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Making Waves

The purpose of healing
is *to bring us* in *harmony*
with ourselves.

–O. Carl Simonton

Early in my experience with complementary medicine, I received a call from a woman who introduced herself as an energy healer and a graduate student in the school of public health. Julie Motz had heard I was interested in offering my patients-especially those with LVADs-more than the usual mix of drugs, surgical skills, and physical therapy that modem hospitals use to fight illness and disease. "Could we talk sometime?" Julie asked, and I quickly answered, "Sure, let's meet."

The words "energy healer" set off no alarms. I knew *energy healing,* or energy-oriented therapies, was an umbrella term that included many kinds of treatments, from acupuncture and homeopathy to therapeutic touch and various kinds of massage. Most of these approaches spring from ancient medical traditions in China and India, and are based on the belief that humans are physical beings as well as systems of energy that determine a person's mental, emotional, and spiritual health, or balance.

Practitioners believe that energy flows within the body through channels called *meridians,* with seven main energy centers

or *chakras* (a Sanskrit word for wheel), aligned along the spine. Each chakra emits and absorbs a different *life force* (the Chinese call this *qi,* or chi), and it governs different areas, even organs, in the body. Removing blockages of the life force along the meridians, creating balance and dispelling illness, is the goal of energy healers. Many of them even claim to see subtle electromagnetic waves, or glowing auras, emanating from people, and these too indicate blockage sites.

When Julie came by for our meeting, I was immediately taken by her quick intelligence and articulate speech. She bubbled with ideas and appeared to have depth in a lot of areas, not all medical. Slightly built, with short hair and a soft-featured face, she smiled a lot and spoke with confidence. And she always wore extravagant hats, eventually earning her the nickname "The Sombrero Woman" from my colleagues.

At the time I had no idea if I would ever actually use her or any of the other self-proclaimed energy healers in a hospital setting. The Julies of the world have no formal credentials, and even though I was running my own program with the LVADs, I was already attracting curious stares from my colleagues for even meeting with someone they probably considered in the New Age orbit. Fortunately, some of my fellow surgeons, like Craig Smith, were fair skeptics. Craig, who is as diligent a surgeon as he is a hard-nosed scientist, supported my forays into complementary medicine, while insisting that everything we used be rigorously tested. For him as well as me, hard data was the best convincer.

I had begun to submit research protocols for studies on hypnosis, music therapy, aromatherapy and therapeutic touch-with sage advice from Don Kornfeld, the head of Columbia University's review board-but my efforts were meeting with limited success. Then one day the solution struck me. I was seeing a female patient who wanted her hair done, much the way my wife, Lisa, wanted a massage in the maternity ward. Of course, I could bring in a hairdresser as an "amenity," so why couldn't I also classify complementary medicine practitioners as amenities, people

who could offer patients breaks from the boredom that blanketed their lives in the hospital?

My patients loved her. It wasn't long before one patient wanted Julie to accompany him into the operating room. George Serafin was convinced that her work had made a difference in how he felt and in his growing confidence that he would survive his medical ordeal. It is highly unconventional for anyone other than the surgical team to be admitted to the OR during a transplant, but I decided to make an exception, because of George's extraordinary history and intense conviction about Julie.

When I first saw George, he looked like a puffy corpse with vital signs that nearly matched his appearance. Under the fluorescent lights of his hospital room, the skin of the forty-six-year-old executive appeared doughy and swollen. The only sign of life was his open, steady eyes. Display screens beeped, a computerized heart monitor rolled out EKG paper, nurses gave their reports, and outside in the hallway a cardiologist opined that George might well be on his way to the morgue.

A survivor of open-heart surgery ten years before, George was now afflicted with end-stage heart disease. He had delayed coming to the hospital so long that even a potentially lifesaving heart transplant could not be done. He was even beyond the help of a mechanical pump. His kidneys had shut down, and his body was so waterlogged that when I pressed my fingers into his shin, I left five inch-deep depressions in his skin. George even admitted that he felt a chill, the first warning of the infection that would probably take his life.

As I prepared my thoughts before making the grim announcement to the family, I took the precaution of having his wife sit down. Then I carefully told of the misery and sure death that would result even if we went ahead and inserted an LVAD.

Then I visited George's room, found him awake, and gave him the dire prediction. He listened to me patiently, then told me he had faced death before in Vietnam. A navy veteran, he had survived security missions under fire and felt he could tell when his number was up. "I'll know when death's time has come," he said, "and this is not it."

Surgeons know that patients who are sure they will die during surgery are all too often correct. But I wasn't sure if the reverse was true.

"George," I said, "I think it's too far gone."

"Doc," George said, "I'm not going to die. I know I won't. I have too much to live for."

So I brought in the LVAD team-nurses, physician's assistants, cardiologists, and social workers-to help determine the most rational course. But with George Serafin our normal criteria seemed irrelevant. He was so determined, so certain he would not die, that I decided to go ahead with the operation the next morning.

Gowned, gloved, and masked, I stood beside George's prone and anesthetized body. Our head nurse slapped the scalpel handle into my hand, and I made the initial skin incision from the top of the breastbone down to the navel. The OR phone rang. Microbiology was calling. The blood culture drawn during George's chill the night before had already grown bacteria. Normally this ominous sign would have cancelled the surgery, but the operation was already under way.

