

“Through Thy grace the sudden shafts of wisdom will dispel error accumulations of countless centuries.”

Whispers From Eternity by Paramahansa Yogananda

CHAPTER SIXTEEN

WEST MEETS EAST: PART II

A FEW MORE CHANNEL ABERRATIONS

Much of this chapter may make more sense to a student of Asian medicine than to the person who merely wants to know about Parkinson’s disease. It is included because I sometimes receive queries from acupuncturists who want to know if any other symptoms of Parkinson’s are related to shifts in channel Qi. Much of what follows may seem obscure to the lay reader. However, even if the channel flow references are hard to follow, the gist, the summary, and the conclusion of this chapter should be clear.

Body-wide auxiliary symptoms

Of course, the *body-wide* symptoms did not fit a location, per se. Nevertheless, some of these symptoms corresponded with characteristics of specific channels. These channels, while not directly injured, might become caught up in the aberrations when Stomach channel Qi became Rebellious.

- extreme sleepiness between 11 p.m. and 1 a.m. (a time of day associated with the Gallbladder channel), with a tendency towards restlessness or insomnia during the rest of the night and fatigue or restlessness during the day

The fatigue may be subclinical during the day; situations that produce a sense of urgency can cause the tiredness to momentarily recede. Because of this fatigue, a PDer may sense a constant internal battle between alertness, restlessness and fatigue. He may draw upon his strong will power to get through the day, sometimes creating mental situations of emergency, fear of failure, or even fear of disappointing someone in order to produce enough adrenaline-based drive to keep going.

- time of greatest discord often between 7 a.m. and 9 a.m.

7 to 9 in the morning is the Stomach channel time of day. At this time of day, a PDer’s overall energy might be either at its height or it may be at the lowest level: he may be at his most dynamic and high-powered, or he may be utterly unable to get up and get going.

The list of body-wide symptoms suggests discord in the Gallbladder and Stomach channels. The Gallbladder- and Stomach-related symptoms support our hypothesis that channel Qi running perpetually backwards in one of the Stomach channels could eventually short circuit into one Gallbladder channel. During the day, and especially during times when the Stomach channel is being stimulated, the excess current in the Gallbladder channel would create a pre-sleep electrical signal in the brain on one side of the brain while the other side maintained a normal waking signal.

From 11 p.m. to 1 a.m. the current in the Gallbladder channel automatically increases greatly. This sends a go-to-sleep signal to the brain. In a PDer, the only time of day when both of the Gallbladder channels are sending the same signal to his brain is this two-hour period at night. This is when most PDers experience an extreme level of sleepiness.

During the rest of the night, the difference between the two sides creates an electrical imbalance, a vibration, an internal tremoring that can cause restlessness and insomnia.

Attitudinal symptoms

Attitudinal symptoms are similar to the symptoms that are “body-wide,” inasmuch as most of them don’t appear in a specific physical location. However, just as certain physical, body-wide symptoms are considered to be related to specific channels, the following attitudinal symptoms are also related to specific channels.

- aversion to or difficulty in visualizing, imagining, or even pretending to imagine either one’s entire body or certain body parts, as being filled with light ¹
- difficulty in creating a mental self-picture of oneself in the here and now
- fear of objectively incorrect behavior, such as tardiness or making an incorrect statement, or making a wrong turn or becoming lost while driving

A majority of my PD patients, before seeing me for the first time, drive to my office the day before the appointment to make sure that they know just where to park and to make sure they don’t fly into a panic/rage by getting lost looking for my office on the day of the appointment. None of my other patients that I know of, in all my years of practice, have done this.

- strong dislike for anyone, even a spouse, to see or touch the feet
- in conversation, often draws the subject away from oneself and towards the other person, or towards more neutral subjects such as philosophy
- very often has a history of dangerous or frightening childhood

¹ There will be much, much more about this symptom later. For now, let me expand on it via an example: one of my patients was a playwright and screenplay writer. He could mentally picture whole scenarios, from the backdrop to the facial expression of every actor in his plays. He could not, however, when doing a dopamine-stimulating exercise, visualize or imagine any light in his body. When asked to visualize his body as being full of light, he protested strongly. He insisted that it was impossible for him to do such a thing. Finally, after months of coaching, while he insisted he couldn’t do it, he did it. At the same moment as he was able to imagine light in his elbow, he inexplicably started weeping. He then cried for almost ten minutes: big, wrenching sobs.

