 4 were designed to apply the context of days one and two, to the lexicon, outlines and clinical models and frameworks of the text, in order to provide educators, clinicians and others with clear models for communicating and applying naturopathic medicine's unique approach/concepts or theory to teaching, research, practice, and public education and policy.

The team confirmed and celebrated their commitment to support the overall goal of sharing diverse insights in order to understand and document the *key deliverables* for the Retreat in all Sessions:

### The Key Deliverables

**Coherence:** Where is there a convergence of views? Where is concordance?
**Diversity:** Where do we see important and valued diversity?
**Omissions:** Did we forget anything? Is anything missing in this text section?
**Controversy:** Where is there any discord? Is there outright conflict?

The specific deliverables and goals for each session are listed at the beginning of each Session Report. They are available all together on pages 25-27 of the Retreat Book, Vol. I.

This essential feedback from the Retreat will inform the Senior Editors team, Associate Editors and writers about the current direction and core content of their sections as the text evolves to its next stage in the editorial process.

### Words of Wisdom from Dr. Bill Keppler

*"During the Retreat, remember that we are all taking a high-level pass, and a low-level "reconnaissance" flight to better understand our current knowledge, then how to apply it to create this precedent-setting textbook."*

Organizations are made up of five kinds of bones:

- **Wish Bones** –who wish other people would do the work
- **Jaw Bones** – who do all the talking
- **Funny Bones** – who are the clowns
- **Knuckle Bones** – who are always complaining; are the nay-sayers
- **Back Bones** – who get under the load and get the work done (the type of people at the Editors Retreat)

There are seven words that are critical for success of the Editors Retreat:

- Unity
- Significance
- Commitment
- Productive
- Completion
- Inspiration



## *Deepening Our Common Context – Days 1 and 2*

# The Healing Power of Nature - towards a common understanding and assessment of the *Vis Medicatrix Naturae (VMN)*

Jared Zeff, ND, LAc presenting for William A. Mitchell, Jr., ND; Wayne Jonas, MD, PhD; James Sensenig, ND; Leanna Standish, ND, PhD, LAc; Stephen P. Myers, PhD, BMed, ND; and Iris Bell, MD, PhD

### *Charge of Session*

The original charge of this session was developed by the science and philosophy editors – to review and address the question: What is the *VMN* or the Healing Power of Nature?

Key questions for discussion included:

- Is the concept of the *VMN* valid or useful?
- If it is valid or useful, then what is it?
- If it is useful, can it be measured? Is it important to measure it?
- Is there a transcendent domain of organization that creates the self-organizing principle of living organisms and systems?

### *Deliverables and Goals of Session*

- To capture coherence, concordance, diversity, conflict, areas missing among the editors and form the base for an "operational" definition of the *VMN*.
- Six chapter drafts on the Healing Power of Nature, which with appropriate revision, will be publishable in the textbook and scientific journals.
- To increase rigor and capacity for scientific exploration or concepts in naturopathic philosophy.
- Draft common elements of the *VMN*.
- Draft models and frameworks for presentation of elements.
- Feedback summary for editors.

## Summary and Outcomes

*Includes core areas of coherence, diversity, omissions, and controversy; also relevant models created by attendees.*

Following the panel presentation, the whole group and small group/breakout discussions ensued. Given the elemental, foundational, and philosophical undertones of the *Vis Medicatrix Naturae* and the concept of the Healing Power of Nature, the group expressed great interest in deepening its discussion on this topic to determine, in particular, where it would discover consensus in order to build a sustainable model of the *VMN*, as well as how to increase the rigor of analysis around the *VMN*.

In large and small group discussions, participants arrived at the following points for coherence, diversity, omissions, and controversy:



## Coherence

- The *VMN* is a term of totality; it must be stated in its full nomenclature: *Vis Medicatrix Naturae*.
- The *VMN* is a force that cannot be seen, but is and can be experienced. Parallel examples included gravity, electro-magnetism, etc.
- The *VMN* is a fact that describes the observable properties of life.
- The historical definition: "The power that is supposed to resist disease and restore health" was presented from a dictionary (Sensenig) and supported.
- The *VMN* is a practical concept; however the concept is steeped in philosophy.
- Collectively, we must *characterize* the *VMN* rather than *defining* it explicitly. This means providing a range of possibilities for its meaning and definition.
- The *VMN* must be connected to naturopathic medicine's unique therapeutic encounter.
- There is a difference between the *VMN*, vital force, life force, and vitality

## Diversity

There are a range of opinions, thoughts, experiences, and perceptions about:

- Whether the *VMN* requires a secular definition or should be spiritually imbued;
- Defining explicitly what the differences are between the *VMN*, vital force, life force, and vitality;
- If the *VMN* is a non-random force;
- What is the *VMN's* role through matter;
- If *VMN* is a process that helps to keep the human system 'open;'
- Upward and downward causation explanations of the *VMN*.

## Omissions

None were indicated.

## Controversy/Conflict

Considerable discussion ensued about whether there is a divine element which is an aspect of the *VMN*, with a trend within the group towards the spiritual as an integral element within the *VMN*. Most seemed to agree to include a spiritual measure within the definition and to "take a stand" in doing so.

However, there is debate and even conflict about this in the profession. There was not full consensus and some disagreement was expressed at the Retreat. The debate is represented by the dialogue about upward and downward causation theories as origins of the *VMN* (and of 'spirit'). There are some who recognize both spirit and the *Vis Medicatrix Naturae* as expressions of an emergent property of complex natural systems. These professionals believe the phenomenon described as the *VMN* acts unpredictably and in an orderly manner because emergent properties of complex natural systems can arise spontaneously and can appear to be self driven.

It was understood and celebrated, however, that further dialogue was required in this area. In order to support further dialogue, the editorial team encourages scholarship in the text exploring, defining, and critically thinking about further spiritual, physical or material explanations of and models for the *Vis Medicatrix Naturae*.



# Plenary Breakout Reports
# Reports, charts or visuals from breakout groups

## *Breakout group charge*

Breakout groups were asked to discuss the following in the context of the core deliverables to determine where there is coherence, diversity, omissions, and controversy:

- Adding to the Panel's presentations, discuss the concept of the *Vis*, and how it is a cornerstone of naturopathic medicine. In our current understanding and application of the *Vis*, is it valid or useful? Please qualify your answer by discussing why it is or why it is not valid or useful.
- Assuming the *Vis* is valid or useful, build on the Panel's presentations to expand on what is the *Vis*? How do you define and describe it?
- Further to the Panel's presentations, are we able to measure, quantify or qualify the *Vis*? Is it important to do so and why?
- Expand on the Panel's presentations on the potential of a transcendent domain of organization that creates the self organizing principle of living organisms and systems.

*NOTE: For the first session of the Retreat, breakout groups did not generally use flipcharts. They started using flipcharts for the remaining sessions.*

## Breakout Group One – report

***Presenter: Cathy Rogers***

### *Group One flipchart presentation*

- Concern with using 'divine intelligence.'
- Explain the *Vis* without using the term spiritual.
- Chapters should characterize, but not define it. Let's describe a range of possibilities.
- Clinical encounter must be a part of it as our philosophy is applied.
- Disease as a process – how the *Vis* operates.
- Therapeutic encounter and what enables us to be a part of the process – self-knowing awareness.
- People want the experience of health.
- Therapeutic encounter, they want that relationship; that's why people keep coming back.
- We need to recognize we come from a position of strength.
- Everything that exists within a context.
- Path of choice.
- It's how we say what we are trying to say.
- We need to think through how we term things.
- Leave absolute definition a little bit more open.

### *Group One oral presentation*

We like the idea of branding this concept; we were attracted to Leanna's sense of claiming this for ourselves as NDs. But if we equate it with divine intelligence, it might be off-putting to our future. It is possible to explain the *Vis* without mentioning anything spiritual or naming it as spiritual. The thing we came down to is that *VMN* as a description, as an equation, is more important than saying



what it is. The chapter(s) should characterize the *Vis*, not define it. Bill said, "Life: you define it by when it isn't there." We are attracted to the *process of healing* versus directing something against an entity in understanding the *VMN*.

The thing that fosters the auspicious moment of change is the self-knowing awareness of the physician.

### *Group One feedback and discussion with plenary group*

The plenary group raised the following questions in response to Group One's Report:

- Are we defining ourselves based on what others will think? Or are we going to say who we are?
- Approach the *Vis* by looking at similarities, and see how they're connected to different cultures and practices.
- Defining the *Vis* in this way is a balancing act that needs to be played.
- Be true to what we really believe and dress ourselves accordingly.
- Philosophy must be flexible and enjoyable.

## Breakout Group Two – report

***Presenter: Bruce Milliman***

### *Group Two flipchart presentation*

- We did not conclude anything; we feel more time is needed
- The terminology should be secular
- The terms must be defined together, not separated.
- Nature: what do we mean by nature? (That which exists is natural.)
- *Vis* is a force, like electricity, which is a force we cannot see.
- "The *Vis* is just there."
- Its course of action (*VMN*) can be measured by its consequences; there are traces of it.
- Use language that has no baggage.
- There should be an element of bridging in our language.
- Shorthand of using the term "*Vis*" may cause confusion.
- Focus should be on the practical aspect of the *VMN*
- Need more time to reach a conclusion

### *Group Two oral presentation*

This Group had some difficulty coming to the point. They reported that they didn't conclude many things, and thought more time could be well spent to discuss this in depth. However, the group concluded that they can't separate the *Vis* from the term *Medicatrix*, and from the term *Naturae*. The term *Vis* just means force. When we put it in the whole phrase, *VMN*, we have the naturopathic medicine brand.

One agreement in this group was the conclusion that this terminology should be secular. It should be as free as possible from terms that would be confusing and that would seem to blend it with spirituality. They recommended avoiding the use of culturally problematic terms; avoid the use of words with baggage. It was also agreed that the ability to use traditional terms should be maintained but we need to engage the ability to bridge the old and modern terminology of the *VMN*. If we use religion or quantum physics there is a sense of timeliness to it. Our goal was how to take old terms



and refer to them, but not get stuck to them. The term *VMN* was a whole statement; it can't be divided out, the group agreed. We need to keep the *VMN* term as one. There is a distinction there that we need to maintain.

The group recommended clearly defining nature. When we use the word nature, there were some interesting points raised, concerning what we mean by nature. That which exists is natural, and that which does not exist is supernatural. Discussion of the "force" led to a suggestion that this force is not directly measurable but is observable through its manifestations. The *VMN* in this group was felt to be a force, which we can't see. Electricity, magnetism, and gravity are forces. That which distinguishes the rock from the frog that sits on the rock is also a force. This is a well understood argument so we should not dwell on it. This force can be recognized by its consequences. It leaves traces.

It (the *VMN*) also doesn't belong to one group. It's just there; everybody knows it. The group proposed that we as NDs should come out of the closet with it.

We were talking about using a language that was not tied to any baggage. The shorthand of using the *Vis* does not work. We've got a three layered concentric circle. *Vis* means force, there's more than that. We can respect our traditions, but we can talk in a language we understand.

Wayne Jonas: "I agree, let's get over the semantics. What's the practical aspect: what flows out of it?"

## Breakout Group Three – report

***Presenter: Emma Bezy***

### *Group Three flipchart presentation*

- It is important to bring science and religion together.
- Address the term – 'divine intelligence'.' What does it mean?
- Clarify the *Vis* and vital force – it is important to define terms based on presentations.
- Address the role of the *Vis* once matter is there.
- Draft one chapter with a variety of views on the *Vis*.

### *Group Three oral presentation*

The group emphasized the importance of bringing science and spirituality and religion back together; to be spiritual without being religious in this text. What has been lost? What do we mean by spirituality and religion? Religion is an organized dogma or doctrine. We looked at being spiritual without being religious, and being religious without being spiritual. In the past, the healers and the spiritual guides were the same people. One role of healers is to help people find their meaning in life.

There is a need to define what we mean by 'divine intelligence;' i.e., what is intelligence that is innate and inherent versus Divine intelligence? What is the difference between an intelligence that is innate, spiritual, or religious and one that is not?

The group discussed Bill Mitchell's definitions, and agreed that distinguishing the *VMN* from vital force is important. Their perspective is that the *Vis* is a larger organizing principle or field, and the vital force is within the individual. Their perspective is that the *Vis* is not a random force. Once there is matter and form, what's the role of the *Vis*. What's the role of consciousness? They



explored the question, what its role (the *Vis*) is after the creation of matter and form, and recommended stating what this role of the *Vis* is when working through matter.

The group recommended that the editors consider a chapter (versus six chapters currently conceptualized) that would highlight the various points of view. There are a variety of ways to operationalize this.

## Breakout Group Four – report

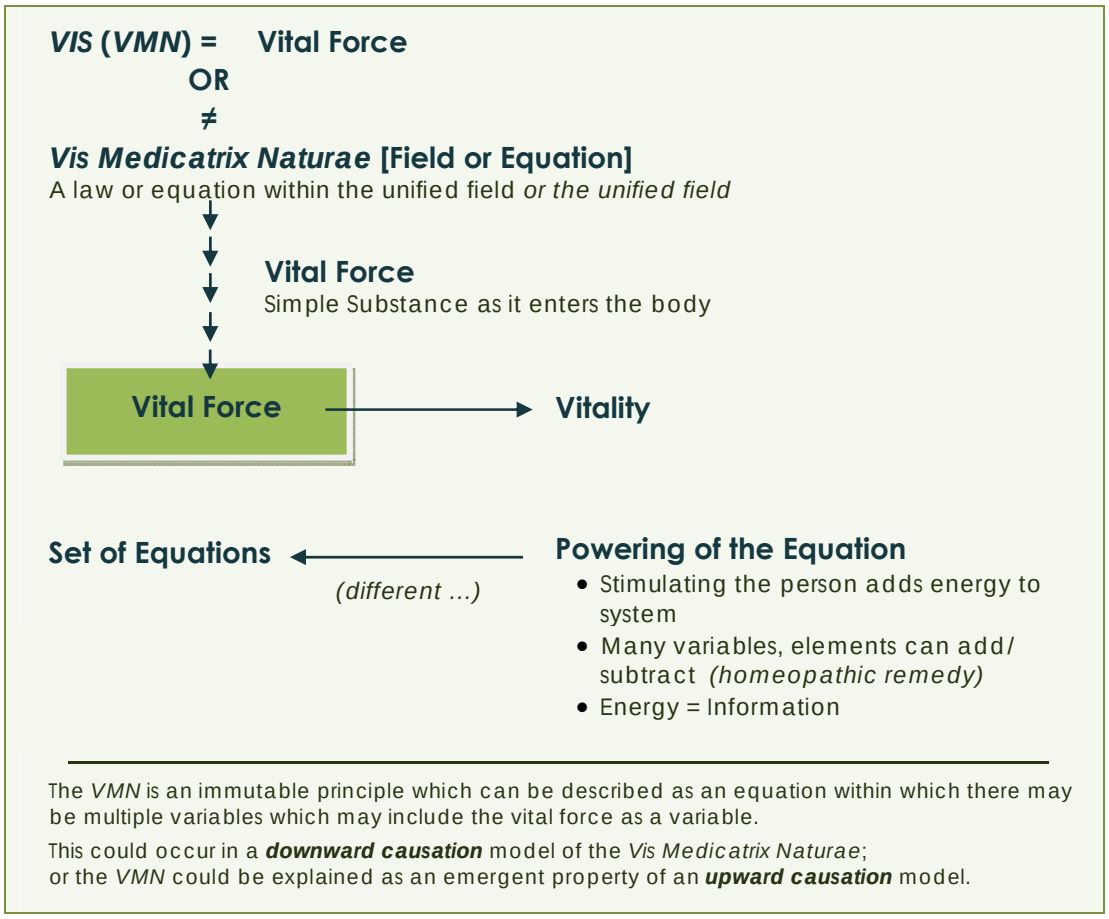
***Presenter: Fraser Smith***

### *Breakout Group Four flipchart presentation*

- Difference: *Vis* and Vital Force?
- Is there concordance between them?
- Distinction between *Vis* and Vitality.
- Overall organizational pattern: field of intelligence.
- Vitality is observable but 'changeable.'
- *Vis* as a 'power.'
- Drive towards healing.
- *Vis* as an animated principle.
- Bill's equation as a focal point.
- Equation with different variables.
- Organization of living being.
- Philosophy and understanding are different.
- Need clarity in definitions.



## *Group Four model/diagram*




## *Group Four oral presentation*

- Vitality is a product or an equation made up of many facets.
- Vitality is not the same as *VMN*.
- Vital force + vitality = manifestation of *Vis* acting within each person.
- Universal = the force within individual.
- Levels exist within levels with *Vis* at top level.
- The *Vis* is a property of life.
- Question: Does vitality include depression?

The Group presented the following question and points of agreement they had reached:

Is there a difference between the *Vis Medicatrix Naturae* [*VMN*] and the vital force [a.k.a. vitality]? We think there's a distinction.

- The *VMN* could be conceived as an overarching force of organization, an organizing field.
- The vital force is more like an overall field/pattern of intelligence as it enters a particular organism. It's a particular manifestation. It is observable and also malleable. The vital force can be manifested even on one's death bed.



- The *Vis* is a 'power.' This spawned other discussions. We discussed the *Vis* as being a power, but that's not what we mean. It's *an intelligence*, a simple substance, or it's a drive towards healing.
- The *Vis* is an animating principle, separate from the body.
- Bill's brilliant work describes the *Vis* as an equation. Maybe we're describing the observable properties of life.
- An immutable principle … which arises from downward causation
- Vitality is one aspect of the person. Vitality is a quality that can ebb or flow. It is a product of an equation made up of several facets.
- Vital force could be manifested strongly in a person who is very sick on their death bed.
- Sometimes we refer to it as an animating principle that is separate from the body. What is that field? A lot of us were interested in using Bill Mitchell's equations. It's something that changes and doesn't change.
- We have a philosophy and powerful vision.

## Reflective dialogue on *Vis Medicatrix Naturae*

### Detailed notes

***Rita:*** We haven't figured it out yet, but that's just fine. Because as soon as we figure it out and write it down, we're going to have to change it. We can write about how there are different takes on the *VMN* on the basic concepts of which we all agree.

***Paul:*** I'm in agreement with Bill Mitchell; the vital force & vitalism are separate from Vis Medicatrix Naturae.

***Richard:*** The issue is moving past dualism. This isn't all about spirit. It's also about matter. It's in the interaction that light comes from it. Getting spirit and matter to work together again seems to be the challenge in our bodies, profession and in the world together. We are getting past the historical baggage that we've inherited.

***Herb:*** My degree is in physics. I'm also a homeopath. We keep calling it the new physics. But quantum physics was formulated a century ago. When Niels Bohr accepted the Nobel Prize in physics for his study of the atom, in truth he discovered there is no such thing as matter - it's all energy. We haven't begun to apply the basic concepts. What allows a fertilized egg to grow into a human being? In The Secret Life of Plants they actually measure the energy field into which the plants grow.

***Dr. Keppler:*** Value what you measure, and measure what you value.

***Louise:*** Richard Feynman says to be a physicist you have to be schizophrenic. The concept of fields of potential and matter arising out of the fields of potential is useful. Intention can be an act of creation that affects matter. Part of this definition of matter that we're stuck in is how do you make this happen versus the philosophical idea that all of this is arising out of fields of potential? In Buddhism there is being comfortable with groundlessness and not understanding.

***Cathy:*** I'm interested in what Leanna was mentioning regarding the causal aspect of this (upward and downward causation theories of the *VMN* and spirit). What I'm interested in is how we talk about utilizing it. How it falls out in the clinical interaction.

***Wayne:*** I'll just warn you that it's a slippery slope, both scientifically and politically. Because it's getting at the issue of non-locality, acausality and all of the tools we have in science deal with



causality. Our models don't know how to handle this. We don't have the theoretical underpinnings to ask the right questions. You can spend a lot of time thinking about this, and not getting very far.

***Louise:*** The Vital Force might be universal. The *VMN* as Lindlahr defined it is the force within the individual that moves toward disease or health. Vitality might be a person's individual measure.

***Stephen:*** The *VMN* is an overarching principle. Within an individual: *VMN*. Vitality is some aspect of that. The *Vis* is a property of life, in which Vitality impacts on it in some way that causes it to be more or less effective.

***Cathy:*** What I like about Bill's equation, is that it's a both/and a thing. I want to be careful to put the bright sun over here and darkness over there. Depression is a right response at times.

***Q: Bruce:*** Your group (Group 4) seems to have differentiated between *VMN* and vital force.

***A: Member of Group Four:*** Vitality was an aspect of the person. It can ebb or flow. It is a product of the equation that we express as *VMN*. If any aspect of that equation is lacking then the result could be lowered vitality or improvement. Are these principles of qi, prana that we are explaining?

***Christa:*** The VF may be equivalent to Hahnemann's 'simple substance'. Vitality would be an individual measure of that person's innate manifestation of *VMN*.

***Jared:*** Your conclusion is that those things are not equivalent. *VMN* is not the same as vitality and is not the same as VF?

***Paul:*** One factor is that they are levels within levels. *VMN* was this overarching principle. As that becomes manifested in an individual, it becomes vitality. The *Vis* is a property of life, self affirming and maintaining life. Would we tackle these pragmatically or cosmologically? We were both. Sometimes we were cosmological, sometimes we would say: ok, what is it that we would do in clinical practice?

***Speaker:*** Vitality seems like a good time. What about depression, being in the dark. Is that vitality? I find it difficult to put it only in the bright sun place. What I like about Bill Mitchell's work is that it's a ratio between the positive and the negative. Depression is an accurate response, a pathway to meaning. There's a good thing about it.

***Jim:*** We keep talking about language that doesn't offend, and also on Dr. Jonas' comment about slippery slope this morning. We are the bastard son of medicine. Are we afraid of offending someone? Are we defining ourselves so that everyone else can love us? Or will we say who we are, and damn the consequences? Let's make it so that people do not reject concepts right away, but so that they understand the concepts.

***Thomas:*** We should embrace the slippery slope.

***Herb:*** The Taoists use water as a symbol of penetrating power. You want to do something powerfully, without engendering resistance. Regarding the bastard son concept: I've been playing the minority game my whole life, and let me say, it's a matter of dressing well. There's a balancing act. "Dress for Success."

***Joseph:*** I agree; we want to hold close to our medicine. In the past, people were enamored by medicine. People are no longer enamored. Let's hold true to what we believe, and be sure we dress it well.

***Pamela:*** Iris Bell and Wayne Jonas are part of this discussion in conventional medicine. If we step back from this choice, the conversation is going to pass us by.



***Rita:*** What if we lose our polarity with the MDs? Where would we come from next?

***Christa:*** If we're going to go down the slippery slope, we may as well ski!

***Mitchell:*** People want the experience of health. We spend too much time on the details. It's like riding a bike. We spend all this time saying we've got these really good chains, but what they care about is the experience of riding a bicycle. People want the therapeutic exchange, the lifestyle, the experience of being healthy. Other things can frame themselves with respect to that. In Ayurvedic medicine, their writings are about their medicine, not about a comparison of themselves.

***Iva:*** Regarding books on Chinese or Ayurvedic medicine, it's not a dichotomy about what they do/we do. It's "here's what we do," end of story. We need to come from a position of strength. What we do doesn't depend on what the conventional medical community does.

***Cathy:*** It is in our history though. Our history is alive with that.

***Pamela:*** It's how we say what we're trying to say. The issue is a paradigmatic issue. Conventional medicine is a changing medicine. That's not the issue. You can be an allopathic naturopath; we all know that. We need to think through how to frame the paradigmatic differences without polarizing.

***Herb:*** Everything that exists happens within a context. If you live with people who think along a certain model, how will you offer a path of choice that will give people what they're looking for?

***Wayne:*** On the other hand, conventional medicine may do this and define naturopathic medicine, and not be so generous with how they define you.

***Louise:*** We might focus on the evidence that it exists and leave the absolute definition more open – much like the concept of gravity.

## Call for liaison comments

***William:*** I'd like to remind you that this is an attempt to write a textbook of naturopathic medicine for students of naturopathic medicine. We're going out to be physicians, and not academic philosophers. It's interesting. But don't get too caught up. It's a lot of cool academia, but I care more about how to use it. We encourage you to spend your time discussing how to apply this, not about what it is. We shouldn't be so concerned with how we're going to appear to the outside or how we'll market ourselves, but how we're going to apply it.

***Wayne:*** "Do the thing you fear and the death of fear is certain." *– Ralph Waldo Emerson*

***Pamela:*** "We all sit "round the ring and suppose, but the secret sits in the center and knows." *– Robert Frost.*

***Stephen:*** The art is the knowledge we bring to the experience of practice. What we write has to lead to the practical experience of the practice of naturopathic medicine.

***Joe:***[6] *Read a quote from Bill Mitchell at the last gathering, on the force*

"There is a force created by the space between what we expect and what we can dream. It is a real force, a real space for "nature abhors a vacuum," and so the space tends to pull the lagging edge to the potential edge.

- The "force" prompts fulfillment.
- This space catalyzes revelation.
- Synchronicity is the everyday experiencing of revelation.
- This occurs when we allow revelation to be a major part of our life. "Ask, and ye shall receive." *Jesus*



- When the student is ready the teacher appears.
- The doctor provides space. He/she provides the larger container for the patient's life….

***Iva:*** This book will also be used by anyone who wants to know about naturopathic medicine, not only students.

[6] NOTE: Joe Holcomb is referred to as "Joe" and Joseph Pizzorno as "Joseph" throughout this document.



# Systems Theory – Dynamic Solutions for Complex Problems in Naturopathic Theory and Practice

Christa Louise, PhD, MSW and Iris Bell, MD, PhD

### *Charge of Session*

Through an overview of the field of Systems Theory, its main concepts, and terms, to explore and improve conceptual rigor and critical inquiry concerning the foundational concepts of the *Vis Medicatrix Naturae*, spirituality and the process of healing.

### *Deliverables and Goals of Session*

- Provide editors with an understanding and overview of systems theory and how it applies to core models in the text.
- Provide solutions for problems raised concerning the core models of the text re order and individualization.
- Increase rigor and capacity for scientific exploration of concepts in naturopathic philosophy.

## Summary and outcomes

*Includes core areas of coherence, diversity, omissions, and controversy; also relevant models created by attendees.*

Following presentations by the speakers, the group as a whole was asked to explore several key questions to ensure that editors were enabled to apply Systems Theory effectively to enhance the text's ability to articulate naturopathic theory and naturopathic medicine in a scientifically rigorous fashion. Presenters, Dr. Louise and Dr. Bell, remained to answer participants' questions, and help participants to explore the following:

- How does systems theory help us to understand our philosophy in a new, clear way?
- What have we learned to enable greater conceptual rigor in our field?
- Does this define our unique identity, and capture the heart of naturopathic medicine?
- Are we closer to identifying a unified theory?

Generally, participants felt that systems theory offered a modern way to understand and model naturopathic medicine; however, at the same time, there was discussion and debate around whether or not systems theory provided any truly new insights about naturopathic medicine beyond what many had learned in naturopathic medical training.

At the same time, it was understood that while naturopathic medicine is working within and moving toward the 21st century model of science, it is doing so "with 19th century basic sciences." A significant impact in improving the rigor of the naturopathic philosophical lexicon would be made by teaching systems theory to the current generation of students. Teaching from the perspective of communicating the "classics" of naturopathic medicine and updating the classics within a systems theory framework, including incorporating modern knowledge about health, and healing and our 'modern world' is recommended. It was suggested that current PhDs and professors within the naturopathic academic community be provided with faculty development opportunities to learn systems theory in order to update current curricula and transfer the knowledge and thought processes to new students.



Given systems theory's relevance and growing impact within the scientific and medical communities, participants agreed that it would be beneficial for it to be part of the curriculum within naturopathic colleges.

Reference was made to *The Web of Life*, by Fritjof Capra, in which systems theory is articulated from the perspective of emergent properties. Each level of complexity demonstrates properties that were not predictable at the previous level of complexity. When exploring the healing of human beings, it is understood that people are still a part of a much more complex system, giving rise to increasingly higher levels of complexity.

The question was asked, does the profession, in the light of systems theory thinking, "update its own language" in order to better explain its inherent observations, assumptions and theories of healing and disease, and become conversant with today's scientific culture, advances, and language?

Participants expressed the desire to incorporate naturopathic medicine's rich history and culture within any systems theory applications within the teachings of naturopathic medicine.

Naturopathic medicine is seen as complex and not protocol driven, to which it is viewed as [not] difficult to apply a systems theory model. Additionally, it was suggested that the textbook and the profession "factor in" and "assess" individualization of care within the framework of systems thinking. Participants also suggested that given naturopathic medicine's view about the inherent interrelationship between nature, environment and health, that any application of systems theory in this text incorporate this traditional and foundational natural systems philosophy and theory of health.

Participants expressed the need to collect more data within the naturopathic field in order to provide raw study materials to incorporate within systems theory applications. Insulin was suggested as an example of a potential model to demonstrate the impact of its use on the entire body.

There was a sense of potential in using and understanding systems theory so that "science can explain what naturopathic doctors do, the healing power of nature, and the process of healing, rather than "having to do it ourselves on an individual by individual basis." Since naturopathic doctors treat the whole person (while study occurs based on parts of the whole person), systems theory was seen as an opportunity to "put the sciences together without taking them apart first."

## Reflective dialogue on Systems Theory

### *Flipchart notes*

- Molecules are transferred forward through egg and sperm – how does this influence or effect us?
- Note research on the memory of water.
- There was not anything that was different from what I heard in medical school.
- Where does that leave us? Update our language. Do we connect with past to come up with new terms?
- Debate our different languaging.
- Research advances that will help with the practices of naturopathic medicine.
- Naturopathic medicine is not protocol driven. Naturopathic medicine is complex.
- Everything is related, e.g., we relate with our environment, maybe we need to do that more.
- Systems thinkers are able to help bridge worlds.
- What are the challenges? Data collection in researching systems is difficult..
- You can use models, e.g., how insulin levels can change the whole body.



- We need to look for patterns.
- We need to factor/assess individualism.
- The closer we get to curative influences, the less local and more global the effects.
- Systems theory should be taught through AANMC in naturopathic medicine colleges.
- We are moving towards 21st century model of science, but with 19th century basic sciences. How do we integrate systems theory? Is it possible to learn and have instructors teach system theory now, for this generation of students? And, the answer is YES.
- Reaffirm in naturopathic medicine education that we are part of a much more complex biosphere.
- The challenge: communicate the classics and update them.
- All parts need to be healthy for a system to function.

## Discussion notes

***How does systems theory help you understand the practice of naturopathic medicine in a different way?***

***Stephen:*** Part of our challenge is not just to rework the legacy of our elders. It's also to incorporate the knowledge of our modern world. These happen in an interactive model. We're not just interpreting our history. We have to incorporate modern conceptualizations.

***Herb:*** Water carrying memory. From the standpoint of quantum physics, then what happens when people are from generation to generation exposed to certain mental/emotional environments? What does that mean for African-Americans in the context of slavery; and for Jews in the context of many years of abuse at the hands of Christianity, culminating in the Nazi experience? Anyway, the issue of memory of water is very fascinating. Thank you.

***Jim:*** I've yet to hear anything that contradicts anything I learned in medical school. I was struck by Iris' comment that in complex systems, we don't invoke the idea of spirituality, because complex systems organize themselves in the best way possible in their environment. What's the "juice" that makes them do that?

***Iris:*** Yes, that's the ultimate question. The people in the field of *Complex Systems* do not want to go there.

***Mitchell:*** We all do mechanistic too. It's not just the vitalistic. It's a false dichotomy. What's important is the interaction.

***Jim:*** I'm struck by the fact that we're moving toward a 21st century model of science using 19th century basic sciences." Where can we find the faculty that can teach what you guys are talking about today?

***Christa:*** It's a matter of training your PhD physiologists in this.

***Don:*** How do we have graduates come out so that they can use this in some way?

***Christa:*** To become a naturopathic physician takes a lot more than becoming a medical doctor. You have to think more about things.

***Louise:*** In *The Web of Life*, I first heard about *systems theory*. Capra talked about emergent properties. Each level of complexity demonstrating properties that was not predictable at the



previous level of complexity. When we are looking at healing human beings, we are still a part of a much more complex system.

***Pamela:*** The old writings of naturopathic medicine, the old nature doctor's writings, they all embedded vitalism in complex systems. Our challenge is to communicate the classics, as well as update those and bring the framework forward without losing what we have. Correct these classics where wrong, but don't lose them. Connect them to today.

***Stephen:*** Gregory Bateson's *Steps toward an Ecology of Mind*. He put forward the idea: can the people in Chicago be healthy if they lived on a lake that was diseased? He suggested that they could not.

***Herb:*** Injustice anywhere is a threat to justice everywhere" (Martin Luther King). If any part of the planet is diseased, we are all diseased.

***Joseph:*** Back when I used to be in daily private practice, I always used to ask patients how they were feeling, before I asked about the changes in specific symptoms or results of treatment.

***John:*** Focus on the business case for a moment. As you move from specific to the global, there's a way that makes the business case: functionality, presenteeism, absence of accessing services. What if the students are taught, these are our endpoints: feel better about themselves, more present/functional, access fewer services (because they don't need them, not because they can't!).

***William:*** I'm excited about the ways of using systems theory. Science is explaining it (naturopathic philosophy), rather than having to do it ourselves. We treat the whole person, but we study the parts. This seems like a way that we could put the sciences together without taking them apart first.

***Christina:*** If systems can provide a way to set up our models in a way that incorporates this, we'll be seeing a whole new profession in 10 years.

***Jim:*** I just had an epiphany about moving toward more global measures. Paragraph nine of the *Organon*. "Purpose: to use our reasoned gifted mind ….for its higher purposes."



# The *Vis* or More than the *Vis*?

# This is the Question! – Determining the Relationship between Spirit and the *Vis Medicatrix Naturae*

Emma Bezy, MSW and Louise Edwards, ND

### *Charge of Session*

To explore the inherent definitional challenge of spirituality and its relationship to naturopathic medicine.

### *Deliverables and Goals of Session*

- To determine the clarity and/or consensus and/or conflict around how spirituality is a part of naturopathic medicine and its practice.

## Review and outcomes of the session

Presenters, Emma Bezy and Dr. Louise Edwards, opened the session with a presentation, and then participants were asked to discuss the following:

- What are the defining elements of spirituality?
- Is consciousness the same as spirit?
- Is the *Vis*/vital force:
- a manifestation of spirit?
- a force used by spirit?
- the source of the spirit?
- the same as the spirit?
- unrelated to the spirit?

The large group discussed these questions, bringing to full circle the earlier discussion on the spiritual concepts and questions about these concepts, inherent within a definition of the *Vis Medicatrix Naturae*.

### *Regarding the defining elements of spirituality*

Overall, there is widespread agreement that a sense of spirit and/or spirituality is part of optimal health.

- Health in and of itself is seen as the goal. Based on Hahnemann's theory, the purpose and reason for health is to use the reason-gifted mind for the higher purposes of existence.
- Good health is viewed as a way to realize and express oneself; to live out one's purpose.
- Another defining element is to appreciate the relationship to the larger whole, the universe.
- There needs to be a reference to morality, particularly "getting along" with other human beings. A sense of service to others is critical to developing gratitude and humility. Being in the healing fields offers that.
- Optimal health provides the freedom to optimize one's potential – free to be the "person one is meant to be." Humans are more than a "bundle of nerves." There is a sense and understanding of free choice and free will which can and does choose action and direction in life.
- The text should further define the difference between healing and curing.



- An optimal role healthcare practitioners hold is to bring "light into darkness."
- Within the naturopathic cosmology, need to separate religion from this discussion and focus on patients' unique spiritual situation and beliefs. To include spirituality within a naturopathic worldview, we need to understand what causes patients to "reach for something bigger than themselves … what empowers them to express truth, beauty, goodness in their lives." Also, "having a sense of purpose, without which is to be in spiritual crisis."
- The definition of spirit is breath, which may be incorporated within the naturopathic worldview.

### *Regarding consciousness and spirit*

- The discussion focused on the nature of consciousness and spirit, with consciousness being a function of awareness of the mind, and spirit being subject to a variety of interpretations, which meant that it needed to be respected as an individualized construct. Participants suggested emphasizing experience rather than belief systems, which can vary greatly across cultures and individuals. Consciousness could be considered part of spirit, but it was suggested not to equate the two.

### *Regarding the* VMN *and vital force and spirit*

- Vital force is seen as a force used by the spirit.
- Spirituality is an aspect of the individual that comes via the vital force, not spirit, which is a noun, a thing.
- It may be difficult to define spirit, but we just measure it indirectly by measuring the epiphenomena.
- Must ensure that we do not equate spirituality with good health. "Even mystics get sick."
- *Vis* is seen as "manifesting locally in the creation of life matter, and out of this life matter comes consciousness."

## Detailed proceedings from plenary discussion

## Reflective dialogue

### *General comments*

- There is a lot of research indicating we can affect our physical form and events through intention, prayer and meditation. We can affect other individuals and conditions in our environment.
- We can gain information without using our five senses, via intuition, dreams.
- Scientifically it's impossible to define what is a true margin, because of mixed energy fields. Basic particles flick in and out of existence. We look like we're solid, but maybe a thousand times a second the particles that make us up are flicking in and out of existence. Wow! That leaves a lot of room for change.
- Time is non-linear. There's some evidence that we can affect our past. This is interesting when we think about healing childhood wounds.
- Book: *Oneness* by Jeffrey Moses, found that love and compassion is a theme in all world traditions as a source of healing.
- A study measured the function of the immune system by measuring secretory IgA, which went up, just by remembering the experience of being loved.



## Specific comments

***Mitchell:*** Transcendent versus imminent spiritual traditions.

***Wayne Jonas:*** If you look across traditions, there are basically four models of healing. Some are very reductionist, linear, causal; i.e., it's not across the board in spiritual practices. The difference between consciousness versus spirit should be discussed.

***Bruce:*** Consciousness is the experience we have when we are experiencing conscious energy.

***Thomas:*** One of my ex-wives is a psychic. She spoke to spirits. Spirits have consciousness, according to her.

***Jim:*** Why can't you use consciousness to boil an egg?

***Stephen:*** In the Hindu approach to life, there's a sense of people being asleep, even though they are conscious. This defines a difference for me. Awareness of consciousness is the property of the body having a brain.

***Mitchell:*** I'm wary of using the word 'spirit.' Spirit, soul, these things have a lot of specific definitions. Spirit is part of a dualistic or tri-istic model that we may not agree upon. We should be watchful of mushing things together. Emphasis on experience, rather than belief systems. Experience is what brings people back.

***Christa:*** I think animals have spirits but I think they have different levels of consciousness. Consciousness is part of spirit but I wouldn't equate the two. Is the *Vis*/vital force a manifestation of the spirit? A force used by the spirit? The source of the spirit? The same as the spirit? Unrelated to the spirit?

***Iva:*** You could say all of them.

***Thomas:*** A little group in the back is unanimous that it's a force used by the spirit.

***Paul:*** I'd rather use the word spiritual as an adjective [an aspect of the individual that comes via the vital force], not spirit, which is a noun, a thing.

***Wayne:*** At the Samueli Institute, we don't define spirit, we just measure it. How? It's not directly measurable. Instead, we measure the epiphenomena.

***Louise:*** There is evidence there is something happening, but the source is inexplicable.

***Mitchell:*** There is value in being wary of the assumption that being spiritual is being healthy. To equate the two is dangerous. The Dalai Lama visits his physician. Mystics have physical problems too.

***Joseph:*** The *Vis* manifests locally in the creation of life matter, and out of this life matter comes consciousness.

***Mitchell:*** Paracelsus said this stuff.

***Wayne:*** To assume intentionality has causal effects, there are great risks. Be careful of the risk of blame.

***Herb:*** This really hits with children: they're angry with their parents and then suddenly the parent dies, and they think they're to blame. What are the defining elements of spirituality that might feed into a good clinical/research definition (and applicable in our cosmology)?



***Jim:*** I've been thinking all these years that health itself is the goal. Hahnemann tells us that the reason to have our health is to use our reason-gifted mind for the higher purposes of our existence.

***Cathy:*** I ask people: why do you want to be healthy? It's about realizing and expressing yourself. Living out your purpose. It's not about getting into your size 10 jeans.

***Jared:*** The defining element of spiritual health being the relationship to the larger whole, the universe.

***Christine:*** It is important to not only be stuck on intellectual faculties. The text should also bring in morality, getting along with other human beings.

***Leanna:*** When I heard the quote [Hahnemann], I thought what he meant was that your higher function was to be awake.

***Jim:*** The English translation is about using our reason-gifted minds for "the higher purposes of our existence," as opposed to using our higher faculties.

***Don:*** We can look at the practical aspects of it. Optimal health is having the freedom to be the person you are meant to be, free from the distortions of living in an imperfect world.

***Fraser:*** We are a distinct being that has free choice. We choose action, we choose direction. We are not just a bundle of neurons. Part of the appeal of naturopathic medicine is that people feel that that truth is respected.

***Letitia:*** My patients whom I feel are spiritually balanced have gratitude, humility. When they find a level in their healing, they find a service. They serve others in some way. That's what happens when they come into that balance of spirituality.

***Rita:*** Death is a victory. We're all going to go there; we're all going to win. There's a higher purpose that transcends this ego. If I thought that our goal is to have a good life in this one life in this one body, I don't think I'd be a doctor in this life. I knew a four year old girl dying of a neuroblastoma, and she brought spiritual gifts to everyone she met. Spiritual adepts are unhealthy (my personal belief). A spiritual adept is someone who brings gifts to others. It includes the step past death. People who are very old souls tend to go through serious depression. People who are calm, cruising through life, aren't being tested in this life.

***Emma:*** What's the difference between healing and curing, but also how do we define disease, failure?

***Pamela:*** How to define spirituality in our practice, and not confuse it with our own views, but hold space for the patient? With my patients I ask: what is that makes you live? Makes you want to get up? Reach for something bigger than yourself? Express truth, beauty, goodness in your life?

***Herb:*** I've had the occasion six times to go into a Washington State prison. These death-row inmates, murderers, wanted me to come back time and again. Bring a light in. Elevate the energy of the place by reaching out to people in their darkness.

***Stephen:*** One of my doctoral students is doing her thesis on Spirituality in Natural Medicine: Reality or Rhetoric? In the naturopathic curricula, I'd be hard-pressed to figure out where spirituality comes in. There are critical components of care that are tied in. First thing, we must completely unpackage it from religion. It's not that spirituality can't have a religious component; it is just that we can also talk to an agnostic or an atheist or a pantheist as well. It's about having purpose in life. It's about feeling like life has joy and happiness associated with it. It is feeling like there is something they can hold on to that has meaning for them. When they lose their sense of purpose, this is spiritual crisis, and we need to address this.



***Joseph:*** Our patients know what their spirituality is. It is best if we can leave it open-ended, without putting a definition on it. Religion set aside, on a scale of one to 10, where is your spirituality. What's keeping you from being a 10. They know what it is; they know what they're at, and what their obstacles are.

***Jay:*** When you get a photo, find an image of yourself approximately half your current age. As you meditate on it, consider that that's a person that's dead. All those cells have died and gone away. But the spirit is still here.

***Jim:*** I'm very sensitive to the fact that of the 11 basic premises that you laid out, that all of them with the possible exception of number 11 are well-known to or part of most esoteric traditions on the planet *[Louise: acknowledges that's a given]*. It's now OK to talk about this because science says it's okay. The religious structure of our day which we call science is putting its stamp on this and it's now okay to come out of the closet. A Cherokee medicine man told me once: "It's amazing; you scientists are getting closer and closer to the truth all the time!" We should not be evaluating the spiritual traditions with the blessing of science, but exactly the other way around.

***William:*** As human animals, we are social creatures. I see spirituality as a factor of relationship, to my world inside, to my world outside. It's all about relationship.

***John:*** Here's an anecdote about Bill Mitchell. Trying to raise money when there's no way to raise money, he went to his patients. This is one way for patients to engage within the community. 116 of his patients did!

***Cathy:*** I had a woman in my tub out on my deck. She was noticing her breath in the cold air, and the steam rising from the tub, and realizing we are all connected through these vapors. In Chinese, the symbol for chi is steam rising from the rice bowl.

***Louise:*** That reminds me that the word Spirit means Breath.



# Epistemology and Medical Phenomenology

## A Primer with Implications for Naturopathic Theory and the Foundations' Text

Christine R. Grontkowski, PhD

### *Charge of Session*

- To assist with editor development.
- To expand conceptual rigor concerning the foundational concepts of naturopathic philosophy as a whole system in the context of classical epistemology and medical phenomenology.

### *Deliverables and Goals of Session*

- To increase rigor and capacity for scientific exploration of concepts in naturopathic philosophy.
- To enable editors to understand the principles, theory, and philosophy of naturopathic medicine in relationship to epistemology, medical phenomenology, and the philosophy of science.

## Review and outcomes of session

Participants engaged in a full group plenary discussion with presenter, Dr. Christine Grontkowski. An appreciative discussion occurred with questions asked of Christine surrounding the impact of phenomenology on naturopathic medicine and philosophy, as well as a review of the following two questions:

- What new discoveries have we made during this presentation?
- What kinds of questions arose for you?

