



IFAF

International Foot & Ankle Foundation

FOR EDUCATION AND RESEARCH

The Foot and Ankle Online Journal

Official Publication of the IFAF

Distant Intentionality Healing And Its Effects On Post-Operative Pain And Narcotic Usage After Foot And Ankle Surgery

by Gerald T. Kuwada, DPM, NMD

The Foot and Ankle Online Journal 6 (9): 1

A double blind, randomized study using Distant Intentionality Healing (DIH) and narcotic analgesic use was completed. The author wanted to determine if there was any difference between the control group and the group receiving DIH on the total number of narcotic analgesics taken after foot and ankle surgery for 3 weeks post-op. The study found that there was on average 7 less narcotic analgesics taken by the DIH group than the control group. The study reveals this is a significant difference between the control group and the group receiving the DIH at p.01 level.

Key words: Pain, Narcotics

Accepted: August, 2013 **Published:** September, 2013

This is an Open Access article distributed under the terms of the Creative Commons Attribution License. It permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. ©The Foot and Ankle Online Journal (www.faoj.org), 2013. All rights reserved.

The author defines DIH as the intent to benefit another human being, living organism and human event. DIH studies number over 2000 since its initial research conducted in the early 1960s. One of the pioneers in this controversial research was Dr. Grad who used animal and plant studies as subjects and paved the way for eventual human studies once DIH was demonstrated to be safe, with no toxic or ill side effects and safe to plants and animals.¹⁻³ HIV-AIDS patients, post myocardial infarct patients, post-op pain, post-op complications were shown to also respond positively to DIH in a significant manner.⁴⁻⁸

The question about how DIH works on living organisms including human beings remains a mystery. Several authors have suggested that the answer lies within quantum physics and the concept of non-locality and entanglement theory.⁹⁻¹¹ The anatomic location of the mind and consciousness have proven to be just as mysterious as physicians and scientists have yet to locate where the mind is located anatomically.¹² Physicists use the term non-locality because the mind and consciousness are not located in a specific anatomic location. Earlier speculations and assumptions were the mind was located in the brain. Brain mapping studies have not corroborated this assumption.¹³ Neuroanatomists have correlated anatomic sites with function of the brain.

Address correspondence to : Gerald T. Kuwada, DPM, NMD, 13701 SE 201, Kent, WA 98042. drgeraldkuwada@hotmail.com

The use of functional MRI (fMRI) has been used to see if DIH increases blood accumulation in various locations in the brain following meditation.¹⁴ Certain experienced meditators have permanently changed their brain function compared to new meditators.¹⁵

The author proposes to use fMRI to study the effects of DIH on brain functioning and the immune system in the future.

Another aspect of this study will determine if there is significant post-op pain rating reduction between the control group and the DIH group during the 3 weeks post-op. This would be correlated with narcotic analgesic usage and may demonstrate that reduction in post-op pain should reduce pain medication use.

Methods

Initially there were 52 patients in this study over a 3 year period. The surgical patients who participated signed consent forms to participate in this study. These patients were randomly selected for the control group and the DIH group. They were not informed which group they were selected for. They were all given 40 pain pills ranging from Demerol, Vicodin, and Percocet. Most of the patients were prescribed Percocet. At the end of the 3 week period they returned to the clinic and the number of narcotic analgesics were counted and recorded by the research assistant. The first week pain rating and the 3rd week pain rating were also recorded for every patient in this study. The surgeon had no idea who participated in this study and which groups they were assigned. For 2 minutes twice daily once in the morning at 5 a.m. and the evening at midnight the author-healer sent the intention of less pain and less pain medication usage to the DIH group. The rest of the time the healer visualized encircling the DIH group in healing light and energy.