On the other hand, one patient had gone to a hypnotherapist prior to her diagnosis to understand why the left side of her body wasn’t working. With the guidance of the hypnotherapist, she was able to mentally create a picture of the inside of her body. The right side was gleaming and functional. The left side, the PD side, was filled with rotting timbers and stagnant water. She was unusual in that she was able to see anything; most PDers can’t even imagine any image or activity going on inside their most effected body areas and are terrified even to take a mental look.

I first began to wonder about the significance of this after my first three PDers answered my not uncommon (in Asian medicine) intake question about childhood with an unexpected coolness.¹

- fear of anxiety or stress-inducing social interactions
- strong aversion to highly charged emotional situations, particularly situations involving anger
- high aversion to being in the vicinity of people who are being overly assertive, threatening, or who might become angry
- depression
- powerful mental attempts at staying busy to combat depression
- high capability for strength, speed, and stamina in his pre-PD years
- dread of making a wrong turn or becoming lost while driving
- inability to cry, especially during his youth
- high intellect
- a keen interest in gathering information. A local doctor in my community was known to tell his PD patients, “My Parkinson’s patients are the best informed of all my patients. Once they’ve been diagnosed, my PD patients usually know more about the latest developments in the field than I do.”

○ Parkinson’s personality

Briefly, the Parkinson’s personality may include emotional-harm avoidance tendencies, strong will power and intensity of purpose.

- strong moral or spiritual leanings, though not necessarily associated with a religious denomination. Many PDers are deeply spiritual. By “spiritual,” I mean that they often try to embody the qualities of service to others, selflessness, detachment from materialism, and asceticism. They often spurn activities that might be considered self-indulgent or flamboyantly self-expressive.
- absence of joy, absence of ideas as to what might bring joy.

Many PDers, when asked what gives them joy, answer that making others happy gives them joy. When asked what someone might do for them to make them happy, or what makes their own chest expand with joy, their own heart thrill with happiness, they have given me statements such as: “It’s been so long, I don’t remember,” “I don’t really feel joy,” “I don’t know,” and “I don’t think I even know the meaning of the word.” (Since joy is the essence of the spiritual life, there can be a certain irony here.)²

¹ Regarding this diffidence in talking about childhood, the intake scenario usually ran something like this: “...and what about your childhood? Anything interesting that you think might be of significance?” The PDers each replied to my query with more or less the same words, while becoming distant for the first time: “I don’t think we need to discuss that. I’ve worked that out.”

I’ve been a primary medical care provider for years; I’ve grown used to people answering my medical intake queries. This evasion on the part of my first PD patients when I asked about their childhood certainly piqued my curiosity. And yet, others were not shy at all; they told me stories of hair-raising violence and cruelty. But they told me these stories in a detached manner, and usually assured me that it didn’t matter anymore, that they had “dealt with it.” Of course, not everyone had a horror story from his immediate family or a childhood that called for a high level of stoicism. But even many of the people from happy homes recalled some injurious event during which they decided to put up a strong face.

² A swami, a monastic yogi, once told me that people with Parkinson’s disease are very advanced souls who have temporarily lost their way. A Tibetan monk stated that people with Parkinson’s are living in their heads; they have forgotten that God is also in their bodies. I have discussed the spiritual aspect of PDers’ lives with

Location of the attitudinal symptoms

At first glance, the Parkinson's personality and other attitudinal symptoms seem to be body wide, and therefore might *not* seem to fit onto a body map. However, the insufficiency of courage and absence of joy can be related, in Asian medicine, to diminished function of the Kidney channel – the channel that supports the adrenal gland and the pericardium. In Asian medicine, the adrenals and the pericardium are related to courage and joy, respectively. In chapter five, a map of the distortions of Qi in the foot shows how the aberrant Stomach channel may cause the Kidney channel to become deflected towards the floor. As noted in the previous section on temperature regulation, this and other aberrations in the Kidney channel can occur because the distortion in the Stomach channel in the vicinity of KI-2 and KI-6, near the ankle. When this occurs, the amount of Qi that flows in the overall Kidney channel is diminished.¹

hundreds of PDers and their family members. Some of these long talks have gone late into the night. The insights from people who have recovered from PD have been especially enlightening. Most recoverers have thought deeply about the personality changes that they experienced during recovery. I have written up the following conceit (extended metaphor) to share the brutally honest self-analysis and conclusions that arose in these many talks.