### *Feedback included*

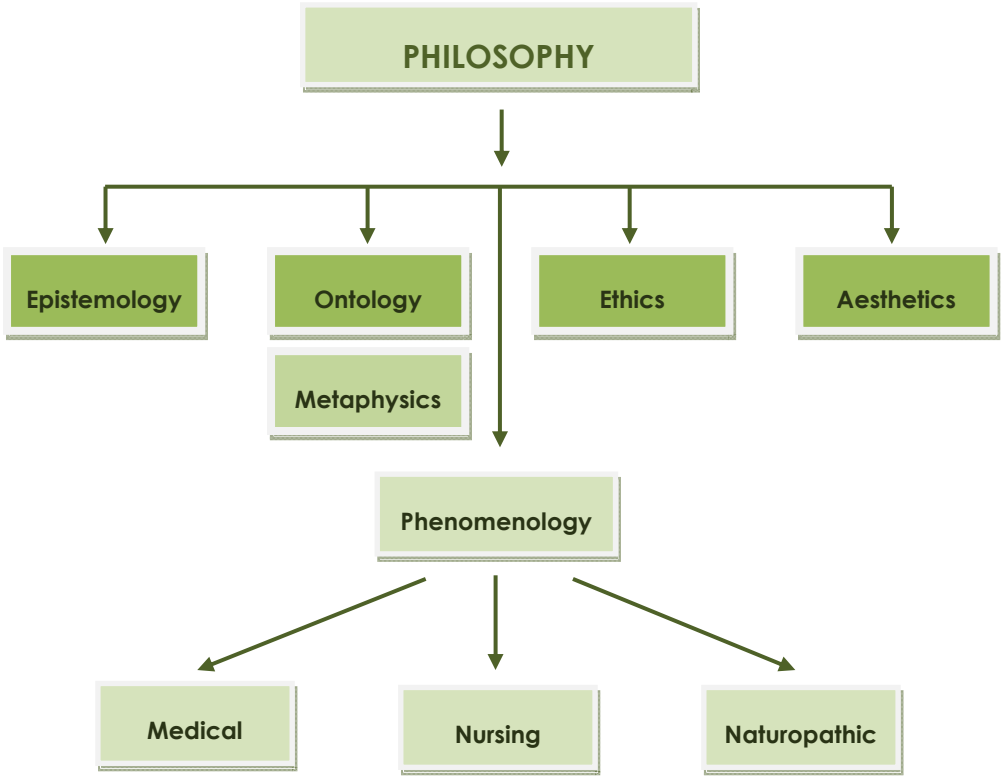
- In order to apply phenomenology to naturopathic medicine, the profession needs to undertake more or continued research, curriculum development, and formal teaching to demonstrate the connections between current naturopathic medicine, science, philosophy, and traditional phenomenology.
- It was agreed that understanding mind-body medicine and homeopathy is a revelation and revolution in medicine.
- In naturopathic medicine, it is understood that there is more inductive thinking necessary (contrasted with deductive, of which there is also a significant amount), given the depth of listening required to treat patients. "Listening has a greater value than logic in the naturopathic profession." Although, listening can nonetheless be viewed as a way to collect facts. One way to explore this is to recognize the teaching of diagnosis as necessarily deductive, and the simultaneous use of compassion as inductive.
- The discussion echoed the dichotomy between empiricism and rationalism. Conventional medicine can be seen as rationalism, whereby a preconceived notion is imposed on nature; whereas, naturopathic medicine could be seen as empiricism, allowing nature to reveal itself.



- Research in phenomenology includes qualitative and quantitative methods to explore and examine a full scope of evidence and to establish evidence-based medicine. Research in the area of mind-matter interactions, for example, could "turn philosophy and science on their heads."
- The *Vis Medicatrix Naturae* could be brought into the naturopathic ontology AND phenomenology because it is seen as real and a fundamental truth. The way to do so is to coalesce the different forms of the *VMN* into one definition.

The following diagram was created to express how naturopathic theory would fit into a larger philosophical metric:

## Fitting Naturopathic Philosophy into This Larger framework




NOTE: Christine Grontkowski volunteered to write a section in the text on this subject matter.

# Detailed proceedings from plenary discussion

### *Flipchart notes*

- Biomedicine as a dominant paradigm.
- Revolution on its way in biomedicine.
- Voltaire's definition of metaphysics.
- NM as inductive thinkers.
- Diagnosis: deductive; Patient: inductive.
- Beginning of a whole new set of thinking in philosophy.



- Naturopathic medicine – allows nature to speak to us.
- Listening to patient's story.
- Need to address full scope when examining categorizing the *VMN*–ontology, phenomenology and epistemology.

## Reflective dialogue

***Leanna:*** Thank you, Chris, for bringing the idea that phenomenology has something to teach us in naturopathic medicine. If we embraced phenomenology, how would it impact:

- practice
- teaching
- research?

***Christine:*** You have already embraced it; you just didn't know what to call it yet in the language of theoretical philosophy. What you could do is show the connection to traditional phenomenology [Heidegger].This will make a strong connection into philosophy of science as a field, so that things such as this [book and naturopathic philosophy] will begin to be recognized by the rest of the world.

***Paul:*** Do we have to do phenomenological research first, before clinical research?

***Christine:*** I don't think so. I'm not sure. You probably have to try to understand that yourselves. One almost always does the traditional medical research first, and then tries to extrapolate that to phenomenological theory.

***Joseph:*** If you were to do a survey of naturopaths, do you think you'd find a preponderance of deductive versus inductive thinkers?

***Christine:*** My hunch is a preponderance of inductive thinkers. I think listening has a greater importance than formal logic to naturopathic doctors.

***Paul:*** I think we mix them. There must be deductive, to exclude certain diagnoses. But when present with the patient, more inductive. It is exciting – switching between them. This is difficult – to train students to do this. But it is interesting to contemplate this.

***Christine:*** This could be the beginning of a new set of contributions to the history of science. A combination of inductive/deductive could be another point in the "Argyle-sock" development of the field.

***Herb:*** The history of homeopathy has been allowing nature to speak to us empirically, and coming to conclusions about that.

***Cathy:*** The Nature of Suffering and the Goals of Medicine talks about listening to the patient's story. The physician's hearing of that gives facts from within. The most important clinical skill is tolerating uncertainty.

***Wayne:*** Research methods fall out into the same interesting dichotomy. Qualitative research falls out of phenomenology. To be evidence-based, you must look at the full scope [including the qualitative].

***Pamela:*** With regard to the Vis, one makes a decision to admit something into one's ontology if one believes it's real. Is there another way we can locate the healing power of nature? Can the Vis move into several layers of the diagram?



***Christine:*** I see several methods of categorizing the Vis, rather than giving it a definition. The different linguistic forms bring in different nuances. It is good if all of that could coalesce into one definition. But it belongs both to ontology and phenomenology, and it may also belong to ethics in a novel sort of way, because part of the work you do has something to do with how moral the actions in your work are.



# Process of Healing and Therapeutic Order Theory

Jared Zeff, ND, LAc; Pamela Snider, ND; Stephen P. Myers, ND, BMed, PhD; James Sensenig, ND;
Joseph E. Pizzorno, ND; Mary Koithan, RN, PhD, APRN, CNS;
Christina Arbogast, ND; Roger Newman Turner, ND; Iva Lloyd, ND;
Herb Joiner-Bey ND, DHANP; and Mitchell Stargrove, ND, Lac

### *Charge of Session*

An in-depth panel discussion to address emerging constructs in naturopathic clinical theory and philosophy, which express naturopathic physicians' world view, understanding of the process of healing, how disease or illness develops, and what creates, sustains, and supports health and vitality, and what disturbs or obstructs it.

### *Deliverables and Goals of Session*

- Proceedings on the Process of Healing theory in the form of outlines, executive summaries and visual models, which capture coherence, concordance, diversity, and conflict, and are moving towards a coherent theory on the process of healing. These proceedings will capture determinants of health and the nature of disease, and incorporate naturopathic philosophy, principles, laws, our critical inquiry, and Delphi data.
- Exemplar of Lindlahr's matrix analysis, with Lindlahr's concepts connected to concepts in new sciences such as Systems Theory.
- The proceedings for this session captured visually and in the form of revised executive summaries and outlines of this section.

## Plenary summary and outcomes

A draft Executive Summary and new visual map of the Process of Healing theory and its models were presented, which incorporated key trends found in the drafts of forty contributor submissions to the FNM on this topic. Early returns from the Delphi Survey on the Process of Healing and Therapeutic Order were presented. The survey expressed general support, numerous modifications and improvements, addressed problems with the constructs, and voiced a minority dissent.

Executive Summaries of the panel members presented emerging changes and improvements, representing evolution to the process of healing theory. Panel members presented these as an in-depth series of focused commentaries and trends, inviting exploration of language and constructs with all participants. Detailed panel presentation summaries begin on page 177 in the Retreat Book, Volume I.

### The Process of Healing: Constructing and Evaluating Naturopathic Theory
### *Researching Nursing Theory: How We Did It*

Special guest and panel member Mary Koithan RN, PhD addressed the development of concepts for a naturopathic 'Metaparadigm' as part of the process of healing, which could then be applied by the Editors to refine and enhance rigor in the text discussion. The Metaparadigm and meta-theory constructs introduced by Dr. Koithan, create an understandable construct for organizing both coherence and diversity taxonomically throughout the text.

It was understood and celebrated by participants that such a construct provides a recognized model for the unity and diversity extant in the profession, and a container for the orderly evolution of



clinical theory, principles and the philosophy of naturopathic medicine. Participants were enlivened by this presentation and agreed to make changes to the agenda in order to provide time for participants to hold a full session on this, to better understand the constructs and to apply and develop them for the text. The Process of Healing Session was redesigned spontaneously to include an emphasis on this new area of dialogue. A Special Session Report in the Proceedings captures this new session, its findings, outcome, and discussion and can be found on page 59 of this report.

## Process of Healing and Therapeutic Order
### *Plenary summary and outcomes*

Six key outcomes arose through the large group's discussions on the Process of Healing and the Therapeutic Order. Due to the decision to establish a session on the Metaparadigm,

These findings have been collected and summarized from a number of sessions and are collated here for ease of access. A number of these findings are found located in the appropriate Session Report. It is notable that issues of individualization versus the linear nature of the model were addressed, along with recommendations to move structure to an earlier level of priority. Finally, assessment and acute management components were fleshed out.

### *I. The Delphi Survey: developing a response to the Process of Healing and Therapeutic Order*

Preliminary results of the first survey distribution, discussed briefly here, were presented for discussion to the Foundations editors at the April Retreat, and later to the members of CCACO. Full results of the survey were distributed to both groups for use in their respective projects, as well as at the Symposium following publication of the text. Feedback from these groups will be utilized to further refine the survey for a second distribution set to be completed by December 2007. These early returns were reported to the Editors from the Delphi Survey (sponsored by FNM and CCACO/AANMC) by core team members Christina Arbogast-Woolard ND (Liaison to CCACO and Foundations group), with comments from Richard Barrett ND, Professor at NCNM. The full report is below:

The Delphi survey is sponsored by the Foundations of Naturopathic Medicine Project (FNM), and the Council of Chief Academic and Clinic Officers (CCACO). The initial distribution of the survey occurred in March 2007 to a pilot group that included a select number of students, faculty and administrators at naturopathic colleges, as well as Foundations Project editors and authors. The survey was distributed with both AANP position papers and the article *The Therapeutic Order (TO)* J. Zeff, P. Snider, S. Myers.

The goal of the Delphi Survey was to receive feedback on the following question: How can we refine a clinical theory or practice model that demonstrates what is distinct about naturopathic clinical thinking, reflects the traditional concepts of naturopathic theory, and does not represent a dogma, and which approximates the heart of naturopathic thinking?

85% of the respondents to the survey felt they were sufficiently familiar with the therapeutic order/hierarchy of healing and the naturopathic model of healing, with almost 30 stating that they had developed their own model or a modification of the therapeutic order for use in clinical practice. 64% felt that their naturopathic education presented an integration of philosophy into clinical theory, though a number commented that they felt there was not enough integration, and insufficient structure regarding clinical implementation.



The majority expressed agreement that the naturopathic profession needs a coherent clinical theory, and that the TO and the process of healing could, upon further modification and expansion, provide valuable tools to practitioners. Examples of the critical comments on these theories included the following: the models need flexibility; the models should contain algorithms; the term hierarchy implies judgment and is restrictive; the model should allow for complexity and individual assessment; the model should reflect the diversity of the profession.

The Delphi 2 study planned for fall of 2007 will address some of the issues in the first distribution which affected outcomes. The second distribution will have a larger target population, a longer response time, and further refinement of the questions to increase respondent totals.

## *II. A Metaparadigm was addressed and cultivated*

Perhaps most importantly, for the first time in the history of the naturopathic profession, a Metaparadigm was addressed and cultivated. Now under revision and further refinement by the Senior Editorial team, and for distribution to the entire team for input, the group as a whole supported the key elements in this first round of synthesis that could be included within (but not limited to) the Metaparadigm, including:

1. *Vis Medicatrix Naturae*
2. Therapeutic Relationship
3. Natural State
4. Health
5. Dual Effect
6. Holarchy [7]
7. Individualization

## *III. Relationship of epistemology, phenomenology with naturopathic theory and principles*

Additional concepts proposed by the participants, metaparadigm breakout reports and discussion are reported in the "Special Session Report on Metaparadigm," which follows. To further the development of the Metaparadigm construct, a graphic was created to express the relationship between epistemology, phenomenology, naturopathic theory and principles for further discussion, revision and integration with the Metaparadigm and meta-theory constructs and model. (Special Session Report begins on page 59.)

[7] A holarchy, in the terminology of Arthur Koestler, is a hierarchy of holons—where a holon is both a part and a whole. The term was coined in Koestler's 1967 book, The Ghost in the Machine. The term is also used extensively by American philosopher and writer Ken Wilber. The "nested" nature of holons, where one holon can be considered as part of another, is similar to the term Panarchy as used by Adaptive Management theorists, Lance Gunderson and C.S. Holling. The universe as a whole is an example of a holarchy, or holarchical system, and every other holarchy we are aware of is a part of this larger holarchy.



**Philosophy**

**Epistemology** | **Ontology** / **Metaphysics** | **Phenomenology**

**Naturopathic Phenomenology** | **Medical Phenomenology**

**Naturopathic Philosophy**

**World views based on the Healing Power of Nature:**
* The *Vis Medicatrix Nature*
* Spiritual
* Ecological
* Holistic (nature/mind/body/spirit)

**Principles of Naturopathic Medicine (6)**

**The Process of Healing: A Unifying Theory of Naturopathic Medicine**

**Healing and Illness as Process & The Nature of Disease (Process Logic)**

**Doctrines and Laws of Healing**

**Assessment Order** ↔ **Therapeutic Order**

**Naturopathic Model: Healing as Process**

**Determinants of Health**

- Move correct structural integrity to 1st level
- Nested systems model (holarchy)
- Star model *P. Mittman*
- Flower model *P. Mittman*
- Concentric circles (3) *A. Moore*
- Order vs. individualization (systems theory)

- Role of vitality in healing reaction
- Physiological phases of disease progression
- Science of suppression
- Physiological normalization
- Adaptation theory

- Rename to "terrain"
- Emphasize biochemical uniqueness, genomics
- Interplay between lifestyle and environment
- Toxemia theories
- Health factors and foundations of health



## *Critical inquiry dialogue*

### *Student Notes #1*

***Christine:*** Are there any naturopathic physicians in Africa? I think of malaria, of HIV/Aids, of the suffering in Darfur, which must have created so much PTSD. Are there NDs with Doctors without Borders? All of those things have to have a kind of moral command, the ethics to take those things to other places in the world, the site of suffering?

***Don:*** I went to Africa last year, Nairobi, Kigali, Rwanda. There are slums in Nairobi.

***Jim:*** Farqhuarson is training barefoot doctors – treating three thousand patients a month. They are working with retroviral drugs for HIV. Working with "barefoot doctors" teaching them some basic naturopathic medicine.

***Herb:*** Dr. Hope Faith is setting up a clinic in Zimbabwe. She's an ND and a midwife. There is no reason we can't extend these therapies to that part of the world. They tend to be very inexpensive. In the Peace Corps, the credentialing is very conventionally oriented. Gates Foundation says, you have to be connected with a pharmaceutical company. For example, let's look at some homeopathic human growth hormone:

- Asked for funding. For increasing the growth patterns of kids that have been dwarfed by AIDS – can't because need to be associated with a pharmaceutical company.
- NDI – Naturopathic Doctors International.
- Naturopaths without Borders – Caribbean, South America, Relief Fund for Tsunami.

***William:*** Southwest College has a program called Naturopathic Physicians Without Borders.

***Christina:*** Students from Bridgeport have gone to Nicaragua. It was hard to apply our principles in that environment.

***Jared:*** See the theoretical framework: on page 250 in the Retreat Book, Vol. I.

We've put out the call – we're organizing. New ideas are fermenting. We're in the chaos phase. Over the next year the goal is to try to simplify and synthesize down into something elegant. We've heard from our brilliant colleagues' new ways to think about this, organize this. Now we're summing up the morning. We're trying to put naturopathic phenomenology into three major categories:

- Spiritual
- Ecological
- Holistic (mind/body/spirit/nature/community/family/environment)

From these fall out the six principles [however they may end up being modified], which brings us to a unifying theory of the process of healing.

The determinants of health may become more oriented to theories of terrain, toxemia.

Healing as process is expanding into ideas of vitality of healing, and Selye's theories of adaptation. Does the therapeutic order contain the correct order? Should items be nested? Are there other graphic models? How do you have an order and individualize at the same time? This can be built into the order. We're in the process of listening, developing, correcting, and about to move into the process of refining, boiling down, rewriting.

This is a graph of what was talked about these two days.



# The Process of Healing - a unified theory of naturopathic medicine

***Therapeutic order concept***

- Does that order really contain the right information and the correct order?
- Concentric circle model
- Star model
- Flower model
- Nested systems model
- Holarchy concept

***Process of healing***
***Determinants of health***
***How that has been modified?***

***The process of healing concept – need to expand***

- Suppression
- Adaptation
- Role of vitality

We are in the process of listening, developing, thinking, and ultimately re-writing this.

***Pamela:*** This is not comprehensive. I think what Jim's talking about rises to a higher level in the taxonomy. And, Chris' question about ethics and morality is interesting and should be further considered. We're trying to model a way of rethinking this because it's basically what we're going to be asking you to do after the break. Theories evolve!

***Stephen:*** In TCM, there are many theories that may be wildly opposing to one another. So, this is true of us as well.

***Don:*** Question for Mary: given the three meta-theories, how does nursing education come out of this?

***Mary:*** At undergrad level, we introduce the theories to the students and explain where the different models are often used, e.g., at most of the research institutions, where we educate masters and doctoral levels, we teach them all three at the undergraduate level, we introduce them, but focus on which ones are operant in different situations. E.g., in the intensive care, we do X, and in the community we tend to do Y, and here's why.

## *Critical inquiry in advance of breakouts*

***Discuss three questions over lunch, and then go straight to breakout groups:***

1. What new discoveries have you made?

2. What were surprises?

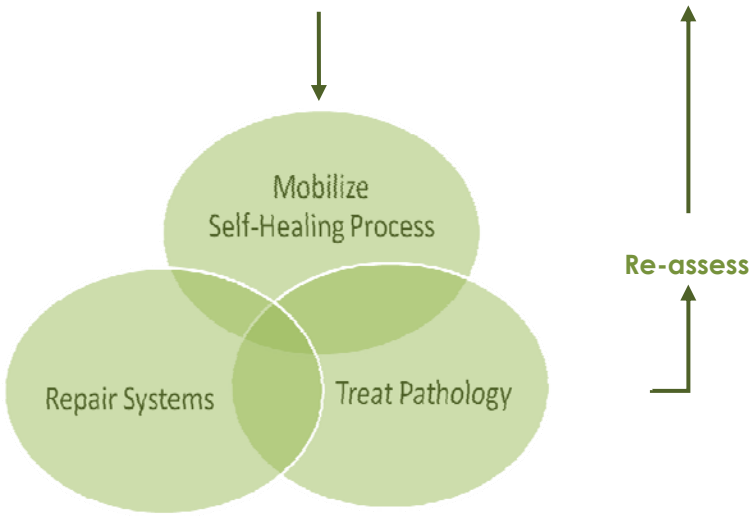
3. Are there special considerations you want to take into breakout groups?



## *IV. The Therapeutic Order as holarchy*

The group conceived a graphic to express the Therapeutic Order as a Holarchy during the Clinical Algorithms session.

**Problem: Hierarchical Depiction of Therapeutic Order**
**Solution: The Therapeutic Order as Holarchy**





# *V. The Therapeutic Order expressed within the framework of naturopathic analysis and case management*

## The Therapeutic Order was also expressed within the framework of Naturopathic Analysis and Case Management

An acuity scale and assessment components an for triaging incoming patients was determined in the Naturopathic Analysis and Case Management session later in the Retreat.

## Concepts for Naturopathic Case Analysis and Management – Chapter One

### *Acuity Scale**

| | **Vitality / Homeostatic** Balance High | **Vitality / Homeostatic** Balance Low |
|---|---|---|
| **Disturbing Factor or Disease Progression** **-Mild-** | Lower Order I | Lower Order II |
| **Disturbing Factor or Disease Progression** **-High-** | Lower Order III | Lower Order IV |

### *Assessment Component**

#### Cognitive Domains of Assessment

- **Health – "State of Health"**
  - Resources available
  - Patient's perspective
- **Causal Factors** – disturbances in the Determinants of Health

} *Both determined by assessing Determinants of Health*

- **Clinical Systems** – based on new naturopathic clinical theory, a.k.a. "**Emunctorology**"

#### Second Order Assessment

- Center of gravity
- Obstacle to cure
- Leverage points
- Vulnerable points
- Stressors: threshold (cumulative effect)
- Blissors
- Total load

*Use both the scale and components from both frameworks and for each case to demonstrate these two models in the text.

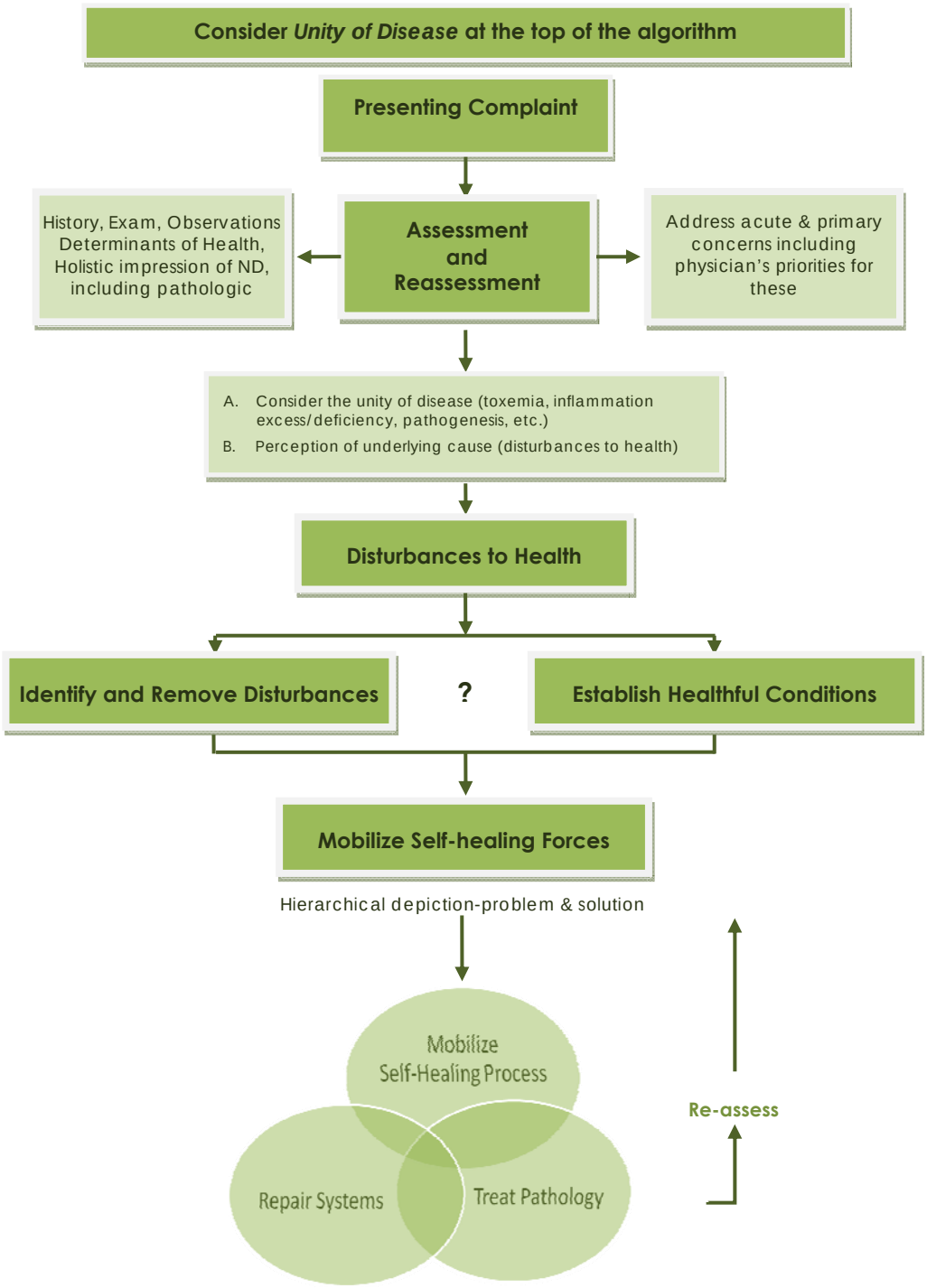


## VI. The Therapeutic Order expressed within the discussion on clinical algorithms and guidelines

*The Therapeutic Order was also expressed within the discussion on Clinical Algorithms and Guidelines*

Through the discussion on Clinical Algorithms and Guidelines, the plenary group was enabled to express the Therapeutic Order in yet another construct, including conceiving a graphic to express the Therapeutic Order as a Holarchy.

### Therapeutic Order Algorithm





# *Special Session Report*
# The Metaparadigm and the Process of Healing

Jared Zeff, ND, LAc; Pamela Snider, ND; Stephen P. Myers, ND, BMed, PhD; James Sensenig, ND;
Joseph E. Pizzorno, ND; Mary Koithan, RN, PhD, APRN, CNS;
Christina Arbogast, ND; Roger Newman Turner, ND; Iva Lloyd, ND;
Herb Joiner-Bey ND, DHANP; Mitchell Stargrove, ND, Lac

*Some repeated material from the Process of Healing Session is included for the purpose of context.*

## The Process of Healing: Constructing and Evaluating Naturopathic Theory
## *Researching Nursing Theory: How We Did It*

Following Mary Koithan's presentation which addressed the development of concepts for a naturopathic 'Metaparadigm' as part of The Process of Healing panel, the Editors present were anxious and ready to begin exploring what this approach means for naturopathic medicine. The Metaparadigm and meta-theory constructs introduced by Dr. Koithan created an understandable construct for organizing both coherence and diversity taxonomically throughout the text.

Because of the interest in the Metaparadigm concept, the Process of Healing Session was redesigned spontaneously to include an emphasis on this new area of dialogue. This Special Session Report captures this new session, its findings, outcomes, and discussion.

| ***Charge of Session*** <br> ***Transition to Metaparadigm*** |
|---|
| The group determined that it wanted to discuss the metaparadigm at greater length during breakout sessions following the presentation in order to utilize the newly acquired knowledge on the structure of theory and Metaparadigm introduced by Dr. Koithan. These new breakout sessions were to identify the key constructs that might be included in a naturopathic metaparadigm. It was evident to the group that this work on Metaparadigm would inform further work on the Process of Healing and would therefore be appropriate and useful as the next focus. |
| The group experienced this as a dynamic breakthrough and a clear area of coherence among participants. It was vital to establish the Metaparadigm constructs which could overarch and unify naturopathic medicine and ultimately would be expressed in clinical theory and case management. This discovery energized the group with unified energy and focus. |

### *Note on charge of the session*

As the charge of the breakout sessions changed in order to build on the momentum of creating a Metaparadigm, the creation of visual summaries of the Process of Healing shifted, emerging spontaneously as part of subsequent sessions.

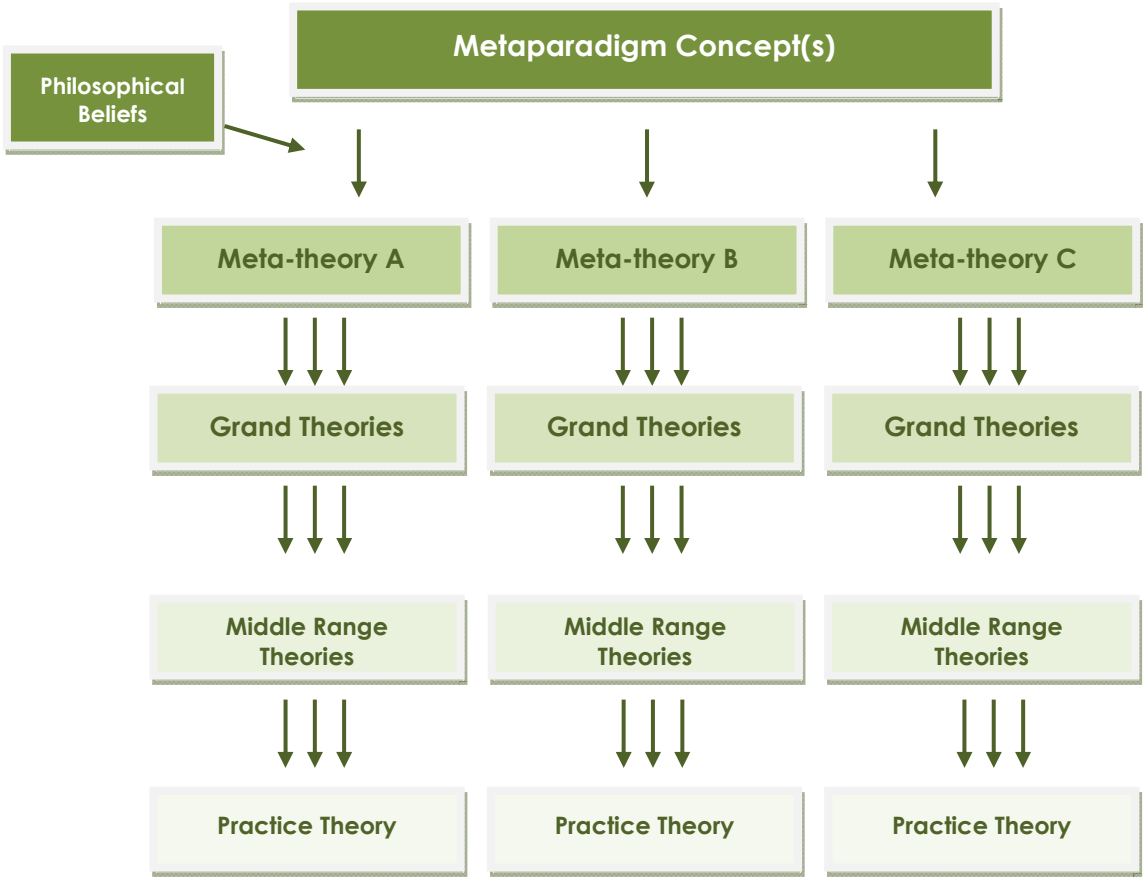
These are assembled in the Process of Healing Session section on pages 49-57 of this report. *The new breakout session charge was to define THE list of items that belong in the Metaparadigm construct for naturopathic medicine.*

It was understood through Dr. Koithan's presentation, that a Metaparadigm required these elements to be true to its purpose, and to be held in the truest sense as a unique 'worldview:'

- A thing or noun (not in relationship to something else).
- Necessary to the profession.
- Cannot be argued.
- Abstract and conceptual.



## The Metaparadigm Model 8




[8] Higgins & Moore, 2000; Walker & Avant, 1995

The above model was adapted from Dr. Koithan's presentation.

The entire group broke for a working lunch to discuss the following questions:

- What new discoveries have you made?
- What were surprises?
- Are there special considerations you want to take into breakout groups?

### *First Metaparadigm breakout groups*

Following lunch, breakout groups formed with the intention of identifying the key constructs in naturopathic medicine, which could then be coalesced into a more unified Metaparadigm at a later point. As a starting point, each group was asked to explore an early set of potential Metaparadigm constructs, with the aim of determining where the group had coherence, diversity, missing areas, and conflict.



To stimulate focused discussion, Pamela Snider created an initial list for examination, including the following:

- *Vis Medicatrix Naturae*
- Therapeutic Relationship
- Health
- Suppression
- Individualization
- Signature
- Minimum Dose
- Dual Effect
- Contagion
- Unity of Disease

As a result of discussing the above potential constructs in breakout groups, the following feedback was coalesced into an early review of how naturopathic constructs might fit into the metaparadigm model. Note: these were early trends based on an introduction to the concept of creating a Metaparadigm. (All responses are included in the following.)

## First Metaparadigm breakout groups-summary of results

### *Convergence*

***(Most often cited contributions, includes all responses for convergence)***

- Least Force, Minimum Dose, Do No Harm
- Relationship and Therapeutic Relationship (including Compassionate Care)
- *Vis Medicatrix Naturae*
- Dual Effect
- Health, Health as Balance, Health as Natural State
- Individualization
- Optimization

*(Additional Contribution)*

- Holarchy

### *Divergence*

*(Most often cited contribution)*

- Nature

*(Additional contributions)*

- Unity of Disease
- Signature
- Contagion (Terrain)
- Suppression
- Relief of Suffering
- Optimal Aging and Death



### Omissions

*(Most often cited responses)*

- Interconnectedness
- Contagion (Terrain)

*(Additional contributions)*

- Treat Whole Person
- Doctor as Teacher

### Conflict/Controversy

There were no outright conflicts to report.

## Summary and outcomes of special session 2 on Metaparadigm from afternoon breakouts of Day 3

Based on Mary Koithan's presentation (The Process of Healing: Constructing and Evaluating Naturopathic Theory), participants returned to the topic of the metaparadigm in the afternoon of Day 3. As a whole, the group felt that a more detailed discussion was required to expand upon the list of potential Metaparadigm constructs determined in a preliminary fashion during Day 2.

During lunch, the Senior Editors Team met with Cathy Rogers and Letitia Watrous who had just presented on Nature Cure in the morning. The agenda's original plan was to engage the group in breakouts following their presentation on Nature Cure, as well as breakouts for Jim Sensenig's and Stephen Myers' presentation on Modalities and Voices of the Elders. These four presenters agreed to forego breakout group discussions for their sessions; instead planning to request the larger group to engage in a follow up discussion on the Metaparadigm construct(s).

Following lunch, Valerie Campbell and the Senior Team explained the new opportunity to the large group. There was widespread receptivity to changing the afternoon's sessions in order to continue to nurture the development of the concepts of the "Metaparadigm" on the process of healing, which could then be used by the Editors to refine and enhance the rigor in the discussion in the text.

A lengthy and dynamic large group discussion ensued with Jim Sensenig, Jared Zeff, and Valerie Campbell co-facilitating. As a result, the group focused the key points of convergence to arrive at the following seven Metaparadigm constructs for discussion that could be further developed and revised by the editors and writers, and ultimately the profession.

1. *Vis Medicatrix Naturae*
2. Therapeutic Relationship
3. Natural State
4. Health
5. Duel Effect
6. Holarchy
7. Individualization



Note: Much discussion ensued about creating a Metaparadigm in the textbook overarching the process of healing theory and principles. Given the precedent-setting nature of the discussion, it was agreed that the list of seven metaparadigm constructs would be reviewed and extrapolated upon by the Senior Editors Team in order to develop a draft for the final text. All participants recognized that this was the solid beginning of a process to determine and conclude the metaparadigm, and that none of the conclusions were "carved in stone." Participants requested that all outcomes, presentations, and flipcharts of the session be carefully preserved for reflection. (See Appendix, page151 for extensive minutes of the Metaparadigm Session.)

# Detailed proceedings from group and breakout discussions

## *Critical inquiry dialogue*

### *Post-lunch plenary group discussion*

***Mary:*** The metaparadigm concepts are meta-constructs:

- These are core constructs, things, entities, concepts – not relationships, not doctrines, not principles.
- These are necessary for naturopathic medicine to occur.
- A profession can have several meta-theories; the meta-theories also could be thought of as schools of thought.
- The thing that unifies the discipline would be the meta-constructs in the metaparadigm. The metparadigmatic constructs are the unifier.
- From the meta-theoretical perspectives – one uses meta-constructs or metaparadigms to define how you interact with and treat patients.
- Grand theories put the metaparadigm constructs together (all or some).

***Stephen:*** Do we accept the concept of *Vis Medicatrix Naturae* in the AANP text, or Lindlahr's concept of the *VMN*? Mary's model allows us to do both:

- *Vis* is a metaparadigm construct, with a very abstract definition.
- NDs can agree that healing power of nature is inherent in all living things.
- Then in the next step down, you can have different meta-theories to describe the *Vis* in more detailed (and non-identical) ways.
- The meta-theories must explain all the constructs.
- Another metaparadigm construct uses the least force.

***Jim:*** The things that fit in the metaparadigm box will be found on page 47 in Retreat Book Volume II. These meta-concepts are necessary to the profession's existence and function.

- They are inarguable (can't argue on application).
- Theory of unity of disease.
- Theory of contagion.

***Mitchell:*** The primacy of the therapeutic relationship is also important.

***Mary:*** The nursing profession spent 10 years at war with each other, trying to get their theories as the one that "wins." We don't have to do that. We can go more abstract and say – what are the



fundamental constructs that all naturopathic physicians will agree on. The meta-theories must then explain all the constructs.

***Jim:*** Metaparadigmatic constructs: they must be:

- Necessary to the profession.
- Inarguable [As to truth. We don't have to agree on how to apply it.]

Examples:

- *Vis*
- Using least force necessary
- Do no harm

What these MEAN in practice would be different.

### *Initial group list*

- Health – as normal
- *Vis Medicatrix Naturae*
- Therapeutic relationship
- Suppression
- Least Force or Minimum Dose
- Would our current 6 principles qualify?
- Individualization
- Dual effect
- Contagion
- Unity of disease
- Doctrine of signatures

## Breakout group reports

### *Charge of breakouts*

Note: the charge of the breakout sessions changed in order to build on the momentum of creating a Metaparadigm. Rather than creating visual summaries of The Process of Healing (as originally intended), the new breakout session goal was to define THE list of items that belong in the Metaparadigm construct.

## Breakout Group One – report

***Presenter: Jim Sensenig***

### *Group One flipchart presentation*

- *VMN*
- Therapeutic Relationship
- Least Force
- Health
- Dual Effect



- Holarchy
- Individualization

### *Group One oral presentation*

Re: Minimum dose – least force is sometimes not taking anything.

Re: Holarchy – everything is seen in everything else, and that is seen in everything else

Re: Dual effect – the law of dual effect – Lindlahr talks about it: The primary effect and secondary effect. The secondary effect is always opposite, a cold pack causes constriction of vessels and muscles; the secondary effect is dilatation of vessels and muscle relaxation. Natural medicine gives the disease to the diseased to kick in the secondary effect. Conventional medicine gives a drug to work on eliminating disease (often fails).

### Plenary group feedback

***Group:*** Why didn't you put the rest of the principles in this list?

***Jim:*** Because we didn't get as far as talking about them. But do no harm and least force is the same thing to me.

## Breakout Group Two – report

***Presenter: Jared Zeff***

### *Group Two flipchart presentation*

- Relationship
- Health
- Least Force [do no harm]
- *VMN*
- Holism
- Prevention
- Unity of disease [*Tolle Causam*]
- Therapeutics [part of our identity is that we're doing something]
- Compensation?
- As above so below [important, but we're not sure how to express it]

### *Group Two oral presentation*

We had some trouble phrasing: Relationship – includes doctor patient relationship. We added to this, therapeutics, e.g., treating the patient. We didn't see that as a lower order for us to do things. Compensation should have a question mark by it.

There was a general agreement that as above, so below was pretty important, but hard to express. Unity of disease was also very important. We would have liked to spend two weeks on this.



# Breakout Group Three – report

***Presenter: Stephen Myers***

## *Group Three flipchart presentation*

Accepted

- *VMN*
- Therapeutic Relationship
- Health as a Natural State
- Minimum Dose
- Individualization
- Nature as Teacher?

Rejected:

- Unity of Disease
- Suppression
- Dual effect
- Instead of contagion, maybe terrain
- Instead of Signature, maybe nature as teacher?
-

## Plenary group feedback

***Don:*** The nature of suffering and relief of suffering. Compassion/care/service should be represented somewhere. What about optimal aging and death? Many of these things could be used by other professions. We were trying to look at how the combination of choices would come up as unique. We wanted to get across the idea of minimal intervention or least force, rather than using the word 'dose.'

OR: health as balance – health as a natural state was seen as better:

Suppression – was not a principle. It was not a meta-concept. It can be used by a naturopath but not a law.

- The signature – was something that should be part of meta-theories or on another level.
- We see in nature and learn from nature, so put down nature as teacher.
- The nature of suffering and relief of suffering – part of the construct of a naturopathic doctor.
- Compassion, care and service were very important.
- Each concept could be adopted by any profession; it is the combination of them that makes us naturopathic physicians.
- Optimal aging and death – struggled with the death. Couldn't describe the care we give at the time of death.
- We didn't go with the words 'least force.' Minimum dose – we are minimalists in the way that we approach things. We like the idea of least force.
- The dual effect and compensation were really important, but they were operatives in the other principles or even in a lower tier, but pervasive in how we apply these principles.

***Pamela:*** I see health as a natural state, but I don't see optimal health or wellness.

***Louise:*** Maybe optimization. Optimizing a person for where they are.



# Breakout Group Four – report

***Presenter: Joe Pizzorno***

## *Group Four flipchart presentation*

Accepted

- *VMN*
- Therapeutic Relationship
- Is Doctor as Teacher the same or different?
- Least Force
- Suppression leads to further illness
- Individualization
- First Do No Harm
- Treat the Whole Person
- Health as Balance? Didn't conclude on this one

Rejected

- Unity of disease
- Dual Effect
- Doctrine of Signatures
- Contagion/Terrain – didn't get as far as this one, so still open

## Plenary group feedback

***Letitia:***

- Include the *VMN*.
- Therapeutic relationship.
- Not sure whether doctor as teacher fits in.
- Didn't like word balance here.
- Health as a natural state I personally like.
- Suppression – what I understood was that when we suppress a symptom, we will have further illness.
- Minimum dose – liked least force better.
- Individualization.
- Didn't understand dual effects or doctrine or signatures so left it out.
- Wanted to express contagion or terrain differently.
- Had first do no harm.
- Treat the whole person.



# Overall plenary discussion following all breakout group presentations

## *Flipchart notes from plenary group discussion and brainstorm*

*Note: These flipcharts are preserved, as presented, for your reference, rather than in summary format, at the request of participants at the Retreat as the early stage of the work.*

### Sheet 1

1. Things, names (not relationships).
2. Necessary to profession.
3. Cannot be argued.
4. Abstract. Includes nature and prevention.

### Sheet 2

1. Nature needs to be included or is nature a fundamental concept?
2. Is *Vis* the nature?
3. Is healing crisis something we need to include?
4. Focus of the discipline of naturopathic medicine.
5. 80% in common.
6. Optimization and wellness
7. Concept versus definition
8. Relationship? Add definition of health?

### Sheet 3

1. Efficiency – less force
2. Health creation!
3. Health as a natural state
4. Individuality – recognize state versus individuation

### Sheet 4

1. Compression of morbidity
2. Individuality versus individuation
3. Optimization

### Sheet 5: World View

1. Sustainability
2. Clarity of metaparadigm
3. Let's talk or determine what all naturopathic doctors agreed upon, e.g., *VMN*
4. Spiritual meta-theory



5. Pull components that all NDs will/can agree upon – common agreement

## Sheet 6

1. Health creation
2. Optimization (as compared to optimal aging)
3. Salutogenesis – refine
4. Wellness – include prevention and death (life stages)
5. Relationship of health and nature to wellness

## Sheet 7

1. Relief of suffering – relationship subsumes
2. Signature – subsumed
3. Suppression
4. List:

- Health
- Relationship
- Nature (also uniqueness of nature and individualization)
- Holism (Whole Person)
- *VMN*
- Least Force
- Individualization
- Unity of Disease (holding spot – treasured item that belongs on different tier)

## Sheet 8

1. A textbook should reflect dialogue.
2. Propose another word on our list is ‘nature’.
3. Can we define it or change it up more than a noun.
4. Prevention.
5. Let’s go through the list, let’s remove duplicates
6. Compassionate.
7. Constructs are more abstract – compensation is not a metaparadigm.
8. Health is O.K.
9. Balance is subsumed into health.

## Sheet 9

1. What is the definition of holarchy?
2. Biology text: each biological system.
3. As above, so below.
4. Holarchy is subsumed under nature as teacher, it’s about holism.
5. Agree on concept of Holarchy – Holograph Nature.
6. Holism.



7. Individualization – it's how we approach this field with every patient. Individualizing medication to each patient.

### Sheet 10

1. There is a difference between metaparadigm and meta-theory.
2. More complete, than less.
3. Individualization is a cornerstone, it is essential.
4. Everything on this list is real, let's put what we flow from.
5. Least Force: Do no Harm – gentle – As little as possible.
6. Nature should be on the list.
7. Optimization; and wellness and health.
8. Health creation (salugenesis) and prevention (salutogenesis).

### Sheet 11

1. We need to address the issue of death; it is an application, not a metaparadigm.
2. Role as change agents – we should use prevention.
3. The variance can really define us.
4. Health, life force – get some specificity for our profession.
5. Health as a natural state/normal.
6. Optimization and Prevention.
7. Relationship, Health, Nature.

### Sheet 12

1. Patricia's words that mean naturopathic medicine, health, relationship, nature, holism, *VMN*, person, individualization, least force, uniqueness.
2. Let's be thorough and complete.
3. Let's let this cook for a while – then decide.
4. We need health, relationship, nature, holism, *VMN*, individualization.
5. We need to have individualization and uniqueness on this list.
6. I like suppression, holism holarchy, least force, unity of disease, when looking at the complete list; it felt unique to describing our profession.
7. A result of a debate – should other organizations be permitted to comment on this list?

## Metaparadigm closing plenary

### *Detailed minutes of discussion*

***Valerie:*** What are people seeing?

***Cathy:*** Something about nature needs to be here because we're naturopaths. We need to have something about interconnectedness.

***Mary:*** That also sounds like a fundamental concept, from listening in on all your groups. And it helps to differentiate you from other healthcare providers.



***Richard:*** When I do admissions, about 80% of the students coming in are part of the environmental movement.

***Jim:*** Can we do a list for the new things that come out?

***Letitia:*** I think nature is up there, within *Vis Medicatrix Naturae*

***Louise****:* I don't see healing crisis. Is that something we need?

***Christa:*** Least force/minimum dose, we're talking about leverage points. Is the concept finding the Leverage Point?

***Mary:*** That's more of a practice theory, a way to intervene; it sets two things in relation to each other. The notion of intervention itself is the broader concept.

