

Cure or Suppression

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Abstract

Regardless of the school of thought, each profession has established its own criteria for determining whether or not an intervention is successful. How a profession defines intervention success profoundly impacts actual clinical practice. I assert here that inappropriate criteria

for defining intervention success and patient healing are foundational to the chronic disease epidemic society is suffering.

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Introduction

Foundational to every healing art is the commitment to heal patients. Over the centuries, many health care professions were founded around a particular philosophy on how to accomplish this goal. Although there have been many philosophers, there have always been only 2 basic schools of thought. I have written on this before and have identified them as “disease treatment” versus “health promotion.”¹ Disease medicine is based on the belief that the body makes mistakes and is the victim of disease and that the role of the doctor is to step in and take control. This is obviously the best approach for overwhelming infections, serious injuries, congenital malformations, and so on. Health medicine, in contrast, is based on the belief that the body has evolved for millennia to be healthy and able to adapt to remarkably diverse and challenging environments and that the role of the doctor is to identify what is blocking that ability to be healthy and to restore optimal function. Each approach has its strengths and weaknesses; neither is complete on its own. Unfortunately, we have learned that while focusing all the resources and attention on disease medicine (which has produced many important benefits) but ignoring—and even suppressing—the health promotion side, we have ended up with the highest burden of chronic disease in every age group ever in human history.

Regardless of the school of thought, each profession has established its own criteria for determining whether or not an intervention is successful. How a profession defines intervention success profoundly impacts actual clinical practice. I believe that inappropriate criteria for defining intervention success and patient healing are foundational to the chronic disease epidemic.

This editorial discusses cure versus suppression, a concept that the founding naturopaths deeply discussed, debated, and understood.

How Should We Define Cure?

I vividly remember a debate I had 2 decades ago with the recently retired dean of a major medical school. We had quite a lively conversation until he interrupted me and admonished me to stop using the term “cure.” He strongly asserted that we can only *manage* disease. I was astonished. As our conversation developed, I soon realized that he was speaking from extensive experience—he considered clinical success as prescribing a drug to a patient that they would use for the rest of their lives if it controlled a parameter that medicine considered important. At first I was a bit angry and defensive, but the more we talked, the more I understood that we had profoundly different definitions of success.

The foundational purpose of a health care professional is to cure their patient. However, the definitions of “cure” range widely. The naturopaths have deeply studied and fiercely debated this concept since its inception over a century ago. They soon came to agree that only relieving symptoms is *suppressive* of the body’s healing efforts and will eventually result in more chronic disease. We now know conclusively that they were right.

Let’s look at some criteria for cure. I propose three:

1. The presenting problem resolves.
2. The problem does not return after the intervention has been withdrawn.
3. The patient experiences a sense of increased health and well-being.

A foundational concept of naturopathic medicine is that a patient’s presenting signs and symptoms are messages from the body that something is not working right. The role of the doctor who wants to achieve cure is to use this information to figure out what is wrong and to address the causes.

The Presenting Problem Resolves

This, of course, is the first criterion. If the problem is not resolved then clearly the intervention was not effective. The challenge is how to define “resolved.” Many situations lend themselves to a straightforward definition. For example, a broken bone is properly set. Another would be a child’s ear infection confirmed resolved after physical examination. However, if the child is having recurring ear infections (6% to 8% of children), although the presenting problem was addressed, clearly the causes of the condition were not.² Same with the broken bone. If the bone was too weak, simply fixing the break does not address the core cause. For example, after the age of 50 years, 40% to 50% of women and 13% to 22% of men have fractures due to osteoporosis.³