People with Parkinson's may feel as if they have spent lifetimes climbing up the steep mountain of self-discipline, seeking God attunement or spiritual progress. They have spent lifetimes practicing mind over matter and denial of the flesh. As they've climbed higher and higher up the spiritual mountain, they've felt a growing detachment from the people in the metaphorical valley below. Increasingly, they have come to view those who were not working at seeking Truth as being earthy, bawdy people, larking about in childlike ignorance.

After lifetimes of diligent exercises for self-discipline and/or spiritual practices, they have developed tremendous mental powers of concentration, superb physical control and strength, the capability to *detach themselves from the sensations of the body*. And then pride over these accomplishments has crept insidiously into their hearts. They have come to feel that they were somehow different from or superior to the less powerful people. When pride came, they lost their sense of direction. They tried to use their hard-won capabilities to fend off the freezing loneliness of their high spiritual altitude.

They magnanimously serve others from their state of spiritual elevation even while they feel apart from them. From high on their metaphorical mountain of spiritual attainment, they become responsible, they take charge, they pridefully give blessings to the underachievers, the incompetent people below. But in the loneliness and emptiness of their attainments, they remain assailed by their infinite fears.

They have forgotten that attunement with God is most easily found via the low-lying paths of humility, devotion, and the trust in God that brings spiritual fearlessness.

And so, by virtue of the Divine laws of cause and effect, they eventually develop this fitting illness. The symptoms of this illness are the logical conclusions of what they have long sought: they have denied the senses of the body for lifetimes, and so the senses become stripped away: taste, smell, and touch are all lost. Their mental determination to be unmoved by worldly events results, eventually, in an illness characterized by inability to participate in the world.

Finally, when they can no longer dress themselves, feed themselves, clean themselves, explain themselves, or even blink their eyes in wordless communication, they may realize that they are dependent for every aspect of daily activity on those very people that they once spurned: the common people down in the vale.

Eventually, after repeated lifetimes of struggling against the symptoms seen in Parkinson's disease, they *will* learn to accept, with humility and gratitude, the ministrations of the kind members of the community. Their minds will someday let go of their fear and pride. When this happens, they will suddenly behold God all around through their remaining senses of hearing, sight, and intuition.

They will hear God's love and sympathy in the gentle patient words of the people who care for them. They will perceive in their heart the good intentions of God flowing to them through the actions of the helpful people of the valley. They will see that the very bodies of even the most unsophisticated people of the valley are condensations of the light of God. The spiritual seekers had never been alone on their mountain after all: God was always there. And there never was a mountain that needed to be scaled.

¹ I need to remind the aggressive acupuncturist that merely needling the Kidney channel will not bring about a lasting benefit in this situation. As long as the Stomach channel is deranged, it will continue to disrupt the

The palpable decrease in Qi flow from KI-1 on the sole of the foot over to KI-2 and other foot points of the Kidney channel do correspond to decreased Qi flow in the Kidney channel. The decrease can have an effect on adrenaline release – which can influence courage. Also, the main branch of the Kidney channel becomes the Pericardium channel.

The pericardium muscles influence the degree to which the heart favors, at any given moment, the sympathetic system or the parasympathetic system. A decrease in the flow in the Kidney channel can lead to decreased function of the pericardium and the nerve function in the heart.

As noted in chapter one, in Parkinson’s disease, neurotransmitter receptor function in the heart is measurably decreased (measured with SPECT scans). This suggests a problem in the Pericardium channel.

Also, many PDers have difficulty in imagining their pericardium relaxing enough to allow the heart to rotate back into the parasympathetic heart position. PDers’ hearts tend to be physically *stuck* in the extremely sympathetic or even the dissociated position, a position determined by the pericardial muscles and the flow of the Pericardium channel.¹ This “stuck heart,” in turn, can prevent a person from resuming parasympathetic mode. The stuck heart can keep a person in sympathetic or dissociative mode. This, in turn, influences thought patterns and attitude.

In Classical Asian medicine, deficiency of channel Qi in the Heart or Pericardium channel is the cause of anxiety.

Therefore, although attitude may *appear* to be body wide, channel pathologies in the Kidney and Pericardium channel can contribute to attitudinal symptoms.