***Iva:*** Needs to be worded in the positive. Health, not disease.

***Mary:*** Right, the focus of the discipline of naturopathy.

***Mitchell:*** I'm amazed at the high proportion of agreement. 80% in common; optimization and wellness. Been hearing the public wants wellness; Health leads to wellness. It's one step beyond. This pulls in terrain and other metabolic things. That will communicate to a lot of people.

***Pamela:*** Southwest passed a resolution to include wellness in the principles. So did Joseph Pizzorno at Bastyr University.

***William:*** A hang up: we're trying to make the definition the concept. Here's the list I see as commonality:

- *Vis*
- Health
- Relationship
- Environment
- Holarchy
- Efficiency
- Optimization or Wellness

Could Relationship hold the concept of health? Relationship within, relationship without.

***Joseph:*** I don't like 'efficiency.' More efficient to use an anti-hypertensive. I prefer least force.

***Roger:*** Our objective is Health Creation.

***Louise:*** Doesn't quite jive with Health as a Natural State. If it's a natural state, then we don't need to create it.

***Roger:*** We're using individualization, which is more like a verb. Individuality may be more the state. Also compression of morbidity – postponing the decline in health as we age.

***Letitia:*** I see individuality and individualization differently. Individuality is a person's difference in say metabolism, but individualization is how we practice: how the doctor dispenses the therapeutic model for that person.

***Herb:*** What about the word "personalizing."

***Mitchell:*** We dealt with individualization as a process, but whole person as a perspective.

***Jim:*** We're now word smithing, but I believe we're pretty much all on the same page.



***Pamela:*** Interconnectedness is one that got missed somewhere. It's in holarchy.

***Stephen:*** Nature as Teacher, which has so many other lessons for us.

***Joseph:*** Roger's compression of morbidity is important.

***Pamela:*** Increasing health span.

***Joseph:*** Compression of morbidity, like Roger said, but says it more nicely.

***Pamela:*** Nothing shall be carved in stone. This is just a snapshot so we can reflect on it.

***Valerie:*** Interesting that you think there's 80% agreement. When we do the tally:

- *VMN*
- Using least force [or do no harm]
- Therapeutic relationship/therapeutics
- Individualization (two out of the four)

***Pamela:*** There are a number of other correlated concepts that need to be clarified.

***All:*** *Agreed: that Senior Editors can discuss this in greater detail.*



# Education: Making Naturopathic Education More Naturopathic

Don Warren, ND, DHANP; Christina Arbogast, ND and Rita Bettenburg, ND

*World Café: Visioning an Ideal Naturopathic Graduate and Implications for Skills, Transformation and Applied Philosophy*

### Charge of Session

To envision future naturopathic graduates, and how such a vision might influence the future evolution of naturopathic medical education.

### Deliverables and Goals of Session

To establish this vision of the ideal ND graduate and in visioning the ideal naturopathic doctor graduate, to determine the changes needed in the content and education process to achieve the "ideal future naturopathic doctor graduate."

## Plenary summary and outcomes

Presenters, Don Warren and Christina Arbogast, previewed a range of opportunities for naturopathic education and philosophy in the 21st century. Following, participants brainstormed the "ideal future naturopathic doctor graduate" in a world café format in lively discussion with key factors being cited as being the most critical to nurture in the profession's newcomers.

Detailed panel presentation summary and drafts begin on page 272 in the Retreat Book, Volume I. See Appendices on page 162 of this report for extensive notes on the world café group discussions and reports.

Factors have been listed related to their key subject areas of discussion, and based on those most consistently mentioned:

### *Attitudes and attributes*

- Active and motivated learner.
- Courageous, determined, and dedicated.
- Ethical and honest.
- Open-minded, neutral, and non-judgmental.
- Patient-centered and honoring patient choice.

### *Knowledge*

- Biomedical sciences.
- Seen through naturopathic lens (philosophy and process of healing and botanical medicine).
- Evidence-based medicine.
- Process of healing, determinants/obstacles to healing; foundations of health and disease.
- Other complementary and healthcare disciplines for collaboration, genome, genetic research, psychoneuroimmunology.



- Public health policy (and interaction with naturopathic medicine), public health systems.
- Philosophy of naturopathic medicine, comparative philosophies and history.
- Traditional naturopathic assessment medicine and skills.
- Diagnoses, therapeutic modalities, clinical methodology.
- Experience, earlier exposure to patient care, exposure to master clinicians, texts written by naturopathic doctors.

### Skills

- Integrate information and manage cases over time.
- Recognize level of disease in people and true cause, hands on exams, naturopathic diagnosis, primary physician/lab diagnosis, subtle sensitivity of underlying milieu.
- Modality proficiency.
- Model the talk, application of naturopathic philosophy, collaboration, educator, effective lifestyle counselors, elicit a sense of health and wellness.
- Intelligent listener, reflective, intuitive, sensitive to culture and class.
- Critical analysis and assessment and thinking, effective problem solvers, evaluate information, access and evaluate research.
- Clinical experience and innovation and savvy, able to develop protocols blending modalities.
- Sound business management, time management, patient acquisition, and retention.
- Bilingual.

### Values

- Altruistic, being of service, charitable, willingness to do pro bono work, aware and committed to environment and ecology and sustainability, humanitarian.
- Authenticity, honesty, humility, integrity, morality, sincerity, courage responsibility.
- Therapeutic relationship, partnership with patient, confidentiality.
- Creativity, discovery, life long learning, education, self awareness.
- Leadership, success, empowerment.
- Respectful, respectful of elders.
- Team work, collegiality.
- Fun, fulfilled.

### Vision

Two vision statements emerged from World Café round tables:

- “Naturopathic doctors are compassionate, patient-centered leaders who act as revolutionary change agents (including in the sciences), are competent and safe primary care providers, and care for individuals, community, and the eco-system, and exemplify the philosophy in personal and professional life as they provide excellent team care.”
- “Naturopathic physicians are compassionate, successful, prosperous change agents practicing from a combination of knowledge, skills, and personal experience … Naturopathic physicians help patients to understand why they are sick, and how to become healthy.”



# Detailed proceedings from breakout discussions

## Facilitated discussion

***Stephen:*** It is a very exciting time for naturopathic medicine across the board.

What was said to a couple of people (the session in the morning was great), we have gotten together to tell each other what we are teaching. Usually we teach alone.

Southern Cross University (SCU) doesn't have as cohesive a profession as in North America. We did hold a nutrition conference – to talk about teaching nutrition to naturopathic medical students.

There were fourteen nutrition lecturers in the same place, and the lecturers articulated that it is not traditional nutrition – it is 'Naturopathic nutrition.' We are coalescing that knowledge right now. We'll need to call a meeting of all clinical educators to do this.

Some observations: You can have a clinical experience without being exposed to eclectic naturopathic medicine. Students should be able to come out with a primary capacity to practice eclectic naturopathic medicine. We had to take naturopathic medicine into University. We want to see how similar the core competencies of the University are to the ones created here.

Part of the process of being part of the academic world is *benchmarking*. SCU did a systems oriented course of medicine. The dean of the faculty benchmarked the program in terms of the programs internationally. We should be using the best ideas everywhere in the world to teach the next generation of naturopathic doctors. We have our own checks and balances, but this is an important consideration.

***Emma:*** It would help to have a monograph that helps to place people within a community. Many sources would not fund a naturopathic medicine school but there are major sources in allopathic medicine.

***Mitchell:*** It is crazy that our best texts are 100 years old. We need to have our own. Why use physiological texts that don't put physiological systems together the way the naturopathic physicians think? We need to decide what the good texts are, and we need new texts.

***Iva:*** WHO used naturopathic medicine as the model of other traditional world medicines to follow, because of the percentage of medical knowledge in it. Only those people with a minimum of five years full time practice could teach… an important point.

***Joseph:*** We have to write our own text books! Because of the Textbook of Natural Medicine, we have good textbook for pathology and physiology, but nothing that bridges that. (Joseph is writing this now.)

***Serron:*** Learning pathology from medical pathology books is a problem perceived by students at NCNM.

***Louise:*** The people who came out of the ND program came out much less healthy. How do you maintain balance in a stressful environment? Need to have some way to bridge this.

***William:*** *(Presented a list of concerns from the student's perspective reflecting consultation with the student consultant team at the Retreat, and his own counsel.)*

- We can't live the philosophy and pass the curriculum at the same time.
- It is accepted by students that it is there for face value and mainstream acceptance.
- We are learning more allopathic medicine than naturopathic medicine.



- It is important to increase the history and philosophy base.
- It's on the syllabus but not in the curriculum.
- Everyone thinks that someone is teaching it, but no one is teaching it (accountability).
- Align what we learn in classroom to what we do in clinic.
- Having some physician heal thyself course.
- Differentiate what would be nice to have and what is not necessary.
- Do not try to integrate with allopathic until we have differentiated.
- Most diagnostic courses are allopathic.
- Do not make changes by adding years, take out the extras.
- Increase nature cure.
- It doesn't seem to be used.
- It is talked about, and is really wonderful, but not used.
- Teach more business management and practice management.
- Evaluate the pros and cons of PhDs versus NDs as faculty in the basic sciences.
- Along with an introductory course of philosophy, have an integration of philosophy in the systems, and then afterwards have a "put it back together" class.

***Christa:*** It is important to have more basic sciences texts.

***Thomas:*** In the 80s, the education was good, because it was based on primary care. There are students now turned out that can't do primary care. This is problematic.

***Christina:*** The standardization will solve a lot of these problems. The educators will comment on this. The breakout session coming is what is essential to be a naturopathic physician.

***Deborah:*** There is a tension between educational and professional issues. We want to increase residencies, but we also want teachers that have five years clinical experience before teaching.

***Paul:*** Can we make it international?

***Christina:*** We need bridge programs.

# Breakout discussions

## *Charge of breakouts*

The goal is to discover the potential opportunities for growth and development of naturopathic medicine. The top subjects provided to participants for discussion at each table included:

1. Vision of the future naturopathic doctor.
2. Knowledge base of the future naturopathic doctor.
3. Attitudes and attributes of the future naturopathic doctor.
4. Skills sets of the future naturopathic doctor.
5. Values of the future naturopathic doctor.



## *Creating Coherent Clinical Applications – Days 3 and 4*

# Critical Information Session
# Text Structure, Milestones, Timeline, and International

Jared Zeff, ND, LAc; Pamela Snider, ND; James Sensenig, ND; Joseph E. Pizzorno, ND; Christa Louise, PhD, MS; Roger Newman Turner, ND; and Stephen P. Myers, ND, BMed, PhD

| *Charge of Session* |
| --- |
| To provide project management and policy overview and the opportunity for questions, problem solving on deadline management, clarifications and changes. |

| *Deliverables and Goals of Session* |
| --- |
| • To review, discuss, understand, and agree upon draft Phase Two Project.<br>• To address and integrate structural concerns and changes to the text. |

## Plenary summary and outcomes proceedings from group discussion

Panelists reviewed the management of the Project nationally and internationally, as well as impact on NPLEX testing. Following the presentations, the plenary group asked questions, received clarification, made requests, and offered feedback to the Panel to assist in advancing the text to its next draft, and to assure the success of the entire Project. Suggestions included:

### *Structure and content*

*Preface*

- Include a "key to utilization" to set the framework of the text.

*Chapters*

- Provide chapter summaries at the end of all chapters to reinforce salient points.
- Under each chapter heading, provide a sub-chapter/heading to succinctly illuminate the focus of the chapter.

*Glossary*

- Include a Glossary of essential terms.

*Sidebars*

- Include sidebar comments to allow for divergent opinions.



*Ease of Access*

- Needs to be concise yet contain all relevant information. Consider publishing in sections as professional journals do. Also use the web for publishing opportunities.
- Ensure that the AANP, students, educators, policy-makers, and the public have early access to the text.

*Subject Matter and Diversity*

- Given the potential diversity of clinical theories within the profession, need to illustrate different theories in contrast to contextualize differences and applications.
- Reflect the whole range of naturopathic physicians' work, with objective review, explanation, and references. Provide:
- what has been documented;
- what has not;
- what needs to be researched and documented.
- Needs a section on diagnosis: illustrate the training functions that occur at naturopathic colleges, and explain what is proven (through evidence-based research), and what is unproven or improvable (articulating the lack of time – 50 to 100 years to have as much evidence based reference material as allopathic medicine).
- Use "language of disease" as a unique aspect of naturopathic diagnosis ("Total Physical Review" and treatment.) *Note: Tom Kruzel to provide relevant examples.*
- At the beginning of the Clinical Section, illustrate the theory of dysfunction. Note: Paul Orrock to provide.
- Show objective assessment
- Include new metaparadigms, define and describe process by which the constructs to be included in the text were/are agreed upon.
- Articulate and demonstrate how naturopathic physicians "ask the right questions," (through open ended inquiry) compared to other health professions. Consider including in the diagnosis section.
- Acknowledge that history's best healers have not been physicians, e.g., intuitive and spa healers.
- Dedicate an economic impact of naturopathic medicine, demonstrating its overall cost effectiveness.
- Communicate that naturopathic medicine is sustainable (agrees with Tom Kruzel re technology). We can show non-technology side.
- Add ethics.
- Tom and Joseph to write about diagnostic cost effectiveness.

## NPLEX

***Christa:*** The purpose of NPLEX is public safety. But, if physicians don't know how to do things properly and safely, what should they be doing for this? We need to document everything, but at this point all we have is allopathic textbook. The best exams are when we have more sources. We can put a case together at this point, but we can't bring it all together because we don't have the references. It has to be a book, then, that is used by all the schools. We need to test on what has been taught in all the schools. The competency movement is really important as well. I like the idea of naturopathic diagnosis. I don't want an exam that an allopath can pass. But, at this point, a little extra studying and they can. Ethics is important, and we want to be able to text. Psychology is



important. It's the only place we can test more than simple knowledge. We need to elicit more than simple knowledge. We hope the book tells us more about the therapeutic relationship.

The textbook should give us some guidance on the importance of the therapeutic relationship. Competency-based assessment has relationship to the text. There has to be a way to test the orientation of philosophy.

## Technology

- Include a CD or DVD of the text.

## Contracts and copyright

- All agreed to sign contracts.
- It is understood that the most recent contract is the final, legal version.
- Received the re-done contracts. Each should receive a sheet with a detailed assignment list from our FileMaker Pro relational database.
- A year and half ago, Elsevier sent out contracts in a *work for hire* model. That would mean they own everything, you can't copy it, it is not yours. We sent these back.
- *In this contract* Elsevier holds the rights to the textbook. The contributors can use contributions for teaching and for journals with permission from Elsevier. If you ask Elsevier, you can often use your work elsewhere.
- Elsevier doesn't want a competitive work that exports all your work to another textbook that is now competing with the current titled work by Elsevier
- Contributor use of information they contributed in the classroom.
- Use copyright on material, and ask to make copies or use under Fair Use policies in most of our libraries. If you are using 10% or more you just need to acknowledge that it is from Elsevier.
- Other contracts void? Write a note on the bottom that this contract supersedes the contract signed before. Keep a copy and date it.
- Ideas are not copyrightable, but words are.
- Taking your work and re-working it for a journal article – a short paragraph is no problem; for anything longer, or tables, charts and diagrams, you have to have permission.
- What we give to Elsevier should not be with endnotes, but we need to edit this, so leave the endnotes in.
- Use Word and the reference system in Word (which is endnotes).
- Forms.
- Conflict of interest form.
- Non-disclosure.
- Editorial process.
- Contracts.

## Permission and other questions

- If a contributor uses information and the source is from the classroom, do they need permission? YES
- Is previous contract null/void once signing these? "This contract supersedes previous contracts."



- If not being paid, how come contracts? Copyright, assignment and use determined by contract.
- When incorporating third party material, how much is required for permission?
- Should we use End Notes? From Joseph: use Word's Program for references for consistency.
- In regard to timelines, do not wait till last minute, and give them less time than you have.

## *Syntax for labeling manuscript files*

Stephen Myers presented a syntax and rationale for file labeling. All editors and contributors are required to use this labeling system when submitting manuscripts.

**FNM - Section. Chapter - Title Document - Version - Date**

**The syntax is as follows:**

**FNM - SX.CX - Short Title - vX - DDThreeLetterMonthYY**

**Examples:**

**FNM - S2.C3 - Whole Person Care - v6 - 14Mar07**

**FNM - S1.C7 - Nature Cure Subsection - v27 - 25Dec07**

## *General - continued critique and exploration*

- Consider writing shorter manifestos, manuals, paradigm models, and critiques to "rough up our own assumptions" to better establish an academic approach to the writing. Establish this as an academic text.
- Do not "shy away" from important realities of naturopathic medicine.
- Remember Retreat will be a regular event. We need to engage in orderly and regular discussion and critical revision of the text through future editions.

## *Feedback and questions to the Senior Editors*

1. Timeline is a good one.
2. Making decisions will come up fast – that's a concern.
3. Issue of editorial decisions, practicality will become obvious.
4. Concern that some timelines have come and gone.
5. Editing ideas to an unknown audience gives editors concern.
6. Getting material written is not an issue, it's the editing of that material, and how to deal with that, modifying, cutting and pasting is a concern.
7. Material needs to meet criteria of Senior Editors team.
8. It's helpful to know what material needs to be integrated and edited with other material for consistency in style.
9. Push for redrafts is a struggle, especially for those who have a practice.
10. Is the goal to make this textbook a single voice?
11. Editorial decision to "break out" a new chapter.



12. Paragraph indicating that the contributor will be subjected to editorial amendment might be helpful.
13. Need to work with lead writer, or editor who are they connecting with.
14. Page 14 of Retreat Book Vol. II shows leads.
15. See new organization chart for roles and responsibilities on page 84.
16. Important that cut and paste be not final draft. That "the part" should be as complete as possible before it moves up to the next level/editor.
17. This network should be buzzing over the next few months.
18. Regular communication throughout the network will be essential.
19. Clarify section leads – are these chapter leads?
20. Splitting the text should occur along philosophy/clinical boundary.
21. May need to submit it to the authors again to make sure that they are still willing to be authors on this work.

### *Timeline to December 2009: Highlights*

| | |
|---|---|
| **September 2007** | Contracts: sent to writers with request to sign off. |
| **November 30, 2007** | Leads deliver manuscripts to Section Editors. |
| **February 29, 2008** | All submissions are in to Senior Editors, and review drafts. |
| | Senior Editors review and reflect back to writers for second drafts. |



# Textbook Production Timeline

*Updated as of 8/18/2007*

**April 1-5, 2007** – First International Editors Retreat at Skamania Lodge

| Track One<br>All Sections and Chapters except Track 2 | Track Two<br>NCAM, Algorithms, Primary Care, Education, Spirituality in NM Definition |
|---|---|
| **July 30, 2007**<br>Symposium Planning Process<br>Initiate Agency Liaison Co-Chairs | |
| **August 2007**<br>Retreat Proceedings distributed | |
| **August-November 2007**<br>Contracts out – Reminder: mailing from Executive Editor regarding new deadline to ALL WRITERS -All contracts out with requests to sign them – Moodle updated. | |
| **November 30 – December 15, 2007**<br>1. All manuscripts in from lead authors<br>2. [9]Associate Editors submit their section's chapter drafts to Executive Editor (EE) based on FNM file naming format. Executive Editor stores electronically. | **November 30 – December 15, 2007**<br>1. All manuscripts in from lead authors.<br>2. Associate Editors submit their section's chapter drafts to Executive Editor (EE) based on FNM file naming format. Executive Editor stores electronically. |
| **December 15, 2007 – March 31, 2008**<br>Associate Editors will commence final editing<br>1. Associate Editors edit manuscripts: then send revisions to your author (leads) to review and revise.<br>2. Do one at a time.<br>3. Use Quinn /Pizzorno. | **December 15, 2007 – February 7, 2008**<br>1. Associate Editors ms posted on Moodle site |
| | **February 7, 2008**<br>1. Associate Editors Moodle Review begins (21 days.)<br>2. Moodle Groups e-mail inviting Moodle review for select groups sent by EE (2/7-11): Spirituality Definition, NCAM, Primary Care, Algorithms, Education, and? |
| | **February 11, 2008**<br>Associate Editors will commence final editing<br>Associate Editors begin editing Use Moodle feedback in your editing process.<br>1. Edit manuscripts: send off to your author (leads) to review and revise.<br>2. Do one at a time.<br>3. Use Quinn /Pizzorno Guideline. |
| **March 31, 2008**<br>1. All ms due from Associate Editors to EE.<br>Approved by Section lead and authors of ms. | **March 31, 2008**<br>1. All ms due from Associate Editors to EE.<br>2. Approved by Section lead and authors of ms. |
| **SPRING 2008**<br>**Symposium Planning Process Begins**<br>Date \| Location \| Save Date Email \| Budget Review \| Sponsor Plan | |

[9] All Section Leads and Co-Leads are now Associate Editors in this Project.

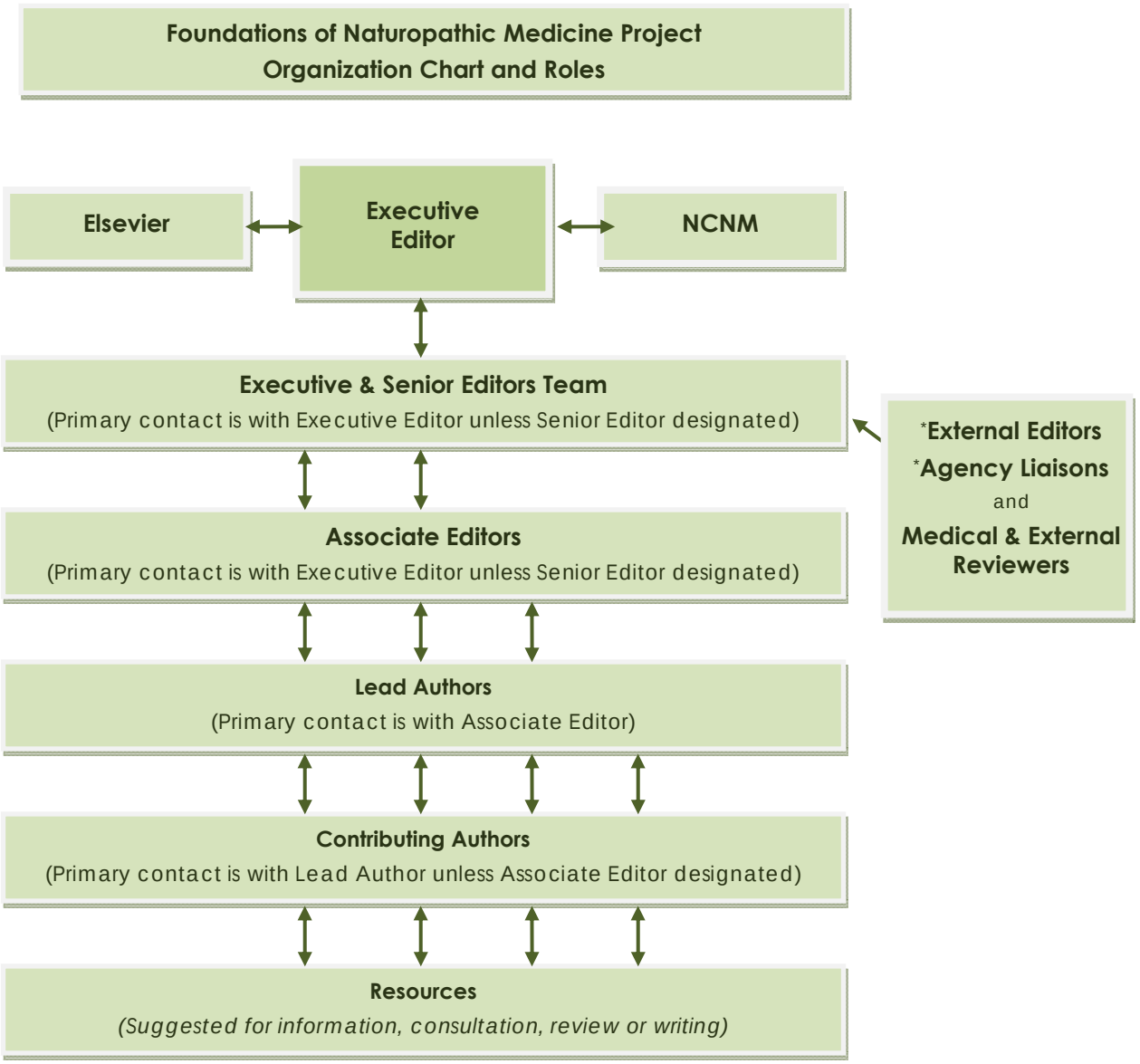


| |
|---|
| **March 31 – August 31, 2008**<br>1. Senior Editors Final Iterative Editing Process begins.<br>2. Associate Editors and all authors are on notice that Editors may be in touch re revisions etc at any time. |
| **At AANP Convention 2008**<br>Symposium Planning Process face to face side meeting |
| **Fall 2008**<br>Senior Editors week-long meeting<br>Symposium Planning Process start monthly meetings |
| **August 31 – December 31, 2008**<br>▪ Senior Editors Final Editing Process<br>▪ Critical/Special Topical Reviewers<br>▪ Agency Liaisons<br>▪ Medical Reviewers<br>▪ Select Senior Editor Full Review<br>▪ Begin reference checks |
| **January 1 – January 31, 2009**<br>Executive Editor collates, reviews and sends review material to Senior Editors in their areas |
| **February 1 – March 30, 2009**<br>Senior Editors integrate reviewers' material & address changes to their assigned area. This may involve communication with anyone down line, including reviewers, authors and Associate Editors. |
| **March 30 – April 30, 2009**<br>Executive Editor integrates reviewed sections from Senior Editors, working closely with Senior Editors and External Editor(s) |
| **April 30 – May 30, 2009**<br>Final External Edit |
| **June 1 – 15, 2009**<br>Senior Editors FINAL review with Executive Editor |
| **June 15 – 30, 2009**<br>Executive Editor compiles with help from Senior Editors |
| **June 30, 2009**<br>**Deliver Manuscript to Elsevier**<br>Textbook in production nine months until March 31, 2010. |
| **SYMPOSIUM – Spring 2010**<br>*Following publication of textbook* |

As of August 24, 2007, Elsevier is reviewing this production timeline with their own schedule and will notify us in the near future of any changes, particularly the relationship of the textbook production by Elsevier in time for the Symposium. Note that the November 30, 2007 deadline for manuscript submission is firm.



# Organization Chart and Roles




This representation of the Foundations Project reporting structure is not to preclude collaboration possibilities. Collaboration is encouraged at all levels. This represents the "chain of review and oversight." Refer to the production timeline for manuscript submission and review process for further clarification.

* Throughout the Project, External Editors and Agency Liaisons will be integrally involved by their participation at the Editors Retreat, and assisting as Co-Chairs for the Symposium (post publication). In fact, some External Editors and Agency Liaisons are Associate Editors and Authors.



## *Creating Coherent Clinical Applications – Day 3 and 4*

# Nature Cure: Honoring the Heart of Naturopathic Medicine

Cathy Rogers, ND and Letitia Watrous, ND

### *Charge of Session*

To present a summary of the authors' perspectives on and definition of Nature Cure in naturopathic medicine, yesterday, today and tomorrow.

### *Deliverables and Goals of Session*

To determine key areas of convergence, diversity, areas missing, and conflict in Nature Cure.

## Plenary summary and outcomes

Following the presentation on Nature Cure by Cathy Rogers and Letitia Watrous, there was widespread agreement with the fundamentals reviewed in this session, so much so, that the breakout group plan was re-choreographed to permit the large group to discuss its Metaparadigm on The Process of Healing.

In particular, there was support for nature cure's discussion on the *Vis Medicatrix Naturae*, vital force, and the therapeutic order. Also, the history of naturopathic medicine as strongly referenced to spa and/or water therapies. There was significant coherence concerning nature cure's foundational and vital role in naturopathic medicine (in terms of past, present and future practice model, and identity); its lack of full expression in today's naturopathic practice and training; and the need to re-focus naturopathic medical education to strengthen this practice model in training and practice. Participants enthusiastically recognize the need for an inpatient care facility, a therapeutic spa or healing retreat and the need to have this accessible to students.

A discussion among the plenary group ensued. Following are the highlights.

- Letitia has an excellent business model for her clinic that she will share. (Non-insurance, cash practice, 35 to 40 patients per day.)
- General agreement that prior to using any medicinal treatments, the blood must be cleansed and 'cleared' through diet and lifestyle.
- There was a discussion about the use of the word nature 'cure,' and whether it is accurate. It was agreed that cures, in fact, had been witnessed (based on the definition, "no recurrence of disease.") Further, that nature is the agent of cure 75% of the time.
- The group discussed the need for care in the use of naturopathic language and its paradigm. Particularly, the concept of an "incurable disease," which comes from the allopathic world. "There are no incurable diseases, but there may be incurable patients."
- Reference was made to "Dr. Dick's" quote to "treat the whole in the middle – the emunctories." This is the starting point of the therapeutic order, and for re-establishing the basis of health. As such, the therapeutic order is non-linear, the *center* in a "sphere of influences." This is a core teaching and understanding of naturopathic medicine, and nature cure practice.
- It was agreed that naturopathic doctors do not "manage" disease like allopathic physicians.



- It was agreed that these thoughts go to the heart of naturopathic medicine, and that participants wish this to be referenced in the text.
- Discussion ensued regarding the availability and ability of coding of such services, using a medical model and integrating as such within mainstream healthcare delivery.
- There was also agreement that participants would like to see the profession organize an in-patient facility that is affordable or free to lower socioeconomic communities. This would provide needed care, offer invaluable training for college residencies, and enable critical research opportunities to demonstrate the efficacy of nature cure using evidence-based and science-based modalities.

## Detailed proceedings from plenary discussion

### *Flipchart notes*

1. A living can be made in hydrotherapy, e.g., in medical spa.
2. To the 'green allopaths,' good guidance in nutrition is important – you can put all the pills into a body but unless you do it to move the blood, it means nothing.
3. Publish on how to open and run a business which incorporates nature cure.
4. Open the emunctories – organs of elimination.
5. There is significance in exploring the difference between the terms nature cure versus naturopathy. Many ignore nature *cure* because it implies complete cure – most prefer naturopathy – think of the term/context of nature cure. We are creeping towards being esoteric.
6. Some continued to argue that sometimes people are actually "cured."
7. This is a semantic issue.
8. Natural hygiene was also called nature cure.
9. Nature cure can also be stated as a natural way of living.
10. Many suffer from *yin deficiency* because they do not feel nurtured.
11. Participants enthusiastically recognize the need for an inpatient care facility, a therapeutic spa or healing retreat, and the need to have this accessible to students.
12. People with end stage diseases that have been cured were discussed, and the cure comes through patients' movement towards health restoration practices.
13. Re-establishing the basis/benefit of health is central to nature cure and naturopathic medicine.
14. In treating cancer/disease, treat the whole – around the center. Presenters and others have witnessed profound healing.
15. Encouragement was expressed as a group, to extend these services to those who cannot afford them. Collectively consider making all services safe and cost effective.
16. Do not give up on integrating into the mainstream. Instead, let's change it, including changing and developing new codes especially so that people with low income can receive our services.
17. It was agreed generally that nature cure is the foundation of our medicine and hydrotherapy is a key part of this – but, we also need more research on this.
18. ***LIAISON***: Students are looking for a book that tells us what to do and how it works. This concerns the students. William asks that we do not wait for the research. We should include it in the book.
19. We need to be careful about the language we use to describe nature cure practice.



20. There are no incurable diseases, only incurable patients.
21. Editorial challenge to Joseph Pizzorno: help us close chapters with our next steps in research.
22. Use this triad: *Patient choice – External evidence–Internal evidence*; to identify where the evidence base lies.

## Reflective dialogue

***Letitia:*** Part of the difficulties in writing the section is not to alienate the green allopaths. We can't put them (the allopathic physicians) down for just treating the symptoms because we do that too. What we're trying to do is articulate *how* it is we do the first three or four goals on the therapeutic order. As long as there's a framework and the ND realizes where they're interacting with the therapeutic order [in terms of symptom treatment], they also know there are these other things to do too.

- Need to address the symptoms.
- We are trying to write down that part.
- Suppression occurs.
- As long as there is a framework, and where you are interacting within the framework, it is. important to connect it to the therapeutic order.

***Paul:*** This is absolutely core, and to lose any of this material we are talking about would be awful. How do you make a living? Do you make the same amount as someone living in the city?

***Letitia:*** I'm a cash practice. I gross $3,000-$4,000/day. I see 35-40 patients/day, and I don't bill insurance at all. It's too expensive.

***Thomas:*** Then go ahead and piss off the green allopaths. The reason is that somewhere in the *Organon* it says that you can pour all the medicines in, but if you haven't cleaned the blood with diet and lifestyle, the medicines aren't going to do squat. You need good nutrition in order to affect a change.

***Pamela:*** Letitia has a profitable business model, and has shared that in the past.

***Roger:*** Naturopaths refrain from nature cure, because cure means that you will never get diseased again. Natural hygiene was called straight nature cure. This is a wonderful expression of our naturopathic principles. I'm wondering, however, about the interchangeability of the words Nature Cure and Naturopathy. *(Reads a quote about the term cure. Is it flaky?*) Is there cure? Does this get us in trouble? I agree with you; I'm just offering this provocative thought.

***Letitia:*** The methods that I use and that my father used – we've seen cures, without a recurrence of the disease. So I like the term cure.

***Paul:*** Is it nature 75% of the time that effects the cure?

***Roger:*** I'm not arguing that we should strike it out.

***Letitia:*** I like nature cure, because my father found that the incurables were cured. We don't "manage" disease, like allopaths.

***Herb:*** I think that sanatorium model is so important to bring back that nurturing that people are so missing.

***Paul:*** Does insurance fund people to go to spas in the U.S?



***Cathy:*** In Europe they do.

***Paul:*** So, in socialized medicine?

***Cathy:*** In the U.S. there are 27 destination spas. They're offering therapies that are paid for. But they are not doing therapeutic spas. In Priessnitz's and Kneipp's time, people were doing this, removing themselves from urban life to restore themselves and their health. We can get rid of chronic perpetual stress.

***Louise:*** Letitia, I sat in with your dad for a week in my third year, and it entirely changed my perspective. People were being cured of "incurable" cases. Step 1- the first tenet in the therapeutic order is *re-establish the basis for health*. Dr. Dick used to say, "*Treat the whole in the middle" (the emunctories).* We're nothing but glorified donuts." From that point forward, that concept has been the core of my practice. This is the reason I'm called back into teaching. Any digression of that is a loss of the core, and the essence of what naturopathic medicine is about. That is the heart and soul of my practice. Not just the core, but the essence of what naturopathic medicine is about. When I think of the therapeutic order, I don't think of it in a linear way. I think of re-establishing the basis for health as the center in a sphere of influences. Without that heart, I could not know how to do anything. Doing just that, I have witnessed the most profound changes in the most advanced pathology. Doing any of the other therapeutics without this center doesn't make sense. I'd like *this* to be the heart and soul of this text.

***Bruce:*** At the risk of appearing heretical… I too agree this is an incredibly important and basic aspect of what naturopathic medicine has to offer. However, I encourage us not to give up on the possibility of extending these valuable services to our fellow travelers who may not be able to afford to access them. We must consider and discuss our responsibility as physicians to make available all the services that are safe, effective and hopefully cost-effective, i.e., reimbursement.

***Letitia:*** Why can't we have our own codes? It's difficult to code in a medical model when I'm diagnosing and treating in the naturopathic model.

***Bruce:*** I'm not defending the current coding system. But it's not cast in concrete. If what we have to offer is true and valid, it will ultimately be codeable. Consider this a plea that we as a profession not give up on trying to integrate into mainstream healthcare delivery, by changing the codes. Let's change the bloody system. If it doesn't work, step up and let's change it.

***Paul:*** Could the profession organize a free clinic for those in low income categories socioeconomically?

***Letitia:*** I'd like to see an in-patient facility where we can access both worlds, and at the same time train our students and our residents.

***Joseph:*** Being the 'heavy' on science-based and evidence-based model: nature cure is the foundation of our profession, and needs to be forwarded. My frustration is why haven't we been doing research in this area? I know the results are remarkable. And we need to make this work reproducible.

***Letitia:*** There are a couple of projects in the works at NCNM; and I am helping some doctors at Bastyr about HIV research on constitutional hydrotherapy.

***LIAISON: William:*** It makes me nervous that things that work might not be put in the book because of lack of answers of how/why do they work. If we wait around for things to be proven before we use them, we couldn't do anything. Those questions should be pursued. The book's on how to do things in practice and point the researchers in the direction of what to go study.



***Pamela:*** Joseph's idea is very important. I would like to challenge Dr. Pizzorno to close the chapters with what is the next area of research at the end of the chapters.

***Joseph:*** Leanna should do that.

***Stephen:*** This concept of evidence-based medicine is poorly understood. It is actually a triad. There is patient choice, external evidence–proven, and internal evidence–clinical experience, known through the clinic. We need to look at absenteeism from work before and after spa treatment. Then you will get insurance.

***Paul:*** There's no chance that it will be boiled down to what's evidence-based. We talked earlier that it's all about how we language it.

***Jim:*** We need to be careful of our language and our paradigm. Remember the concept of an incurable disease comes from the allopathic world. There are no incurable diseases, but there may be incurable patients.

## *Summarized key points*

***Pamela:*** Joseph articulated earlier a great solution:

- Address what evidence is there, whether there is/isn't
- What research needs to be done
- Editorial challenge to Dr. Pizzorno – that we close the chapters with what's the next step in research for this?

***Joseph:*** *Leanna should do that.*

***Stephen:*** "Evidence-based" is poorly understood:

- Patient choice;
- External evidence [been proved scientifically];
- Internal evidence [things known by clinical experience].

***Stephen:*** Somebody needs to look at, not the increase in WBCs, but what's the rate of absenteeism before entering the spa, then after entering the spa. Then you'll get insurance reimbursement.



## *Creating Coherent Clinical Applications – Days 3 and 4*

# Naturopathic Medicine Modalities: Evolving with the Progress of Knowledge

Stephen P. Myers, ND, BMed, PhD and James Sensenig, ND

Detailed panel presentation summaries begin on page 27 in Retreat Book, Volume II.

### *Charge of Session*

To provide feedback to enable the Modalities chapters to produce the first definitional statements of naturopathic modalities in the context of naturopathic philosophy and theory; and to represent the full range of expression extant by naturopathic doctors whose practice and jurisdiction scope vary.

### *Deliverables and Goals of Session*

- To help to define a Modality.
- To determine whether to group Modalities as clusters or to identify them as individual components.
- To determine how best to incorporate the teachings, insights and experiences of elders into understanding and synthesizing Modalities.

## Review and outcomes of session

As with the nature cure session, the Modalities session leaders released their breakout group work in order to create time and space for the process of healing metaparadigm discussion. The panel answered questions in a plenary group discussion following their abbreviated presentation.

## Plenary key recommendations

### *Defining Modalities*

- Try to process and/or "fit" modalities into the processes of the therapeutic order.
- Define the particular modality, but also demonstrate its naturopathic utilization.
- Change the title of modality from "Naturopathic Modalities" to "Modalities Used in Naturopathic Practice" ("Modalities do not define naturopathic doctors or practice." Also, other healthcare providers use these modalities.)
- Need to determine where homeopathic theories fit into naturopathic theory.
- Acknowledge with modalities that we use the least force first.

### *Modalities as clusters or individual component*

- Naturopathic medicine is a complete system, and then there are modality clusters within that system, and within that specific treatment technique.
- Give expanded chapters for all modalities that fall under clusters. They merit discussion.
- Incorporating teaching, insights, and experiences of elders into modalities.



- Regarding the use of drugs: sometimes, using the least force is prescribing drugs; however, it must be known where this application fits into the therapeutic order.
- "We do not 'own' these things … they were around before us." Naturopathic doctors apply modalities differently; are the "best at strategies and complexes." Therefore, it is critical to demonstrate the uniqueness of naturopathic constructs.
- "There is no such thing as an allopathic drug or a homeopathic drug. It is either allopathic to the case or homeopathic to the case. It is not what we are doing, but why we are doing it, and how we are doing it. We are the restorers of health."

## Detailed proceedings from plenary discussions flipchart notes summarized

1. Instead of trying to fit into the modalities, we should see if they fit into the processes of the therapeutic order.
2. Define the modality; for example, how is it used naturopathically?
3. It is not modalities that define us.
4. Provide expanded chapters for all modalities that fall under clusters. They merit discussion.
5. People who don't understand medicine use drugs.
6. For "green allopaths," drugs are an important part of rights. Allopathic to the case or homeopathic to case depends on what we are trying to accomplish.
7. Use the least force first.
8. We are best at strategies and concepts.
9. We use botanicals and homeopathy, etc. all together.
    5. If we have the right to prescribe drugs, we have the right to recommend that people stop taking drugs.

## Detailed minutes

***Joseph:*** A suggestion for Stephen: maybe instead of fitting modalities in, we should try to place it under auspices of the therapeutic order?

***Stephen:*** Most of the modalities probably feel they fit in multiple places in the therapeutic order. Herbalists do comply with the whole of that domain. We've asked the modality people to address the therapeutic order in their writing. It might be interesting afterward to pull it out into some sort of synthesis.

***Paul:*** We've had this same debate in the Physical Medicine Chapter. I propose a change in the title, they are not naturopathic modalities; they are modalities that are used in the naturopathic practice. Non-naturopaths also use them. That might change the way they are written. Define the modality and how is it used in a naturopathic way.

***Herb:*** But from the standpoint of branding, we may want to keep naturopathic on it, because this is a book on naturopathic care.

***Bruce:*** There is a complete system (that's naturopathic medicine); there are modality clusters; and there are specific treatment techniques.

***Louise:*** I also agree with Paul. We shouldn't try to claim the modalities. I think it shows disrespect to those practitioners that are not NDs. Physical medicine included electrical stimulation,



manipulation and massage. If these modalities are placed under an expanded chapter, then that is okay, but it would be better if they are separate because of distinct application and effects.

***Patricia:*** These being modalities that naturopaths use, it allows us to align with the meta-theories idea that Mary laid out. E.g., which meta-theory does homeopathy fall into? Where do the theories that underlie homeopathy fit within our theory?

***Joseph:*** I actually argued against access to prescription rights, because I don't think we need them, and people who don't know the medicine well enough will use drugs because it's easier. However, others argued that it was useful politically [and they turned out to be right], and useful in a place where a doc is in a rural area where everybody isn't necessarily committed to naturopathic medicine, and our ND is the only doc they have access to. We should address this issue. We are using the term green allopath; however, we do want to use drugs as they are the best intervention. People who use drugs do it because they don't know what else they can do. If you prescribe drugs, you are considered a primary care physician. If you can do it and choose not to, it makes more sense for how our philosophy is better. Sometimes the least force is the drug, and we should show where it fits into the therapeutic order.

***Stephen:*** How does it fit into the modalities chapter?

***Joseph:*** Sometimes the least force is the drug, and also, to show how it fits into the therapeutic order.

***Mitchell:*** We do not own these things. They were around before us. However, we apply them differently. We are best at strategies and complexes. We need to show the uniqueness of the constructs. Sending someone off to another physician to get antibiotics is not helpful for the therapeutic relationship.

***Letitia:*** Another reason to expand our formulary – if we can prescribe the drugs, we have the right to take patients off of them.

***Jim:*** There is no such thing as a drug or herb that's homoeopathic or allopathic. It is either allopathic to the case or homeopathic to the case. It is not what we are doing, but why we are doing it*; how* we are doing it. We are trying to move the patient towards health. Sometimes it's appropriate to suppress symptoms. But, if on the whole, we're aiming to move the patient to a restoration of health, that's naturopathic medicine. We are the restorers of health.



## *Creating Coherent Clinical Applications*

# The Elements of Naturopathic Primary Care: Evaluation, Management and the Ecology of Healing

Bruce Milliman, ND; Thomas Kruzel, ND and Rita Bettenburg, ND

Detailed panel presentation summaries begin on page 146 in Retreat Book, Volume II.

### *Charge of Session*

To present a synthesis of definitional work on the elements of modern Naturopathic Primary Care in the context of naturopathic philosophy, traditional naturopathic practice, and the classic principles of primary care evaluation and management.

### *Deliverables and Goals of Session*

To answer the following questions for the Panel:

- What are the distinct elements of care, evaluation, and management that define the naturopathic model?
- What elements do we hold in common with conventional Primary Care providers?
- What impacts do issue on safety, efficacy, cost effectiveness, and accessibility have on advancing our model while maintaining our integrity?
- What is the transformative potential of modern Naturopathic Primary Care for the healthcare delivery system?

## *Plenary summary and outcomes*

Following the presentation on Naturopathic Primary Care, the large group formed breakout groups to discuss the above questions. Following is the feedback from participants within the large group setting, and from dedicated discussion during breakout groups. It is notable that in the clinical specialties session that follows, a generalist model (primary care whole person generalist) emerged, which presented common elements of what naturopathic physicians do well in primary care as a framework to overarch the clinical specialties section. This clinical specialties model was recognized as having implications for the elements of the naturopathic primary care model in this section.

### *Naturopathic Primary Care definitional elements*

- The caregiver the patient goes to first for care is his/her primary care giver, within the legal jurisdiction of the geographical area of practice.
- Coordinates the patient's care (i.e., consults and co-manages and refers).
- Has greatest responsibility for patient's care.
- Naturopathic doctors are generalists in whole person care.
- Uses the *least force* model.
- Naturopathic interventions are consistent with its philosophy, and are not inherently harmful.
- Naturopathic care is premised on empowering patients to take control of their health.



- Naturopathic doctors regularly assess and monitor the parameters of health.
- Philosophical approach is oriented towards cure by supporting the body's innate healing process.
- Evaluative techniques focus on patterns of causation, including obstacles to cure.
- Evaluative element are:
- more subtle,
- more functional,
- standardized,
- pre-pathological.
- Wider array of interventions: physiological and pathological and pharmacological.
- subtle interventions such as energetic, homeopathic and spiritual

### *Common elements with conventional primary care providers*

- Shared understanding of pathological diagnosis and pathological intervention
- Shared level of basic training (breadth and depth of basic medical sciences).

### *Impacts*

- Scope, access and integrity of naturopathic private practice
- What is the role of NDs in public health policy?

### *Accessibility*

- Naturopathic care is less accessible (mainly from cost and/or insurance and coding perspectives).
- Patients self-select.
- Naturopathic medicine is predominantly middle-class. But the bulk of disease rests on the lower socioeconomic groups. How do we get naturopathic medicine to the masses?