I continued, opening a space above the peritoneum-the sac containing the intestines, stomach, and liver-to implant the LVAD pump. Next, I used a surgical jigsaw to cut through the sternum, exposing the chest cavity and eventually George's enormous, melon-size heart. I then diverted the blood from the heart into the heart-lung bypass machine. His lungs were now deflated, his heart halted, and for several hours he was kept alive by the heart-lung machine. I stitched the LVAD tubes into the corresponding heart openings, and turned on the device. Off

the heart-lung machine, George's pump-aided heart started up again.

But his battle had only just begun. Scar tissue from a prior bypass operation and liver damage from his failing heart led to torrential bleeding-a problem I could not stop. I put bone wax on the sternum to reduce the ooze. I added concentrated clotting factors from other patients onto the wound. I transfused blood-clotting factors and platelets. I took package gauze and put manual pressure on every bleeding site I could find. George still bled. I left his chest open for three days, operating every day to stop the bleeding. George remained unconscious with a breathing tube in place. On the third day the bleeding finally stopped. George was still alive-not by much, but holding on.

The next morning George regained consciousness. As I examined him, I smiled, thinking of all the heroics performed on his body, but I didn't tell him of the war we'd waged. Later he asked me, and I described what happened. He smiled, then he shocked me. "That's what I thought," he said, adding that for three days he had felt as if he'd been swimming through a thick soup that buoyed him up but also made his movements difficult. His head also seemed heavy, yet he saw a bright light overhead. He thought that if he could just stay under the light he would live. Each time the light moved, he would maneuver himself back into the center. Finally, the light didn't move; he was safe.

"You remember that?" I asked him.

"That's *all* I remember," George said. "I kept thinking, 'I'm not dead yet. I have to get back under the light. I do that and I'll be all right.' "

While awaiting a donor heart, George began treatments with Julie. She had asked me to run through everything that my surgical team and I would do to George, so she could take him through the surgery step by step on an emotional level. I had seen how she had greatly lowered anxieties in other patients. We had given them questionnaires asking them to evaluate how energetic and anxious they felt before and after Julie's treatments.

Almost invariably they claimed to feel more energetic and less tense with the sessions.

So when I replaced George's old diseased heart and the pump, Julie was there, gowned and masked like the rest of us. She first positioned herself at his feet, and with her eyes closed, she rubbed and squeezed them, looking as if she were in some altered state herself. Later she moved to his head, keeping her hands floating a few inches over his forehead, never distracting me or interfering with surgical procedures. Actually, during the entire struggle to transplant George safely, I was so riveted on my trouble-shooting tactics that I hardly noticed Julie and her ministrations. Only when the surgery was long over, after she asked George to "welcome" his new heart with words of appreciation, did she tell me her unique interpretation of the operation.

"For him it was like running a marathon," she said.

"I know the feeling. I've run a few myself."

"His body was really struggling," she continued, "working just as hard as you. He never gave up. That's why he's so tired now. It's not because of the anesthesia." She added that she had seen George in the pre-op waiting room, and he seemed to have a confident grip on the ordeal ahead. In the OR, because George had renal insufficiency, she focused on his kidneys-using the energy emanating from her hands to shift and ease the energy "blockage" in his kidneys. Later, he boasted that his urine output had risen.

For Julie, and increasingly for me, getting to know a patient was less a matter of connecting the dots from what I read on a chart than it was "reading" a patient's emotions. A person's medical history, the vital stats, the opening of the chest, seeing the effects of nicotine or a fat-heavy diet-these were so many external facts. Her assessment of a patient's internal or emotional life, the distresses of grief, anger, loneliness, or ongoing pain-this she would pass on to me as an additional guide in healing.

George is now back to a normal life, running his own busi-

ness. "Before all this happened," he told me, "I never went to church. Now I go every Sunday. I've got my life back."

I explained my initial reservations about operating and my very human limitations as a surgeon. "Sometimes," I added, "it's better to be lucky than good, although I like to be both."

George shook his head. "Naw, Doc," he said. "See, I just don't quit. I don't know the word."

Every clinician has cases that defy easy explanation. Usually, we mumble something about luck or chance, shake our head, and move on to the next patient. But George's story and Julie's role in it stuck in my mind. As she reminded me, I should never underestimate the effect of a patient's willpower on the body.

"I believe emotions are of the body, not of the brain," Julie would say. "Fear, anger, love, pain-they occur in the body. Too much repressed anger, and the result is depression and illness. Anger is the emotion that most affects the heart." In turn I mentioned studies that confirmed the depression-heart-disease link, including the observation that depressed patients have higher levels of stress hormones in the blood than those in non, depressed people. This results in higher blood pressure, a speeded up heart rate, and blood that clots more easily-all factors contributing to major cardiac problems. Moreover, depressed patients produce higher levels of cortisol, which can exacerbate the erratic heartbeats that often precede sudden death. Cortisol also decreases the secretion of growth hormone, which shifts the body's cholesterol toward the dangerous low-density lipoproteins (blood fats) and away from the high-density ones that protect blood vessels.

Then Julie explained that sometimes during sessions she would get visions or images of great sadness. She explained that healing occurs through relationships, which for her often means physically touching patients. "When I touch people," she explained, "I feel things. It's not hot or cold. It's more like a tingling and a pressure. I don't

have to touch. I *like* to touch. Patients in hospitals are terribly touch-deprived."

Julie also insisted that I should talk to my patients during surgery. If I (and probably most surgeons) don't mutter words, even prayers and pleas, under our breath to our patients, we direct thoughts to them. I remember as a med school student watching my father-in-law in the OR. Gerald Lemole, a famous heart surgeon, would tell his unconscious patients to get their hearts to beat stronger and to stop bleeding. He would pretend to say this tongue in cheek, but I think deep down he was serious.

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