Electrical aberration at the end of the Stomach channel can be detected disrupting and diminishing the flow of the Kidney channel. This in turn diminishes flow in the Pericardium channel. The Pericardium channel can also be diminished by selective dissociation from the heart. A person with only psychogenic parkinsonism may not have any of the channel aberrations from foot injury, but he may still have inhibition of the Pericardium channel that *mentally* have been set in motion.

Many PDers in our experience have had both of these inhibitions: one from injury, one from selective dissociation.

Kidney channel. The underlying problem must first be addressed. Premature treatment of the Kidney channel can actually add energy to and thereby worsen the Rebellious situation in the Stomach channel. Also for the acupuncturist, the reason the Kidney channel is diminished overall is because the errant Stomach channel Qi gets shunted back into the Spleen channel at SP-6, leaving an overall deficiency in the Kidney channel.

¹ The reader who is baffled by the idea of a heart “position” might want to try the following exercise. Imagine that your heart has a spindle running through it from top to bottom. Imagine that the heart can rotate around the spindle. First, rotate the heart counterclockwise as far as it can go (counterclockwise while looking down at the heart, from the head.) Hold it in this position for a moment. Notice the tightness in the chest and the overall sense of tension and anxiety. Next, imagine the heart rotating the other direction as far as it can go. Notice a sense of heaviness and sleepiness. Finally, let the heart go back to its first position, “facing forwards.” Notice the sense of alertness and the feeling that something pleasant is emanating outwards from the heart. When I write about PDers’ deficiency in the pericardium (the muscles that surround the heart and also allow the heart to rotate counterclockwise or clockwise in response to sensory input or bedtime), I am referring to the way that many PDers’ pericardium seems to be stuck in the “anxious” position. Many PDers are unable to successfully perform this exercise.

PD personality: not for everyone

Not every person with Parkinson's disease has all the symptoms listed in this chapter – including the symptom of “Parkinson's personality.” I have met people with bona fide Parkinson's who do not fit the “classic” Parkinson's personality profile and do not the attitudinal symptoms listed above.

Even so, for the most part, people with PD might be described as ***being, or having been in their youth or at their moment of injury***, self-denying stoics who are willing to serve others but not themselves, and who would rather die than reveal to the wrong person that they have been physically or emotionally injured.

For example, you read in the case studies chapter about Gus, whose injury was received during a war-time battle: immediately before, during, and after the time of injury, his personality was, of necessity, very much like that of the classic, wary, PD personality. However, prior to the war and after the war he had a very easy going, almost happy-go-lucky personality. His stoic, dissociated personality was compartmentalized in his brain; it only remained with regard to his foot injury and that day of death. The stoic personality was locked up in his brain in the same brain compartment as his war injury. The rest of his personality was not typical of the Parkinson's personality.

Although his ordinary personality was normal and content, this one small part of his mind and memory remained ever under stress and dissociated from his conscious sense of self.

He did not develop Parkinson's until he was in his mid-80s. The lateness of his injury (early 20's) and his predominantly non-PD personality are possibly the reason for his very delayed onset of very mild Parkinson's.

Oppositely, people whose PD manifests early or hard and fast tend to fit fairly closely the generalities about the Parkinson's personality.

Symptoms that don't fit the map: exceptions to the rule

Some PDers had symptoms of rigidity, pain, dystonia, numbness or immobility at unique locations, locations that were not in common with other PDers. Very often, these unique points of pain did not fit on the Stomach channel or Large Intestine channel. These extra locations were usually scattered sparsely on one or two different channels and each scattering was unique.

Over the years, we learned that the extra problem areas were usually located at body parts that had received injuries at some time in the past: a broken rib, a badly sprained wrist, a surgery or a whiplash accident. These injuries were always present *in addition* to an unhealed foot injury. These injuries often felt, to the health practitioner's hand, as if they were still unhealed.

Clarifications and caveats

For research purposes, I did not include any PD patients in our write ups who had a significant, known medical situation in addition to their Parkinson's symptoms. People with a history of stroke, heart disease, or anything that might confuse the data were not included in the research.

Also, remember this: no one PD patient will necessarily have all of the symptoms, classic western medicine or auxiliary symptoms, described in this chapter. At his time of diagnosis, he may have only a few symptoms. The symptoms of Parkinson's disease usually develop gradually. At first they may even be intermittent.