### *Efficacy*

- Patients return due to increasing wellness, rather than disease management.

### *Cost effectiveness*

- Lower costs in the long run due to preventive model of care, health promotion, and lower cost interventions

### *Transformative potential*

- Re-orienting the present healthcare system from a disease-centered to a health restoration model.
- Our interests are best served by focusing on who we are, and what we want to articulate to others.
- Removing the element of fear about disease that is so widespread (germs, bacteria, viruses), and cultivating an awareness of personal health instead (empowerment).



## Reflective dialogue with panel plenary

***Bruce:*** The goal here is to represent the scope, access and integrity of naturopathic private practice. The terms in use have changed. Back when I was in school, the terms in use were generalist versus specialist. Now it's primary care provider. The current concept is: Medical Home, though I'm not sure if this term will stick. It just means whoever sees a patient at first blush. I also don't want to use the word allopathic, because it's not allopath versus naturopath. Allopath is in opposition to homeopath. I also don't want it to be an us/them conversation.

***Thomas:*** I have read this document. I think it is important for this to be part of the book, but there was no mention of standards of practice and standards of care. This is a great place to put it in. We're claiming primary care territory; therefore, we have to address this issue somewhere.

***Rita:*** I will talk to this. I just got assigned to the section. I haven't had a lot of input into it. I have a question: I haven't heard how we look at people who do not practice as naturopathic physicians? How do we look at NDs who decide not to practice? [E.g., going into public health]. I've heard them discussed as "they're not really naturopaths." What is our role in public health policy? (Maybe they're talking about vaccinations, how we look at them?) I work in a collaborative clinic – two NDs and one MD. We see patients underinsured or uninsured. We proved really good naturopathic care, but it is not the care you will see in the offices. How do you want to look at a heroin user that has infections? What is the least force? To show the user how to inject without causing more infections, and give them an antibiotic. What about low-income clinics, e.g., at shelters? We do this as part of our colleges. It's a different kind of care. They don't have food, shelter.

Let me tell you about Frank. He was a 58 yr old intravenous drug user that lived on the streets since Vietnam. He came in every week on my shift, and had us dress his 25 abscesses. One day he pulled me in close and said, "God is going to bless you as I bless you, because you care about me and you make me safe and I just want to say thank you."

***Iva:*** In response to "what we do about these NDs?"… Canadian College has five community satellite clinics that are free. It's the intention and strategy of CCNM to plan that 25% of our grads won't practice. E.g., eight of our NDs are in the Federal Government. We have to encourage this and plan for them--train people so that they can do other things.

***Rita:*** That adds to my question – from the framework of philosophy, how do we look at this?

***Stephen:*** We talk with our grads about various destinations they might end up in. This needs to be articulated. On another topic, to a vast extent, naturopathic medicine is middle-class. But the bulk of disease rests on the lower socioeconomic groups. How do we get naturopathic medicine to the masses? I'm not looking for an answer; just that it needs to be considered.

***Jared:*** When you pose rhetorical questions: how do you rationalize the therapeutic order concept? There is no conflict to me. The other question you posed. There seems to be a disparagement with those that don't practice.

***Rita:*** I have heard that, though I would like to see this room able to describe and defend it. I agree with you, Jared. But, I hear it very often, and I want to make sure the rest of the community doesn't miss the point.

***Joseph:*** When you talk to public health, you don't leap to talking about vaccinations. They will throw you out. Most of public health dollars are not spent on health promotion. It's individual care, in public settings, e.g., low income clinics or jails. In general, they're quite receptive to what we



have to say. The frustration public health people have is that the public health funds are not spent on health promotion. They are spent on disease care and contagion control.

## Summary of proceedings from group and breakout discussions

***Jared:*** Some naturopaths have the idea that we shouldn't consider ourselves primary care physicians. Primary care is the highest level when dealing with patients. When I was licensed, I could sign birth certificates and death certificates. In licensed states we have been primary care physicians. The muscle of the Flexner report was graduates that can sit the boards and get licensure. Another argument (from Patrick Donovan): we are just not as qualified; we shouldn't be primary care, because we don't have the training. I don't like that. The default definition in my license says I am a primary care provider. That is the definition. I make primary decisions; I am responsible. No one else takes responsibility for my decisions. The burden of my choices is on me.

***Rita:*** I agree (about) why people think that we shouldn't be primary care. Many people don't want to play the political game. One of the fears/objections I have heard expressed is about having to comply with the public model, that our 'lack of training' will be found out. I don't know how to make AANP happy. We already *are* primary care. We need to make a definition.

***Letitia:*** I don't think that primary care means we have to comply with the public model. In the medical world, primary care is insurance based.

***Christina:*** We cannot be defined as primary care because we are getting in trouble in unlicensed states.

***Bruce:*** The actual issue is about defining us, so that a lay person (can) know who we are, and what we do. I can speak from dealing with regulatory bodies and insurance over decades. Our interests are best served by focusing on who we are and what we want to articulate to others. Either we define ourselves or someone else will. Either we seize what is ours or someone else will. We don't want to define ourselves to make the other guys happy.

***Letitia:*** Is there a definition of naturopathic primary care?

***Bruce:*** The 1978 WHO definition of primary health doesn't define naturopathic medicine. It defines primary care. Primary care is essential healthcare made accessible to the community that the community can afford. Contain first encounter deals with individual, family and community. The underlying assumption is that you have a safe, licensable, regulated set of standards that protects the community and assures the individual that you can make medical decisions.

***Jared:*** What are the distinguishing features of the naturopathic model?

***Bruce:*** I think that it is absolutely unique that we enter a situation and are trained to use lesser force.

***Letitia:*** My levels of evaluation are different and much more subtle. We can pick up changes in the metabolism, before they show up in the blood.

***Joseph:*** Let's define it as primary patient responsibility. Primary care does not mean that we follow an MD's standard of care. But, we must report contagion. Vaccinations: we have authority but not requirement to give these.

***Roger:*** Primary care is having the skill to take the patient as first contact, for the patient to come without other professional referral.

***Louise:*** Primary contact, go to person with primary responsibility, and coordinates care within the scope of the jurisdiction.



***Dr. Keppler:*** Can you explain to me the difference between healing and cure. If you say I've completely cured or completely healed him, those are different.

***Joseph:*** They're the same.

***Roger:*** Healing is a process. They could both be verbs, but there is a subtle difference.

***Joseph:*** You may heal a person and not cure their disease.

***Jay:*** It seems that if you're curing, you're overcoming the negative. If you're healing, you're enhancing the positive.

***Joseph:*** We need to do standard of care consistent with our philosophy. It may be useful to state safety explicitly. We've added 'safe and effective' to all of our work, in the last two years. (But) e.g., fasting is not safe. Our therapies do no harm but the patient's response may be adverse.

***Roger:*** We could introduce a concept of inherent harmfulness. Our interventions are mostly not harmful in themselves; many conventional medical interventions can be harmful even when correctly prescribed.

***Rita:*** There is a point in therapy that you're doing a risk-benefit analysis. Risks get higher further down the order.

***Thomas:*** A physician's clinical judgment is based on available evidence. If evidence requires short term steroid use, we deal with consequences later. We don't need to agonize over that.

***Don:*** If we look at meta-theories, there are those who are naturopaths that will look at it from unity of disease, and some who will look at it as functional medicine. It's a way of bridging gaps.

***Thomas:*** Conventional medicine compartmentalizes the body, and this is an attempt to de-compartmentalize.

## Breakout groups

### *Charge of breakouts*

To explore key questions of clarity, including:

- What are the distinct elements of care, evaluation and management that define the naturopathic model?
- What elements do we hold in common with conventional primary care providers?
- What impacts do issues on safety, efficacy, cost effectiveness, and accessibility have on advancing our model while maintaining its integrity?
- What is the transformative potential of modern naturopathic primary care for the healthcare delivery system?
- What are the elements of naturopathic primary care that are central in conveying the unique identity and practices based on the profession's foundational philosophy? For example, physical medicine and the healing modalities are unique features of naturopathic primary care practice.



# Breakout Group One – report

***Presenter: Rita Bettenburg***

## *Group One flipchart presentation*

*Naturopathic primary care*

1. Least force model
2. Wider elements of evaluation:

- more subtle
- more functional
- standard
- pre-pathological

3. Wider range of intervention:

- physiological as well as pathological/pharmacological
- subtle interventions: energetic, homeopathic, spiritual

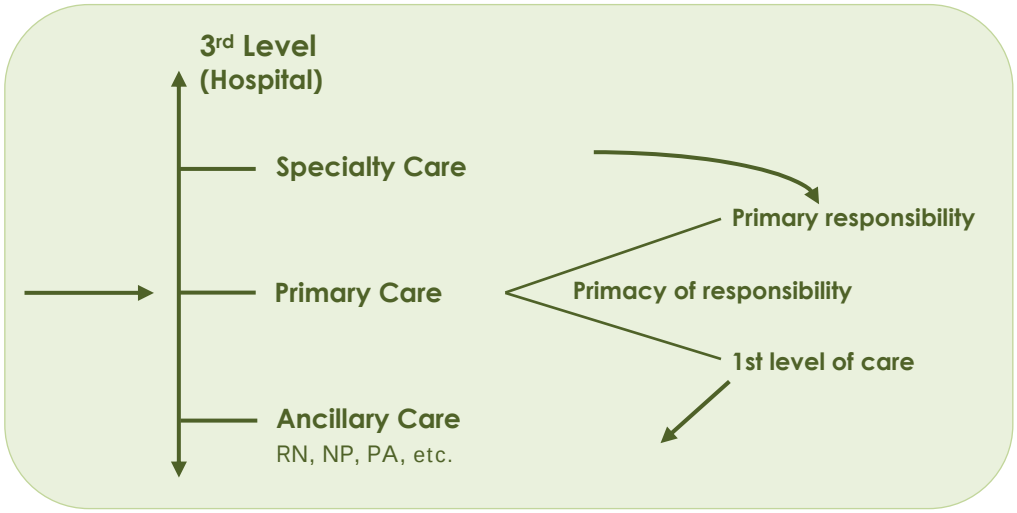
*Common elements with standard medical providers*

1. Shared understanding of:

- pathological diagnosis … science is "public domain"
- pathological intervention

2. Common level of basic training:

- Breadth and depth of basic medical sciences




*Accessibility*

1. Less accessible

- financial

2. Why not take insurance?
3. Coding issues – insurance
4. Patient selection – self-selected



*Efficacy*

1. Patient return due to wellness versus getting < / disease management

*Cost Effectiveness*

1. Lower level of safe and effective
2. Health promotion
3. Lower cost intervention

*Actions of ND as PCP*

1. Making primary decisions
2. Essential healthcare is made available …
3. Practitioner of first encounter
4. Responsible for medical decisions
5. Refers as necessary
6. Consults/co-manage/refers along guidelines

## Group One oral presentation

The group spent most of its time debating primary care. There is a concern about the states that are trying to get licensed. However, naturopathic medicine is defined that way. In defining what primary care was, we used several different descriptions. Whether or not it gets in the way of the licensure, we as a profession need to deal with that, because that is what we do. We are primary care. We addressed the following, and these are our conclusions.

*What is primary care?*

- Primary care physicians make primary decisions. They are involved in a primary encounter and they are responsible to make those medical decisions, and we refer, co-manage and consult when necessary.
- Primary care – a group of physicians that are the first level of care, and have primary responsibility. Ancillary care is at the first level, but does not have the primary responsibility, and specialty care has primary.

*What are the unique elements of naturopathic primary care?*

We provide the least force model, we do pre-pathological evaluations. We have wider range of intervention; because we do pathological and physiological interventions and pharmacological interventions. We also do energetic interventions (the level of treatment that is not physically tangible).We have a shared understanding of pathological diagnosis, and have common level of basic training with MDs.



*What impacts safety, efficacy, cost effectiveness in naturopathic medicine?*

The issues of insurance affected how this came out. The group explored why NDs should take insurance. Coding issues were raised and debated. What do we do when insurance does pay for us, but we upcode to compensate for the level of service?

The real issues are cost effectiveness.

*What is the transformative potential of naturopathic primary care?*

- We came up with cost effectiveness. We can do it cheaper. Our heath promotion creates lower cost intervention.
- The biggest issue in healthcare right now is pharmaceuticals.
- We can do more with less, and with less money than pharmaceuticals.

*What are the elements of naturopathic primary care that are based on the naturopathic philosophy?*

We decided we already answered that.

## Plenary feedback to group one

***Thomas:*** The licensing process in AANP is exceedingly difficult. Regardless of where you go, you will have opposing forces. We adopted the position that there were things we wouldn't do, but if we did get in at the ground floor, we would go back to legislation and ask for them. If we are primary care, we will be getting things back.

***Stephen:*** If you are not primary care, what are you?

***Rita:*** They are considered specialists in naturopathic medicine, but they practice at primary care level. They are classified differently.

***Pamela:*** There are six states that state primary care in law. These statutes don't define us as specialists or need referrals; they define us by primary care scope. The things we don't do. We are not limited, but we are not defining ourselves within the law.



# Breakout Group Two – report

***Presenter: Roger Newman Turner***

## *Group Two flipchart presentation*

*1. Primary Care Definition:*

- contact
- responsibility
- co-ordinates care

*2. Philosophy (elements of care):*

- oriented toward cure
- supporting innate healing process

*3. Ability to recognize (evaluation):*

- patterns of causation
- pathophysiology and pathology
- obstacles to cure

*4. Management:*

- any intervention is consistent with our philosophy that is not inherently harmful
- educate and empower patient to take control of their health
- regularly assess and monitor parameters of health

*5. Transformation:*

- changing from dz /tx model to health restoration model fundamentally transforms all aspects of healthcare

## *Group Two oral presentation*

Primary care was our focus. Before we could get in the door of primary care, we asked what is meant by primary care in the naturopathic context? We call it primary contact, accepting responsibility for the care of the patient, and being coordinator of care but with restrictions from state laws.

In Australia and the UK, we can take someone off the street and recognize the danger signs, but are not responsible for their total care (don't have prescription or vaccination rights).

We are primarily oriented towards cure.

We have the ability to recognize the elements we hold in common with medical doctors, and to recognize patterns of causation, the pathophysiology of the situation, the pathology, and the obstacles to cure/restoration of normal function.



The question of management involves:

- Identifying what our capabilities would be as practitioners.
- The use of any intervention that is consistent with our philosophy.
- In naturopathic terms, this intervention generally does not have the potential to do harm. (In contrast to pharmaceuticals that often do have the potential to do harm).
- Naturopathic care also carries a responsibility for educating and empowering patients for their health, as contrasted to normal healthcare's reliance on the third party (physician specialty).
- to regulate and monitor the health of a patient.
- the potential for cost effectiveness.
- Changing from a disease-centered model to a treatment/patient-centered model, which effectively transforms all levels of healthcare.
- We need to remove the element of fear that is so widespread in the population about disease.
- We have a great power as naturopathic physicians to allow people to take control and remove the fear.

## Plenary feedback to group two

***Joseph:*** I would change one comment on safety of therapies.

***Roger:*** We said our intervention is consistent with our philosophies, and not inherently harmful.

***Bruce:*** Something that is inherently harmful that is used by the other side is?

***Roger:*** Non-steroidal anti-inflammatories are harmful even when applied correctly.

***Louise:*** We didn't go into that much depth. Sometimes when you get to step seven in therapeutic order, the application of a steroid is the appropriate thing to do in short duration.

***Pamela:*** I've struggled with this one. If a substance poisons an enzyme system, this is different from what facilitates an enzyme system.

***Joseph:*** The main effect of most drugs is to poison enzyme systems. Most herbs are used to poison enzyme systems just not as much. Some herbs are turning on and off genes. And some drugs are doing it too, but most drugs are poisoning enzyme systems.

***Rita:*** The risks get higher as you go down the order. Our group talked about the fear of practitioners with very, very ill patients. We need to know that we can treat everything (maybe not alone).

***Thomas:*** I don't know why we agonize over this. If we need to use a steroid, we will deal with the problems afterwards. It must be done.

***Cathy:*** Dick Thom says that it will take three to five years to fully come back from an illness.

***Roger:*** One thing that we ought to clarify distinctly is the difference between the primary care abilities internationally and state by state.



## *Creating Coherent Clinical Applications*

# Application of Naturopathic Theory to Population Groups and Clinical Specialties:

### A Naturopathic Approach to Whole Person Practice, the Whole Person, and the Ecology of Healing

**Clinical Subgroups and Categories – Keeping Them Naturopathic and Individualized**

Tom Kruzel, ND and Paul Orrock, ND, DO, RN

Detailed panel presentation summaries begin on page 185 in Retreat Book, Volume II. Appendices can be found beginning on page 196 of this report with presentation notes and breakout group discussions.

| *Charge of Session and Breakouts* |
|---|
| To review and advance an innovative section design and internal chapter framework, which reflects the heart of naturopathic medicine, yet is recognizable to conventional providers, in effect, creating an accessible framework for presenting the full scope and context of naturopathic clinical medicine as described in naturopathic principles and theory. |

| *Deliverables and Goals of Session* |
|---|
| • To capture recommendations to the challenges raised by the editors of this section.<br>• To obtain feedback on the chapters' formats, including revisions to chapter sequence, structural feedback, subheadings/ structure consistency with NM codification versus reductionism, disease oriented or 'green allopathic' codification.<br>• To allow for the maximum of creativity in the writing of each section.<br>• To provide advice regarding each of the chapter's core importance to the text. |

## Plenary summary and outcomes

In conjunction with Session A: Primary Naturopathic Care, following the presentation on Clinical Specialties, by Tom Kruzel and Paul Orrock, the plenary group formed breakout groups to discuss the above questions. Following is the feedback from participants within the plenary setting and from dedicated discussion during breakout groups.

### *Coherence*

Overall, the group was very pleased with the proposed direction of this area of the text, particularly the strategy of utilizing a chief health complaint and searching for "cues" into and between other systems in the body.



Participants appreciate the strategy of writing text that articulates the "how" of naturopathic doctor "thinking." For example, in the case of gastroenterology, the text would not discuss how to treat a stomach ulcer; rather, what does it mean that someone has an ulcer in the first place?

Participants suggested using case examples to illustrate the above points.

The group suggested and endorsed strongly using the word 'clinical systems' instead of 'clinical specialties' in order to better reflect the term meant by clinical specialties.

It was strongly agreed to introduce the interrelationship of systems as a principle of this section, which would be reflected throughout; to develop chapters from this perspective. Thus there would be no chapters on "ologies;" rather, chapters would be developed on this complex and systems approach to diagnosis, along with laws or tenets of the healing process, reflecting the primary care NDs' whole person approach for all care entry points

It was also agreed that the idea of including emunctorology was a good one. (The idea of understanding of function of bowel, liver, kidneys, skin, and lungs in health and illness in the whole person and across systems.)

It was further recognized that for some individuals, functional medicine may be a good entry point as a framework for understanding the relationship between physiological clinical systems; and this must be placed within the context of naturopathic theory, including the unity of disease.

It was agreed that the opening chapter would be more extensive, and it would be rewritten to reflect and integrate the frameworks presented in the breakout and plenary sessions. This would allow the following chapters to be shorter, with cases, and presented from the perspective of the opening chapters presentation of the clinical application of theory, as described in the groups, to systems of the human being.

## *Omission*

It was suggested that the editors include an example of patients with mental and/or emotional complaints.

## *Diversity*

It was proposed that the endocrine system be included with the meta-systems.

Eliminate midwifery; use 'obstetrics and natural childbirth.'

## *A suggested example for chapter layout*

1. *Introduction: The Naturopathic Approach*

- Overarching Themes, Vis Medicatrix Naturae and Metaparadigm
- Philosophy (bridge to process of healing, the therapeutic order and case management)
- Systems Approach
- Problem Solving
- Mind – Body –Spirit
- Contents of chart on page 52 showing revised process of healing, therapeutic order, terrain and metaparadigm



*2. Systems*

- Environmental Medicine
- Emunctories
- Metabolic Medicine (Marz)
- Nutrition
- Oncology
- Endocrinology
- Immunology
- Clinical Genomics
- Constitutional Medicine
- Others?

*3 Sub-Systems*

- Cardiovascular
- Dermatological
- Gastrointestinal
- Hematopoietic
- Respiratory
- Neurological
- Musculoskeletal
- Renal and Urinary
- Ophthalmology
- Reproductive
- Endocrinology
- Special Senses

*4 Case Studies*

- Consider using with commentary as placeholder chapters. Use throughout all chapters.

*5 Populations (Health throughout the Lifespan)*

- Pediatrics
- Geriatrics
- Men
- Women
- Midwifery, Obstetrics and Natural Childbirth

## Summary of proceedings from group and breakout discussions

***Louise:*** The way you illustrate how you look at the patient (and the system is really beautiful) – taking the chief complaint and looking for cues into other systems, is really brilliant.

***Iva:*** Something I notice missing – someone who comes in with a mental/emotional complaint.

***Thomas:*** We were having a problem with that.



***Louise:*** We cannot publish the book without these 14 topics.

***Thomas:*** But we don't have the author's perspective.

***Jared:*** We're not writing on how to do all these things. We're writing a textbook on how we think. We don't have to have a chapter on every one of these. That's not the point. That's another book.

***Thomas:*** What we were asked, was, what makes us unique in this area. E.g., skin as an organ of elimination. E.g., in gastroenterology, not how to treat a stomach ulcer, but what does it mean that someone has an ulcer? Talk about what an ulcer is in a naturopathic perspective in both a microcosm and macrocosm.

***Cathy:*** It's exciting to write it that way. Consider, where you don't have a full chapter, consider putting a case. And this might include more than one – ology.

***Mitchell:*** Stir it up and get five to seven that are functional in orientation, not structural. I tell people, I don't treat skin problems. I want to make your skin better, but that's not what I'm going to treat. Explain this.

***Christa:*** I'm uncomfortable with the word "specialties." It implies something about treatment, or something that you would do other than as a primary care naturopath. I'm not quibbling with the word "cardiology," but with the word "specialty."

***Thomas:*** Paul discusses that we are not interested in cardiology, but in healing the heart. But the public goes into a cardiologist for a heart problem. We need to, at least for now, stick with what the public understands.

***Christa:*** I'm debating the word specialties.

***Kavita:*** I was looking at the special populations section, and I was thinking of it more in terms of life span.

***Pamela:*** Try clinical systems instead of clinical specialties.

***Stephen:*** Specialty is a concept. Naturopathy is defined as a whole person skill. We have naturopathic sub-specialties, such as gastroenterologist. The primary specialty of all naturopaths is to be generalists.

***Iva:*** In Canada, "specialty" is not a legal term we're allowed to use.



# *Breakout groups*

## Breakout Group One – report

***Presenter: Paul Orrock***

### *Group One flipchart presentation*

*Application of Naturopathic Theory to Clinical Systems (title)*

**Introduction: The Naturopathic Approach**

1. Overarching
2. Deep
3. Philosophy (bridge to process of healing /therapeutic order)
4. Systems Approach
5. Problem Solving
6. Mind/Body/Spirit
7. Contents of chart on page 52 showing revised process of healing, therapeutic order, terrain and metaparadigm

**Systems**

1. Environmental Medicine
2. Metabolic Medicine (Russ Marz – rename)
3. Oncology
4. Immunology
5. Clinical Genomics

**Sub-Systems**

1. Cardiovascular
2. Dermatological
3. Endocrine (these are good examples of complete overarching systems)
4. Gastrointestinal
5. Hematopoietic
6. Respiratory
7. Neurological
8. Musculoskeletal
9. Renal and Urinary
10. Reproductive
11. Special Senses

**Case Study based with commentary as a fall back (for placeholder chapters).**



## *Group One oral presentation*

The group spent most of its time trying to categorize the subchapters. Paul acknowledged that the editors would appreciate new names onto the list to get these different things done. The team was aware that this section is the clinical one; where will emerge the application of clinical theory to clinical systems. He then presented the group's proposed model on the flipcharts above. Paul commented that if we don't get really well written chapters, and we keep them all in, there will be some chunky chapters and not very full chapters.

## Group feedback

***Bruce:***

- Respiratory – is that where we get the ENT?
- Ophthalmology – add eyes.
- Can we get rid of midwifery because it doesn't belong to us, and use obstetrics and natural childbirth.

***Pamela:*** ACNO – just renamed their board, and they would like us to have midwifery, obstetrics and natural childbirth.

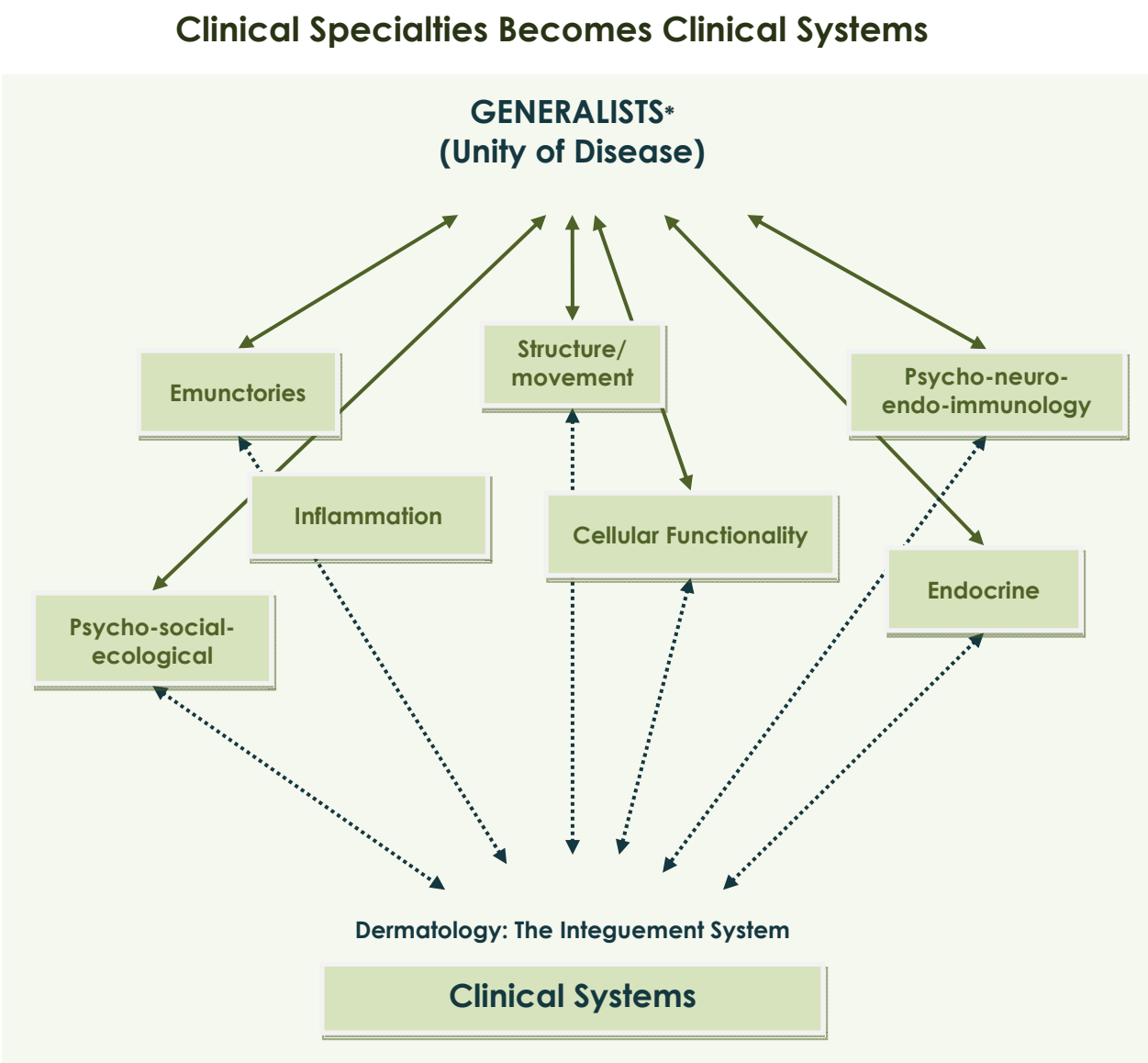
***Louise:*** I'd just like to speak to including endocrinology in the larger system. It is one of the most integrated systems in the body. I rarely see people these days without some aspect of an endocrine imbalance.



## *Breakout Group Two – report*

***Presenter: Iva Lloyd***

### *Group Two flipchart presentation*




* Primary Care, Whole Person Generalists

### *Group Two oral presentation*

The group went back to the question of how it wanted to structure the ideas. They explored how naturopathic physicians actually practice. A naturopathic doctor takes us to the top. That is how we differ. We look at all of the different things, and then end up treating the GI. The new level is ***Emunctorology.***



***Stephen:*** Generalist – primary care whole person generalist is what we are. Specialty is a concept. Naturopathy is defined as a whole person skill. You cannot be a gastroenterologist and have Naturopathy as a specialty. We are generalists. We have naturopathic sub-specialties, such as gastroenterologist. The primary specialty of all naturopaths is to be generalists.

## Group feedback

***Jared:*** Are you proposing a new structure to this aspect of the text book?

***Iva:*** Yes.

***Louise:*** I like how the two group models are similar. I would argue to pull out of emunctories. Is it specifying detoxification? I know that most of that is through the emunctories, but I am talking about the toxins that come in from the environment. We carry 25 dangerous chemical toxins. We have this ambient load of chemical toxins. Need to add a category.

***Iva:*** We were putting that in ecological.

***Louise:*** Think that ecological should be pulled into its own category.

***Thomas:*** I think that it is interesting (the unity of disease concept). It is up to the physician to decide what the problem is and go from there. Some people would choose to treat skin diseases in the generalist type of way.

***Mitchell:*** I broke out the meta-systems that liver is in all of them, and hormones are in all of them, but they do have centers of gravity.

***Paul:*** I can see how to pull the boxes into the system. I asked to do this because some authors have already written that way. Adding the multi-systems approaches to our endocrinology would be great.

***Iva:*** The people who are writing the chapters (regardless of the system) would.

***Stephen:*** We have provided three levels for the way that the naturopath approaches the case, and a complex level of thinking on how naturopaths look at a clinical case. I hope someone takes up the challenge to write an introductory chapter on Emunctorology.

***Thomas:*** If we examine how we practice, this is how we have delineated it. We don't choose. I do a lot of proctology, but I still treat the whole person. I see a lot of problems in the colon, not the rectum. To heal the rectum you need to heal the colon.

***Pamela:*** This is really exciting. Wonderful work on everyone's part. Walter had a discussion with me. He wants to call environmental medicine, environmental medicine and depuration. I see that we are missing the determinants of health, or how we live.

***Iva:*** That's how we see the psychosocial.

***Pamela:*** We also had genomics with constitutional medicine.

***Joseph:*** I like this re-conceptualization. I think there are some mixed metaphors. I would put it in successive terminology. I would put it in digestive system.



## *Creating Coherent Clinical Applications*

# Naturopathic Case Analysis and Management Towards a Model of Naturopathic Case Management: A Light for Our Path

Fraser Smith, ND and Stephen P. Myers, ND, BMed, PhD

Detailed panel presentation summaries begin on page 224 in Volume II of the Retreat Book.

### *Charge of Session*

To address the question: what is a model for naturopathic case management that explicitly applies naturopathic philosophy, principles, and theory to practice?

### *Deliverables and Goals of Session*

To answer the following questions:

- Basic consensus on what should be in an NCAM model.
- Clarity around difference between NCAM, clinical theory, philosophy.
- Insight into which areas of NCAM need further development or clarification.
- Identify key areas of the reasoning process and conceptual framework of the naturopathic doctor.
- Outline for further development of what case management is in terms of naturopathic physician's role and, in particular, as primary care providers.

## Plenary summary and outcomes

Following the presentation on Naturopathic Case Analysis and Management, the large group formed breakout groups to discuss the above questions. Following is the feedback from participants within the plenary setting and from dedicated discussion during breakout groups.



Following is a basic model for naturopathic case analysis and management that was advanced for group discussions:

# Concepts for Naturopathic Case Analysis and Management – Chapter One

### *Acuity Scale**

| | **Vitality / Homeostatic** Balance High | **Vitality / Homeostatic** Balance Low |
|---|---|---|
| **Disturbing Factor or Disease Progression -Mild-** | Lower Order I | Lower Order II |
| **Disturbing Factor or Disease Progression -High-** | Lower Order III | Lower Order IV |

A Naturopathic Assessment Model with additional aspects was presented (below).

### *Assessment Component**

## Cognitive Domains of Assessment

- **Health – "State of Health"**
  - Resources available
  - Patient's perspective
- **Causal Factors** – disturbances in the Determinants of Health
- **Clinical Systems** – based on new naturopathic clinical theory, a.k.a. "**Emunctorology**"

*Both determined by assessing Determinants of Health*

## Second Order Assessment

- Center of gravity
- Obstacle to cure
- Leverage points
- Vulnerable points
- Stressors: threshold (cumulative effect)
- Blissors
- Total load

Details of this session discussions are found in the Appendices of this report on page 202. There was significant coherence concerning the further incorporation of assessment and diagnosis in the NCAM section. The second breakout group presented a more prescriptive rather than an algorithmic approach, and it was generally agreed that these two approaches constituted excellent modeling direction for the NCAM editors to utilize in further drafts.

## *Assessment*

- Include cognitive domains of assessment: physical and pathological understanding of the patient as an individual.
- Utilize empirical knowledge.
- Causal factors: disturbances in the determinants of health.
- Appreciate the fact that there are multiple places in the spectrum between wellness and disease. Therefore, using the therapeutic order, need to ask and assess:



- Current level of health of patient.
- Determinants of health.
- Identify pathology, severity of pathology, and physiological function.
- Confirm disease/diagnosis before applying treatment.
- Assess 'center of gravity' of illness – is it physical, mental, emotional?
- Determine genetic propensity (including family history) versus environmental factors.
- Determine time allowances available for intervention.
- Understand level of vitality of patient and assess life force.
- Level of toxicity.
- Use of dysfunction to begin focus of assessment, diagnosis, and treatment; understand if condition(s) is acute or chronic.
- Determine underlying causes of condition(s), and associated factors.
- Understood that "patients always know what is wrong, and naturopathic doctors need to interpret patients' knowledge."

### *Management*

- Establish base line by assessing specific symptoms.
- Next, can apply remedies and treatments with aim to improving vitality of patient.

### *Intervention*

- Sequencing of treatment modalities needs to be individualized.
- Determine whether to provide remedy first to prepare patient through detoxification, dieting, lifestyle modifications.
- Utilize supportive therapy for organs.
- Recommended not to address patient's toxicity until after several visits. Assess whether center of gravity has changed and assess any changes in toxicity.
- Attempt to induce a healing reaction and/or crisis (mixing hydrotherapy with metabolic approach is more effective).
- Stabilize the patient, then push them to higher levels.
- Note: "when in doubt, detoxify the liver"

## Summary of plenary reflective dialogue

***Fraser:*** This is not easily reduced. Rationalistic (allopathic) treatments are based on names of disease, through linear thought. This is not what we do. We do naturopathic case analysis. Treating the cause requires more understanding of the patient than just their diagnosis.

***Stephen:*** The difference between what most of our experienced practitioners would do versus what students would do is what we wish to capture. This is a model to get them started to give them an orientation, and then with further study and experience, it should evolve. The responsibility of diagnosis is on us not to rely on another doctor's diagnosis. It is very important that minds are open to all the diagnoses in the broader sense, before narrowing down the list to a single allopathic diagnosis It is also Important to learn the skill of western diagnosis, then ask them provide their naturopathic diagnosis.

***Louise:*** Case analysis dovetails with the unity of disease earlier group discussion. The end point, diagnosis of disease is of secondary or tertiary importance (but) ….we must emphasize the



endpoint. Having a diagnosis, I am looking for the disturbances (in which) the body's innate healing processes are causing the symptoms. Maybe we can integrate that.

# Breakout sessions

## *Charge of breakout*

The breakout discussion will revolve around advising the editors and writers to determine the best and most creative ways to present this section of the text. Recommendations will help to understand the weighting between case review and theoretical frameworks, as well as interpreting case management in an analytical and/or intuitive manner. Additionally, proceedings also provide a descriptive or illustrative approach to describe case analysis and management.

Key questions of clarity include:

- In your view, what would you suggest as the optimal way to present this chapter? What would the weighting between case examples and theory be? Why?
- How might we develop a descriptive model of Case Analysis and Management? Is there a way to capture it in the form of an illustration, a systems model, a holistic model, etc.? If yes, how? If no, why not?

## *Summary of breakout group presentations*

- Cognitive domains of assessment.
- Assess determinants of health to evaluate patient's perspective and resources.
- Seek causal factors as disruptors of determinants of health.
- Dysfunction is where we start aiming our focus.
- Second order assessment to consider.
- Center of gravity.
- Obstacles to cure.
- Leverage points.
- "Vulnerable points."
- Stressors: threshold (cumulative effect).
- "Blissors."
- Total load.
- A more descriptive than algorithmic model suggested: Need to confirm:
- level of health, function, dysfunction;
- elements of focal distress, and recognizing that it will move around.
- Lot of emphasis on how the patient presents:
- noticing level of distress;
- issues of toxicity, and burdens.
- From someone to learn, they need the infrastructure. They cannot just learn from a case. Need theory and infrastructure for analyzing a case.
- Unity of disease suggests a common etiology for diverse disease manifestations.
- Think in terms of cumulative effects and total loads.
- Determine vital reserve or 'potential for health.'
- First assessment is acute or chronic.



# Breakout Group One – report

***Presenter: Louise Edwards***

## *Group One flipchart presentation*

Use both framework and cases to demonstrate case analysis and management.

*Cognitive Domains of Assessment*

- Health – "State of Health"
- Resources available
- Patient's perspective } Both determined by assessing Determinants of Health
- Causal Factors – disturbances in the Determinants of Health
- Clinical Systems – based on new natural clinical theory, a.k.a. "Emuncterology"

*Second Order Assessment*

- Center of gravity
- Obstacles to cure
- Leverage points
- "Vulnerable points"
- Stressors: threshold (cumulative effect)
- "Blissors"
- Total load

## *Group One oral presentation*

The group determined that it was important to give both the framework and the cases to demonstrate a case management model. Addressing the cognitive domains of assessment, this group determined that assessing patients' state of *health* is really important. Not just the imbalances or disturbances. Not just the disease and symptoms. What is healthy about the patient's state? Such an assessment is a way of empowering people, instead of focusing on suffering. It's focusing on what is working as well. It is about focusing on the patient's perspective. Some patients may be doing "okay," in spite of their problems. This is in part because of their health resources.

Next, it presented as important that NDs assess the underlying imbalances in things that determine our health. Both the state of health and causal factors of the disease are determined by assessing the determinants of health.

The group then turned to emunctorology – the new way of looking at things, not the classic systems, but the broader. It came up with a second tier and suggested ways to weigh the different domains. These are aspects of this second tier assessment:

- The center of gravity – which clearly can change from visit to visit.
- What is the obstacle to cure?
- Identify points of leverage – what the client is willing to change.
- Vulnerable points – susceptibility. If we are all equally stressed, we would all have different susceptible/vulnerable points.



- We assess vulnerable points.

The team then talked about stressors and blissors (from Dr. Myers). Suggesting its relevance, the group affirmed that if NDs are not practicing disease based medicine, they are practicing a health based medicine. We decided to include blissors as referencing the state of health and health resources.

Further recognition was made of the threshold that is reached – how often NDs have someone in their 30s come to the office with arthritis. Tell them to stop eating the food. The patient says they have been eating it all along, but we know that it is a cumulative effect of repeating those stressors and blissors (what could be keeping them afloat all this time).

Finally, it was agreed that if one looks at the full list of the determinants of health, there could be a single imbalance causing severe pathology, but more often it is a combination of determinants together in a *total load*, bringing to a threshold where symptoms manifest.

### Group feedback

***Don:*** I feel very privileged to be part of what we have accomplished, and that is not just one of us but all of us, who has created this. And we should look back that way.

***Louise:*** I remember when we were younger, less sophisticated and more willful. How this level of collaboration was more difficult, but we now have depth, wisdom and maturity that allows this to occur, and I honour this growth in all of us.

## Breakout Group Two – report

***Presenter: Mitch Stargrove***

### *Group Two flipchart presentation*

This group's approach was very different; presented as more descriptive than algorithmic.

In evaluating the patient, err on the side of caution. Is this urgent or acute? Where are our bifurcations? Is there pathology or pathophysiology? We want to evaluate the following:

- Ascertain level of health, function, dysfunction.
- Identify any elements of focal distress, and recognizing that it will move around.
- Evaluate with emphasis – how the patient presents.
- Notice and assess level of distress.
- Look at issues of toxicity, and burdens.
- Look for clusters.

Remain attentive to the reversible or irreversible nature of the patients presenting, and other concerns:

- Solicit the patient's story, not just in facts, but in presentation.
- Identify how their diagnosis is "sitting" with the patient.
- Review their motivation, their lifestyle.
- Evaluate their change capacity and history.



- Consider what kind of therapeutic relationship one has with the patient. How are we going to have a successful relationship?
- Evaluate and select both specific and non-specific therapies – healthy living and bringing in health therapies.
- Consider that one may first need to get *movement* in the patient. Our group was aware that as physicians we are working with people being stuck and the system being closed.
- What about the patient with some level of dysfunction, and will this work in those situations?

## Group feedback

***Iva:*** I see a number of words and languages that fit very nicely into the framework that we have. I see the two ideas of these last groups as fitting very nicely.

***Jared:*** What came up for me was that everyone that sees this will see that.

***Mitchell:*** We had trouble making the analysis, management and assessment. It was hard to make that delineation because we are always going back-and-forth, back-and-forth.

***Letitia:*** I think that is a great comment. The first part is mainly assessment, and I think it fits into assessment really well.

***Jim:*** I think the reason this is resonating, is that we are all saying that yeah, that is the way that we do it, but we have not been able to articulate it. We are all thinking the same way in the meta-concept, but are different on the details.



## *Creating Coherent Clinical Applications- Day 3 and 4*

# Clinical Algorithms and Guidelines - Our Philosophy in Action

Herb Joiner-Bey, ND; Patricia Herman, ND; and Ryan Bradley, ND

Detailed panel presentation session summaries begin on page 228 in Volume II of the Retreat Book.

### *Charge of Session*

To illustrate the overall thought process by which naturopathic physicians inquire, perceive, ponder, and intervene in the health of the individual patient.

### *Deliverables and Goals of Session*

To recommend revisions and find agreement regarding a model core algorithm:

- Where is there coherence?
- Where is there diversity, which should be reflected in the algorithm?
- Are there notable conflicts?
- Are there components of the algorithm missing?

Participants will understand the distinction between the role of algorithms and guidelines.

## Plenary summary and outcomes

Following the presentation on Clinical Algorithms and Guidelines, the large group formed breakout groups to discuss the above questions. Following is the feedback from participants within the large group setting and from dedicated discussion during breakout groups.

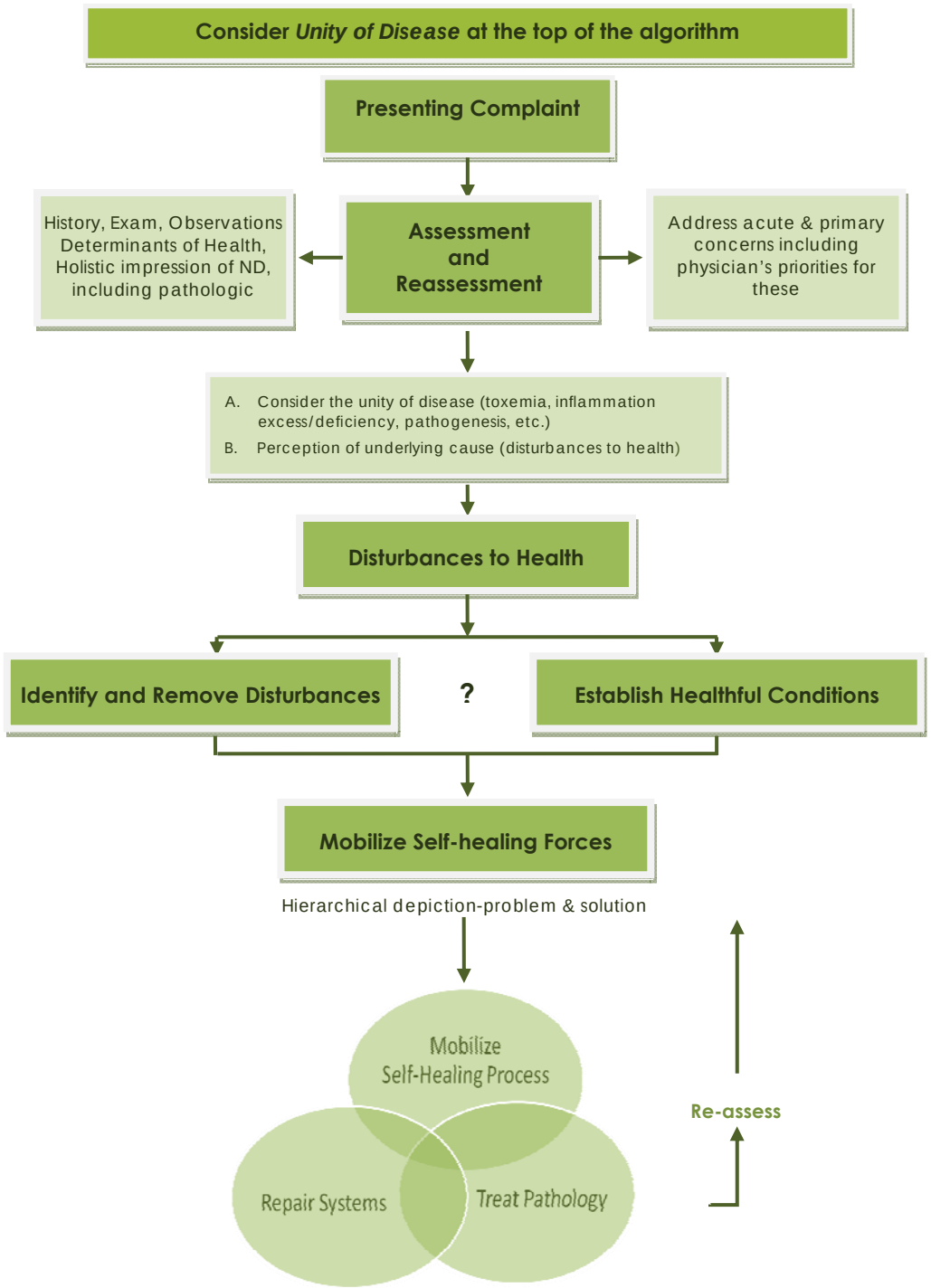
### *Algorithms and Guidelines recommendations*

- Include the therapeutic order definition: it is a continuum of therapeutic intervention from least force to greater force.
- Also consider using the unity of disease at the "top of the algorithm."
- Describe elements of therapeutic encounter rather than the disease; also, associate the algorithm with a specific finding rather than a disease, i.e., breathing problems and/or presentations of suffering instead of asthma.
- Include examples of algorithms as cases (i.e., asthma showing flexible algorithms).
- Delete the word "allopathic" from the lexicon, and replace with "conventional" or "standard" medicine. Conventions and standards change, so more accurate in describing this kind of medicine.
- Important that the therapeutic order is not the *basis* for the algorithm. It informs the algorithm.
- The algorithm needs to describe the elements of a therapeutic encounter, and not the disease in the conventional or standard model.