Results

The null hypothesis in this study is that there will be no difference between the control group and the DIH group regarding subjective post-op pain rating and pain pill use. The null hypothesis was rejected as there was significant difference between the control group and the DIH group at the $p .01$ level using a 2 tailed z score test. The mean score for the control group is 38.4 pills taken per patient. The mean score for the DIH patients is 31.9 during the 3 week post-op period. The mean pain reduction score for the control group is 3.3/10 with 0 equal to no pain and 10 equal to the most severe pain. The DIH group mean pain reduction is 3.96. This is calculated by subtracting the 1st week subjective pain score from the 3rd week subjective pain score. The control group mean subjective pain rating was 5.54/10 for the first week whereas the DIH mean subjective pain rating is 6/10. The mean pain rating score at the end of 3 weeks is 2.23/10 for the control group and 2.03/10 for the DIH group. There were 11/25 or 44% patients in the control group who had a pain rating of 0/10 at the end the 3 week post-op period. There were 33% or 8/24 for the DIH group who had 0/10 pain rating at the end of the 3 week post-op period. There was one patient in the control group who had a subjective pain rating for all 3 weeks of 10/10. The control group patients took a total of 960 narcotic analgesics during the 3 week post-op period. The DIH group took a total of 767 narcotic analgesics over the same period. This is 193 less pain pills taken by the DIH group which correlates positively with the groups lower mean pain rating at the end of the 3 weeks contrasted to the control group. The surgeries ranged from digital procedures, simple to complex bunionectomies, midfoot procedures, rearfoot and ankle procedures.

Discussion

This study reveals that the DIH group took less pain medication and had less pain post-op following foot and ankle surgery. Three patients were removed from the study due to injuries suffered during the 3 week post-op period. All 3 patients skewed the data and were removed from the study as they required more pain medication. Two patients were from the DIH group and one was from the control group. For example the patient from the control group took a total of 130 pain pills during the 3 week post-op period. Whereas the 2 from the DIH group totally took 170 pain pills. Two patients had triple arthrodesis performed and were prescribed Demerol for the 3 week post-op period. Most of the patients were prescribed either Vicodin or Percocet. There is a positive correlation between less subjective pain experienced and using less pain medication which one would suspect would occur. Conversely, having more post-op pain correlates to using more pain pills which is predictable. The DIH group had a higher first week subjective pain rating mean score than the control group. However, by the end of the 3 week post-op period the DIH group had less subjective pain mean score than the control group.

Though the difference between the control group mean of 38.4 narcotics taken and the 31.9 mean for the DIH group doesn't seem large, yet, when extrapolated over many patients who have had surgery, the number has economic impact on patients, insurance companies and our health care system. According to the World Health Organization (WHO) the USA ranks 38th in the world for health care.¹⁶ It is also regarded as the most expensive health system in the world. Perhaps using DIH and other economic and beneficial treatment regimens will help to improve our use of our wealth in a more productive manner and distribute health care to more Americans who are currently locked out of our health care system.

For example, if 50000 patients in the state of Washington had foot and ankle surgery in 2012 and each patient was prescribed 40 tablets of a narcotic analgesic, for the control group whose mean use was 38.4 pills per 3 week post-op course this would translate to 1,920,000 pills for 50000 patients. For the DIH group with a mean use of narcotics being 31.95 per patient, this would translate into 1,597,000 pills. The DIH patients would have taken 322,500 less narcotic analgesics during the 3 week post-op period. If 40 tablets of the narcotics retail costs 38 dollars this translates to a total savings of 306,375 dollars for DIH patients who had foot and ankle surgery. If you add all the surgical patients from all the surgical disciplines in the USA in a single year, and assume that DIH would affect these surgical patients similarly as the patients who had foot and ankle surgery, the savings would be in the billions of dollars. There would also be an additional benefit of avoiding or decreasing complications and side effects of taking narcotic analgesic usage due to DIH use.

How DIH causes the affect based on the healer's intention remains a mystery at this time. Previous functional MRI (fMRI) studies on DIH patients have shown that there appears to be specific areas of the brain that are stimulated during DIH healing sessions. The recipient's precuneus, anterior cingulate, middle cingulate gyrus and frontal lobes are stimulated during the DIH healing sessions by increased blood flow. The precuneus functions in a wide spectrum of highly integrated tasks including visiospatial imagery, episodic memory retrieval and self processing operations like first person perspective. The anterior cingulate gyrus also has multiple complex functioning including self awareness of errors being committed and reaction to this awareness. Risk predictions, cognitive control, emotion regulation, conflict monitoring adjustments in behavior, minimizing distractions are also some of the functions. Other functions include but not limited to problem solving, concentration on tasks, information transfer from auditory stimuli to the cortices for processing, empathy from pain and cravings. The middle cingulate gyrus functions primarily in the regulation of the hypothalamic-pituitary-adrenal responses primarily to stress.