This challenge becomes far more difficult when a simple measure, like blood sugar control, is tested. “Cures” for diabetes happen all the time with berberine, metformin, and insulin if our only criterion is stabilization of blood sugar concentration. All would agree that improving blood sugar control is a good measure of diabetes control, as this correlates with a decreased incidence of the serious sequelae of advanced diabetes. However, this is a poor measure of cure and a good illustration of the problem of relying only on signs and symptoms or laboratory tests as the only measures of intervention success. As documented in the editorial I wrote in 2016, “Is the Diabetes Epidemic Primarily Due to Toxins?”⁴ the metals and chemicals that have contaminated our environment are so effective at causing insulin resistance and pancreatic damage that they are labeled by researchers as diabetogens. As I discussed, arsenic, polycyclic aromatic hydrocarbons, polychlorinated biphenyls, and others appear to be the primary cause of the diabetes epidemic. By only controlling the blood sugar but not addressing the cause of the loss of blood sugar control, the true underlying problem is not addressed or even recognized. This problem results in more chronic disease; for example, arsenic is a major cause of cancer,⁵ polycyclic aromatic hydrocarbons are a major cause of lung disease,⁶ and polychlorinated biphenyls are a major cause of rheumatoid arthritis in women.⁷

The Problem Does Not Return After the Intervention Has Been Withdrawn

This second criterion seems pretty straightforward: If the problem does not return upon completion of treatment, then the patient is cured. However, the effect of environmental challenges and genetics necessitates a more sophisticated approach.

Let’s take as an example a woman in her forties with a family “herstory” of all her female forbears dying of complications from osteoporosis. Dual-energy x-ray absorptiometry (DEXA) scanning has shown she already has osteopenia. The conventional approach would have

been to treat with bisphosphonates or other drugs that slow the bone breakdown process. Although bone density will be apparently maintained, interrupting the bone remodeling process eventually results in weaker bones more prone to breakage (see the book on healthy bones that I coauthored in 2021 for an extensive discussion of the long-term effects of these drugs on bone strength).⁸ Unfortunately, the more natural supportive interventions with vitamin D, calcium, and estrogen proved ineffective, and she continued to lose bone. Then genetic testing became available, and she was found to have several vitamin D receptor gene single-nucleotide variations resulting in substantially impaired ability to absorb, transport, and use vitamin D. Intervention required 14 000 IU of vitamin D. After 2 years of this high dosage, her bones began recalcifying, and after several more years, not only did she not progress to osteoporosis, her bones are now normal. While we were able to decrease her vitamin D dosage, the needed 4000 IU/day is still way above normal. But if we take her off the high dosage of vitamin D, she will lose bone again.

Another example is a patient with asthma. Drug interventions help her breathe—clearly, these are critically needed. But the condition continues unabated, becoming worse and worse as higher and higher dosages are needed to breathe. She is fortunate to have gone to an integrative clinician who measured her urinary sulfite to sulphate ratio and found it elevated. The enzyme that converts sulfite to sulphate is molybdenum dependent; providing the patient with intravenous molybdenum totally resolved her asthma. But she needs to continue taking oral molybdenum. About 3% to 10% of people with asthma appear to have this genetic need.^{9,10} (Side note: Appreciation to Jonathan Wright, MD, who introduced the urinary sulfite to sulphate ratio to me over 40 years ago. I saw many patients totally resolve their asthma simply with intravenous or oral (takes longer) molybdenum.)

Another example is a person with chronic obstructive pulmonary disease who lives in a city. Taking extra vitamin C resulted in substantially fewer respiratory symptoms.

Each of these cases illustrates an effective intervention that must be continued. I would still assert that these interventions are curative.

The Patient Experiences a Sense of Increased Health and Well-Being

This third criterion is straight out of naturopathic philosophy. As I tell students, if our core approach is to promote health and physiological robustness, then intervention success and patient healing is not the only resolution of the presenting problem. Patients’ bodies should also be functioning better, and patients should have a sense of improved well-being. The side effects of symptom treatment are other symptoms. The side effect of curative medicine is improved health.

Conclusion

Of course, in clinical practice there are a lot of gray areas. Sometimes drugs are indeed curative. Sometimes we need to prescribe suppressive medications to alleviate suffering or because no cure is currently known. Nonetheless, the health care system must address these core concepts of health promotion or else the chronic disease epidemic will continue to increase unabated. I believe the disease “management” protocols that conventional medical schools teach are a major cause of physician burnout. Physicians go into medicine to cure people but find they are simply prescribing drugs according to algorithms that don’t address why their patients are sick.

The optimal health care system prioritizes health promotion and only uses disease medicine when the former is not enough.

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