- Provide examples of cases or therapeutic encounters to illustrate the *use* of the algorithm, using the example of asthma, illustrating two or three different cases that conventional or standard medicine might call asthma.
- It is absolutely critical that naturopathic algorithms teach people how naturopathic doctors think, rather than setting up rigid formulae for how to treat patients.
- Therefore, a proposed model:

## Therapeutic Order Algorithm





# Breakout groups

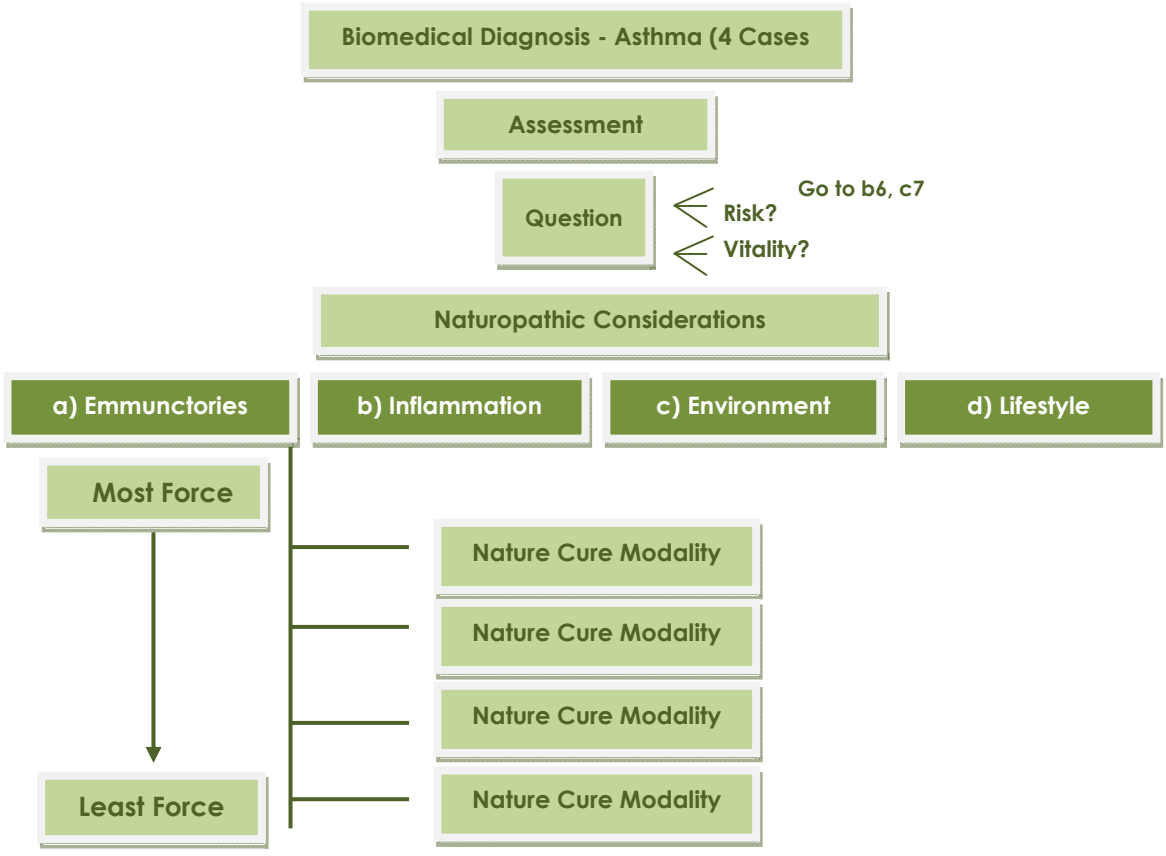
## Breakout Group One – report

***Presenter: Letitia Watrous***

### *Group One flipchart presentation*

- The therapeutic order is a continuum of therapeutic intervention from least force to greater force.
- The algorithm should describe elements of therapeutic encounter not disease.
- For the text: "Generic Therapeutic Encounter Algorithm."
- Examples of algorithms should be cases, i.e., Asthmas – four cases with flexible algorithms.
- Delete the word "allopathic" from our lexicon. Replace with "conventional" or "standard" medicine. (Note: standards and conventions change.)
- How to apply the "Therapeutic Order" to the patient – algorithm.
- Describe as "an" algorithm – not "the" algorithm.
- Associated not because a diagnosis, but with a specific finding: e.g., HgAIC.
- The problem of naming: note the difference between a breathing problem versus asthma. E.g., "presentation of suffering."
- Begin with a specific finding, e.g., an elevated Hgb. With a symptom picture of suffering. (Entry point into the algorithm) →presenting complaint →initial assessment - →immediate/acute concern. If we don't ship them off to the ER, then we start with assessment.

### Generic Therapeutic Encounter Algorithm





### *Group One oral presentation*

The group advised that authors needed to describe the elements of a therapeutic encounter, and not a disease. It needs to be a general encounter not a diagnosis. Examples of algorithms should be cases not diseases, as members asserted that patients don't come into your clinic with asthma, they come in with symptoms.

One can have cases that fit under medical diagnosis, but in those algorithms that they should cover the therapeutic modalities. If a person with a biomedical model of asthma is the focus, that way it incorporates the therapeutic order. Of course, you have to assess – are they in immediate danger of death? What are the risks? If risk is high, then one moves from least force to gross force.

Following that level of acute and primary assessment and management, if an ND is looking at emunctories, maybe the lung meridian is blocked. At this point, one can treat with nature cure first, and then we can intervene with ephedra if necessary.

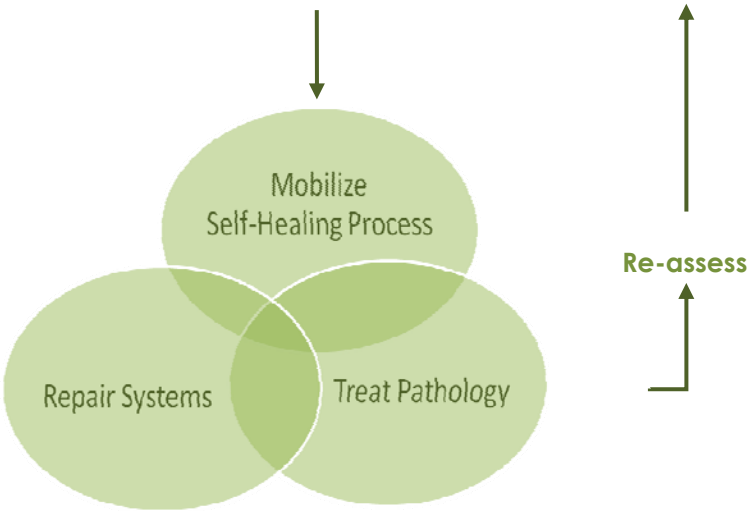
## Breakout Group Two – report

***Presenter: Jared Zeff***

### *Group Two flipchart presentation*

#### *THERAPEUTIC ENCOUNTER ALGORITHM and Therapeutic Order as holarchy-hierarchical depiction*

**Problem: Hierarchical Depiction of Therapeutic Order**
**Solution: The Therapeutic Order as Holarchy**





### *Group Two oral presentation*

Our group came up with almost an identical scheme with some distinctions.

We began with a caveat from Bruce. He wants us to replace allopathic with conventional/standard medicine. We considered how do you apply the algorithm to demonstrate us? We cannot begin with a pathologic diagnosis.

We agreed that we should begin with a specific finding. Like an elevated hemoglobin, with a symptom picture of suffering. That is the entry point into the algorithm. *Consider "unity of disease" at the top of the algorithm. (See flipchart diagram on page 122 and 57.)*

1. We have our presenting complaint.
2. Then we have our initial assessment.
3. That may lead us to an immediate/acute concern.
4. If we don't ship them off to the ER, then we start with assessment.
5. Next is evaluation of determinants of health.
6. That includes a pathological assessment.
7. We ask – what are we considering, and where we are going to go?
8. First consider the disease and its etiology.
9. From here the physician prioritizes, identifies and removes disturbing factors.
10. We are starting to get away from a linear conception of therapeutic order.
11. We are calling this a therapeutic blend, repairing systems, treating pathology.
12. So the therapeutic order dissipates out of a linear into a holographic process.

It is the same basic idea as group one.

## Summary of proceedings from plenary and breakout discussions

***Iva:*** I want to go back to algorithms. The assessment aspect is missing. When we are looking at asthma, we change to treatment right away. Middle layer of naturopathic considerations, these are the considerations of our treatment, to structure that for our format. I think that the language is very important.

***Herb:*** The assessment aspect is in it, but not "algorithmed" out.

***Letitia:*** I see a real problem with these. The markers that are used are allopathic diagnoses. I can't ignore that – because we diagnose before that. We are using the diagnosis of diabetes – what about those people with pancreatic insufficiency? You need to talk about toxemia. Do it. If we need to go to hospital care, then we need to follow the therapeutic order; this doesn't follow that at all. This is a very allopathic model. Is the AANP going to take these guidelines and adopt them?

***Ryan:*** This model is management only. That is true in the ideal world. I don't think this algorithm is all inclusive; it doesn't direct treatment or laboratory assessment in any way.

***Letitia:*** As long as that is the only marker, because it will get that way.

***Ryan:*** That is the discretion of the provider.



***Letitia:*** The insurance industries are already regulating us. That at Group Death, it will cover only five diagnoses.

***Fraser:*** We can talk about management and assessment, but you can't talk about one without the other. When you talk about treatment protocol and management, assessment is right in there.

***Don:*** This is really the way we practice. We just haven't been able to articulate it.

***Herb:*** When we are intervening, we need an objective measure to know we are having an impact. By what objective measure is what I am doing working?

***Pamela:*** Want to clarify that the reason that we are here is that nobody has had the answer as to how to structure our thinking. They have brought their drafts forward. This is not set in stone.

***AANP:*** There are many ways to get involved to direct the outcome to be closer to your vision. So, please become more involved instead of less involved in the process.

***Jim:*** Something that Iva pointed out is that nothing is the same as it was on Monday. There is an emergent paradigm. There is so much talent in the room. It may change how we do this. And we may want to invite more people to deliberate.

***Don:*** If this text is published in 2009, what is happening to the material in the mean time?

***Joseph:*** I have a journal that would be delighted to publish this information, and we are currently talking to AANP to make this a member benefit.

***Iva:*** I would like to get the NDs in Canada presenting to get their feedback.

***Pamela:*** Elsevier is concerned to balance this. If something is going to be published in the book, you can't just put it in a journal.

***Joseph:*** It can't be the same written work, but it can be the same ideas.



# Closing Plenary

The following heartfelt remarks were shared by each participant at the conclusion of the Retreat.

Pictured here at the Closing Plenary are Senior Editors, Joseph Pizzorno, Roger Newman Turner, Jim Sensenig, Stephen Myers, Jared Zeff, and Executive and Senior Editor, Pamela Snider.

Photo courtesy of Sarah Spring, NCNM 2007 ©

***Fraser Smith:*** A lot of firsts happened this week. For example, having consensus about clinical theories, and really codifying our medicine. Knowing Pamela in meetings and Deans' Council. Here's a lot of work really coming together. It's tremendously important for our profession. This is a real turning point for our medicine. It's exceeded what I had hoped we could do!

***Mitchell Stargrove***: It's never real until it's real. This is the only kind of crowd who could generate this experience. I've been anxious for us to look at what we're doing and aspire to and articulate that well. It's going to be good for us and our students. I'm going to need 10 hydrotherapy treatments as well. My next steps are recovery of sleep deprivation, working on this Project and another textbook; and I'm looking forward to all of this. Also, building relationships with all of you. Therapeutic relationships aren't only with our patients.

***Christina Arbogast Woolard***: I'm feeling humble. I'm grateful for being here. I'm excited to bring passion back to the schools.

***Iva Lloyd***: As representative of CAND, I had two thoughts: a sense of urgency, and that the marketplace was shifting (we can't lose it). I'm pleased. Feel better that we're on track. I have a responsibility to get the naturopathic profession up to speed. I didn't know you all before. It took a while because I'm shy. I've met a lot of kindred spirits and like minds. Thank you.

***Kavita Sharma***: I came with no expectations. I am excited to be here. It came at a perfect time for me. I get bombarded with the physicality of work load. We go back to our institutions for big reasons. We want to spread the word of what naturopathic medicine is all about. I was feeling a sense of lost vitality. This is the perfect thing for me to go back, and spread the energy. We have a visiting elders program at CCNM. Bill Mitchell was going to come to our College on April 2nd, 3rd and 4th. So, he's brought me here. My father looks down below, and I believe that we just have to trust the power of the universe, and it will show up.

***Don Warren***: I came with two parts of our chapter that have not been written. Our session has well armed us, and provided us with a network of students and faculty to make naturopathic medicine more naturopathic. I trust that we'll make this a reality. I'm humbled to be here. The collective mind and the goodwill have been unique, and should energize us and push us forward. A year and a half ago things looked bleak. I appreciate Pamela who rose beyond adversity, and found a home for this. Also, appreciation to Dr. Keppler for associating NCNM to the Project.



***Christine Grontkowski***: I am so grateful to have become a part of this Project. Thank you, Pamela. And, our combined thanks to Bill Keppler.

***Joe Holcomb***: I was unsure what to expect. I'm a liaison for Naturopathic Society International, which used to do a bit in the past, but is currently fledgling. I wasn't sure what my role was here, but I had fear because of the caliber of people here, and that I'd be sitting in your presence. What I came to understand is that you all have the spirit of this medicine in your hearts. Speaking from Naturopathic Society point of view, we can rest easy knowing that this book is in your hands, and we can rest easy to the future of naturopathic medicine.

***Patricia Herman***: I'm grateful and honored to have been invited to be here. Thank you, Dr. Keppler. Pamela, you're amazing. You guys are all amazing. I know now what a group birth might look like!

***Ryan Bradley***: I feel honored. My appreciation to Pamela for inviting me. We are creating channels of communication for two powerful initiatives: advancement of philosophy and naturopathic medicine. I offer myself as a conduit of communication in any way.

***Sarah Spring***: Thank you for bringing me here.

***Paul Orrock***: I came from across the seas to see the future. Don mentioned the future. I'm certain of it now. This has been a week that this medicine has made a big step forward. This is a scholarly foundation. We've put a line of bricks around it in a scholarly sense. I'm confident to go home, and spread that confidence. It's a big step forward for our country. It's great to see the family again. You are a great group to be around. Thank you, Dr. Keppler. Pamela you're amazing! Valerie and team, well done.

***Serron Wilkie***: I feel incredibly honored to have witnessed and been a part of the Retreat. I was moved to tears several times. You will be happy to know that a lot of what students have been worried about has been addressed here. The group that is the Traditional Naturopathic Student Association is you guys. Thank you for sharing, and being open to hearing my input.

***Deborah Epstein***: When I started school, I didn't know much about naturopathic medicine at all. I thought it is what we call green allopathy, and thought that was a fine way to practice, and better than conventional medicine. Then, I realized it was so much more, and became frustrated that it was just a little glimpse. This is so exciting that this Project is underway. I feel better knowing that this is happening. Thank you for including us in this conversation. I've had a fabulous crash course in naturopathic medicine. I'm also reminded of that opening session during which we were talking about plants. I'm sure that all of you got the passion flower vine glory. The blooms are stunning. That is just like that in this room. Everyone here is blooming. It's such a beautiful experience tending to the vine. Thank you. It's been really exciting.

***William Franklin***: Wow! I am deeply thankful for being invited. Thank you for indulging my comments and questions. We had been heard before any of us spoke. A lot of the concerns that we came here with have been discussed and dealt with. I am aggravated and frustrated with school, but also happy. This week has been amazing. I look forward to seeing the result of all this. I can't wait to get back and run my mouth. I promise I won't use any of the text. Thank you for the people who have connected with me on a personal level. It's been nice to talk to my heroes.

***Thomas Kruzel***: I have been privileged to be a part of significant events in naturopathic medicine. This is the most significant, and I am pleased to be a part. I came thinking; this is going to be a lot of work. But I was excited, and this has exceeded my expectations. I just said, "Pamela, I'll just do what I need to do." This has been so helpful; a heartwarming way to connect to all of you. Thank you.



***Bill Keppler:*** I want to acknowledge and thank all of you for being a part of this. Thank you to Pamela for the hundreds of hours of work, the dedication, the commitment, and the hard work. Also, take a look at the comments on the screen.

- Naturopathic medicine is a flower that is yet to bloom
- Take out the word, "yet"
- You all are the backbone, and look at what you have accomplished
- Unity
- Significant
- Commitment
- Production
- Completion
- Inspiration
- Accomplishment

I believe individually and collectively, we have accomplished it. I encourage each of you to debrief yourselves, and keep this alive. Bill Mitchell would be pleased with this day, and this Retreat. Thank you all. Thank you, Pamela, for your leadership, inspiration and mentorship.

***David Odiorne:*** I just figured out why Dr. Bettenburg and I work well together: we both have a cynical attitude toward big projects!

***Pamela Snider:*** But you do it!

***David Odiorne:*** Do we have a choice?!" People say to me, 'You're a chiropractor why do you want to come work here?' Medicine is broken in this country. Chiropractic ain't gonna fix it. NM has the potential to fix it. This week, you've convinced me that that potential is going to be realized.

***Sue Yirku:*** I met Pamela in the integration project, which a lot of you worked on. This Project and the ones you're working on are a continuation of your life's work. We've all been 'Snidered!' You're doing a great job. Congratulations to all of you!

***Kate Williams:*** I'm grateful to be here. This is a powerful experience. Knowing you and I have all grown up and have this happen is weird and exciting! I hope to continue to enjoy this Project. Thank you, Pamela and Dr. Keppler. I hope I can get more good publicity out for you all in one way or another.

***Herb Joiner-Bey:*** I have a tremendous sense of awe. Everyone here has a tremendous sense of generosity in their hearts and minds. I know what it means to be 'Snidered!' Pamela is a sorceress; we've all been mesmerized.

***Letitia Watrous:*** I'm thankful and honored. It's a major struggle for me to get out this nature cure section with the many struggles that have been thrown at me in the last year or so. This has helped me start my book on nature cure, which we need. At the first meeting with Pamela, I told her this Project is absolutely crazy. It still is, but that's okay. Thank you for being patient with me everybody.

***Emma Bezy:*** There were two points in time in my career that stand out. In one case, I almost went to allopathic school. Another time, I almost went to Bastyr. So part of what I'm glad to be doing is coming back at this the other way. In all of my work and practice, this has been where I am, folding in any psychological and neurological processes. Continuing my work with Louise has been such a joy. I'm coming at this with all the writers with renewed vigor!

***Louise Edwards***: Twenty-five years ago, I asked for a path to help change what was happening on the planet. I was led to naturopathic medicine through prayer. I've noticed I don't know my own fear until I feel safer. I get super-confident without acknowledging the fear. I started here out of fear. I put my



practice down, and came back to medicine out of fear out of losing our medicine. I didn't notice that until I was sitting in this circle in the last two days because I felt on safe ground. It's not fear if there is no courage. It's not faith if there is no doubt. This is the path I've been called to in order to restore the planet.

What does it mean to be in love? Often we use that term as a duality between individuals. It has come to me recently. The totality of love is the deeper meaning. That's how I feel in this circle. Thank you for the love we share, and for your deep wisdom. It's that synergy that's going to transform the planet.

***Bruce Milliman***: The metaphors that are resonating with me about what's going on here are oscillating between Vatican II and the Starship Enterprise. It needs to be acknowledged that the incredible leadership that we have managed somehow by faith, or by Pamela's skillful efforts: to bring together internationally three continents on our Senior Editor Team, I can't imagine who I'd rather have leading us. The support, vision, and faith, and belief that have been shown by Dr. Keppler and all of us is something that makes it clear that we do not need to have all the fears, doubts, and insecurities about our medicine being compromised. We will not fall between the cracks because we are in such good hands. Thank you all!

***Sharon Fisher***: Before the retreat, I was at the top of a huge mountain range, and we were going to come down. After this time we've arrived, and we're ready for the next challenge. I commend you all for your service, intelligence and commitment. It's a joy to work with you.

***Brewster Scott***: I had no idea what I was getting into, and now I'm more hooked than ever before. I want to be every one of you! I want to take every one of you, put you into me, and do what you're doing. Wow! That's where I am!

***Jay Johnson***: I think you all know how I feel about hanging out with you all at every opportunity I can. If any of you did not get a copy of the CD of Bill Mitchell and Vital Force, I have copies. Pamela said I could offer this suggestion: I am reminded of a meeting of another organization I'm a part of. It has a big annual convention. As well as a meeting at the end of each academic year, grad students present theses, honors, awards, and lectures. That's something to throw out as a challenge. Thank you.

***Joseph Pizzorno***: When I was a naturopathic medicine student, I was working at the University of Washington Medicine. I asked an MD what did he think about naturopathic medicine. He said, "You're limited by your philosophy." I said, "Interesting, I think you're limited by your lack of philosophy." Then, someone once said the problem of psycho-tropic drugs is that people think they're better but they're not.

This idea started as an idea in 2001 for Pamela and me to write a book. Pamela said this was an opportunity for our profession to find out who we are and blossom and change healthcare.

***Roger Newman Turner***: I had gained the impression that American naturopaths were hard-nosed scientists. That's probably because I'd met Joe Pizzorno! But, Joe and I are men after our own hearts. It's nice to know that our medicine has a philosophy to it. This is the first time there has been an attempt to come together in this way, articulate these philosophies, and codify our knowledge. I'd like to thank all of you for companionship, friendship and, in particular, Pamela, for the many long-distance calls we've had – some distance 'Snidering!' I certainly experienced that. There has been tremendous vitality and enthusiasm. I look forward to going back and spreading the word that we're trying to get the naturopathic philosophy well established. We've made a tremendous step forward!

***Jim Sensenig:*** I'm still intrigued … Does that liken me to the cardinals or the bones?

***Louise Edwards:*** Bones in drag!



***Jim Sensenig**:* Nonetheless, at the last break I was wondering along the lines of what Tom said. There has been the Centralia Summit. By what name might we remember this gathering? The Skamania Convocation? Louise reminded me that 25 years ago when we were forming the AANP, she and Lori came up to us and said, "We're Louise and Lori, and we're here to help." I realize that all of us are saying the same thing. John Bastyr said that the light of this medicine will always shine through in spite of politics and other challenges. We're seeing that here. Finally, I'm moved by the amount of emotion in this room. A line from one of my favorite movies to share: "I'll have what she's having!"

***Stephen Myers**:* I'm first reminded by when heaven and earth meet, it serves the wise person to cross the water. Interesting process for me, I've come a full circle in my life. The last time I heard people as cats meowing was in my high school. One of my teachers said: Miles, you sound like a pregnant pussy cat. For the next six years, whenever I opened my mouth, everyone would say, "meow." There is a story of Tom Buckley, who didn't' want to live in servitude, so he lived with the indigenous people. So if you survived, you had 'Buckley's chance.' What is it to be 'Snidered?' In the future, people may not know why they use the term to be 'Snidered.' Perhaps historians will know she's a woman who lived in the beginning of the 21st century. To be Snidered is *to give into the irresistible force calling you to follow your heart.* Thank you Pamela.

We've been called to do something that is incredibly important to the future of our medicine. This is the textbook I would have wanted to have. It's calling to be written, and it's our duty to write it. It will be the primary textbook to teach the next generation of naturopathic education. I have no doubt that you saw that very early in the process, Bill.

I acknowledge your wisdom and insight. Some said that we're not the people to try to put this together. Pamela persevered through difficulty. We find growing evidence that it was essential, representative and represented the heart and soul of naturopathic medicine. I feel gifted and humbled to share this opportunity.

***Jared Zeff**:* In 1993, I wrote an article. At the end I asked colleagues to criticize and develop the idea. So, I decided I was going to write a textbook on naturopathic medicine philosophy. Pamela said, "Joesph and I have a contract." Then, she wanted to ask Jim. Then, she wanted a symposium. Even a week ago, I was not sure about all this. But, I am so deeply impressed and grateful for what has happened here this week. This task will be completed in a more glorious way than I ever could have imagined. I'm impressed and grateful. I have to say, Pamela was right!

***Pamela Snider**:* That is an unusual moment. I'm pausing here. Wow! I'm going to try to not tear up. I'm going to go back to one of my first teachers; one of those teachers who had just graduated. I was terrible to him. I thought, what could you possibly know that I could learn from you? He was Dr. Randall Bradley. And it is his quote I share year after year with our incoming naturopathic students, and my respect for his wisdom only grows deeper each time.

> *Medical philosophy comprises the underlying premises on which a healthcare system is based. Once a system is acknowledged, it is subject to debate. In Naturopathic medicine, the philosophical debates are a valuable, ongoing process which helps the understanding of health and disease evolve in an orderly and truth revealing fashion.*
>
> Randall Bradley, ND, Philosophy of Naturopathic Medicine. *Textbook of Natural Medicine*. Pizzorno, Murray. 1985.

What you have done here is remarkable. I have witnessed that the success of this meeting is due to each of your intense preparation and thinking. There is not one of you who we could have done this without. I really honor you, and thank you all so much for this. I also want to acknowledge the generosity of your spirits. You're not just writing, but you are each leading ... breaking into whole new terrain. I've never had the experience of working in such an altruistic, but fierce, positive, and powerful arena. I couldn't think of so many of the things you've thought of. Each of you is my teacher. I call you teacher.



What we've accomplished this week has gone beyond my wildest dreams. I didn't imagine that this would happen. And, you know how wild my dreams are! I'm humbled, privileged and honored to lead this process. Thank you for your trust in me.

I want to convey my thanks to several people specifically, and I'll start with Bill Keppler. Thank you. Your fearlessness in the face of incredible adversity was a turning point for me. Your elegance in the way you manage things is a constant inspiration. Thank you for your wisdom and for being there every day. There are many turning points where Bill advised me quietly behind the scenes. He was always right. Thank you for your gifts to this profession, this Retreat, the Foundations Project, and to me.

Thank you, David, for being there also, and for your technical wizardry.

Thank you, students, for being our heart. You carry the code. You're our hands, and you are our future. We do this for you. Thank you.

Thank you, Senior Editorial Team, you wise elders. This team (and Roger from afar) has capably earned this position. Your genius keeps me going. These are powerful leaders.

Thank you, Joseph. With Joe's hard nose, he also has a soft heart. He has taught me that we can do anything that we need to do as long as we believe in it and keep going. Thank you for empowering me.

Thank you, Roger; thank you for bringing in the wisdom of the world elders.

Thank you, Jim; thank you for the meta-uber-alpha-prime paradigm that you have been bringing us to, for all these years.

Thank you, Stephen; thank you for your passion, support, friendship, and brilliance.

Thank you, Jared; thank you for your genius and elegance of thought. Also, for being my real brother, for walking so closely together with me in this Project. Actually, it's you who is usually right. We've been talking about this medicine and listening to your voices and hearing you separately across many regions. It's been like music. Across many regions, I could hear the chords.

Thank you, Bill!



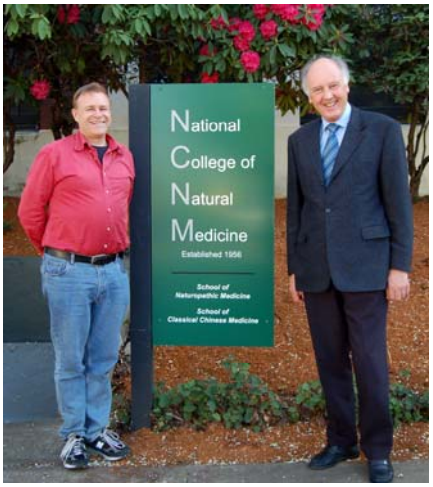



THERAPEUTIC ENCOUNTER
ALGORITHM
biomedical diagnosis: Asthma
assessment
naturopathic considerations


Wild Birds


HEALTH


Nature as Teacher
Natural Medicine
Compassionate Care


National
College of
Natural
Medicine
Established 1956
School of Naturopathic Medicine
School of Classical Chinese Medicine

# Appendices

# Report to the Council Members of the Council on Naturopathic Medical Education (CNME) Naturopathic Foundations Project; Editor's Retreat April 1-5, 2007

*It was a dynamic and historic five days.* There was animated and fertile discussion throughout the week, with outcomes far beyond anyone's expectations. The meeting started with a reception and welcome at NCNM, the academic home for the Foundations Project, followed by an outdoor opening ceremony at Skamania Lodge, where the elders of the profession were honored. There was a special time of remembrance for Dr. Bill Mitchell and the rich contribution he made to the Project, the profession, and to the individuals gathered.

The featured speakers provided frameworks for looking at systems and network theory (any theory of naturopathic medicine should be considered in the light of a "whole systems" model). Also, a structure was provided for constructing and evaluating naturopathic theory, which (when fully developed) will enable the coherent articulation of the theoretical knowledge of the practice of naturopathic medicine.

Textbook lead-writers presented material related to the chapter for which they were responsible. This was followed by animated discussion from the floor. Breakout sessions were interspersed throughout the days, and were focused on specific issues relevant to the textbook. The outcomes of the breakout sessions were reported back to the group as a whole, eliciting further discussion. The facilitator made sure that each participant had an opportunity to contribute, including the organization liaisons.

Although there was a great diversity of individual positions and a wide variety of proposed concepts presented, the ideas began to re-form in a most unifying way. Many times as discussion advanced, there came that uncanny feeling that something new had arisen out of the discussion, and it was something everyone felt they could live with (even feel good about). It was certainly a breakthrough to see the that there could be a unifying structure that made room for the great diversity of practice styles, yet honoring and retaining the historic roots of our profession. The concepts of metaparadigm and meta-theory (better to be explained in a longer document) and the development of conceptual models all sounds very academic on paper, but during the presentations and the following discussions, the participants realized that we were being given a set of tools to take our principles, philosophy and clinical theories to another level.

The Retreat ended with a special acknowledgment of Dr. Bill Keppler for his important contributions to the profession, the most recent being his presidency at NCNM. His invitation to move the Foundations Project to NCNM as its academic home made the vision of Dr. Snider and others a reality. Tribute was also given to Dr. Snider for her vision and tenacity in moving the whole Project forward, often times with great obstacles to overcome. The beneficial outcomes of this Retreat will ripple across the profession in the months to come, and will influence in a most positive way the next generation of naturopathic doctors. - *Don Warren, N.D. DHANP, Past President, CNME*

## Naturopathic colleges participate

A critical aim of the planning team achieved at the Retreat was participation by all colleges and key agencies within naturopathic medicine. This included a passionate group of naturopathic medical students from four colleges who functioned as consultants and volunteer staff. These students represented the Traditional Naturopathic Society (NCNM), the Nature Cure Club (Bastyr), and the Naturopathic Societies (SCNM and UBCNM).

## Retreat evaluation reports available

Evaluation of the Retreat was very positive, exceeding expectations. A Strengths, Weaknesses, Opportunities & Threats (SWOT) analysis was done, and comments are available upon request. A summary of the findings follows.

# Summary of International Editors Retreat Evaluation

*Following the International Editors Retreat held at Skamania Lodge April 1-5, 2007, participants were sent an evaluation survey to provide feedback to the Foundations Project on the effectiveness of the Retreat. Twenty-six of33 possible respondents replied. This report documents these responses, which show a significant level of* success was accomplished. The true measure of the success will be the final publication of the textbook, which the Retreat and its proceedings aim to support. A total of **79%** of participants responded (26 of 33).

## I. Expectations

*In your experience, please rank how well the Foundations Editors Retreat met your expectations.*

**Ninety-two per cent** (24 of 26) **respondents ranked that the Editors Retreat either "significantly exceeded my expectations**" (88%) **or was "slightly above my expectations"** (4%). While one (4%) indicated that their expectations were "met;" another respondent (4%) did not answer this question, sharing that "I had no expectations."

## II. Sessions Value

*Do you believe the presentations, breakouts, ideas, and discussions from the retreat assisted you in clarifying your area of the text and its relationship to other areas of the text?*

**Eighty-five per cent** (22 of 26) **responded that the sessions either had "significant value"** (52%) **or "above average value"** (33%) **to assist in clarifying their area of the text and its relationship to other areas of the text.** Two (8%) respondents indicated that the "sessions were useful," and one (4%) determined them of "moderate value."

## III. Key Deliverable

*How well did you experience the key deliverable of finding coherence, acknowledging diversity, revealing omission, and identifying conflict? Indicate whether "All proceedings select from below the key deliverable?"*

**Eighty-one per cent** (21 of 26) **marked that the key deliverable was "extremely well met"** (27%) **or "well met"** (54%). The broad scope of this question pertained to several key deliverables with four components, as a few respondents pointed out, made it a difficult value to qualify. Five respondents (20%) felt that the key deliverable was either "adequately met" (12%) or "moderately met" (2%).

## IV. Conference Materials

*How satisfied were you with the conference materials provided?*

**Seventy-seven per cent** (20 of 26) **responded that they were either "extremely satisfied" with the conference materials** (35%) **or "very satisfied"** (42%). Five (19%) reported they were "satisfied" with the materials. Two (8%) did not reply to this question.

## V. Speakers & Presenters

*Overall, how satisfied were you with the speakers/presenters?"*

**Ninety-six per cent** (25 of 26) **responded that they were either "extremely satisfied"** (52%) **with the speakers and presenters at the Retreat or "very satisfied."** (42%) One (4%) respondent indicated they were "satisfied."

## VI. Facilitation

*Overall, how would you rate the conference facilitation by Campbell & Associates?*

**Seventy-six per cent** (20 of 26) **found that the conference facilitation was of "extremely high value" and "high value"** (both 35%). Five (19%) respondents indicated that the facilitation was of "appropriate value," and one (4%) determined it of "moderate value."

## VII. Organized & Run

*Overall, how well did you think the conference was organized and run (agenda, schedule)?*

**Ninety-six per cent** (25 of 26) **of respondents ranked that the conference was organized and run "extremely well"** (62%) **or "above average"** (35%). One (4%) did not reply to this question.

## VIII. Participant Needs Met

*Please rank how well the Foundations Editors Retreat met your needs, hopes and desired outcomes.*

**Eighty-eight per cent** (23 of 26) **responded that the Editors Retreat either "significantly exceeded my expectations"** (77%) **or "slightly above my expectations"** (12%). Two (8%) respondents replied that their expectations were "met," and one (4%) respondent did not reply to this question.

This question was a second verification to assure accuracy in measuring the key question of whether editor expectations were met at the Retreat. In question I, **92%** (24 of 26) responded that their expectations were either "significantly exceeded" or "slightly above" expectations, comparing nicely to **88%** responding in VIII that their expectations were either "significantly exceeded" or "slightly above" expectations.

## IX. Facilities

*Overall, how satisfied were you with the conference facilities, including meals and rooms?*

**Ninety-two per cent** (24 of 26) **responded that they were either "extremely satisfied" with the facilities at Skamania Lodge** (35%) **or "very satisfied"** (35%). Two (8%) respondents indicated they were "satisfied" with the facilities.

# The *Vis Medicatrix Naturae* Session
# Detailed notes from breakout group discussions

## *Breakout Group One*

***Thomas:*** I thought it was good. Enjoyed all input. I liked the tie-in with physics. One thing Wayne Jonas brought up: when you have treatment as being a large part, and then flipped to environment being the large part. If we're talking about the *VMN*, it's the environment. In the geopolitical view, no country has prioritized the environment part. Example: school nutrition provided by taco bell. I think we need to think about the other forces that come into play, such as the forces that run our communities.

***Cathy:*** I likely don't understand field theory and downward causation. Yet, I have a feeling that there is a causal plane, and that's what I'm hearing, that we should take a stand about a causal plane. For me, that fits with working in the therapeutic relationship; holding environment where interaction (mutual) brings forth a healing from both parties.

***Jared:*** I have an absolute and unshakable belief in what we would call God. It's inherent in what we do, and what I do. However, my approach to teaching this medicine is that that is not necessary. What is necessary is taking the concepts behind the medicine, and articulate to the student so that the student has these when a patient sits across from them.

I try to meet my patient where they are: fundamentalists, atheists, Jews, etc. I find it necessary to understand and work with deep causes in the person, which I consider to be spiritual. I have to explore those things with respect to the patient. It is not necessary that I have an understanding beyond what Eric Yarnell would understand. In an operant sense, this can be described in what they eat and what they think, and find the area that is disturbed, even on the spiritual level, which does not require a belief on the spiritual level. I require it, but I don't think we need to stick a stake in the ground, and take a stand on it.

***Leanna:*** The book should explain what it means to be a good Naturopathic physician that does not have anything to do with the spiritual world. I had the opportunity to guest lecture in Bill's class, Advanced Therapeutics. My lectures were: healing with the mind. It is possible with a human being to exert an effect on another human being from a distance. And I also discussed shamanic practices. I think spirituality is important when discussing therapeutics, but not when describing the foundation of the medicine.

***Jared:*** Eric would agree you can heal from a distance. But, there is not necessarily supernatural.

***Leanna:*** The idea that we believe in supernatural is garbage.

***Rita:*** Someone said there is no distinction between nature and God.

***Don:*** I personally feel that there is a God, although I can't define God. The idea that the *Vis* is like a god in the sense that we can observe it and have faith in it, but we cannot prove it like we can other scientific principles. But, we can describe and apply what we observe. For us to have a definition is very difficult. This is a description of what we observe. We can describe the causality of it. I feel that is satisfactory. An historical description, an equation, we should leave it open.

***Leanna:*** Is it essential? We need a chapter to explain how we use the *Vis* so that the student can know what they're talking about. I am putting my stake in the ground. Jared, same for you. But, that has very little to do with how I deal with an atheist. But, it does affect my therapeutics.

***Jared:*** I really enjoyed your presentation. I gained more than anyone because of the clarity of your presentation. I like the Cartesian dualism that the mind and body are separate, that that is not the case. We may perhaps need a glossary.

But, if I were to ask each of you how you would define life, I don't think any of us could define life, and give a definition that could hold. What's the best definition: death? It's one of the absolutes. I tried to use that logic. I'm an empirical person. It's important to characterize the *Vis*, rather than try to put a definition. I realize there's a glossary in the back of the book. But, you'll trap yourself if you try to capsulate. I think you need to characterize it, but not try to define it.

***Christine:*** I agree with Bruce in a number of ways. The *Vis* is a complex set of concepts. It may not be a single concept; therefore, a single definition won't hold. One may take a number of classification themes within the context of each type of medicine. Do that within a chapter on the *Vis*. What is it considered in a variety of medicines? No definitive definition. It'd be a teaching tool of great richness to do this, rather than a single definition. It takes the context in which something is considered: social, linguistic, familiar, etc.

***Dr. Keppler:*** If you were to make it empirical (like in a bell shaped curve), then, you'd have the confidence intervals.

***Don:*** But people all understand that the body has the capability to heal itself. Then, who cares why this happens?

***Thomas:*** People inherently understand that. The problem is when their belief system overrides.

***Don:*** What I appreciated about your talk is that it was a process that came about, that you came to on your own. Having you come to this conclusion has more power than many of us who don't have that background, is very powerful because you came to where you're from.

***Cathy:*** All this brain research says that to the extent to which a parent has a self-knowing awareness, their child is more securely attached, and their child has more positive mental. It's true with a physician. The extent to which a physician knows him or herself allows for a more successful interaction.

***Christine:*** Wayne said it was a slippery slope. Was he saying that if we talk about this, are we going to be in arguments forever?

***Thomas:*** It is a slippery slope, and it's one we need to get on. That is historically our style. It's important to do that.

***Cathy:*** What's our coherence?

***Jared:*** There's a separation between clinical practice and the philosophy behind clinical practice. The application of the philosophy is different from the philosophy.

***Wayne:*** There has to be some understanding of the philosophy to apply it. We can apply the philosophy as a model – as a construct without understanding fully the *Vis* – but we need to define the philosophy in order to apply the philosophy.

***Thomas:*** We need to have the concepts of the philosophy in order to apply it.

***Christine:*** One of the things that Cartesian dualism does to separate mind and matter. In your thinking, is there a continuity that can also be seen in the consideration of the *Vis?*

***Leanna:*** Yes, so, one can formulate different aspects of the *Vis* in ways that are conceptually clear, but that are not reductionist. We must have a chapter that characterizes the *Vis*. Pedagogical tool. Everyone agrees: the healing power of nature. But, then, what about you're sitting in a room with a patient with metastatic breast cancer? No. Putting aside the question, is chemotherapy a natural medicine? We believe in the healing power of nature. People light up when I tell them this. This could mean diet, being connected to the cosmos, or this other way of talking about the *Vis* as causative, as God. We need to explain to students that that is a different way of talking about it. You don't need to believe in God to be a great ND.

***Don:*** In this chapter, how do we take what we've characterized, and apply it in a clinical way. This is import to show what defines us as different.

***Jared:*** When I describe to students, the *Vis*, I take the AANP definition line by line. When we say that healing is a process, as opposed to directing therapy against an entity. . .

This leads me to a set of clinical questions and clinical explanations. This leads me to an ordered approach to therapeutics. A clinical theory of application is contained in that definition that tells me what to do as a doctor: understanding the process. *VMN* creates a set of clinical instructions that don't fundamentally depend upon causal fields (as you start thinking about them, that's where it takes you, but that is not required..

***Dr. Keppler:*** There should be a chapter on pedagogical technique.

***Thomas:*** This is what Paul and I have been debating. We haven't been able to figure out what it is that we need to apply to the clinical section. This is one of the discussions we really wanted to be part of because we needed direction.

***Don:*** In reflection: in a textbook, it's interesting and good for study, to say that these are potential explanations. That gets a dialogue going, but we haven't contained it, we haven't defined it. It gives students with a physics background permission to start thinking and imagining.

***Cathy:*** One of the things I got from Bruce's writing: there are a lot of ways you can stimulate transformation. Transformation is a very important concept here.

***Leanna:*** I agree

***Cathy:*** Even witnessing a transformation is powerful. Have you ever seen someone?

***Leanna:*** Yes. I've seen people live happy with zero platelets. I send patients to you because you can produce a momentary state of health. That experience of well-being is powerful. One thing that is clear is that we do need a chapter – the pedagogical tool. You'd be the best, Chris, to do this. It's a philosophical question.

***Cathy:*** It's interesting to trace the lineage.

***Leanna:*** Everybody's screwed up about this. We could lift the whole medical community with this information.

## Breakout Group Two

***Bruce:*** Descartes and his students were finishing up a class in which they were discussing: is life real? Upon completion, is this an illusion, dream, reality? They were on the 2nd floor. Those of you who feel that this is a dream – leave through the window. The rest of us will go down the stairs. The whole question of the *Vis*. There was a time when people were trying to figure out magnetism, subatomic particles. Call it what we want, we just have to come out of the closet with it.

***Herb:*** If we're going to talk with other people about it, we have to be very careful about the language. Instead of miasm – chronic reactional mode. The language has got to be clear. We have the field of the universe. We have a human being. All are parts of the *Vis*. How are we going to tie down the language, so there's no mistaking what we're talking about?

***Mitchell:*** Using words that have not already been entrapped by common language. *Vis* – nobody knows what Latin means. You start getting into vitality, spirit; people already have pictures in their heads. It doesn't necessarily communicate. Let's start with the function, and say: what should we call this function? Rather than starting with the word, and saying, what does it mean?

***Iva:*** I'm concerned with interests keeping it narrow and tightly defined. You can explain anything by the Ayurvedic five elements. Here's the overriding definition, but yes it's going to change. The language becomes a restriction

when you try to put too many aspects into the same definition. E.g., what is vitality with respect to cellular function? That is easier.

***Bruce:*** How about if we try to explain, what is electricity? I can't explain it, but that doesn't stop me from turning the switch, and knowing that electrons move, and ultimately the light turns on. What I believe our charge is to say, we can give it a name, but we can't deny it exists, and we all rely upon it.

***Iva:*** If you don't know, you can ask an electrician. If you want to know about vitality/*Vis* – ask an ND [or other doctor; not co-opting it for NDs only].

***Herb:*** Start with where we agree. Living things have the ability to maintain themselves, repair themselves. Living systems are open systems. Let's start there, and then attempt to branch out. Consider: the evidence of things not seen.

***Paul:*** Worldview and philosophy should come first. Moms/dads can have, without being doctors. That's vitalism. It's a philosophical view of the world and reality. Not ours. Then you can apply that in different settings, e.g., apply it to health and healing. *Vis Medicatrix Naturae* means the application of vitalism into medicine.

***Mitchell:*** But the word's trashed. Because allopaths will start talking about uric acid in the 60s. Let's pick an unencumbered word. Make reference to old terms. Having models as opposed to strict definitions will serve us becoming more fluid. We all experience things, but it's been given different names. Start with the experience.

***Iva:*** Let's look at: these are the categories; now, what word fits? The wrong term is being used, and people are looking out a different window.

***Iris:*** I'm not sure you need vitalism to be naturopaths. Hahnemann says the vital force is a spiritual energy, and you have to treat at that level. The tools you use are also working on the physical/natural plane are more in the realm of nature than vitalism. You can be a naturopath without being a vitalist. You can't really be a classical homeopath and not be a vitalist. The complex systems we're looking at are interactive between top-down and bottom-up. You don't have to use vitalism if that turns off part of your audience. Living systems are not linear. They're beyond our comprehension and we're always going to be simplifying.