Frontal lobe functioning involves reasoning, planning and problem solving, speech recognition, movement and emotions. The healer's parahippocampal gyrus is activated during the healing session. The parahippocampal gyrus functions in memory retrieval, creation of memory and communication and visual cues. It appears that DIH affects the brain in complex ways in order to respond positively to the intentions of the healer. The author proposes to use fMRI to further investigate what goes on in the brain during the DIH in the healer's brain and the target patient's brain during the healing session. Based on other studies using fMRI, experienced meditators had areas of the brain that were permanently affected compared to beginning meditators. This is consistent with other physiologic effects of experienced versus beginning meditators. The experienced meditators typically had lower physiologic effects such as pulse, respiration, galvanic skin response, brain wave activity and more.

Conclusion

DIH significantly reduced the number of narcotic analgesics taken during the 3 week post-op period after foot and ankle surgery. The DIH patients also had less pain contrasted to the control group. Logically this is what you would expect that if you have less pain a patient will take less pain medication as demonstrated in this study. Lastly there were no complications or reported side effects of DIH use in the DIH patient population during the 3 week post-op period.

References

1. Grad, B. The Biological Effects of the Laying on Hands on Animals and Plants: Implications for Biology: Parapsychology: Its Relation to Physics, Biology, Psychiatry. Ed. G. Schmeidler. 1967. Scarecrow Press, N. J.
2. Grad, B. A Telekinetic Effect on Plant Growth, Part 2: Experiments Involving Treatment of Saline in Stopper Bottles. International Journal of Parapsychology, 1964, vol. 6: 473-498.

3. Grad, B. Healing by Laying on of Hands: A Review of Experiments in Ways of Health: Holistic Approaches to Ancient and Contemporary Medicine. Ed. D. Sobel. 1979 Harcourt Brace, NY.
4. Sicher, F., Targ, E., Moore, D., Smith, HS. A randomized double blind study on the effect of distant healing in a population with advanced AIDS-report of a small scale study. Western Journal of Medicine. 1998. 169(6): 356-363.
5. Harris, W., Gowda, M., Kolb, KW, Stychacz, CP, Vacek, JL, et al. A randomized controlled trial of the effects of remote, intercessory prayer on outcomes in patients admitted to the coronary care unit. Archives of Internal Medicine. 1999. 159(19):2273-2278.
6. Kuwada, GT., Distant Intentionality Healing for reduction of post-operative pain following foot and ankle surgery. A randomized, double blind study. Submitted to the Journal of Alternative and Complementary Med. 2006.
7. Kuwada, GT., Distant Intentionality Healing (DIH): A randomized double blind study on post-operative care and cost to care for complications following foot and ankle surgery. 2012 Foot and Ankle Online Journal 5 (1): 1-10.
8. Jonas, W., Crawford, C. (eds.) Healing: Intention and Energy Medicine: Science, Research Methods and Clinical Implications. 2003. London: Harcourt.
9. Einstein, A., Podolsky, B., Rosen, N. Can Quantum Mechanical description of physical reality be complete? Phys. Rev. 1935:47:777-780.
10. Pizzi, R., Rantasia, A., Gleain, F. et al. Non-local correlation between human neural networks. In: Donkar, E., Pirick, AR, Brandt, HE. Eds. Quantum Information and Computation II. Proceedings of SPIE 5436:2004: 107-117.
11. Standish, L., Johnson, J., Clark, L., Todd, R., Kozak, L. Evidence of correlated fMRI signals between distant human brains. Alt. Therapies in Health. 2003. 9:122-128.
12. Lazar, S., Bush, G., Gollub, RL, Ricchione, GL., Khalsa, G., et al. Autonomic Nervous System: Functional Brain mapping of the relaxation response and meditation. Lippincott Williams and Wilkins, Inc. 2000.
13. Achterberg, J., Richards, T., Salomie, IA., Cooke, K. Individual Recipients' functional brain changes during distant intentionality. A fMRI Analysis. Presented at the North American Research Conference on Complementary and Integrative Medicine, May, 2006.
14. Davidson, RJ., Kabat-Zinn, J. et al. Alterations in brain and immune function produced by mindfulness meditation. Psychosomatic Medicine. 65(4):564-570. 2003.
15. Shealy, C., Smith, N., Liss, T., Borgmeyer, S. EEG Alterations during Healing. Subtle Energies. 2000:11(3):241-248
16. World Health Organization. World Health Organization Report 2000. Geneva, Switzerland. WHO: 2000.