***Paul:*** *Vis* means force. *Medicatrix* means medicine, and *Naturae* – of nature. When you put the phrase together, it means something different than "the *Vis*."

***Herb:*** As a physicist, looking at physics: life moves against entropy. It's a phenomenon we haven't come to terms with it. When an organism dies, we see it. The body disintegrates. But life is different. There's a force moving against entropy.

***Bruce:*** Can we articulate the difference between the healing power of nature and this force? It seems our charge is to articulate clearly between the vivifying force, and the healing power of nature. What is it that makes me alive, compared to a piece of meat? That's not the healing power of nature. That's just me being alive.

***William Franklin:*** I don't think we have to know what it is; we just have to have a definition of it.

***Mitchell:*** I like Paul's thought about taking the phrase apart, what they mean apart, what they mean together [*Vis Medicatrix Naturae*]. This is interesting methodologically.

I think we have to talk in terms of examples [Illustrating the phenomena that we can't necessarily explain.]

***Paul:*** In Australia we're very secular. We use spiritual instead of spirit. It's an influence, that's part of the map. Not spirit that some religion defines. The language needs not to divide.

***John:*** When you talk about it as intelligent – this is not religious, but very interesting.

***Herb:*** The guy who came up with the equation that tells you about the probability of finding an electron or other subatomic particle in a particular location… Towards the end of the career, he talks about the intelligence of the universe. For a physicist, this is extraordinary. Niels Bohr did this too. You can couch it in language that does not bother the biologists. So yes, you can keep it secular. How are you going to come up with the language that's not going to turn them off?

***Iva:*** But keep in mind that this book is in the future.

***Bruce:*** They're not directly measurable; they are manifestations.

***Herb:*** Yes, in physics, no one has ever seen an electron. But you can see the manifestations of it.

***Mitchell:*** Conventional medicine is about getting rid of your symptoms. Someone who dies can be in health. Wellness is about being in the cycle of life, about self-awareness, healing on a deeper level than your lab tests. It's not all about making it perfect.

***Bruce:*** The healing power of nature. It works just as well for surgeons and radiation oncologists.

***Paul:*** We disagree with conventional medicine on what "cure" means.

***Iris:*** Consider global versus local. You cut out a tumor: You've fixed the local problem. But the person is going to have consequences [injury] of that treatment, but the cancer might have gone. Are you treating the global or the local?

***Iva:*** Initial assessment of risk. Triage first: life or limb? Then go on with therapeutic order.

***Bruce:*** What do we agree on? Let's summarize.

- The system has a tendency to heal itself.
- We can't separate the *Vis* out of the *Medicatrix*, from the *Naturae*.
- Terminology should be secular. Don't use culturally problematic terms.
- The "force" is not directly measurable but it's observable through its manifestations.

***Mitchell:*** The doctor-patient relationship is a pivotal thing there. Without that, all this is futzing around. They only put up with your therapies because they like that you're taking care of them.

***Paul:*** I disagree; people come see us because they share our worldview. It's well established in Australia.

***William:*** What does nature mean? What does supernatural mean? Supernatural is antiquated: of or relating to an order of existence beyond the observable universe. It's a useless term. The thing about nature is that it's everywhere. The worldview of loving and wanting to participate with nature is not unique to us. Everybody is walking around/living in it. But some people are deluded about this. They think they're living outside of nature. Suddenly, they come up with a disease, and they don't know why. Nature needs to be a bigger word, and not just represent camping.

***Bruce:*** Adding to the list.

- Clearly define nature.

***Herb:*** The goalpost changes as the technology changes; as we get the instrumentation to measure things.

***Paul:*** Let's not say "current scientific theory" because what's current now will not be current in five years. Instead name the theory. Leanna wants to say "quantum theory is part of us…" Well, in five years it will be something else.

***Iva:*** We talk about treating the whole person – but then the flow chart or the breakdown is at the cellular level. What window are we looking out (referring to) when we use the language?

## *Breakout Group Three*

***Speaker:*** James heard all the same thing in different ways. There is coherence around the ideas not the language. Vital force = quantum theory.

Vital force is different than the *Vis*. i.e. cause versus description; a unified field for the expression. The *Vis* moves us in the direction of health. We are using terms interchangeably and sloppily. What do we mean when we say vital force, *Vis*, etc.? We can provide a measure of the vital force, but not the *Vis;* it's something else. Within the person it is considered vitality. Vital force= universal animation. *Vis*= power or force within organism that resists disease. Vital force: tendency to move toward order. The amount of energy within individual; this is more measurable.

***Jim:*** The energy to move in a certain direction, and the concept that it moves in a certain direction; a unified field that is perfect in itself. It's a universal principle that says that all of life moves toward perfection.

***Louise:*** A whole, one whole of which all is a manifestation, divine, etc., the field of potential out of which all matter arises. It's the ordering principal that allows matter to manifest. This is apparent in all matter. As humans, we have consciousness, and bodies that manifest from the field of potential, and manifests as all things.

***Jim:*** The terms that we are using are not vigorous enough. This is a point of diversity. We have not agreed on which terms are applied to which concepts. If we elevate *Vis* to meet the all creating force, what do we call the tendency to move toward balance? As doctors do you have a sense of a patient's vitality? ***Ye, they all answer***.

***Fraser:*** Definitions are important. The healing power of nature you can observe in action. *Vis* is a lot more mundane; historically, it resists health. It is not the animating principle. Conscious intent can affect and change the ordering of the physiology by working with this grander force field by stimulating something within the individual.

***Pamela:*** The *Vis* versus *VMN* – are they actually the same? The *Vis* doesn't feel like the whole picture. *Vis* means force. Nature was included in the *VMN*. So it [*VMN*] embraced the broader field. The healing power of nature is the broader field that reflects natural law, which as it descends into matter, is or expresses itself as the vital force, vitality: expression of vital force. Someone who is dying can have incredible vital force, but no vitality.

***Jim:*** Vital force: unified field that. The dynamism is the vital force. When I stick needles in him, I am stimulating this.

***Louise:*** How to we define nature? *Vis* resists disease? I resist this. The manifestation of signs and symptoms is an expression of the body's inappropriate response to the loss of balance. The force that allows the homeodynamic mechanisms to act. Nature, water, air, food, etc. that we live within – that helps us order.

***Patricia:*** There is a difference between the equation and empowering the equation. The first defines a set of relationships (a system set of laws, network, organizational process, order, intelligence, or matrix). In the case of the *Vis*, these relationships or equations dictate how a body heals itself. Science has defined parts of this system, such as the processes involved in elimination or in scar formation. I believe that these processes, the equations, are for the most part unalterable. They exist whether they are in use or not. Instead, to stimulate the *Vis* is to empower the system to allow it to work. This can be done by releasing energy from places it is stuck, or where it is being used up or drained by other (e.g., defensive) processes, and allowing it to power the healing process.

***Jim:*** Epiphany: the way he understood Bill: the statement is a statement of a fact, about natural phenomenon in mathematical language. This statement is unchangeable. We can change the variables but the result is the same. *VMN* as an equation describes an immutable principle with changeable variables. The concept of resisting disease: it is disorder re-establishing order. As we move from balance, we develop compensation or response, but when this response is delayed or lagging, then we have to stimulate and re-balance. Homeopathy tweaks the balance just a bit further to regain balance. Maybe we don't need to think of it this way. In order for anything to change that is in disorder there has to be a change of direction. On the day you turn it around there is a reaction (aggravation) then it

starts moving in another direction. [Therapeutic order/process of healing.] If I push you far enough something will respond. Is this the *Vis* or the vital force? That is the force that expresses your vitality. When measuring vitality, the vital force is preceded by vitality. If you have the vital force flowing through this, and then you stimulate – what are you doing?

***Louise:*** What is nature?

***Christa:*** The law can only observe the effects, but can't observe the actual.

***Louise:*** The nature of consciousness can't describe it, but it exists.

***Pamela:*** There is a section in the text for this characterizing our knowing of the *VMN* through other media of knowledge such as art, music, etc. – The Many Ways of Knowing the *Vis*.

***Christa:*** Think of it like music. We can study the vibrations but the piece of music is not simply the vibrations. We can only talk about it in the world of metaphors. Maybe this is the only way to talk about it is in metaphors. The *Vis* is like circulation to living systems. What we are describing is a property to life. Vitality or the vital force some inherent force that doesn't manifest with as great a power. An individual with a lot of vitality doesn't need much stimulation at all; whereas, the opposite is true of someone without a lot of vitality.

***Fraser:*** *VMN* versus vital force. The *VMN* is an overarching force of an organizing field. The vital force enters a field. Is the *Vis* a power? Sometimes this is what we mean in terms of intelligence. It is a living force toward healing, an overall organizing field. Using the equation is as a focal point for this. Law. Permanent. Metaphors. Observable properties of life. In terms of downward causation: the *Vis* is an immutable principle such as an equation. Philosophy and understanding. Vital force: universal with Hahnemann's substance. Vitality: individual measure of a person's *Vis*. *Vis* is a property of life.

***Cathy:*** Let's imagine vitality being a good thing. Is depression vitality? Can depression be an accurate response or a pathway to meaning?

***Emma:*** Concerning divine intelligence: does Lindlahr's definition include this? Is it about the individual's character or spirit? The *Vis* is not a random force, and its role of bringing matter into form; the role of human consciousness to form matter. It would be useful to have one chapter where there are different points of view, and different ways to think about this. Regarding spirituality and the *Vis*: spirituality was not mentioned in the definition. Healers and spiritual guides used to be the same people; to help people find their meaning in life. We may need a reformation on the scientific side too.

***Bruce:*** The term *VMN* was a whole statement without dividing it out. We can't have one without the other. We need a definition of the word nature: what do we mean by nature? That which exists is natural and that which doesn't exist is supernatural. Another word for that which exists IS natural. *VMN* is a force that we can't see. All the discussion that we are having is much ado about nothing. It doesn't belong to anyone and everyone knows of this. It is not seeable or knowable; it is a force which leaves traces. It is recognizable in everything living like trees but not viruses because they are not alive.

Some things are more subtle, and so some don't see them or know how to work with them and some people do.

***Cathy:*** Regarding claiming the *VMN* for ourselves: it is possible to explain the *Vis* without using anything spiritual. The *Vis* is a description. The chapters should characterize the *Vis*, but not define it, but describe a range of possibilities. One has to enter the therapeutic encounter. The *VMN* as the philosophy is applied there. Let's look at the process of healing; we see disease as a process, the therapeutic order as a process. The therapeutic encounter is what enables us to be with patients, and foster transformational change as being self knowing awareness.

### *Breakout Group Four*

***Joseph:*** This is a brain dump of real gold.

***Roger:*** We have coherence and diversity, unless we come down to a materialistic definition. This is the essence of diversity. I've been doing it for the longest of anyone here. It is not the luxury of academia to do this exploration.

***Joseph:*** Leanna resonates with me the most.

***Roger:*** Takes us back to what Lindlahr said: It doesn't matter what matter is, but the way we work with matter. Ultimately, we may be able to explain what this is in physical terms, biochemical terms, and electric/energetic terms. Nobody knows what the meaning of life is. I am waiting for TOE (theory of everything).

***Joe:*** Book (Henry Lindlahr wrote): there is nothing outstanding about him except, he put everything in a clear and concise format. Not everything he said fit from my world view, but I appreciate all that was said in the proceedings before.

Question whether all of the organizations are studying it from a holistic point of view because they are caught up in the mechanistic view. But very exciting that the organizations are willing to acknowledge it, and do something about it.

***Emma:*** There is something that is imbuing either spirit or matter. The medicine is a way of creating a bridge between those two. Its causal end is coming through. I am very glad that we are bringing vitalism back. Spirit is in matter, but not of matter.

Very difficult to articulate, but it is very good that we did this.

***Wayne:*** If you are using the same words with different meanings, we are talking without communicating. Language is very important. Historically, vitalism and mechanism have teetered/tottered back and forth, dominant and recessive. We have already gone down this road. We ran into trouble – look at qi and translated energy. But in western medicine, we use energy as qi, but qi is a conscious energy. It is not translatable. And the terms are interchangeable. DON'T TRY TO FIND A *VIS* DEVICE.

***Joseph:*** *Vis* as a manifestation of hidden energy of universe (Leanna) very similar to him

Universe – goes to heat. It goes to lowest form of energy. EXCEPT life. There is something that creates life, and it is intelligent (Lindlahr said). It is not a random force; it is something real and very powerful. The *Vis* is the organizing structure that then allows the manifestation of matter. But once it is manifested, WHAT ROLE DOES *VIS* PLAY? NOW THAT IT IS MANIFEST? How much does the *Vis* still impact the manifestation?

***Christina:*** The term chi – how it is used and described: it is the life force. What is the difference between this and *Vis*, measurable, so it is defining the indefinable (spiritual element)?

***Rita****:* As soon as it can be measured and defined, it is no longer a mystery; it is science.

Measuring this has no immediacy or importance to me. We don't have to force this into a box. Then it is no longer real, no longer alive and will no longer evolve with us as a species. In 100 years, we will think this conversation will seem funny to us. Don't feel the need to put this in a box. We need to make this inclusive so we can grow.

***Susan:*** I missed the discussion. This reminds me of Thomas Kuhn's book: talk, discoveries happen, feels like we are on the verge of discovering something that in the future time we will look back and say OF COURSE.

***Joseph:*** Pamela thinks this should be six chapters; I think it should be one chapter.

***Roger:*** I agree: a definition of *Vis* that embraces the fact that there are several different pathways to the *Vis*, and accepts that, because we need to get this out to students and readers in a useable form. There are other aspects of philosophy we have to deal with.

We need to keep this spirit throughout the book, even if one chapter. Helps define the *Vis*. (White shirt.)

***Wayne:*** One chapter for philosophical aspects/historical aspects/terminology/acknowledging the individuality of this. Red shirt – long period of time where science and religion were one and the same. But, they have been pulled apart. Both have suffered as a cause.

AGREE THAT *VIS* SHOULD BE ONE CHAPTER

OTHER THINGS LIKE APPLICATIONS CAN BE ANOTHER CHAPTER.

***Joe:*** What role does religion play here? Lindlahr didn't bring in religion. Do we do the same?

***Rita:*** Lindlahr brought in spirit. If we bring in religion, it will be disastrous.

***Wayne:*** But spirituality is a type of religion in a way.

***Joseph:*** Clarified that religion is the self-perpetuating body's spirituality – find meaning in life.

What can we bring to the group: THERE IS A DIFFERENCE BETWEEN RELIGION AND SPRITUALITY?

***Roger:*** Spirituality is non-denominational – no matter what beliefs and non-beliefs that the world can accept universally

***Joseph:*** So do we agree with Lindlahr's definition? But we need to know: What does intelligence mean in Lindlahr's definition, and that's how religion plays a part even though religion has not served us as naturopaths.

***Wayne:*** Creativity – producing new things – how far does it distill formulae? What is our role? Does consciousness influence material/ if it does, than our consciousness can be creative.

***Joseph:*** But there is a chasm – but the feelings can affect one's own body. But, now we are looking at something that affects outside one's own body.

***Wayne:*** Non-locality shows that our thoughts are fundamentally important in creating the universe. We participate in choices and free will, and creativity; we are not just products of God.

***Joseph:*** We will not measure the *Vis* directly.

***Wayne:*** The components that facilitate the human development – what characterizes the inner and outer environment? In the inner field, they can enhance compassion, empathy, communication; you can measure expectation.

***Joe:*** If we can understand the equation (Mitchell). Is there a difference between *Vis* and vital force?

***Joseph:*** I didn't get that they were different. What do we say about that?

***Joe:*** The vital force is our character; the spirit that inhabits our bodies. The *Vis* is directly interacted with, but we are much a part of it. We are not it. It's a rough understanding.

***Rita:*** This needs to be clarified. Give a deliverable to the group. Describe an operational definition of the *Vis*. How might we increase the rigor of sciences? What are the common elements of the *Vis*?

## *The following sessions do not have appendices:*

### *Systems Theory: Dynamic Solutions for Complex Problems in Naturopathic Theory and Practice*

See Reflective Dialogue on Systems Theory on page 36 in this report.

### *The Vis or More than the Vis? This is the Question! Determining the Relationship between Spirit and the Vis Medicatrix Naturae*

See detailed proceedings from plenary discussion on Spirituality starting on page 40 in this report.

### *Epistemology and Medical Phenomenology*

See Epistemology and Medical Phenomenology beginning on page 45 in this report.

### *Process of Healing and Therapeutic Order Theory*

See dialogue on the Process of Healing and Therapeutic Order Theory on pages 49-57 in this report.

### *Nature Cure: Honoring the Heart of Naturopathic Medicine*

See Nature Cure session proceedings on page 85 in this report.

### *Naturopathic Medicine Modalities: Evolving with the Progress of Knowledge*

See detailed minutes on Naturopathic Modalities on page 91 in this report.

# Metaparadigm Detailed Minutes of Breakouts

### *Breakout group discussions*

## *Breakout Group One*

***Vis Medicatrix Naturae***

Consensus; agreement.

**Holism?**

***Mary:*** This might be more of a philosophical tenet rather than a thing/health as balance? [Or normal.]

***Jim:*** I would argue this is unique, and essential. Normal or harmonious vibration. This is our reference point, focal point. Historical corollary: theory of unity of disease.

***Christa:*** Just Health itself, versus health as balance, doesn't seem very useful.

***Jim:*** What we call Health is not the same as what other professions call health. Our predecessors define health as balance.

***Leanna:*** I don't find this a useful concept. I don't use this.

***Mary:*** Do you need to describe health in order to describe naturopathy?

***Jim:*** Our way of treating disease is to restore normal health, which is different than conventional medicine which is about suppression of symptoms. The corollary for that is the idea that there is one disease: disturbance in the force.

***Herb:*** Does that concept hold up?

***Jim:*** I'm focused on treating the person, not the disease. Restoring "government."

***Rita:*** I don't want to put something in there that says disease. I want to focus on health.

***Christa:*** What about healing?

***Herb:*** But this sounds relational, like moving from one state to another. I'm just making a statement about what's behind the word healing.

**Conclude with: Health**

**Suppression**

***Rita:*** More about a theory, not at the metaparadigmatic level.

***Herb:*** The Chinese perspective: you treat the deficiency, not suppress the excess.

***Kavita:*** Symptoms of the labor of the body. Scratch from the top level list. Remove from the list.

**Individualization**

***Jim:*** Is this a concept or a theory? Joe's concept: isn't individualization an expression of the *Vis*?

***Herb:*** Life expresses itself in an individualized way. We humble ourselves to the observation that we move in harmony with the life force of the universe. This was agreed upon.

**Doctrine of Signatures versus Holarchy**

***Jim:*** This means: “as above, so below.”

***William:*** Everything is a part *and* a whole.

***Christa:*** Like a hologram.

***Fraser:*** It’s recursive.

***Jim:*** Maybe we should call it Holography.

***Pamela:*** I Like that! The Doctrine of Holography. Or maybe the Doctrine of Holarchy.

***Jim:*** I think holarchy might be a modern word for doctrine of signatures.

**Minimum Dose versus Least Force**

***Jim:*** Using least dose necessary. What is the absolute least I can do to produce the desired outcome? What’s the lowest common denominator?

***William:*** Maybe elegance?

***Herb:*** I love that.

***Fraser:*** Allopathy tries to take control. We’re not trying to control; we’re trying to let nature control.

***Jim:*** We ask this in every other area of life except medicine: what’s the least I can do to get the most?

***Herb:*** That’s called laziness.

***Jim:*** So minimum intervention; is this going to make it?

***Christa:*** Minimum dose sounds like a substance. What about least force?

**Generally agreed upon: least force**

**Law of Dual Effect**

***Jim:*** Any intervention has a primary and secondary effect. The secondary one will be the lasting one. This is why allopathic medicine cannot work.

***Herb:*** The classic example is constitutional hydrotherapy. You put on cold, and it gets warmer.

***Rita:*** Can’t we define ourselves without comparing ourselves to anybody.

***Jim:*** We don’t have to put down another profession.

***Mary:*** You’re talking about treatments you use. There are therapeutics.

***William:*** Dual effect just describing action/reaction.

***Mary:*** I wouldn’t put it there. It’s not a THING.

**Therapeutic Relationship**

***Christa:*** A lot of people would consider this primary. You can’t do your medicine without relationship.

***William:*** As a concept, relationship is at the core of everything we do.

***Mary:*** The notion of naturopath as teacher.

**Environment**

***William:*** The concept of internal/external environment.

## *Breakout Group Two*

Metaparadigm constructs:

Inarguable.

Essential:

1. *VMN.*
2. Doctor-patient relationship: docere is the action or behavior within the relationship.
3. Health is balance/alignment.
4. Holism: community.
5. Unity of disease or health: contagion: tolle causum.
6. Individualization.
7. Least force: first do no harm.
8. Dual effect: any substance administered will have opposite effect.
9. Suppression.
10. Community health falls out of holism.
11. Doctrine of signatures: as above so below is this holism, part of 10 and four.
12. Tolle causum: what are we directing?
13. Ease suffering: what we do, is possible to have balance with suffering. Leave suffering as a primary idea. Homeostasis: action and reaction.

Mental images of things; use single words.

Health: suppression, first do no harm, ease suffering.

Therapeutics, intervention.

1. Health.
2. Least force.
3. Relationship.
4. *VMN.*
5. Prevention.
6. Holism.
7. Individuation.
8. Unity of disease.
9. Therapeutics: is there a word that is broader than therapeutics?
10. Signatures: physiological response, energetic, biological, (as above so below) action/reaction, all things are representative of their manifestation. Holographic covers it. Symbolism.
11. Compensation.
12. Dual effect: intention (not essential: put under therapeutics or with relationship) use this every time you play pool and try to get a ball into a pocket indirectly.

If you just tossed out a bunch of nouns these are the words that you would see to describe.

## Breakout Group Three

***Stephen:*** Very exciting.

***Don:*** Bring unity to profession so that no one can be excluded.

***Stephen:*** There can be a physiological model of the *Vis*.

***Mitchell:*** Want to be dualistic or mind over matter; you can be! Not homogenous group, and that's great.

***Stephen:*** When we have exhausted the constructs, we will need to put some words around the construct.

***Bruce:*** The system tends towards health. Don't understand health as balance.

***Mitchell:*** Balance is static. Equilibrium is much more dynamic.

***Don:*** Too simplistic to talk about health.

***Mitchell:*** We support health as a dynamic equilibrium. Support may not be the right word.

***Stephen:*** Well if we put up health, what are we agreed upon?

***Bruce:*** There is a tendency of the world to health. A driving force towards it.

***Stephen:*** That is *Vis Medicatrix Naturae*.

***Mitchell:*** That maybe is a subset of *Vis*. Can't forget the practical indications of health as balance (about diet and exercise, etc.)

***Stephen:*** Health as balance is described by Jim as the natural state for the human organism is to be in health.

***Mitchell:*** Describing therapeutic goal?

***Don:*** We are talking about overarching concepts. NOT TREATMENT. We have a unique combination of things. Everyone is interested in health.

***Stephen:*** Put up individualization.

***Mitchell:*** Individualization of care.

***Joseph:*** Individualization is a core concept.

***Bruce:*** It is one. Family practitioners in Seattle; that is a core concept as well.

***Stephen***: Don was right. It is the combination of concepts that defines us. I will treat each person as an individual, but that doesn't mean that I will treat you as a whole person. So I think the whole person is another construct.

***Mitchell:*** Don't always treat the whole person – if someone has a broken leg …

***Don:*** I see someone as a whole person, even if they have a broken leg, and that is what I treat, because I connect with them as a whole person.

***Joseph:*** Can you put the two together – individualization of the whole person.

***Stephen:*** See that, but keep them separate, because they talk about two important things.

***Stephen:*** Suppression was one.

***Mitchell:*** It is the separation of tactics, and we aren't dogmatically against suppression. We want to support the whole person.

***Stephen:*** If we put it as a construct, we're saying we will never suppress anything, but that is not true.

***Mitchell:*** It is derivative from half the principles; it is an operative principle.

***Bruce:*** It is part of Mary's lower echelon, but that doesn't mean that you should suppress fever or diarrhea?

***Stephen:*** If you have a two year old with 40 degrees Celsius, then I would suppress very.

***Bruce:*** Agreement that this should not be there.

***Stephen:*** Least force.

***Bruce:*** Least force and minimum dose are different?

***Mitchell:*** How about minimal intervention?

***Richard:*** Most bang for the buck.

***Stephen:*** Vote for least force.

***Joseph:*** Clarify not minimum dose?

***Don:*** The minimum intervention is a good principle, but if least force covers that, then

***Mitchell:*** One is vernacular; one is a medical term.

***Don:*** Least force/minimum intervention?

There was agreement.

***Stephen:*** Doctrine of signatures.

***Bruce:*** Misleading and ambiguous. Big problem.

***Mitchell:*** Premise of doctrine of signatures – as above so below, as below so above. Principle is learning from nature. It applies to this and gives it broader expression.

***Don:*** It could be a meta-theory.

***Bruce:*** It is not a metaparadigm.

***Mitchell:*** It is one specific example of learning from nature.

***Stephen:*** Is nature as teacher a core concept?

***Don:*** I like that.

***Bruce:*** Sounds good, hard to argue with that.

***Bruce:*** Doctrine of compensation.

***Mitchell:*** That's down one notch, probably part of minimal intervention, nature as teacher, whole person. It is part of each of them.

***Stephen:*** Dual effects.

***Mitchell:*** Something can be a medicine as a poison.

***Bruce:*** The unity of disease.

***Don:*** I believe that it is in the meta-theory, not a metaparadigm. I'm trying to find those things that all our colleagues will agree upon.

***Stephen:*** We gave up dual effect. I'm not sure it's a construct. Is it a concept?

***Mitchell:*** Susceptibility versus contagion. We are trying to support their healthy terrain.

***Stephen:*** Optimize the terrain.

***Bruce:*** The whole notion of death, dying and suffering; somehow, is hugely lacking in the six principles. Relieve suffering.

***Mitchell:*** That fits into individualization and whole person.

***Stephen:*** I would articulate compassionate and empathetic care.

***Mitchell:*** I think we should put something in about the therapeutic relationship.

***Don:*** Is compassionate care to fit in here?

***Bruce:*** It is a free standing entity.

***Mitchell:*** Compassionate service and relief of suffering.

***Stephen:*** I think we should put them in three construction: compassionate care (what are you going to bring to the individual), relief of suffering, and the therapeutic relationship.

***Mitchell:*** Word service is better than care.

***Bruce:*** I like that, because care is a part of service, but service is not part of care.

***Stephen:*** Service is something you get done to your car.

***Mitchell:*** Not in all circles.

***Don, Bruce, Stephen, and Mitchell:*** I think care/service is important to put down as such.

***Joseph:*** Health as a normal state.

***Mitchell:*** Normal equals cultural norms. I think more health is a natural state. Health comes naturally.

***Bruce:*** Some people will have problems with it. Death is a natural state.

***Mitchell:*** Death is not unhealthy.

***Stephen:*** Can death be a success?

***Richard:*** I have a colleague who wrote a book about how to have a death.

***Stephen:*** Need to take into account aging, and death, and how they are natural processes.

***Mitchell:*** Found that wellness was more important than health, and transition through life stages.

***Stephen:*** I would say aging and death are natural processes.

***Don:*** Talk about optimal aging and something death I don't know what yet.

***Joseph:*** Someone can die, and that is a healthy thing. That can be a natural state.

***Bruce:*** We can't just put death out there. Can't just put a descriptor out there. We are all going to die. Dieing is the natural and successful culmination of life.

***Stephen:*** Successful and dignified.

***Don:*** Not always, some people are robbed of life through an accident.

***Bruce:*** Optimal aging and death – let's leave it at that.

Metaparadigms agreed upon:

- Vis Medicatrix Naturae
- Whole person
- Individualization

## *Breakout Group Four*

***Joseph:*** Looking at naturopathic principles on page 247, my sense is that these are all meta-concepts. Do we have congruency?

No comment.

***Joseph:*** Looking at laws of healing on page 247, none of these. Do we agree?

***All:*** Yes.

***Christine:*** Is there a distinction between alignment and attunement? I've noticed the word mis-tunement. Strange word. Is that….?

That's a Hahnemann term.

***Joseph:*** Health is balance. I'm not sure what that means.

***Letitia:*** Imbalance serves its role as chaos.

***Letitia:*** The concern is that when you achieve health you are in balance. But is that a metaparadigm? I don't know.

The seven things we've identified as metaparadigms. There are only a few that are nouns. The others are imperatives.

Health as balance would be. I think it could be one of those metaparadigms. Do you?

***Letitia:*** Does every naturopath see health as balance? I think we all do.

***Cathy:*** We can all agree that a person has a wholeness, and that's what we want to relate with. But, ultimately it gets farther on the grid to say that's how we treat the person.

***Joseph:*** Can we think of a situation in which a person is healthy, but not in balance? Does balance imply balance with the external as well as the external environment? Does this need modifiers, okay by itself or should we move on?

***Letitia:*** I think that needs a lot more defining. It's probably a sub-paradigm.

***Joseph:*** Let's put a question mark next to it.

***Group:*** Yes.

***Christine:*** I've always been puzzled by use of 'suppression' under the heading 'doctors of naturopathic medicine'

***Letitia:*** It's a summary. Suppression of symptoms leads to further illness.

***Joseph:*** (Repeat concept.) Perfectly said.

Next concept.

***Letitia:*** So, individualization of therapies. Or therapeutic approach.

***Cathy:*** (Clarifies.)

***Letitia:*** Yes, individualizing the therapies for patient.

***Christine:*** I have difficulty with this concept.

Doctrine of signature.

***Letitia:*** The universe.

***Joseph:*** I'm going to have trouble agreeing to this one.

***Letitia:*** Does everyone agree that doctrine of signatures is something naturopaths use?

***Joseph:*** Example: Ginseng looks like a man; therefore, is used for a man.

***Christine:*** So, because a plant is shaped a certain way, it has certain capabilities.

***Cathy and Joseph:*** I don't like it.

***Letitia:*** It's an old theory.

***Christine:*** It confuses aesthetics with usefulness. That can't always be right.

***Joseph:*** So, there's a question on that.

***All:*** Yes.

***Joseph:*** Least force. Can we agree on that? About non-naturopaths is there an understanding?

***All:*** Yes.

***Joseph:*** Chris, thanks for being here.

Efficacy of the therapeutic relationship.

***Letitia:*** Another term: the doctor-patient relationship.

***Emma:*** Are we talking about the healing power of that relationship? I don't know that efficacy captures that. Suggest: doctor-patient relationship.

***Cathy:*** I don't like doctor as teacher. I always reinterpret that.

Doctor-patient has hierarchical feelings.

***All:*** Yes.

***Joseph:*** Dual effect. I don't get it. Is that general versus local effect?

***Letitia:*** Different. More like yin and yang.

***Cathy:*** If we don't know what it is, do you think it belongs?

***All:*** (Laugh).

***Letitia:*** Terrain: contagion. Is the concept of the terrain more instrumental that the contagion itself?

***Emma:*** I thought they were talking about susceptibility.

***Christine:*** My question about contagion and even terrain is that it has a public health concept to it. Is that important to this?

***Joseph:*** It's both. If you give a person XXX, you'll overwhelm their system. Terrain is just as important as the contagion.

***Emma:*** It's about the vitality.

***Letitia:*** Or the imbalance.

***Christine:*** But, it's not a piece of property or the country.

***All:*** No.

***Joseph:*** So the terrain is more important, but the cotangent a part of it.

Since I left Bastyr, I haven't had a cold. I used to get a cold every three months.

Is there some way we can say this.

***Letitia:*** It's a core concept of naturopathic medicine. The terrain and contagion relate to a person's health.

***Roger:*** We address the terrain.

***Joseph:*** We use goldenseal with someone who has an infection.

***Letitia:*** Old docs would say toxemia.

***Joseph:*** We're stuck on this. Let's come back.

***All:*** Yes.

***Cathy:*** And it might fit into "treat the cause also."

***All:*** Yes.

***Joseph:*** We don't need to worry about overlap.

***Joseph:*** Okay, healing process is ordered and intelligent.

***Letitia:*** That's the *Vis*.

***Cathy:*** Isn't that the *VMN*?

***Joseph:*** It's slightly different.

***Emma:*** It seems like more of a system thing. Self-healing principle.

***Letitia/Cathy:*** It's under the *Vis*.

***Joseph:*** You could have a healing process without the *Vis*. I think. I could make a case for it. I think. Are you all okay with "the healing process is ordered and intelligent."

We're going to make the number of these, and make them fewer.

***Cathy:*** Okay, I can I agree with it on that basis.

***Joseph:*** Removing the obstacles to health. That's an underlying concept. There's nothing you can say to that.

***All:*** Silence.

***Cathy:*** This is definitely the role of the physician.

***Joseph:*** So it's not a meta-concept.

MARY ENTERS

***Cathy:*** A meta-concept had to do with person.

That the person is the recipient of care, what we do with that.

***Cathy:*** So, we have the treat the whole person.

***Mary:*** So that would be a metaparadigm.

***Cathy:*** We have the idea that persons are interdependent. The bigger environment has an effect on us and us on it.

***Joseph:*** Let's all go through all these and say what we're thinking.

***Letitia:*** Did we talk about unity of disease?

***Joseph:*** Yes, that makes no sense to me.

***Cathy:*** Yes, the imbalance of proteins.

***All:*** Take it out.

Minimum dose is in.

First do no harm is added.

Treat the whole person.

***Joseph:*** How about symptoms are the labor of the body?

***Emma:*** It's unique to look at symptoms that way.

***Joseph:*** Symptoms are manifestations of the body's attempt to get healthy (said with feedback).

***Cathy:*** Is there any more complexity in modern times because of our level of suppression?

***Joseph:*** I love the concept, but I'm not sure if it's true. You (Tish) are sure, why?

***Letitia:*** That is how the body is telling you what it needs by manifesting symptoms. It's the same in homeopathy, naturopathic and Chinese medicine. I look at the pulse, breath, symptoms. That's how I know what to do.

***Joseph:*** How is a migraine as the body trying to say*?*

***Letitia:*** Toxication of the liver.

It's a symptom leading you on how to treat it.

***Joseph:*** How is that an indication of the body trying to get better? It's a reaction of the detoxification. It's a message, not a healing process.

***Letitia:*** It's not a healing. It's a message. It says the "burden of the body." This is what it is.

***Joseph:*** But, it says a …

***Cathy:*** (Repeat idea.) It's not just that the body is trying to get healthy. There are multiple medications, etc. We may not be reading it right if we're looking at that.

***Letitia:*** Symptoms show the method of cure (read). That might tell me what we're looking at.

***Cathy/Joseph:*** Top of second page of writings.

***Joseph:*** This last sentence. No question that homeopathy has influenced us, but ...

***Group:*** Agreed that this sentence was not right.

What makes naturopathic medicine unique?

***Joseph:*** We look at symptoms as messages.

***Cathy:*** We look at a symptom in a certain way that should be a metaparadigm. But, what exactly?

***Joseph:*** This is just getting interesting.

# Education: Making Naturopathic Education More Naturopathic -World Café

## Visioning an Ideal Naturopathic Graduate and Implications for Skills, Transformation and Applied Philosophy

1. Vision of the future Naturopathic doctor.
2. Knowledge base of the future naturopathic doctor.
3. Attitudes and attributes of the future naturopathic doctor.
4. Skills sets of the future naturopathic doctor
5. Values of the future naturopathic doctor.

### *1. Vision of the Future Naturopathic Doctor – detailed notes*

#### *Breakout Group One*

***Thomas:*** They need well-rounded basic education in clinical sciences as well as biomedical sciences. When they graduate they should be able to enter a residency program of some sort, taught in the most educationally appropriate and clinically effective way.

***Stephen:*** We learned them in systems.

***Thomas:*** They need to have a really strong foundation in the basic sciences.

***Christina:*** What's the grand vision? They should embody the *Vis*; they should embody nature cure.

***Stephen:*** Need a capacity to work in a broad range of clinical placement options (including hospitals).

***Christina:*** Or a broad patient care base? Your ideal graduate should be able to grow out, and teach to groups of people, as well as in their own practice.

***Joseph:*** Caution: a person going through four years of school, not going to be an expert.

***Christina:*** I'm thinking of the ideal.

***Roger:*** Primary care capability. That's the bottom line, I would've thought. Add on human qualities, of compassion…

***Christina:*** Embody the *Vis*. We keep saying we're graduating docs who embody green allopaths. They should be able to use nature not only as a philosophical construct, but also the modalities that involve nature.

***Patricia:*** How about if they are themselves healthy?

***Christina:*** We talked at some point about self-questionnaires. They need to internally measure.

#### *Breakout Group Two*

***Mitchell:*** Connecting the past and the future. We need to be aware of the past, traditions, and also to be projecting forward, and be innovators.

***Richard:*** Being perceived as leaders in naturopathic medicine.

***Iva:*** What's the difference between leader in naturopathic medicine and leader in medicine? Other professions are adopting some of our tenets/therapeutics. It's more about leaders in medicine in general.

***Mitchell:*** They should be able to embody the art plus the science.

***Richard:*** They should be models of optimal health.

***Mitchell:*** Within their potential.

***Iva:*** Walking our talk is important. E.g., what are you using for cleaning supplies? What are you offering in the cafeteria?

***Iva:*** Disease is a not a punishment; it's a process.

***Mitchell:*** Concept of being cosmopolitan: they need to be able to understand multiple perspectives, to be aware of different cultures, different subcultures.

Iva's proposed vision statement: Naturopathic doctors are leaders in medicine that lead by example, and with acceptance and respect of all cultures and people.

***Richard:*** Should put in something about being successful.

### *Breakout Group Three*

***Fraser:*** Leadership positions in healthcare.

***Paul:*** They need to be compassionate patient-centered physicians, primary care providers.

***John:*** They need to do competent team care, to be integrators.

***Pamela:*** Our graduates should be taking care of the planet, the ecosystem, the community, the terrain.

***Pamela:*** Should they be smart? Competent? Likable? Provocateurs? Revolutionary? Change agents? Safe?

***Leanna:*** Especially in scientific research!

***Pamela:*** Care of individuals and the ecosystem.

***Pamela:*** Walks their talk.

***John:*** Healthy.

***Pamela:*** Exemplifies the philosophy in their personal and professional worlds.

***Pamela:*** Here's our draft: Naturopathic doctors are compassionate, patient-centered leaders who act as revolutionary change agents (including in the sciences), are competent and safe primary-care providers and care for individuals, community, and the ecosystem, and exemplify the philosophy in personal and professional life as they provide excellent team care.

### *Breakout Group Four*

***Emma:*** Extreme entrepreneurs. Being a good businessperson? Healthy, having balance.

***Cathy:*** Self-aware, compassionate and clinically skilled.

***William/Emma:*** Naturopathic physicians are compassionate, successful, prosperous change agents practicing from a combination of knowledge, skill and personal experience.

### *Breakout Group Five*

***Louise:*** I like this last one. The third group is a concise version of the second.

***Joseph:*** Naturopathic physicians help patients understand why they're sick, and how to become healthy.

***Louise:*** Something about transforming the whole healthcare system

***Herb:*** Naturopathic physicians lead the way towards humanizing healthcare.

***Joseph:*** Naturopathic physicians improve the health of the individual, family, society, and planet.

***Louise:*** Naturopathic physicians are the primary care providers of the future.

#### *Abbreviated notes of key points*

Naturopathic doctors are compassionate, patient-centered leaders who act as revolutionary change agents (including in the sciences), are competent and safe primary-care providers and care for individuals, community, and the ecosystem, and exemplify the philosophy in personal and professional life as they provide excellent team care.

Naturopathic physicians are compassionate, successful, prosperous change agents practicing from a combination of knowledge, skill and personal experience.

## *2. Knowledge Base of the Future Naturopathic Doctor – detailed notes*

### *Breakout Group One*

Core knowledge base failure is when the exam door closes and when the doctor sits down with the patient. The experience of not knowing is disturbing. Knowledge is great.

We need more knowledge on how to apply the principles and philosophy as they apply clinically; this is a major complaint from students. These need to be repeated in every course! We have to know why they are being taught what they are being taught. In basic sciences, but also (and most importantly) in clinical years.

This is more input on the clinical encounter. It needs to be taught and modeled. There is an art to this, and some are not qualified teachers. How do we get qualified teachers? We need to change pay with the college administrators, because good doctors are not teaching. The best experts are in the conventional universities, but not in naturopathic medicine – they are out in the field. All the colleges make the same as a grad school teacher. Having NDs not as full time faculty but as part-time because they love to teach, and then the money is not as important.

### *Breakout Group Two*

- Process of healing is understood.
- Texts written by NDs.
- Ability to integrate, knowledge base that leads to understanding, with biochemical research, and is fully flushed. Taking the education, understanding biochemical from a naturopathic perspective.
- Being able to assess and treat the patient without necessarily putting a diagnosis on it. Not a cookbook. Understand the process of healing.

### Breakout Group Three

- Traditional naturopathic assessment skills.
- Comprehensive knowledge of the modalities.
- Knowledge of human nature.
- Understanding different aspects of health and disease.
- Exposure to master clinicians.

### Breakout Group Four

- Knowledge of kinds of third party payments.
- How naturopathic medicine fits in public health: and its relevance to naturopathic care.
- Knowledge of the system: know it well enough to know how to work with it.
- History and philosophy of naturopathic medicine.
- Knowledge of other disciplines.
- Maintain the knowledge of the adolescent.
- Systems of subtle anatomy and physiology.
- Knowledge of the efficacy and efficiency of our medicine.
- Understanding of research of naturopathic medicine research methodology, and the limitations of standard research.
- Typical unfoldings of cases. Typical algorithms. Clinical methodology. Encompasses variability.
- Knowledge of knowledge acquisition.
- Genome. Psychoneuroimmunology. Cutting-edge research and science.
- Traditional naturopathic medicine.

### Breakout Group Five

#### Aspects of health and disease

- Biomedical science seen through naturopathic lens.
- Biomedical sciences.
- Biomedical sciences integrated with naturopathic philosophy and process of healing.
- Botanical medicine.
- Business/practice management.
- Comprehensive knowledge of basic therapeutic modalities.
- Determinants of health/obstacles.
- Diagnostic skills – naturopathic – but of mainstream.
- Earlier exposure to patient care.
- Experience.
- Exposure to master clinicians.
- Great knowledge is not enough.
- Homeopathic medicine etc.
- Integrate biomedical knowledge into our model.
- Knowledge about achieving greater knowledge.
- Knowledge about the genome, genetic research, psychoneuroimmunology.
- Knowledge of comparative philosophies and history.
- Knowledge of evidence.
- Knowledge of more public systems

- Knowledge of other complementary/other healthcare disciplines for collaboration
- Knowledge of public health policy and its interaction with naturopathic medicine
- Knowledge of traditional historical naturopathic medicine methods.
- Philosophy of naturopathic medicine – integration of these two.
- Process of healing.
- Process of healing fully understood.
- Texts written by NDs.
- Traditional ND assessment skills.
- Typical pattern of clinical methodology.
- Understanding of research methodology pertinent to naturopathic medicine and of traditional methodologies

## 3. Attitudes and Attributes of the Future Naturopathic Doctor – detailed notes

### Breakout Group One

***Louise:*** Interesting diversity.

***Christine:*** Person has an open mind so that the person can listen, but can be open to what the patient revealed. Openness to colleagues, to their experiences, discussion of the things that are problematic with clients (maintaining confidentiality).

- Extending care – going to other countries, NDWB (Naturopathic Doctors Without Boarders).
- Extending the knowledge and experience farther than themselves.

***Kavita:*** Respect, understanding, open mind.

- What are the benefits? Comes from being open minded. No judgment. Understanding that the client is never wrong in their states.

***Christine:*** What about creativity?

***Louise:*** I think that is important in crafting individual treatment plans. Asking people to eat well, but don't have the money. Need to be creative to find the resources to do what you ask.

The ability to teach:

- That is a skill that needs to be developed. We teach every day in clinical practice, and to the profession, and the community – with teaching courses.
- Needs to be able to do pro-bono work, and serve.

***Christine:*** NCNM takes care of more homeless people than any other organization in Portland.

***Louise:*** The willingness to build bridges among diverse groups and cultures, ethical behaviour, communication, awareness.

***Bruce:*** I'm with students every hour of every day. I have strong feelings about attitudes and attributes:

- Expect the bird in the nest.
- Want to see enthusiasm.
- Need to be crowding in.
- Being bold.
- Self-directed learner.

- Self-starter.
- Active participation in the patient interaction.
- Recording the subjective, objective findings (don't speak unless spoken to).
- Hungry.
- Cannot be passive. Must be active learner.
- Passion.

### Breakout Group Two

***Fraser:*** Look at our systems – they are used to passively taking on the information, and now they have to figure out how to do stuff and suddenly be active. Independent learning must be fostered from day one.

***Patricia:*** Self directed learning important. Active engagement in finding things out.

***Paul:*** Patient-centered, compassionate, confident inquiry.

***Joe:*** Comfortable in not knowing, and still functioning.

***Patricia:*** Humility.

***Herb:*** Good business manager.

***Mitchell:*** Willingness to take on challenges, emanating success.

***Rita:*** Professionalism.

***Mitchell:*** Humility.

***Herb:*** Dr. Bastyr was that way. No ego is important.

***Rita:*** A double-edged sword.

***William:*** Congruency.

***Herb:*** Integrity, honesty.

***William:*** Being of service; you're not doing them a favour, they are doing you a favour. You don't hold the power, you imbue the power.

***Herb:*** You are the junior partner in the relationship.

***Mitchell:*** Detachment.

***Christina:*** Objective.

***Herb:*** To let the patient make the choice that they want to do.

***Mitchell:*** Acceptance, faith.

***William:*** Attributes of a spiritual warrior.

***Mitchell:*** Have to be mother and brother too much.

### Breakout Group Four

***Stephen:*** Tolerance of ambiguity.

***Christa:*** Dedication, humility.

***Don:*** Reflective.

***Christa:*** Smart.

***Stephen:*** Determined. Someone who is willing to dog a problem.

***Christa:*** Persistent.

***Don:*** A certain kindness that does not always present itself.

***Christa:*** Charitable, compassionate.

***Don:*** Wisdom.

***Stephen:*** Capacity to juggle paradigm.

***Christa:*** Systems thinker.

***Joseph:*** Willingness to push boundaries of knowledge.

***Stephen:*** Pioneer knowledge.

***Joseph:*** Leadership.

### Breakout Group Five

***Iva:*** Non-judgmental or neutral.

***Iva:*** Do we have open minded?

***Joseph:*** Public virtue, which means to sacrifice one's own welfare for the good of the community.

***Iva:*** Attitude of strength.

***Roger:*** Vocational drive, commitment, resilience.

***Iva:*** Professionalism.

***Iva:*** Acceptance.

***Leanna:*** Having good boundaries.

***Iva:*** An attitude of primary care.

***Iva:*** Do we have diversity? When you go to geriatrics, pediatrics and palliative care, you need to switch.

***Emma:*** Diversity of practice skills then?

***Emma:*** An embracing of diversity.

### Abbreviated notes

- Ability to teach
- Acceptance, honoring patient choice
- Attachment, objectivity
- Awareness

- Being of service
- Boundaries
- Capacity to juggle paradigm
- Charitable
- Communication
- Compassionate
- Confident interaction/active learner
- Congruency
- Courage
- Dedicated
- Determined
- Discussing the things that are problematic with clients (maintaining confidentiality)
- Diversity of practice and skills
- Emanating success
- Empowering
- Ethical behavior
- Extending care
- Flexible in roles
- Good boundaries
- Good business management
- Honesty
- Honoring diversity
- Humility
- Humility
- Independent, self directed
- Integrity
- Motivated learner
- Neutral
- Non-judgmental
- Open minded
- Openness to colleagues, to their experiences, with patients, community
- Passionate
- Patient-centered
- Persistent
- Pioneer of knowledge
- Primary care
- Professionalism
- Reflective
- Respect
- Self-starters
- Smart
- Spiritual warrior
- Strength
- Systems thinker
- To build bridges between diverse groups
- Tolerance of ambiguity
- Understanding
- Vocational resilience

- Wear multiple hats
- Willing to take on challenges
- Willingness to do pro bono work
- Wisdom

## *4. Skills Sets of the Future Naturopathic Doctor – detailed notes*

### *Breakout Group One*

***John:*** What about having an external review group? People charged with thinking about where naturopathic medicine is going, and if we're directing students to where the medicine is going.

***William:*** You can't assimilate until you know where you're going.

What do we want the naturopathic medicine graduate to have as skills?

***Don:*** Physical, clinical, laboratory diagnosis.

***Letitia:*** Primary care.

***Paul:*** The skill of surgery? I'm being a devil's advocate because it's not in Australia.

***Don:*** The ability to apply naturopathic principles, philosophy, theories in practice.

***Paul:*** Into medicine? Application.

***Paul:*** What about patient advocacy, environmental advocacy. Attaching activities in the world?

***John:*** Comfortable collecting and skills in basic research: qualitative, quantitative.

***Paul:*** Critical reading skills. Including philosophy, etc.

***Letitia:*** Proficient in nature cure therapies.

***Don:*** Communication is a skill.

***Paul:*** Therapeutic interaction.

***Don:*** Communication to the world and therapeutic.

***Paul:*** Including publishing scholarly work. Communicating our method.

***Don:*** Something that I haven't been able to have an answer for: how do we define the base level skills for all of the therapies that we have: nutrition, homeopathy. At the level of a graduate as opposed to a homeopath.

***Letitia:*** Modality proficiency.

***Paul:*** Primary care diagnosis has been mentioned. Do you need surgery?

***William:*** Business skills.

***John:*** Some knowledge of the healthcare purchaser. Beyond the individual consumer.

### Breakout Group Two

***Pamela:*** Taking a good blood pressure.

***Christine:*** Good start.

***Iva:*** Patient relationship. Is that covered?

***Stephen:*** They need to be effective counselors.

***Herb:*** Ability to see through the facade. Incisive insight. Intuitive.

***Herb:*** Bruce called it "clinical savvy." He was a March 15th Pisces who intuitively knew about the patient.

***Stephen****:* Effective problem solvers.

***Herb:*** And the ability to manage cases over time. As things change. Follow the *Vis* over time.

***Pamela:*** Good time management skills.

***Stephen:*** Effective eclectics.

***Rita:*** Integrative skills.

***Herb:*** Yes, the ability to develop protocols, blending modality. Individual.

***Pamela:*** Clinical innovation.

***Emma:*** Skills is differentiated from knowledge. Yes. Critical appraisal skills.

***Stephen:*** Clinical experience. The most significant component of conventional medical education is that you get to see one of everything, if not two. The fact that you can physically see things adds to your knowledge.

***Herb:*** Looking over the shoulder of an internist at a hospital was great.

Collaboration.

### Breakout Group Three

***Joseph:*** Glaring holes. Able to make a pathological diagnosis. Be able to recognize true cause of disease.

***Thomas:*** Ability to recognize the level of disease. If it's a critical case, they should know to get it to the appropriate facility.

***Cathy:*** Ability to illicit a sense of health or wellness.

***Louise:*** Ability to model it. Living well.

***Patricia:*** Read the literature. Critical thinking.

***Joseph:*** Ability to gather data was there.

***Brit:*** Evaluation and self-reflection.

***Cathy:*** I was troubled by the role of the medical expert. It's not that a physician shouldn't be knowledgeable and able, but the hierarchical relationship is not useful when you're wanting to teach someone about self-care.

***Louise:*** (Clarifies question.) This made me think about public health.

***Iva:*** Naturopathic doctors should be able to interface effectively with other health practitioners.

***Patricia:*** According to Bruce, a skill is to be able to have them come back to their second visit.

***Cathy:*** It's giving people a sense that working on their health is a process.

### *Breakout Group Four*

***Mitchell:*** How about intuitive perception?

***Bruce:*** Deep and broad understanding of human physiology. MDs don't have an adept understanding. Being able to take an objective understanding, and integrating it into naturopathic

***Mitchell:*** Flexibility

***Richard:*** That's an attitude.

***Bruce:*** Hands-on physical diagnosis. I've seen MDs who don't properly exam.

***All:*** Yes.

***Bruce:*** And naturopathic physicians as well.

***Richard:*** It's on here, Bruce.

***Mitchell:*** How about perceiving subtle patterns? Pulse diagnosis, abdominal. Not gross things, but variations in function. Subtle sensitivity.

***Christine:*** Awareness of the underlying vibes.

I would like to see intelligent listening, and ability to ask questions to go deeper.

***Leanna:*** That's a keeper.

***All:*** Yes.

***Christine:*** Bilingual skill. The patient population in the US is increasingly ...

***Christine:*** We should all have Spanish as our second language.

***Mitchell:*** Cultural and class sensitivity.

### *Breakout Group Five*

***Christa:*** Intuitive, insightful – those are attributes. Which of these are skills? These are skills to acquire and attain: evaluate research, critical thinking.

***Fraser:*** Recognize level of disease.

***Christa:*** Clinical experience is not a skill.

***Fraser:*** Spelling it's and its properly. Is making a prognosis on the list?

***Pamela:*** Ability to listen effectively. Interdisciplinary skills.

### Abbreviated notes

- Ability to integrate information.
- Ability to manage cases over time.
- Able to make a pathological diagnosis.
- Able to model the talk.
- Able to recognize level of disease in a person.
- Able to recognize true cause of disease.
- Access and evaluate research.
- Application of naturopathic philosophy.
- Bilingual skills.
- Biomedical sciences integration.
- Business management.
- Clinical experience.
- Clinical innovation.
- Clinical savvy.
- Collaboration.
- Critical analytical skills.
- Critical assessment skills.
- Critical thinking.
- Develop protocols blending modalities.
- Educator.
- Effective eclectics.
- Effective lifestyle counselors.
- Effective problem solvers.
- Elicit a sense of health and wellness.
- Evaluate information.
- Hands on exams.
- How these skills distinguish natural medicine globally.
- Intelligent listening.
- Interface effectively with other healthcare professionals.
- Intuitive insight.
- Modality proficiency.
- Naturopathic diagnosis.
- Patient acquisition and retention.
- Primary care physician/lab diagnosis.
- Reflective skills.
- Sensitivity to culture and to class.
- Subtle sensitivity of underlying milieu.
- Time management skills.

## 5. Values of the Future Naturopathic Doctor – detailed notes

### Breakout Group One

- The core values of a naturopathic doctor … sounds like humanistic stuff.

- Honest.
- Keeps their mouth shut, maintains confidentiality.
- Responsibility.
- Compassion.
- Inquisitive.
- Life-long learner.
- Open to new ideas.
- Critical thinking.
- The skeptical … requires an appropriate level of evidence.
- Element of process orientation. It's not just about answers. It's about method. How about rigorous? Yes, that is a nicer way of saying skeptical.
- Altruistic.
- You hear about doctors who will do it for profit, and others who will do it for help
- We want people to be successful, fulfillment.
- There is an element in our profession about sharing information, how about collaborative.
- Humility is kind of arrogant.

### *Breakout Group Two*

- I would add to that a mechanism for self awareness and discovery.
- Open-mindedness.
- A deep sense of morality.
- Humanitarian principles.
- Courage: it is a mark of the naturopathic community.
- Core values: it is how they behave.
- What about collaboration?
- Ability to communicate clearly. Is that a skill or value?
- Good communications is a value, or is it a skill?
- Integrity, respect; what about respect for nature, internal coherence? It means being true to yourself. What you say you are, you are.
- I think that discovery, or invention, creativity, and discovery.

### *Breakout Group Three*

- What about contribution?
- I think the future naturopath would be called to it … doing it because it is there.
- Is this a place for interconnectedness? I think that a core value would be they are passionate about people … like relationship.
- I think they need to be passionate advocates … but more than that they need to embody the principles of naturopathic medicine.
- Value health in themselves and in others, so the term is "walk the talk."
- Authentic, or sincere, without flaw or flack.
- Humility.
- One thing I see as an issue is leadership. Is it a value? Aspiring to leadership is something that is important.
- Ecology, taking a stand on nature.
- Sustainability.
- Commitment to ecosystem to ecology.

### *Breakout Group Four*

- There should be something as ND as teacher.
- To value education.
- Valuing the necessity for new medical knowledge.
- How about empowerment.
- Feedback, collaboration.
- Value the planet.
- There is something to be said about value in team work.
- One of the other things is valuing the work of the elders, ancestors.
- Valuing the unknown.
- Valuing progress, I was also thinking valuing time.
- They should value their profession.
- The value should reflect our metaparadigms, e.g., supremacy of *Vis.*
- Congruency.
- What about value the patient?
- Values individuality.
- Fun.
- Value relationship with our co-workers, e.g., collegiality.
- Honest sweat.
- Therapeutic relationship.
- How about value your educators, donors, contributors?
- Valuing your personal time.
- Valuing your patient's time.

### *Abbreviated notes*

- Altruistic
- Ancient traditions of healing
- Aspire to leadership
- Authenticity
- Collaborative
- Collegiality
- Commitment to ecology
- Commitment to Gaia
- Commitment to sustainability
- Compassionate
- Confidentiality
- Congruency
- Courageous
- Creativity and discovery
- Critical thinking
- Education
- Empowerment
- Feedback
- Fulfilled
- Fun
- Good communication
- Honest

- Honest sweat
- Humanitarian principles
- Humility
- Individuality
- Inquisitive
- Integrity
- Life-long learner
- Mechanism for self-awareness and discovery
- Morality
- Need medical knowledge and diagnostic skills
- Open-mindedness
- Open to new ideas
- Partnership with patient
- Progress scientific
- Respect for elders
- Respect nature
- Respectful
- Responsibility
- Rest and reflection and restoration
- Rigorous
- Sincerity
- Successful
- Team work
- Therapeutic relationship
- This is their calling
- Value primacy of *VMN*
- Value the planet
- Value your educators, donors, contributors
- Valuing your personal and patient's time
- Walk the talk
- Willingness to give a contribution
- Work-life balance

# Critical Information Session

## *Text Structure, Milestones, Timeline and International*

### *Flipchart Page #7*

1. If a contributor uses info regarding source/classroom – need permission?
2. Previous contracts null/void once signing these? "This contract supersedes previous contracts."
3. If not being paid … how come contracts?

### *Flipchart Page #8*

1. Incorporating third part material? How much required for permission?
2. End note?
3. Joe's request:

- use word for references for consistency
- Joe's end notes discussion during break

### *Flipchart Page #9*

1. Timeline – December 2008!!
2. Track One:

- April 30th – contracts out (requests to sign)
- June 30th – manuscripts in to YOU (section leads to section editors) … (next drafts and new writings)
- October 30th – review all writing
  – submissions in
  – senior editors then review and reflect back to you

### *Flipchart #10*

1. Timelines:

- do not wait till last minute
- give them less time than you have

### *Flipchart #11*

#### *Feedback*

1. Timeline is a good one
2. Making those decisions will come up fast – that's a concern
3. Issue of editorial decisions, practicality will become obvious
4. Concern that some timelines have come and gone
5. Editing ideas to an unknown audience gives editors concern
6. Getting material written is not an issue, it's the editing of that material, and how to deal with that, modifying, cutting and pasting is a concern. We should try not to edit the intent. If need be we need to sent it back.

### *Flipchart #12*

#### *Feedback*

1. Material needs to meet criteria of Senior Editors team
2. Helpful to know that material needs to be integrated, edited with other material for consistency in style
3. Push for redrafts is a struggle especially for those who have a practice as well
4. Is the goal to make this textbook a single voice –
5. Editorial decision to "break out" a new chapter

6. Paragraph indicating that the contributor will be subjected to editorial amendment might be helpful

### *Flipchart #13*

1. Lead writer, who are they connecting with -
2. (Refer to chart in PowerPoint)
3. Important that cut and paste, be not final draft – that "the part" should be as complete as possible before it moves up to the next level/editor
4. This network should be buzzing over the next few month
5. Clarify section leads – chapter leads?

## *Reflective dialogue*

### *Regarding the text*

***Louise:*** If we are going to split the volumes, we should do it between philosophy and clinical applications.

In Mary's presentation, she was comparing theories from a number of different authors. How are we going to juxtapose our different theories in an understandable manner? I suggest that the theories be next to each other, and an explanation of why they are there, and a comment by the other theorists, of the opposing theory.

***Stephen:*** There needs to be another voice behind each chapter, to represent other sections of the profession. E.g., the idea to iridology, we need to have someone comment on how there is no scientific proof of iridology, and that understanding constitutional types is not completely figured out with iridology.

***Dr. Keppler:*** We need to enumerate the key to utilization (how the text will be utilized):

- There should be a chapter summary at the end of each chapter, with the basic chapter points.
- There should be a glossary of key terms – doesn't have to exhausted, but needs to be defined.
- Make a plea for sidebar comments. All successful textbooks have sidebar comments. They allow a divergence of opinions or philosophy.
- Under each chapter, we need to have subchapter headings that succinctly enumerate what the chapter is about.
- Need to make sure that technology is a part of the textbook. Kids today are more knowledgeable and capable with technology.

***Roger:*** It makes a textbook more readable to have sidebars and comments:

- We need to reflect what people are doing out there, no matter how flaky it may be, as long as we give a comprehensive overview of the evidence of these flaky techniques. We want to make sure that if these things become widely accepted, and we overlook it, we will end up with egg on our faces.

***Joseph:*** One way to do this – look at a concept in naturopathic medicine. What has been documented as accurate, inaccurate, and what has not enough research?

***Stephen:*** We can accommodate both of these. A lot of the diagnostic tests have not had to face the challenges that conventional medicine techniques have faced. It is important to look at experimental design for our future researchers.

***Bruce:*** There is a lack of a section in my reading for diagnosis. There is modalities, nature cure, and primary care, but don't have any specific area set aside to address issues of diagnosis. It plays a very large role as clinicians. We need to set aside a section, so that we can allude to clinical setting, and those things that are unproven or not provable.

***Joseph:*** A clarifying question. We are talking about this text book – is there a section of diagnosis?

***Bruce:*** On the face of the book, it appears to be missing.

***Iva:*** When you look at the size of the book, you need to have a book before you write a Coles notes version.

- We don't have a complete history of naturopathic principles and practices.
- About the fluff stuff – I do some of it. The continuing education and CCNM. E.g., Iridology was an additional revenue source. The public began to think this is what NDs do.
- The manual must focus on the core. Whatever else is for the individual.

***Thomas:*** We use those techniques, but we use the language of the disease to make the diagnosis. Many NDs look at the patient and disease, and make diagnosis about signs and symptoms of the disease process. This needs to be addressed.

***Joseph:*** Can you be more explicit?

***Stephen:*** Listening to the body as the core Hippocratic diagnostic tool.

***Thomas:*** Cole's diagnosis cue daben? When I am listening to person with and abdomen. What does the pain feel like? Where is the pain traveling? Then I lay the patient down and challenge that area to see if it is a pancreatitis. Then, I will do amylase test to substantiate them.

***Rita:*** Diagnostic books from 1800s:

- The medical community has articles saying the danger of evidence-based medicine to the medical practice.
- Evidence-based will shrink our scope.
- The reason we don't have an evidence base, because we haven't had time. But we have the EXPERIENCE. And it encourages the profession to.
- Why would we do what screws up the other docs?

***Thomas:*** He doesn't ask the patient questions first. He does his physical diagnosis first.

***Paul:*** There has to be a section on diagnosis. This is the first part of the clinical theory. It is important to write a theory of the technologies of diagnosis should be objectively assessed.

***Don:*** A dilemma in what looks like a breakthrough. I see that meta-theories are a way to break through to allow for diversity. The dilemma is a book that is three years away. How are we going to identify this? How are we going to choose the meta-theories without completely re-writing the text?

***Herb:*** Human beings do not lack the ability to find effective answers; they just fail to ask the question in the right way. I wonder if in the diagnostic session, there is a tone of open-ended inquiry. How should NDs inquire of a patient about the disease? What is the nature of the inquiry based on the philosophy? What questions do we ask and why?

***Fraser:*** When I look at this book, I see our first flyer at a scholastic scale. We need to make an academic statement. We shouldn't have a problem with the controversial aspects of the book, just criticize them. This discipline gives a doctorate credential. The volume is not as important as the tone. We may have a contract to fill, but we need:

- A manifesto – about what we believe on healing.
- And a clinic book.
- Then the text.
- But, then lots of criticism.

***Christa:*** We are sustainable. If the power went out, I would much rather have naturopathic doctors. I don't know where ethics is in this book.

***Pamela:*** There's a chapter.

***Cathy:*** Naturopaths later have scientific support. Finding documentation to support that the most world-renowned healers we know of, were not physicians. They were intuitive healers, e.g., Father Knipe.

***Pamela:*** This is a beginning. This Retreat is meant to recur every 5 years. Also, should we re-evaluate the symposium?

***Joseph:*** Thank you for the focus of diagnosis. We need to figure out how much of this book should have diagnosis, or how much should go into a different, more focused book.

### *Regarding contracts*

*Pamela:*

- You all received the re-done contracts.
- A year and half ago, Elsevier sent out contracts in a work for hire model. They own everything. You can't copy it, it is not yours.
- Elsevier – holds the rights to the textbook. But the people's contributions are for teaching and for journals. So, if you ask Elsevier, you can use your work elsewhere.
- Don't want a competitive work that exports all your work to another textbook that is now competing with the current title.
- There maybe omissions to correct.
- FileMaker Pro is a relational database.
- Each of you should get a sheet with a detailed assignment.

***Louise:*** If a contributor uses information they contributed in the classroom, do you need to ask?

***Bruce:*** It says if you are using 10% or more you just need to acknowledge that it is from Elsevier.

***Louise:*** If you signed the other contract, are the other contracts void?

***Pamela:*** Write a note on the bottom that this contract supersedes the contract I tried before.

***Joseph:*** Ideas are not copyrightable, but words are.

***Christa:*** So I can take my work, and re-work it for a journal article.

***Don:*** Incorporating materials from third parties.

***Joseph:*** A short paragraph, no problem; anything longer (tables, charts and diagrams) you have to have permission.

- What we give to Elsevier should not be with endnotes, but we need to edit this, so leave the endnotes in.
- Use word and the reference system in word (which is endnotes).
- Does anyone not know how to use this system? (Several hands go up).
- Okay, we will do that at the break in room three.

### *Four forms*

- Conflict of interest form.
- Are you working for an organization? Who is paying for you?
- Editorial process policy: overarches conflict of interest policy. It describes the editorial process. Purpose is to make it clear that medical reviewers are not the final say. Neither are the agencies.
- Non–disclosure agreement: how are we doing with that?
- We are going to talk about the timeline. We are at midlevel in drafting. By April 30th, all the contracts will be out.

- We will send a reminder to all writers (one email) to tell them when they need their submission in.
- It is harder for people to feel that this is real.
- If we are going to deliver the manuscript to them by December 2008, we have to work on track one.
- June 30th and October 30th section leads go through the editing with your authors.
- What we need from each of the leads and co-leads, November 30, 2007, we need your final manuscript. Everyone has a specific responsibility. If you have questions with that, you can talk to me about that one on one.

***Joseph:*** Timelines:

- Don't wait until the last minute.
- Don't give it to us the last week.

***Pamela:*** Always give them less time than you have.

- Your instructions for the people writing to you: you need to tell your people that you need it a month early, because you will be getting it a couple weeks late.

### *Regarding working towards a common goal and meeting timelines*

***Fraser:*** With this timeline, we will get great discussion on the wiki, but the tough decisions will come up fast. We will multiply ideas, and soon time will rear its head. Then the editors will have to make the decisions in eight weeks, but you need to remind the writers that you appreciate them, but decisions must be made.

***Bruce:*** I don't know how many other people are actively engaged in dealing with people, because that has come and gone for me. I found:

- Need to get rid of the "us and them" language.
- Some people gave unwieldy submissions.
- Others gave too brief high school type submissions.
- Need to be willing to cut the ideas. And, tell the people that there will be such a re-arrangement of their work, that it will unrecognizable as their own

***Joseph:*** Don't change the content or the essence of the idea. I will freely edit, but if it is unreadable or unsalvageable, I send it back to the author, and tell them how to change it.

Unless you have a lot of experience writing and editing, you should ask someone more experienced to make sure that your improvement is actually improvement.

***Roger:*** Sometimes material will be withdrawn because they do not want to comply with the other.

***Letitia:*** Run across struggles with docs that don't submit, even though we want their submissions, so we have had to drop them.

***Cathy:*** So you want the textbook to come out in a single voice?

***Bruce:*** When the seven of us merge our work, it is a completely homogenous mish mash of cut and paste, so that the various ideas will be indistinguishable from one another. This doesn't look like something from one person or another person, but from the whole group.

***Jared:*** When you have re-worked that, you need to submit it to the authors again to make sure that they are still wiling to be authors on this work.

***Roger:*** What would be helpful would be a simple paragraph that is issued to every contributor, just so that they know that their submission will be edited and may not be recognizable at all, and that it will be sent back to you to make sure that the author is okay being an author of the conglomeration.

***Paul:*** In Australia, haven't heard anything. Does the person who is the lead writer in each bit, needs to send out this message to the authors they cover?

***Stephen:*** Have a multifaceted structure – asking everyone to stand up to the plate. Pam is working full time on the text. She is the executive editors → senior editors → section leaders → part leader → lead authors → contributors → resource people (don't contribute/write, but help by tapping into their knowledge and resources). We need to take responsibility for each part. If you are responsible for a chapter, then you complete it to the best of your ability, and then hand it up to the part leader. And then the part the leader needs to do their best is to get the part together as fully as she can. Pam is playing the top of the tree and bottom of the tree, due to ineffective communication. So you need to make this network buzzing. There needs to be communication on a regular basis throughout the network.

***Stephen:*** Turn to page 14 of Retreat Book Vol. II, if you have it in front of you.

***Pamela:*** It shows you who you are lead on.

***Bruce:*** If you are a section lead, but sections one to five are actually a chapter. So, lead authors are working on chapters, but section leads are working on chapters?

***Valerie:*** Now can we take a moment to reflect on how are you going to make this work for yourself? Vivian will hand out the sheet, and how are you going to make it happen yourself. Says what your mission is.

***Christine:*** I have been drafted to do a section on *Vis*…

***Pamela:*** That is a chapter. Your section responsibility was science.

***Thomas:*** I am going to now sign a form that I will do the thing that I have committed to do. I have a problem with that.

***Louise:*** I would prefer to email that list.

***Pamela:*** It is not a form to sign. It is a facilitated reflection. It is meant to be helpful.

***Letitia:*** Pam, we need your submission for the nature cure section.

***Pamela:*** Should I do that now, as I am in the process of final editing?

### *Editorial process policy*

***Bruce:*** (Discussing experience of requesting papers.)

***Joseph:*** Our job is to make it a good book. When a chapter comes to me, I edit as long as I don't change the content or intent. Only once has it happened that someone didn't like my adjustments.

***Pamela:*** Sheila Quinn said the same thing. We wrote this contract.

***Joseph:*** I want to say, I've done this for 20 years, and I'm good at this. If you haven't done this, get others to help.

***Roger:*** I've been herding in six to eight authors in the UK, with it provided it would have to be integrated with other material. My experience has been like Bruce's material of poor quality that I've had to send back. Even people contributing to scientific journals have to do this.

***Letitia:*** I may be saying what Cathy is thinking. Cathy and I have been trying to herd many. We've run across struggles with docs who don't send information to us. We're practitioners too. We're seeing people 12 hours a day, four days a week. So we have to be patient, and pushy. We've had to drop people who couldn't submit. Then, things that we want to add come back as crap.

***Cathy:*** Do senior editors intend to make the textbook in a single voice?

***Pamela:*** Yes.

***Roger:*** A paragraph to every contributor that they will be subjected to editorial amendment might be helpful.

***Pamela:*** Along with a deadline email, and a notice that they will be able to view anything that has their name on them.

***Paul:*** When does the person who is the lead writer need to contact Elsevier?

***Pamela:*** The editorial process is pictured here.

***Stephen:*** It's a multi-faceted structure. (Explanation of flow.) For process to work best, everyone will take responsibility for their portion of the text. Section leader will make their section readable. Lead author will put their chapters together. Your responsibility is to get the chapter as complete as possible toward publication, then pass it up. Senior editors need to be in contact with contributors. We need more communication happening in the tree. Pam is currently being asked to be the top and the root of the tree. There is not effective communication. The opportunity is that we've got three months before final draft is submitted. Make the network buzz.

***Pamela:*** Paul, your question can be directed toward Stephen. Section leads are on the front of your chapter outline, or in the front of the book.

***Bruce:*** It doesn't jive with the flow chart.

***Pamela:*** End of contact list, on day one. Page 14 of Retreat Book, Volume II. This is how you know where you're a lead. If you have questions, ask me. That's a backbone list. This is a process. If you're a section lead, you're reporting to the senior.

***Bruce:*** The sections and chapter leads are mixed up.

***Pamela:*** I'm going to send you a document to clarify all of this.

### *Regarding NPLEX*

***Paul:*** in the registration act for osteopaths in Australia, we did a trial where massage therapists, osteopaths and others sat for the osteopathic exam, and they all passed it. Competency-based assessment has relationship. There has to be a way to test the orientation of philosophy.

# Primary Care

## Breakout group discussions

### *Breakout Group One*

***Pamela:*** The idea that some naturopaths have that we shouldn't consider ourselves primary care physicians. That scares and frustrates me. We need to know if there is a fear about this.

***Rita:*** I agree; why people think that we shouldn't be primary care. Many people don't want to play the political game.

***Letitia:*** I don't think that primary care means we have to apply to the public model.

***Rita:*** I don't either, but that is one of the fears/objections I have heard expressed.

***Christina:*** We can't use this terminology because it is hurting us in unlicensed States.

***Letitia:*** In the medical world primary care is insurance-based.

***Pamela:*** I don't agree with that; primary care is the highest level when dealing with patients.

***Christina:*** But that is.

***Jim:*** In licensed states we have been primary care physicians. The muscle of the Flexner report was graduates that can sit the boards, and get licensure.

***Bruce:*** The actual issue is not what the interest groups think of us. It is about defining us, so that a lay person who wants to know who we are and what we do. I can speak from dealing with regulatory bodies and insurance over decades. Our interests are best served by focusing on who we are, and what we want to articulate to others. Either we define ourselves or someone else will. Either we see what is ours and take it, or someone else will.

***Christina:*** I agree, but there is still the inconsistency in our message. We cannot be defined as primary care because we are getting in trouble in unlicensed States.

***Bruce:*** KCOW, ANP, and Australia – will have to make that decision.

***Bruce:*** If we do it your way, we all get fewer choices. If we do it my way, then you can opt out. We expand our choices for the profession. If you want to mess with the bull, you have to deal with the horns. If there is a good argument for this, I want to hear it.

***Christina:*** It is fear-based.

***Jared:*** Another argument (from Patrick Donovan): we are just not as qualified. We shouldn't be primary care, because we don't have the training. And I don't like that.

***Roger:*** I think that you're right. That is part of the fear. That someone might find that out.

***Jared:*** When I was licensed, I could sign birth certificates and death certificates. What else is it? If I need more training, I can get that. I don't want to lose that. I don't want to be relegated to the …

***Roger:*** I don't know how to make AANP happy. We already ARE primary care. That is how we are licensed. We need to make a definition.

***Christina:*** That is pressure.

***Bruce:*** The thing about fear – it has come up several times over the last three days that Jim and Tom have said we don't want to define ourselves to make the other guys happy.

That is a deep and heartfelt thing that people feel they must somehow accommodate to get the licensure through. There is just as much fear in the other side of the medical arena. You must be strong. You can't blink. We got invited down to make a presentation. Tom Drost – an MD surgeon who went through the whole Naturopathic program. They are able to listen to him because he has an M behind his name. We are doing it slowly and hatching out the overlap. Like it or not, we all went to medical school. Like it or not, we are all licensed. There is a whole bunch of stuff.

***Christina:*** An MD said, "We want to do what you do." There is a jealousy aspect. We want to spend an hour with our patients, but my licensure says that I can't.

***Louise:*** Is there a definition of naturopathic primary care?

***Jim:*** The default definition on my license says I am a primary care provider. That is the definition. I may make primary decisions; that I am responsible. No one else takes responsibility for my decisions. The burden of my choices is on me.

***Bruce:*** 1978 WHO definition of primary healthcare provide: if it doesn't define naturopathic medicine, it defines primary care. Primary care is essential healthcare made accessible to the community, which the community can afford. Contain first encounter, deals with individual family and community. The underlined assumption is that you have a safe licensable, regulated set of standards that protect the community, and assures the individual that you can make medical decisions.

***Jim:*** That is the key element – the responsibility of making medical decisions.

***Bruce:*** That can be something that people want to do, but it is.

***Roger:*** Part of primary care is to refer when necessary.

***Bruce:*** The patient with the presenting complaint presents, he treats, consults with an appropriate provider, co-manages with an appropriate provider or refers to appropriate providers. Each of those has a specific protocol. That is something that primary care providers do.

***Roger:*** As opposed to urologists – who are not primary care providers? They are referred to.

***Bruce:*** Ask what you do if blood in urine and abdominal pain, they will say why don't you order a spiral CT, and call me back when results are back.

***Roger:*** We need to parquet the patient – you inform the patient, you tell them what the alternatives are, what problems there are with the treatment, and maybe we don't know what they alternatives are. The referral is what the alternatives are about.

***Jim:*** Primary care is not under any other regulatory body. I have never seen urologists not as primary care providers.

***Bruce:*** Any urologist will say that they are not a primary care provider. They are constrained by their board for diagnosing. They are not in the primary care. A primary care provider – every seven years, they go through a re-certification on the primary care interface.

***Jim:*** The primary care is both the first level of care, but they are responsible to only themselves. Specialty care does not do the first level of care. (They are referred to).

Ancillary care may be first level of care, but are responsible to primary care physician. I had never looked at it this way before.

***Bruce:*** The primacy of the responsibility (keeping the reigns) is kept by the primary care. In co-management, the reigns are still kept, they make some decisions, but the primacy of responsibility stays with the primacy of responsibility. But you don't keep that when you refer. In Bastyr, there seems to be a treat/refer switch. There needs to be co-managing. You need to keep the granularity. 98% of the time the primary care provider can treat it.

***Christina:*** Some of this is seen, that referral happens constantly.

***Christina:*** In Southwest – the school turned a patient away because it was too complicated.

***Roger:*** This is important, it needs to be addressed.

***Louise:*** It is true you need to get extra help or refer if you cannot deal with someone, but mostly that has to do with not getting along with patients.

***Roger:*** You can get a diagnosis from a urologist, and people call me allopathic. But, you get the patient back, so why not get the tests done that can be covered by the insurance.

***Jim:*** What are the distinguishing features of the naturopathic model?

***Bruce:*** I think that it is absolutely unique that we enter a situation, and are trained to use lesser force. We feel good about it. We are entering in at a different level of force, and we have the ability, and training to be able to go in at a higher force, and we won't feel guilty for being a green allopath or too "woo-woo." We have granulation of choice.

***Louise:*** My levels of evaluation are different, and much more subtle. We can pick up changes in the metabolism, before it shows up in the blood.

***Bruce:*** We may be evaluating people in the pre-clinical or pre-pathological state.

***Louise:*** They don't fix what's not broke. We catch it before it is broke. A patient came in with me, and my MD says, "I'm fine, but I still feel awful, and I have migraines, but there is nothing wrong with me."

***Bruce:*** We need to say that we have a range of interventions. I don't have the distinction between physiological and pathological. I make the distinction between physiological and pharmacological. I make pathological diagnose. I don't want to be excluded from that. If we can influence their physiology in a positive way over pharmacologically doing so, we will always choose the physiology.

***Roger:*** Also, it is important to bring in subtle interventions: energetic, homeopathic, spiritual.

***Jared:*** We understand in great detail standard medical concepts of diagnosis and intervention. We may not use it, but we know how to do it.

***Bruce:*** Shared understanding and usage when appropriate. I don't do them frequently, but when physical diagnosis won't get what we want, we can use nuclear scans, etc. I think we are all thankful that is there, because we wouldn't be able to get to patients. That domain does not belong to MDs or NDs.

***Jim:*** That is the common territory of physicians regardless of their stripes.

***Louise:*** Science is public domain.

***Roger:*** Be careful that we don't assume that MDs and others don't use the things that we do. We can't say they don't have the art part.

***Bruce:*** I totally agree. At least in MD, they are admirably aspiring to de-bunk their approach. We will never be MD doctors even if we want to be, and they will never be NDs unless you go through the training.

***Bruce:*** Accessibility.

***Jim:*** We are less assessable.

***Roger:*** Because of financial issues and maybe numbers, well insurance.

***Bruce:*** MD primary care physicians are also under the same crunch. It sucks both ways.

***Jim:*** That may be a reverse accessibility issue. People go to me, expecting to pay, not knowing if they will be reimbursed. They go to MDs without thinking about it.

***Bruce:*** If part of our driver is to maintain access (in many instances in primary care), the reimbursement issues are pretty much homogenous. If I code and document properly, I can get paid for the same level of service the same amount

***Roger:*** But Washington has a better system.

***Jim:*** There is a political issue – we should be equal politically. You say that we are depending on how we approach it. There are other aspects. Naturopathic doctors were sued by Blue Cross, by the way that their insurance forms were worded. Blue Cross did not want to do pay them, and they got around having to.

***Bruce:*** But they were upcoding. They were claiming 99215 all the time, which you have been doing complete physical diagnosis. No one can claim that level of service over more than one visit! They admitted it afterwards.

***Jim:*** They were trying to get the service component in

***Bruce:*** That should have been delineated in a different way on the form.

***Louise:*** The other reason – the difference of the patient that comes to you – someone who is paying out of their pocket, wants to be there, and they want the change.

***Bruce:*** That is arguable. There is a tremendous amount of self-selection among the medical population. I don't think it is absolute.

***Roger:*** This is too complicated to have a simple answer to.

***Bruce:*** Every primary care provider is bound to keep your patient safe. If something is not getting better, then we don't tell them to get back and back for longer and longer.

***Bruce:*** Guess what is the major driver for cost in health profession is? Pharmaceuticals.

***Bruce:*** It costs $1,000 a day for drugs.

***Bruce:*** We have a chance because we do least force, we provide a lower level, lower cost disease management, health promotion, disease prevention.

***Christina:*** Are people coming back because they are getting sicker, or because they are getting better? Also there was diabetes prevention program – they started it, it was so successful, than they stopped it because they didn't want people flocking to them.

***Bruce:*** There are things that we do collectively that no one else does. We all use certain things in common, even green allopaths. Some people cannot get certain things anywhere.

***Jim:*** I listen to them, do physical exams – I am practicing medicine reminiscent of the 30's and 40's.

***Bruce:*** People relate to us ironically as a physician, and as MDs in a corporate way.

### *Primary Care Breakout Group Four*

***Patricia:*** What is primary care? Let's be clear.

***Joseph:*** Good Question. Break to: direct access to patient, and providing comprehensive, primary provider of care. In Australia are first contact, but they don't become primary provider.

***Roger:*** Same in the UK. That's an issue of scope too.

***Joseph:*** Huge training applications.

***Patricia:*** Is it still primary care if it's not providing the bulk of the primary practice at first.

***Joseph:*** Let's define it as a primary patient responsibility.

***Roger:*** Having the skill to take patient without prior contact. For the patient to come without referring. Confine it to that before we talk about scope of service.

***Joseph:*** So, first contact more so than primary patient care responsibility.

***Louise:*** Primary contact: go to person primary responsibility, and coordinates care within the scope of the jurisdiction.

***Roger:*** That's taking it wider than is the case. A lot of the disciplines are focused. DOs or DCs are primary care, because they're …

***Joseph:*** Subparagraph: in other countries primary care physical may not have all these. Number one: first contact.

***Louise:*** We need to keep it broad. It's really different in an unlicensed state. No legal scope of practice. Majority of people would say I'm the primary care provider. Bruce said in WA there are legal mandates. When we have broad prescriptive authority, laws may mandate using a drug as a standard of care. There are questions.

***Joseph:*** We need Bruce. I can't imagine a standard of care being imposed. Primary care does not mean that we follow an MD's standard of care. But, we must report contagion.

***Louise:*** Vaccinations.

***Joseph:*** Authority, but not requirement.

Bruce enters.

***Louise:*** (Clarifies using drugs as a standard of care.) You had argued for having a scope of prescriptive authority in order to keep a standard of care. Is this inaccurate?

***Bruce:*** Yes.

***Joseph:*** Are you required to vaccinate?

***Bruce:*** No.

Bruce leaves.

***Joseph:*** Some states, countries, you may choose not to do all those things.

***Patricia:*** The primary care definition is that this a definition that is going to define our scope, education, attempts for licensure.

***Louise/Joseph:*** All of the above.

***Patricia:*** So there are lots of implications.

***Joseph:*** (Question one.) I start with the philosophical part. We're oriented toward cure, and supporting the body's healing processes.

***Patricia:*** Point to the defining philosophies.

***Joseph:*** The *Vis* stuff. So, the evaluation is: being able to recognize and diagnose physiology, pathophysiology, and the blockages to cure, which I define as evaluation. Notice I'm using broad language here.

***Louise:*** Education and empower to continue to move towards health.

***Joseph:*** That's a management statement. Maybe to recognize and understand the cause.

***Louise:*** The obstacles to cure.

***William:*** It feels like you've described evaluation thoroughly.

***Louise:*** Maybe, recognizing the cumulative underlying imbalances. Obstacles doesn't cover that.

***Joseph:*** Example?

***Louise:*** Torticulus. Obstacle is spasm of muscles, so we need to release. But underlying imbalance: inflammatory diet, work with a phone like this, dehydrated, spouse yelled at them. Underlying imbalances lead to that.

***Joesph:*** So.

***Louise:*** I think of it as imbalance. When I look at the totality of the determinants, this accumulative effect that manifests pathology.

***William:*** Then focus on curing the person, rather than the pathology.

***Louise:*** But, that's not complete. That errs toward disease focus. It's not inclusive of the underlying disturbances. So, maybe that's it: recognize.

***Roger:*** The patterns of causation.

***Louise:*** I'd like to list that first rather than pathology, pathophysiology. It's easy to get pulled off to identifying the disease.

- Clarify list again
- Recognize:
- Path of causation
- Pathophysiology
- Pathology
- Blockages to cure

***Dr. Keppler:*** This is something that should be in the glossary. To an outsider, we'd want to see that.

***Joseph:*** Note: our definition of primary care should be in the glossary. How would a public health person define primary care?

***Dr. Keppler:*** We bridge the gap between traditional and naturopathic medicine. We wouldn't fully get the NM PC.

***Patricia:*** Let's talk management.

***Louise:*** So, our philosophy is oriented towards cure, and supporting the body's innate healing process.

***William:*** Should we add curing the 'whole person.' That's different than curing the pathology.

***Louise:*** It's implicit in our philosophy.

***Joseph:*** I like cure. Maybe that's another glossary term: cure.

***Dr. Keppler:*** Can you explain to me the difference between healing and cure. If you say, "I've completely cured or completely healed him," those are different.

***Joseph:*** They're the same.

***Louise:*** To heal someone else is an external force. Cure can happen without an external force. There can be innate healing. It's like the physiology question. Is it the physicians role to heal or ...

***Roger:*** Healing is a process. They could both be verbs, but there is a subtle difference.

***Joseph:*** You may heal a person, and not cure their disease.

***Jay:*** It seems that if you're curing, you're overcoming the negative. If you're healing, you're healing you're enhancing the positive.

All really liked it.

***Joseph:*** Management.

***Louise:*** Well, coordinates care is in our definition, but worth putting under management.

***Joseph:*** Anything that supports our philosophy. Any intervention.

***Patricia:*** Is management?

***Louise:*** I like that. How about any intervention consistent with our philosophy?

***Joseph:*** Better.

***Roger:*** Right.

***Patricia:*** What about patient safety issues? No matter what you're doing for treatment, you need to measure these things. More checks and balances.

***Joseph:*** Will you say that in one line?

***Patricia:*** Consistent with our philosophy, and within the realm of standards of patient safety. I don't know. This should be consistent with our philosophy. But, we need to ground into our primary care provider philosophy.

***Joseph:*** So, consistent and safe and effective. But that is our philosophy.

***Patricia:*** I want to say that it's grounded in consistency of safety. There's a tendency to throw things into the larger definition, but it needs to be said. Baseline, minimum care standards. The basic management issues.

***Joseph:*** We need big statements.

***Louise:*** Standard of care is Pandora's box.

***Joseph:*** We need to do standard of care consistent with our philosophy. It may be useful to state safety explicitly.

***Patricia:*** It's good to have those in there for the policy makers. This is not a document just for us.

***Joseph:*** Carroll said "cure them or kill them." In Washington state, most of Carrolls. His kills are what wiped out our legal status. So, maybe we should say that maybe there are things that we don't use.

***Joseph:*** Intervention that is consistent with our philosophy, and safe for the patient. I'm really worried about this (he comes around to Pat's side).

***Louise:*** What does that imply if it's a statement? It seems implicit.

***Patricia:*** If we're going to let everything be implicit, we could just sum it all up.

***Joseph:*** We add safe and effective to all of our work (in the last two years) E.g., fasting is not safe.

***Patricia:*** And neither are most drugs. The word safe is heading there, but there should be something else?

***Louise:*** Curative?

***Patricia:*** No. I don't know the answer.

***Louise:*** Does no harm. Even if they're fasting, that's risky, but we're careful.

***Joseph:*** Our therapies do no harm, but patient response may be.

***Roger:*** This concept of inherent harmfulness. Herbs do not have it. Allopathic drugs are by definition harmful. The argument is that.

***All:*** We like it.

***Patricia:*** But, we're just talking about therapies. Is a therapy, management. What about how often you see them?

***Joseph:*** Management is a detail on standard of care.

***Louise:*** Management applies a timeline.

***Joseph:*** But, it is just what they wrote, we have given.

***Patricia:*** Patient education and communication should be part of management. I don't know how to get the temporal quality of doing no harm in there.

***Louise:*** What about educating and empowering people toward optimization of health?

***Joseph:*** Do we want to have another statement?

***Louise:*** We've got intervention, but docere- teaching. One thing I tell people: I want to set you free so you don't need me. That's part of how I manage them.

***Joseph:*** Management is intervention.

***Louise:*** I am engaged in intervention. Educating and empowering – I want to get out of the process.

***Patricia:*** Any intervention and the process of that intervention is blah, blah.

***Louise:*** Educate and empower the patient to optimize their health.

***Joseph:*** I want to say to take control of their health.

***Louise:*** Lovely, what was it the first day – to treat to empower the patient to take control?

***Patricia:*** But it's broader than intervention. That's the way Bill said it. It's intervention over time, and it involves a temporal type responsibility. I don't know how to solve that, but I feel it is important.

***Louise:*** I might have come up with a statement: regularly assess and monitor parameters of health. So, an annual physical. Etc.

***Joseph:*** Where does this fit?

***Louise:*** Under management.

***Patricia:*** It's inherent, but you have to say it.

***All:*** Good point.

***William:*** Do we want to agree to one of these today, or might there be a meta-theory?

***Joseph:*** We want to know exactly what they said.

Safety question: We haven't yet addressed cost effectiveness and accessibility.

***Louise:*** Those have so much to do with licensing, insurance models, public health. This is a huge discussion.

***Patricia:*** The concept of the whole person says that we take their financial situation on as well.

***Roger:*** From experience, I say, cost (not safe/effective; accessibility has geographical implications) is a restraining factor. In a way, it's a good thing, throws me onto my traditional diagnostic skills.

***Louise:*** Given the complexity of this question, let's move on to this next one.

Reduction of chronic disease, therefore, end stage care costs. Optimization of general health.

***Joseph:*** Change from disease treatment to health restoration primarily transforms the model of healthcare.

***Patricia:*** Naturopathic medicine will illuminate the present healthcare situation in a way to highlight what is not working and show what could work.

Primary care definition:

- Primary contact,
- Responsibility,
- Co-ordinates care.

Philosophy – elements of care.

Supporting innate healing process.

Ability to recognize (evaluation).

Pathophysiology and pathology.

Patterns of causation.

Obstacles to cure.

Management: any intervention is consistent with our philosophy and is not inherently harmful

Educate and empower patient to take control of their health.

Regularly assess and monitor parameters of health.

Transformation

Changing from disease to treatment model to health restoration model fundamentally transforms all aspects of healthcare.

***Bruce:*** I want to know something that is inherently harmful that is used by the other side.

***Louise:*** We didn't get to go into this in-depth, but after we put it up there in terms of the therapeutic order, in step seven, application of a corticosteroid is inherently harmful.

***Pamela:*** I've struggled with that too. Joe said that if a substance poisons an enzyme system versus facilitates an enzyme system. The green drugs might facilitate. Joe moves in.

***Joseph:*** The main effect of most drugs is to poison the enzyme system. Most herbs are used to poison enzyme systems, just not as much. Some change genetic manifestations – turn on and off genes. But, if you look at commonly prescribed drugs – they poison enzyme systems.

***Rita:*** There is a point in therapy that you're doing a risk-benefit analysis. Risks get higher further down the order. I like what you said about fear. There is a fear in providers in dealing with complex cases. Tell our students that we can treat everything.

***Thomas:*** I don't know why we agonize over this issue. As physicians, clinical judgment is based on available evidence. If evidence requires short term steroid use, we deal with consequences later. We don't need to agonize over that.

***Cathy:*** Dick Thom said (after last year's gathering) that he tells his patients that it will take 3-5 years to recover. That's something as a specialist in the psych aspect – that's really important. As primary care providers, you'll have a long term relationship.

***Roger:*** One thing to clarify: in terms of primary care providers' capabilities: we would not prescribe steroids or antibiotics.

# Clinical Specialties

## *Breakout group discussions*

### *Clinical Specialties Presentation Notes*

Intro: The naturopathic approach to systems:

- Overarching
- Deep
- Philosophy: bridge to process of healing , therapeutic order and case management, systems approach, problem-solving
- Metaparadigm
- Mind/body/ spirit
- Slide list
- Systems:
- Environmental medicine
- Emunctories
- Metabolic (Marz)
- Nutrition
- Oncology
- Endocrinology
- Immunology
- Clinical genomics
- Constitutional medicine
- All specialties that cross more than one of the systems
- Subsystems:
- Cardiovascular (system)
- Dermatological?
- Endocrine (system)
- Gastrointestinal (hepatic)
- Hematopoetic
- Respiratory
- Neurological
- Musculoskeletal
- Renal and urinary
- Reproductive?
- Special senses
- Reductionistic systems
- Populations:
- Peds
- Women
- Men
- Geriatrics
- Midwifery, obstetrics, and natural child birth
- Case study based with commentary as a fallback.

### *Breakout Group Two*

- Case studies from physicians. Not going to be disease-based, rather how a naturopath would approach the person. What is unique?
- Template: tries to summarize how they approach these 12 things page192.
- Key issues specific to naturopathic management.
- Meta-structure for the author to offer a checklist.
- May narrow these down a little.
- Not such a long list so that the chapter is not so big. Issues that make it special.
- Things that are specific to us like quality of life – like in geriatrics.
- Some are just like orthodox, and don't need to put this in.
- Still go changing small lifestyle things.
- Got draft of geriatric, men's and women's, and pediatrics.
- Specialty in midwifery and oncology.
- Immersion specialties.
- HANP homeopathic specialty.
- Population groups as separate.
- Organ systems, systems, big word systems, pediatrics, women's, and men's.
- Who has actually written in these themes? Just being supportive. Should they really be named here?
- They are right now; maybe we should be more strict about it. See if they want to add something in writing.
- Page196 (186) Crinnion uses a special detoxification protocol.
- Don't want a modality along with the specialty.
- Special population groups.
- Do we rename the sections; try to get rid of names?
- Names don't mix together.
- Populations groups and –ology (systems) groups, cross-systems (specialties) systems of practice.
- Miscellaneous or special interest group (NOOO).
- Clinical systems: body systems, population groups, biological systems, systems of practice.
- Integrated systems approaches (Marz.)
- They are not just single systems.
- All the systems are going to connect.
- Grouping of things that just don't fit. Are they clinical systems, practice systems, biological systems?
- They might argue biological – they are mind/body systems.
- Are we representing a specialty within the profession? To show the naturopathic approach within this system not a specialty.
- This should inspire textbook on these topics, though, and should be thought of this way. Full chapter clinical applications.
- Metatital for this section – still need this.
- All the ologies are integrated, and they all cross systems.
- Clinical systems felt like a good overarching name.
- Were trying to say specialties without calling them specialties.
- How about a clinical systems approach to populations?
- Systems and populations. Ones based on functional systems.
- Communities and populations.
- Populations shouldn't be first; it should be third.
- Small at smallest system, and moving toward the largest system.
- Ologies to populations.

- Communities found in medicine all the time. We treat them in their own unique communities, and belief system.
- Slightly different approach than psychology or mental health.
- This is a modality though?
- Naming them may be important though.
- What about spirituality?
- Or integrated systems stuff on mind/body?
- Clinical systems: big rubric, application of naturopathic theory or philosophy.
- Theory to or in clinical systems.
- Introduction: uniqueness of the naturopathic approach.
- Going to be a large overarching chapter now.
- Then we have the scroll of subchapters struggling with three section names.
- Need to emphasize that these are not specialties.
- Windows to the organism.
- Centers of gravity.
- Allopathic medicine specializes in these but they are only our windows.
- Systems, subsystems and populations.
- Ologies, environmental systems and geriatrics examples.
- These are not body systems; these are whole approaches.
- Systems: emunctories.
- This sounds good theoretically.
- Russels renamed.
- Application of naturopathic theory to clinical systems.

### *Breakout Group Three*

***Thomas:*** Our naturopathic medical schools need to be as a resource for a mentorship for case consultation for younger physicians.

***Iva:*** Naturopaths have a tendency to tell people everything they need to know, at the door. When we talk about the specialties, we need to just think about that as an entry point to the patient's condition.

***Thomas:*** We have a specialty group in oncology now. They're quite well organized; basically all they do. Large field, nobody has a corner on it. Utilizing their services, in my area, they have a knowledge base that's greater than mine, because they're up on the latest stuff. That's beneficial to me, so I send my patients for consult.

Modalities specialties:

- Midwifery.
- Homeopathy.
- AAACO? (What's this group?)
- Injection therapy (prolotherapy).

But therapeutic specialties is a different thing.

***Don:*** We are primary care physicians, and there are a few specialties.

***Stephen:*** Difference between specialization in oncology and specialization in cardiology. Oncology is a disease that affects the whole body. Politically, I think it would be good to be moving towards specialties, more so sub-specialties. A naturopath who doesn't remain an eclectic generalist will miss a whole lot of things. Then, perhaps sub-specialties in a particular area. One that's obvious to me: psychoneuroimmunology. This makes more sense as a

naturopathic subspecialty than cardiology. Maybe the vascular system would be valid, if not taken separate from the rest of the circulatory system.

***Don:*** We've used much of the conventional model in the education system. Why don't we just say this is our model?

***Thomas:*** Well you understand the historical reason, the Flexner report, Spitzer… from a political standpoint it's served us relatively well.

***Don:*** We're in a different place. Medicine itself is in a different place. They're changing; it's not a time to model them.

***Stephen:*** I'd like to propose a new naturopathic specialty: Emunctorology: bowels, liver, kidney, lungs, skin.

***Iva:*** Add to that language, and the menstrual cycle.

***Cathy:*** Why not throw out the idea of superimposing specialties on us. It's separate from people's marketing of their own practices.

***Thomas:*** We're to look at these from the standpoint of what makes us unique. E.g., skin being a reflection of the inner state of the body. Dermatologists don't do that. There's a value to our perspective, and make sure our students get that. There's a naturopathic approach to diseases of the skin.

***Iva:*** I like having other terminology, but there's a tier system. We're generalists first. There's a middle layer: psychoneuroimmunology, emunctories, inflammation, structure etc., before we get into the sub-specialties. Because when we talk about what naturopaths do really well, it's this middle layer of things. From a marketing, or even communication layer, we can't throw it out. But we say, this is the third layer, not the first.

***Thomas:*** I like Cathy's idea of addressing these specialties as a case study, but show how naturopaths view a complaint from a particular body system. So not a gastroenterology chapter, but a series of cases.

***Herb:*** Things that you would normally go to a GI doc for, but how we look at it

***Cathy:*** Showing how a GI case really morphs into something. To give people a glimpse of how we look at the patient. Then I would get rid of the specialty language. Maybe say the GI system, but still illustrate how following the symptom brings you back to the whole person.

***Don:*** People who end up "specializing," don't start. E.g., Marty didn't start out as a cardiologist. They start out as a naturopath, and end up following an interest. Then, they become very good at this area of interest. But, they also do everything else.

***Iva:*** What do you think of this concept of layers?

***Thomas:*** Has merit. Not sure if you realize this, but in the last few minutes what we've really been discussing is the unity of disease.

***Kate:*** This sounds like good structure to distinguish the naturopathic way of looking at. A place in the chapter for distinguishing it. This is how MDs look at it, and this is how NDs look at it.

***Thomas:*** I think we've decided to do away with the "specialties" tag.

***Herb:*** Start with the concept of unity of disease. From that, go on.

***Iva:*** If we look at that layer, are there other words that should be there?

Stephen proposes a parallelism of the terms:

- Psychoneuroimmunology

- Inflammology
- Structurology
- Emunctorology
- Functionology

***Cathy:*** The different processes, these are useful ideas. A nifty way to fit cases into the structure.

***Thomas:*** Useful ideas. Labeling where we're hung up.

***Iva:*** I like the idea of identifying it as the unity of disease. Maybe even as the title.

***Herb:*** It's discussed as a principle.

***Don:*** Do the folks who look at it as functional medicine look at it as the unity of disease?

***Thomas:*** I don't believe so. Looking at the functional medicine, it's a way to train MDs to be naturopaths in a way they can understand it. It's not at our level.

***Herb:*** It's the physiology of organ systems.

***Thomas:*** Not that we've dismissed it, but it's not the whole idea.

***Don:*** If we look at metatheories, there are those who are naturopaths that will look at it from unity of disease, and some who will look at it as functional medicine. It's a way of bridging gaps. People have the idea that the people writing this textbook are coming at it from one area. How do you deal with that in this chapter? We haven't even decided what the metatheories are.

***Thomas:*** I don't know that it's a gap. I think we put out everything, and people will take from it basically what they bring into it. I expect this book will be controversial even within the naturopathic community. It'll be good fostering dialogue. I was impressed with Leanna Standish. She's a dyed in the wool scientist, when she stood up and said, "I understand there are other realities." It was like, "welcome home." If she can do it, anybody can do it.

***Cathy:*** Endocrine function is something we haven't named in this middle tier.

***Thomas:*** Ties in with body energy, chakras.

***Iva:*** Other thing missing is movement. E.g., cardiovascular.

***Stephen****:* Maybe psychoendoimmunology.

***Cathy:*** Do you have the information you need?

***Thomas:*** Yes, and I think we're going to need some close senior editor involvement. Roger Newman-Turner, because he's primarily a clinician.

***Thomas:*** Conventional medicine compartmentalizes the body, and this is an attempt to de-compartmentalize.

***Iva:*** Most people who come see us come through the back door (thinking they have a specialty problem). And we have to show them where the front door is.

***Thomas:*** Allopathic endocrinologists see the thyroid as a thyroid. The whole endocrine system is balanced in a delicate way, and it's a matter of discerning where the lesion occurs.

***Stephen:*** I would agree with that as psychoendocrinology.

***Iva:*** So let's review the list:

- Emunctories

- Inflammation
- Structural alignment/movement
- Cellular functionality [metabolic? Hormonal? Thinking about the genomics that Joe brings in.]
- Psychoneuroimmunology
- Endocrine function (endo-immunology?)

*Practical Endocrinology* was published in the 1920s.

***Cathy:*** I propose instead of "generalists –" Whole Person Approaches.

***Thomas:*** Yes, as a concept of primary care.

***Stephen:*** The benefit of the term "generalist" is that it's used in conventional medicine also and it means something, at least to me.

***Don:*** So we're a primary care generalist.

***Stephen:*** Or a Primary Care Whole-Person generalist.

***Iva:*** Does the concept of spirituality fit in this layer?

***Cathy:*** I think it's in PNI.

***Thomas:*** Under each there are sub-sets.

***Thomas:*** The clinical systems are the clinical systems, even though we're looking at unity of disease. It might manifest as a skin disorder. A person comes in with a skin disorder, and in the process of evaluating it, we will look at is as a reflection of the internal body.

***Cathy:*** This is really the clinical inquiry process. This assumes that we're looking at a whole person. This is a thinking process.

***Herb:*** It's the conception of the whole person that informs the inquiry. The philosophy informs the inquiry.

***Thomas:*** This is a good start.

***Don:*** We're missing the social aspects. Psychosocial/ecological. Looking at the aspect outside of the person himself.

***Thomas:*** Person comes in with a skin rash, then we go through all these things.

***Iva:*** Back to what you're saying about the schools housing the "specialists". The schools have the knowledge base.

***Thomas:*** They would have somebody doing research on inflammation, and the modulation of it.

***Thomas:*** In the introduction we need to talk in some way about the way we assess the strength of the vital force and how that informs our treatment.

# Naturopathic Case Analysis and Management

### *Reflective dialogue*

### *Student's notes #1*

***Fraser:*** Not easily reduced. Rationalistic (allopathic) treatments based on names of disease. Linear thought this is not what we do. Naturopathic case analysis. Treating the cause more understanding of patient than just their diagnosis…. Hahnemann: gives some general directions. Only reproducible as we go from patient to patient.

***Stephen:*** Difference between what most of experienced practitioners would do versus what students would do. This is a model to get them started to give them orientation, and then with further study and experience it should evolve. Not trying to outline THE naturopathic case analysis, all ours have slight variations. Students wouldn't do PE before taking a history. This is for the advanced practitioner. Focus on case management where your ideas are moving from one idea to the next. Develop an educational model for beginning students. Responsibility of diagnosis is on us not to rely on another doctor's diagnosis. Very important that minds are open to all the diagnoses in the broader sense before narrowing down the list to a single allopathic diagnosis.

***Letitia:*** Flow charts next topic.

***Joe:*** Assessment for logic is very important. Most people only use the true positive for diagnosis and ignore negative findings or other methods. MVP 95% have magnesium deficiency, muscle cramping is not predictive of magnesium deficiency.

***Louise:*** Case analysis dovetails with unity of disease earlier group discussion. The end point, diagnosis of disease is secondary or tertiary. We are looking for the underlying disturbances, not the disease. We treat the underlying disease.

***Fraser:*** Do want to stay away from disease paradigm. Pay attention to mental emotional perspective.

***Stephen:*** Important to learn skill of western diagnosis , then ask them to provide their naturopathic diagnosis.

***Louise:*** Point taken – very dicey edge where we are repeatedly caught up, because we come from a paradigm that is focused here hard to get out of this paradigm. Took a long time to get out of this paradigm, especially in the ology courses later in school. Makes her leery of having this a part of education because so easy to drop into this framework again. This needs to be an adjunct aspect of diagnosis.

***Cathy:*** Students in a rush and get it right, and please supervisors. This gets in the way of working with patient. Need to support their connection with the patient.

### *Student's notes #2*

***Joseph:*** I am adding – I thought that the idea that base assessment from questioning. Most people use the true positive, but ignore the false positive. You think a patient has magnesium deficiency. If they have muscle cramps, then they should have magnesium deficiency. Mitral valve prolapse: 14% in magnesium. It is only found in 4% of population. If information is prevalent in population, it is not very predictive.

***Louise:*** It is lovely how we interact. We must emphasize the endpoint. Having a diagnosis, I am looking for the disturbances that are the body's innate healing process that are causing the symptoms. Maybe we can integrate that. It seems like a natural dovetailing of what is going on. The methods of analysis are beautiful, but the endpoints are different.

***Fraser:*** I want to stay away from pigeon-holing. For example, a patient went downhill after an episode of terrible grief.

***Stephen:*** We think it is a responsibility as educators, that our students need to get the skills to reach the medical diagnosis. Then we ask for the naturopathic diagnosis, and list the features of the case that come out of the medical diagnosis.

***Louise:*** Point well taken. This is the very dicey edge. We come from a culture where healthcare is a disease-based process.

- In TCM, the first year was educating me out of a disease based model.
- After I came out of that, the next years were dropping back into a disease model. I understand the importance of being able to look at disease. But I am leery of putting that in our philosophy, because it is so easy to fall in to. So I would put that as secondary or tertiary. I would put it as an adjunct aspect of diagnosis.

***Cathy:*** When students are in a rush to get it right and please their supervisors, that kind of anxiety gets in the way of being with the patient. We need to foster being with patient.

***Stephen:*** I agree with Bill Mitchell, that the purpose of the first visit is to ensure a second visit.

## *Breakout Group Three*

***Presenter: Louise Edwards***

### *Group Three flipchart notes and presentations*

Both framework and cases to demonstrate

- Cognitive domains of Assessment
- Health – "State of Health"
    - Resources available
    - Patient's perspective

} Both determined by assessing

Determinants of Health

- Causal Factors – disturbances in the
- Determinants of Health
  Clinical Systems – based on new natural clinical theory, a.k.a. "*Emunctorology*"
- Second Order Assessment
- Center of Gravity
- Obstacles to Cure
- Leverage Points
- "Vulnerable Points"
- Stressors: threshold (cumulative effect)
- "Blissors"
- Total Load C

### *Group Three oral presentation*

Cognitive domains of assessment.

Assessing their state of health is really important. Not just the imbalances or disturbances. Not just the disease and symptoms. What is healthy about it?

It is a way of empowering people instead of focusing on suffering. It's focusing on what is working as well.

It is about focusing on the patient's perspective. Some people can be doing okay in spite of their problems, and that is part of their resources.

Assessing the underlying imbalances in things determines our health.

The state of health and causal factors by the disease are determined by assessing the determinants of health.

*Emunctorology* – the new way of looking at things, not the classic systems, but the broader.

We came up with a second system. Ways to weigh the different domains.

The center of gravity – which clearly can change from visit to visit.

What is the obstacle to cure?

And identify points of leverage. What they are willing to change?

Vulnerable points – susceptibility. If we are all equally stressed, we would all have different susceptible/vulnerable points.

We assess vulnerable points.

We talked about stressors and blissors from Dr. Myers.

If we are not practicing disease-based medicine, we are practicing a health-based medicine.

We decided to include blissors – referencing the state of health.

The threshold that is reached – how often have we had someone in their 30s with arthritis, and tell told them to stop eating the food, but they say they have been eating it all along, but we know that it is a cumulative effect of repeating those stressors and blissors (what could be keeping them a float all this time).

If you look at the full list of the determinants of health, there could be a single imbalance causing severe pathology, but more often it is a combination of determinants together in a total load bring to a threshold where symptoms manifesting.

## Group feedback

***Don:*** I feel very privileged by what we have accomplished, and that is not just one of us, but all of us, have created this. And we should look back that way.

***Louise:*** I remember when we were younger, less sophisticated and more willful. How this level of collaboration was more difficult, but we now have depth, wisdom and maturity that allows this to occur, and I honor this growth in all of us.

### *Breakout Group Four*

***Presenter: Mitchell Stargrove***

### *Group Four oral presentation*

***Mitchell:*** Our approach is very different. We were more descriptive than algorithmic.

We were erring on the side of caution. Is this urgent or acute? Where are our bifurcations? Is there a pathology? Or pathophysiology? We want to confirm:

- ascertaining level of health, function, dysfunction;
- any elements of focal distress, and recognizing that it will move around;
- we placed a lot of emphasis on how the patient presents;
- we are noticing level of distress;
- looking at issues of toxicity, and burdens;
- We are looking for clusters.

We are always keeping in mind, are there things that are reversible or irreversible?

- Patient's story, not just in facts, but in presentation.
- How their diagnosis is.
- Their motivation, their lifestyle.
- Their change capacity.
- What kind of therapeutic relationship we have. How are we going to have successful relationship?
- What are specific and non-specific therapies? – healthy living, and bringing in healthy therapies.
- First need to get MOVEMENT. We're thinking about people being stuck, and the system being closed.
- What about the patient with some level of dysfunction, and will this work in those situations?

## Group feedback

***Louise:*** I forgot one point in mine. We felt it was important to give the framework and the cases to demonstrate.

***Iva:*** I see a number of words and languages that fit very nicely into the framework that we have. I see the two ideas of these last groups as fitting very nicely.

***Jared:*** What came up for me that everyone that sees this will see that.

***Mitchell:*** We had trouble making the analysis, management and assessment. It was hard to make that delineation because we are always going back and forth, back and forth.

***Letitia:*** I think that is a great comment. The first part is mainly assessment, and I think it fits into assessment really well.

***Jim:*** I think the reason this is resonating, is that we are all saying that, "Yeah, that is the way that we do it." But, we have not been able articulate it. We are all thinking the same way in the meta-concept, but are different on the details. We can now.

## *Breakout groups discussions*

### *Breakout Group Three*

***Stephen:*** Fraser, this is your breakout group.

***Fraser:*** The two big questions, do we want to stick with cases, and let them speak for themselves, or do we want them to do more in an analytical model. There are a couple of things. Normal structure and function, system's function, pathologic domain, study of the individual manifestation of disease, theory of disease and healing, dealing with the person, not just an abstraction. You can't take this out of context. You do it and learn by doing it. It is part of you.

***Louise:*** Do we have a designated note taker?

***Stephen:*** You are.

***Fraser:*** With this chapter, there will be cases that come after this discussion. Should we keep in this much theory or cases?

***Rita:*** From someone to learn, they need the infrastructure. They cannot just learn from a case. We need theory and infrastructure for analyzing a case.

***Fraser:*** Call it framework for the case.

***Rita:*** I keep going back – this is a textbook. The people reading it are going to be beginners.

***Stephen:*** Its primary purpose is a teaching tool.

***Rita:*** When you do a case, you put one case in there.

***Fraser:*** You can teach that way from the case. Analysis is a cognitive function, so we have to talk about thinking when you are doing analysis. Are there other ways to capture this that are not in there yet?

***Louise:*** I look for the disturbances in the determinants of health – I think of causality. It could fit under normal structure and function. But, it doesn't feel right, but I think that in terms of unity disease, we need to look at correcting the imbalances of the determinants of health. It is step one in the therapeutic order.

***Christine:*** Can you explain unity of disease?

***Louise:*** Look at rheumatoid arthritis and migraines with different symptoms. If you assume that the symptoms are a way of restoring balance due to an imbalance. So you ask why do those symptoms show up? Could be that they are eating an inflammatory diet; they are dehydrated, that they have a genetic component, don't get exercise (stagnation of blood and lymph). Given individual manifestations, there are two different diseases, but they have the same cause. That is the unity of disease.

***Christine:*** Does that mean all diseases are the same disease?

***Louise:*** Well the etiology is the same.

***Fraser:*** Five different presenting complaints that can be traced back to a few disturbances. I understand that there is some Sherlock Holmes thing.

***Louise:*** The thing about this being inherent to us. Not to a beginner. There is nothing in this list that would make me think of causal factors.

***Stephen:*** All of these factors are pathological. Maybe part of this is to assess health. Not disease.

***Louise:*** Can we say causal factors and disturbances in the determinants of health?

***Stephen:*** They are good for the list, but they should be sub-points under the theory of disease and healing.

***Louise:*** It is appropriate to make it sub there, but I don't want to make it sub, because this is primary.

***Christa:*** Can you give some one word determinants?

Love.

***Louise:*** Love, air, food, water.

***Christa:*** I get it.

***Louise:*** I would argue for putting this up top. Causal factors in the determinants of health.

***Stephen:*** And state of health has to be in there as well.

***Fraser:*** That ties into so many things, knowing where somebody stands.

***Louise:*** Do we want to elaborate?

***Stephen:*** I think we have to, the state of health assessment. The whole thing could be called health assessment. This is the domain called state of health.

***Christa:*** Yeah, resources.

***Louise:*** Yes.

***Christa:*** So causal factors are the opposite of the resources of health.

***Fraser:*** There is a sense of economy there that is quite nice.

***Stephen:*** State of health is a patient perspective. Two people with the same injury, and one can see themselves as relatively healthy, and the other as relatively debilitated.

***Louise:*** Both of these are assessed by evaluating the determinants of health.

***Stephen:*** The state of health is the patient's perspective. It is how they feel about how the way that they are.

***Louise:*** Ah, but isn't there more than that?

***Stephen:*** Yes, the determinants of health are part of it, but the patient's perspective is also important. An individual may not care about the problem stopping from exercising, whereas another one can be grieving about the problem stopping them from exercising.

***Louise:*** Obstacles to cure and leverage points; I don't know how they fit in?

***Stephen:*** I hear a second order approach. You take the history, within this you look for the obstacles to cure and leverage points.

***Fraser:*** It's the information that you are using to draw out the points.

***Louise:*** Do we need to add on any other domains before we go to second order?

***Roger:*** Do we need to look at systems function?

***Christa:*** I think that they were just adding on.

***Fraser:*** What I was trying to capture – we see a patient with PMS. There are exogenous estrogens coming from drugs. Hepatic detox is not clearing the estrogens. We look at systems and see connections. It's not hypothyroid and normal or hyperthyroid and normal; it's a continuum

***Stephen:*** To me, it is all about the second order assessments. It is often the weakest link organ system that has been a problem in their long term history. Center of gravity: where the gravity is in the current context. Weakest link (vulnerable points – contributed by Louise) is where they are more likely to break down, but may not be the center of gravity.

***Christa:*** It is certainly not something that you can grasp or see easily. It comes with practice.

***Christine:*** Vulnerable points match with leverage points.

***Louise:*** Sometimes but not always. The vulnerable point can be joints, but the leverage point is to change coffee intake, but not the diet yet. If you use the leverage point, you can change the vulnerable point.

***Louise:*** Are there any cognitive domains or secondary assessment points?

***Roger:*** That's why I wanted to talk about systems function.

***Stephen:*** It's not secondary, its second order. The first and second order assessments are happening simultaneously.

***Fraser:*** We might have mashed together second order functions.

***Louise:*** I would argue for including system functions, but looking at it differently. Not the traditional systems, but unconventional systems. I think in terms of cumulative effects and total loads – 30 year old gets. The cumulative effect of eating wheat over time, has now gotten to the point that you have arthritis. It is a cumulative effect of a prolonged behaviour can create pathology. If you rub your finger back and forth through the skin, it may be pleasant, but it becomes …

***Stephen:*** Cumulative effect of stressor. A guy came up with the opposite of a stressor, as a blissor.

***Louise:*** Cumulative effect of stressors reaching threshold.

***Stephen:*** I would not be assessing cumulative effects. I would be assessing those things that have reached the threshold.

***Louise:*** Total load is when you are evaluating determinants of health. Someone can be very ill from being dehydrated, but they could be ill from bad diet, dehydrated, stress, etc.

***Louise:*** Can we call these imbalances in determinants?

***Stephen:*** Stressors can be anything. The thing is the psychological effect of the stressor on a person. If I teach it, I try to identify stressors, thresholds (from the cumulative effect). I would want to assess blissors.

***Louise:*** And aren't you shocked by those people that don't know?

***Stephen:*** Well, I am more shocked that they rarely do them. They know, but they don't do it.

***Fraser:*** One question to take back to the larger group: when we look at management (which is when we get into controversy), does your assessment dictate your case management?

### *Breakout Group Four*

- Model of naturopathic case management.
- Cognitive domains, physical pathological understanding the patient as an individual, empirical knowledge.

- Assessment: multiple places in the spectrum between wellness and disease.
- Take a patient with type II diabetes .
- Is this the person's diagnosis? Or, are we going to have to make a diagnosis? Confirm diagnosis. Is that the first question that we would ask?
- What is it? Assess the level of health that they are, and look at determinants of health.
- What pathology is going on?
- Need to have diagnosis before applying treatment.
- Were assuming we have to ask the patient.
- Ascertain the level of pathology.
- Look at a little differently; make assessment based on history and center of gravity. Good idea based on blood sugar levels based on this.
- Assessment language? What is first step on assessment? Set up one all aspects. What are they? Genetic propensity or environmental (Keppler).
- Assess the role of pathology. Assess the level of physiological function.
- Full family history.
- Example of center of gravity: family history on intake.
- ROS note: labored breathing.
- Observation: peculiar ways of breathing perfectly okay without any s/s, but urinating 10-15 times a day, top at that point collect urine.
- Do you have time for intervention? Are they okay to get through interview?
- Chest pain gets then treated much sooner. Center of gravity: listening to patient, and how they answer questions; their voice sounds.
- Center of gravity as pain: symptom of greatest distress shifted to mental emotions.
- Dysfunction is where we start aiming our focus.
- Level of vitality prognosis is more important.
- Assess life force.
- Animation, engagement.
- Judgment based on level of toxicity.
- What are the most important and life threatening at this time?
- Assessment is dependent on stage of disease. Approach we are talking about is not the majority of patients we see. Trying to rule out disease, not looking for it. If satisfied that we've exhausted all possibilities, need to know how serious the chronic state often is not urgent.
- First assessment is acute or chronic.
- Where is the center of gravity: pathology and pathophysiology?
- Presentation of the disease first, and DM next.
- A patient is coming in with cc: excess urination is this acute or urgent or chronic realm of pathology or pathophysiology.
- Therapeutic order differentiates this.
- Does this person need more invasive treatment after through all other steps?
- Diagnostics are not allopathic; shouldn't dismiss it, just put it in its proper place.
- Is this all? Tertiary effects?
- Next step: look at whole patient: assessment of pathology.
- Usually see patients who are already diagnosed.
- What is behind the pathology?
- Determine the underlying causes and associated factors.
- Understand the state of that person.
- What are we specifically looking for?
- Center of gravity: where is the problem lying?

- Apply remedy.
- And improve vitality of patient.
- Important part of assessment: patients always know what is wrong with them and we just have to interpret it.
- May focus on therapy that will get quick change.
- Assessment of health status and stress level.
- Management:
- Irregular heart beat.
- Check b. glucose, Doing ECG, get right away. Symptom specific assessment.
- To establish a base line.
- Intervention:
- Looking at a patient as a whole.
- Give remedy first off or diet first.
- Then use supportive therapy for organs.
- Sequencing element is individualized.
- Not deal with patient's toxicity on first couple of visits.
- Center of gravity has changed at a later date.
- Blood sugar has dropped.
- Reduce hiatal hernia to treatment arrhythmia.
- Now look for toxicity.
- Constitutional hydrotherapy with every patient.
- Trying to achieve a healing reaction/crisis. Almost never have crisis because use homeopathy.
- Mixing hydro with metabolic approach because it makes it more effective.
- Want a model that will work with many different approaches. Be more general.
- Get them moving.
- Stabilize, support, and then push them again.
- When in doubt, detox the liver.
- Two things coming up: nonspecific interventions versus specific intervention for specific diagnosis.
- Can treat the pattern or the person.
- Are you aimed at treating something, maintaining or improving?
- Something irreversible?
- Dr. Dick and Dr. Bastyr didn't get together much, and need to do this. This is great.
- Don't use labs the first time. But, if not getting action, then use labs.

# Clinical Algorithms and Guidelines

## *Reflective dialogue*

### *Student's notes #1*

***Iva:*** Thank you very much. I want to go back to algorithms. The assessment aspect is missing. When we are looking at asthma, we change to treatment right away. Middle layer of naturopathic considerations: these are the considerations of our treatment, to structure that for our format.

***Herb:*** The assessment aspect is in it, but not algorithmed out.

***Iva:*** I think that the language is very important.

***Letitia:*** I see a real problem with these. The markers that are used are allopathic diagnoses. I can't ignore that, because we diagnose before that. We are diagnosing diabetes – what about those people with pancreatic insufficiency? You need to talk about toxemia. Does it need to go to hospital care? Then, we need to follow the therapeutic order. This doesn't follow that at all. This is a very allopathic model. Is the AANP going to take these guidelines?

***Ryan:*** This model is management only.

***Letitia:*** Case management is not this. We intervene at a much earlier stage

***Ryan:*** That is true in the ideal world. I don't think this algorithm is all-inclusive; it doesn't direct treatment or laboratory assessment in any way, but it proposes …

***Letitia:*** As long as that is the only marker because it will get that way.

***Ryan:*** That is the discretion of the provider.

***Letitia:*** The insurance industries are already regulating us. That a group death will cover only five diagnoses.

***Herb:*** When we are intervening, we need an objective measure to know we are having an impact. By what objective measure is what I am doing working. Atherosclerosis – lower LDL, it is doing everything along the way step by step, so that no matter where LDL is, it does not affect …

***Pamela:*** Want to clarify that the reason that we are here is that nobody has had the answer as to how to structure our thinking of how to structure our thinking. They have brought their drafts forward. This is not set in stone.

***AANP:*** There are many ways to get involved to direct the outcome to be closer to your vision. So, please become more involved instead of less involved in the process.

### *Breakout Group One*

***Presenter: Letitia Watrous***

#### *Flipcharts and presentations*

Flipchart Page 1

1. Therapeutic order is a continuum of therapeutic intervention from least force to greater force.
2. Need to describe elements of therapeutic encounter not disease.
3. For the text: "Generic Therapeutic Encounter Algorithm"
4. Examples of algorithms be cases, i.e., Asthmas – 4 cases with flexible algorithms.

Flipchart Page #2:

1. Delete the word “allopathic” from our lexicon. Replace with “conventional” or “standard” medicine. (Note: standards and conventions change.)

How to apply the “Therapeutic Order” to the patient – algorithm.

1. “An” algorithm – not “the” algorithm.
2. Associated not because a diagnosis, but with a specific finding: e.g., HgAIC.
3. The problem of naming: breathing problem versus asthma. E.g., “presentation of suffering.”

### *Oral presentation*

Need to describe elements of a therapeutic encounter, and not a disease. It needs to be a general encounter, not a diagnosis.

Examples of algorithms should be cases.

If you want algorithms, will be based on cases, not diseases.

They don’t come into your clinic with asthma. They come in with symptoms.

You can have cases that fit under medical diagnosis, but in those algorithms that they cover the therapeutic modalities.

You have to assess – are they in immediate danger of death? What are the risks?

If we are looking at emunctories, maybe the lung meridian is blocked. Then, we can treat with nature cure; then, we can intervene with ephedra.

In teaching students the way we do what we do, then you …

If risk is high, then you would go from least force to gross force.

If we are talking about a person with a biomedical model of asthma, that way it incorporates the therapeutic order.

***Jim:*** One thing. Something that Iva pointed out is that nothing is the same as it was on Monday. There is an emergent paradigm. There is so much talent in the room. It may change how we do this. And, we may want to invite more people to deliberate.

### *Breakout Group Two*

***Presenter: Jared Zeff***

### *Group Two flipchart presentation*

Consider “Unity of Disease” at the top of the algorithm. (See flipchart diagram in this report on pages 57 and 122.

### *Group Two oral presentation*

We came up with almost an identical scheme. Ours is a little better though.

We began with a caveat from Bruce. He wants us to replace allopathic with conventional/standard medicine.

How do you apply the algorithm to demonstrate us?

We cannot begin with a pathologic diagnosis.

Begin with a specific finding. Like an elevated Hb. With a symptom picture of suffering.

That is the entry point into the algorithm.

We have our presenting complaint.

Then we have our initial assessment.

That may lead us to an immediate/acute concern.

If we don't ship them off to the ER, then we start with assessment.

Evaluation of determinants of health.

That includes a pathological assessment.

What are we considering, and where we are going to go?

First the disease and its etiology.

From here, the physician prioritizes; identification and removal of disturbing factors.

We are starting to get away from linear conception of therapeutic order.

We are calling this a therapeutic blend, repairing systems, treating pathology.

So the therapeutic order dissipates out of a linear into a holographic process.

It is the same basic idea as group one.

## *Group feedback*

***Don:*** This is really the way we practice. We just haven't been able to articulate it.

***Bruce:*** How are people going to feel who are not here? Will open the book and say, "Look at that; that is just the way I think."

***Fraser:*** We can talk about management and assessment, but you can't talk about one without the other. When you talk about treatment protocol and management, assessment is right in there.

***Don:*** If this text is published in 2009, what is happening to the material in the mean time?

***Joseph:*** I have a journal that would be delighted to publish this information, and currently talking to AANP to make this a member benefit.

***Iva:*** I would like to get the NDs in Canada presenting to get their feedback.

***Pamela:*** Elsevier is concerned to balance this. If something is going to be published in the book, you can't just put it in a journal.

***Joseph:*** It can't be the same written work, but it can be the same ideas.

***Louise:*** How many teachers do we have in the room? That is how the information gets out. We can discuss it among our colleagues, and in the classroom. I intend to apply it right away.

***Mitchell:*** We can create position papers that are not going to be in the book, that summarize these points, that don't belong to Elsevier, but belong to the Foundation, for use.

***Pamela:*** I am really aware that we are under a non-disclosure agreement, so we can incubate it. Let the senior editors take this into counsel so that we can get at the right approach, so we can get guidelines, and it comes out in a coherent manner.

***Stephen:*** I think that these core ideas get written down, and get refined. If people are willing to put their hands up and spend time refining this, as Paul said.

***Pamela:*** Elsevier wants to support our advancement, but they don't want every chapter in our book to go into journal articles.

## *Breakout group discussions*

### *Breakout Group Two*

***Bruce:*** We need to delete from our lexicon: allopathic. It is divisive, not contributory.

This is in my notes. I do it, too. You'll find it in my chapter, but I think we need it out. We're talking about distinguishing ourselves. Let's come up with common framing.

We shouldn't use standard or conventional. Standard and conventions are changing. If you mean, "People who use these tools in this way," the meanings won't change.

***Herb:*** The purpose here is to …without using conventional pathological diagnosis as labels.

***Paul:*** We need clinical examples. One idea: when we come up with an algorithm, it should be titled correctly. Not THE algorithm, but an algorithm, e.g., for when hemoglobin. A guidance.

***Jared:*** If that's what would have been said, Tish wouldn't have been upset.

***Bruce:*** A decision tree.

***Herb:*** We have the therapeutic order, flow chart and the safety issues. That's why Ryan was speaking. That's why they're coming up with guidelines.

***Paul:*** There's a point you reach that you stand back and don't make decision. I call it the holistic impression. If you're doing a clinical situation, it's there in the therapeutic order. You might get a point in the decision tree that says, stand back and apply the philosophy again.

***Herb:*** What I showed was what was in the textbook. Now, the assessment piece has to be there. Now, it is used with a chief complaint. A person might have joint pain, but their problem might be leaky gut. So we need the assessment piece and the application piece.

***Bruce:*** It's the naming. I have a problem when things are called "asthma."

***Herb:*** Agreed.

***Bruce:*** Could we have consensus how we name things. E.g., asthma is a breathing problem; "breathing dysfunction," "asthmatic breathing." One is a functional description; the other is a diagnosis.

***Paul:*** The problem is: what does the patient arrive with?

***Herb:*** At some point in the book we need to start with the patient walking in the door.

***Jared:*** What is the outcome here? Constructing an algorithm system for a young doctor that incorporates theory. How do we construct algorithms that include MM thinking?

***Herb:*** Douglas columns does a flow chart. Chief complaint walks in the door. From there, you start the whole thought process.

***Paul:*** Start with breathing dysfunction.

***Jared:*** So do we call this a symptom presented?

***Herb:*** Presentation or image of suffering.

***Paul:*** What if they present with "check-up?" That's a whole different world.

***Herb:*** This is in terms of teaching a student.

***Kavita:*** Students will get their hands on this.

***Jared:*** Tish fears that this will be imposed upon her by an authority.

***Kavita:*** Is breathing difficulty what we're talking about. We have naturopathic medicine. Not to blow this up, but this should be more complex.

***Herb:*** The entire text of naturopathic medicine is written with these terms. Present a complaint, how do you look at a case?

***Bruce:*** What's left out of this algorithm? Patient presents with "pain in head." Next thing that happens evaluation process. History, questions, exam, objectification maybe. You may drag in a Spiro meter (if it's a breathing problem).

***Paul:*** It's a box next to "attend to acute concerns."

***Bruce:*** If that's there, this plays pretty well.

***Herb:*** This is therapeutic order flow chart.

***Jared:*** In the current version of the therapeutic order: A. address acute concern. B. disturbing factors. (Side note: he forgot.)

***Paul:*** The cause of disease needs to be there before.

***Bruce:*** You can't have a therapeutic order until you have assessment. NOTHING is step one. Solicit, gather.

***Herb:*** What do you call it?

***Jared/Bruce:*** Naturopathic assessment.

***Bruce:*** Based on that assessment, establish the conditions for health/healing. (History--> PE --> obj.)

***Kavita:*** We collect information from a patient as soon as they walk in the door.

***Herb:*** What language do we use?

***Paul:*** We call it holistic impression.

***Paul:*** Do we then ask us to decide the cause of disease? Go back to unity of disease. We should make it explicit.

***Kavita:*** Unity of disease: emunctories, toxemia.

***Herb:*** Do we need statements saying how we are perceiving underlying cause of disease?

***Bruce:*** Assessment process leads to a naturopathic medicine diagnosis.

***Herb:*** Explicit as it can be.

***Joe:*** Why not unity of disease?

***Bruce:*** I have a problem with the term, 'toxemia.' It's a thought-stopping term. It doesn't mean anything.

***Kavita:*** Does it not go back to the emunctories?

***Bruce:*** Drunk, stoned, constipated, on and on and on. What is thought-provoking of a life form, there are things that can be in excess/deficiency in that life form that can be problematic. Things that are externally invading that are problematic. There aren't a whole lot more in the paradigm of toxemia that fall under the same hologram. If you talk about toxemia, you have to talk about deficiency.

***Paul:*** It might be good to leave specific word out.

***Kavita:*** There's more than that.

***Bruce:*** Exactly.

***Herb:*** So what word says holistic and naturopathic?

***Bruce:*** Not sure. I say excess or deficiency.

***Jared:*** Disturbances to health.

***Paul:*** Obstacles.

***Jared:*** It's one of the disturbances.

***Bruce:*** The whole rubric might be under disturbances.

***Jared:*** Why aren't you healthy? Disturbances (many examples given).

***Herb:*** Thank you so much. This is very helpful.

***Bruce:*** I think we're over the tough part.

***Herb:*** This is where the philosophy is in the clinical experience.

Cheers to Jared for putting these things together.

***Bruce:*** Now for identify and remove factors disturbing.

***Herb:*** The box to the right: add establish healthy lifestyle.

***Bruce:*** My dad memorized everything.

***Herb:*** Now, this is not something that comes after the last page. It happens concurrently.

***Bruce:*** Right – you could make three arrows instead of two.

***Paul:*** Can we verbalize where the center of gravity is.

***Herb:*** Good point. The patient may say it's joint pain; we would say leaky gut.

***Bruce:*** We need a reminder for "physician prioritization."

***Jared:*** How to graph that? So, "prioritize based on physician diagnosis, patient consciousness/ judgment/presentation."

***Jared:*** Address acute concerns could mean ER or adjust neck.

***Bruce:*** If something acute is going on: everything stops. You're examining a patient, and they pass out. Or, an acute migraine. You don't go through all this stuff.

***Jared:*** If there is an acute emergent event, that's what this said. Or, if a patient comes in with three or four complaints; I do my assessment and find five or six other things. That they didn't know. That's not an acute emergency, but it has to be dealt with or followed up on.

***Kavita:*** So we've decided priority based on assessment.

***Bruce:*** In establish healthful conditions box, is where that goes.

***All:*** No.

***Jared:*** Patient comes in with leg; patient's feet hurt so bad, he can't work. Goes to ER, and is given vicodin. It keeps coming back. I discover he has DMII that puts him down here.

***Paul:*** Maybe we need backwards and forwards arrows.

***Sue:*** So there are constant reassessments.

***Bruce:*** Box should say assessment/reassessment.

***Herb:*** What about the second piece?

***Jared:*** In terms of a chronic problem we think in terms of prioritization. If someone comes to you with arthritis, one way of thinking is NSAIDS and prednisone. Another way of thinking is, "why are they sick?" (List steps taken.) It should be constructed in a different way.

***Paul:*** So, let's take out the hierarchy. Perhaps circles or.....

***Bruce:*** A Ven diagram.

***Paul:*** That might not do it. More like three concentric circles with an overlap in the middle.

***Herb:*** So it's three dimensional spheres.

***Paul:*** Mobilize is the major one.

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*We believe those who compromise what they believe in to satisfy their goals wind up dissatisfied with their accomplishments. In everything we do at Priority One we keep in mind this simple statement. We know* ***integrity brings both ourselves and our clients' satisfaction****. Priority One Nutritional Supplements Inc. is a family owned and operated company dedicated to the holistic field of medicine, providing the best in quality, and service since 1987. We specialize in manufacturing pure, high potency supplements for the healthcare professional. 1-800-443-2039*

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*Bezwecken does not advertise, thus we mention Dr. Shefrin's contributions to the profession. "Dr. Shefrin is a living remnant of the legacy of the early alumni of NCNM – one of the first forty graduates." His extraordinary sacrifice and vision are truly commendable. He has given tremendously to support and pull together our naturopathic colleges in times of great need. We thank and treasure him for his decades of philanthropy, leadership and heartfelt contributions to the profession.*

*Excerpted from Bezwecken CEO, David Shefrin's recognition and honorary doctorate (Doctor of Laws) presented to him by NCNM.*


# National College of Natural Medicine

*The Foundations Project gratefully acknowledges NCNM, our academic home, for its tremendous support and leadership. The NCNM community's extensive involvement and its steadfast, collegial and creative commitment were pivotal to the success of this Retreat. Our heartfelt thanks, warmest appreciation and respect to Dr. David Schleich and Dr. William J. Keppler (President and President Emeritus) for their synergy of vision, leadership and support. Dr Keppler's astute vision, integrity, courage, and wise guidance was essential to our achieving this step; and Dr. David Schleich's long standing vision, dynamic and inspiring leadership, deep scholarship on professional formation, and staunch commitment were vital in advancing through the many joys and challenges of this initiative. We thank Dr. Pauline Baumann and the NCNM Board of Directors for NCNM's warm welcome to our academic home, and Dr. Baumann for her beautiful vision for the medicine; and Nancy Garbett, NCNM's Board of Directors Chair, for her leadership in taking us to the next level; and finally, our appreciation to Dr. David Odiorne for his savvy Moodle expertise and many hours of essential work on behalf of the FNM.*

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