And for those of you in the audience who might have Doctor's Disease or hypochondria, remember: although each of the preceding symptoms is often seen in conjunction with

Parkinson's, in and of itself it is *not necessarily a warning sign or precursor of Parkinson's disease*.¹

Finally, don't forget: the symptoms of idiopathic Parkinson's disease are somewhat different from the symptoms of drug- or toxin-induced parkinsonism; these forms of parkinsonism do not necessarily have the auxiliary symptoms, nor do the natures (excess or deficient) of the symptoms of drug- or toxin-induced parkinsonism necessarily conform to the nature of idiopathic Parkinson's symptoms.

Adding weight to the hypothesis: symptoms of recovery

Wonderfully, the *nature* of each problem area reverses itself during recovery. For example, during recovery, the flaccid muscles of the face may begin to spasm; this spasming and tension are signs of returning strength: the reversal of their previous limpness. On the other hand, the rigid muscle of the neck may become so limp that the recovering PDer can't hold his head up for several days.

The reversal of rigid and limp pathologies during recovery suggest that the nature of the symptoms is as significant as the location in understanding the pathologies of Parkinson's. The extreme degree of reversal suggests that the tissue damage is deep; nerves, muscles, brain connections all behave as if they have been dormant or damaged and need to heal. This suggests that most PDer's have had ongoing damage along the Stomach and Large Intestine lines long before they were ever diagnosed. This also fits with our hypothesis.

The significance of Location-specific Symptoms

Although I now know many ways in which "death of the dopamine cell" theory does not explain away all the pathologies of Parkinson's disease, the map exercise was the first time it really hit me. The location-specific symptoms of Parkinson's suggested that Parkinson's disease is primarily an electrical disorder, a channel disorder.

Not only does a map of symptoms paint a picture of the Stomach and Large Intestine channels, it conflicts with the idea of a systemic dopamine problem. The symptoms of Parkinson's are located in certain areas and not others: a *systemic* dopamine deficiency could absolutely not explain why specific muscles consistently had problems and others did not.

For example, many PDer's originally have tremor in their index finger along the course of the Large Intestine channel. The other fingers are usually not involved until the PDer begins to mentally dissociate from his now problematic (tremoring) hand.

Also, certain facial muscles are typically affected, but not others; a PDer cannot use the muscles of the face that create a "ball" or "apple" in the cheek while smiling but he can easily raise his eyebrows by lifting the muscles of the forehead.

PDer's often have no proprioception in their middle toes. (Proprioception is the ability to feel where a body part is even when one's eyes are closed or the body part is outside of the field of vision). PDer's usually cannot separate their 2nd and 3rd toes on the SSFA. They can often move and detect the location of their other toes.

If the problem was truly one of dopamine deficiency, all toes, all facial muscles, all fingers, should have equal or randomly occurring difficulty in proprioception and movement initiation.¹

¹ Doctor's disease is the tendency to imagine that one has the symptoms that one happens to be reading about. This not uncommon syndrome is particularly rampant in medical schools; some would-be doctors truly feel, and sometimes visibly manifest on their bodies, the symptoms that they happen to be studying.

This brings to a close the sections that show how the symptoms of Parkinson's disease can be best understood by recognizing the changes in channels that occur in people with Parkinson's. The rest of this chapter closes off the subject of Part I of this book: The Cause of Parkinson's Disease.

FINDING THE CAUSE OF PARKINSON'S DISEASE

The first map

The first time I mapped the symptom locations, I saw that the Stomach channel might provide answers for the underlying cause of Parkinson's disease. But at that early date, expecting a Stomach channel aberration to account for the brain changes seen in Parkinson's disease seemed to be asking too much.

Then again, these combined symptoms of Excess or Deficiency presenting in PDers were baffling. I could not think of any systemic condition in the brain that could create conditions of excess in some parts of the body and conditions of deficiency in others. *If all the symptoms of Parkinson's were due to a dopamine deficiency, all the pathologies should have the same deficient nature.*

Poor muscle tone from dopamine deficiency should produce limp muscles throughout, not the blend of limp and rigid that is seen in Parkinson's disease.²

In the meantime, questions remained. What about the brain's cellular changes? Was the stoic attitude the thing that prevented the foot injury from healing? If so, how?

The Stomach channel story could not, at first glance, answer all the questions. However, it did give a good thumping to the increasingly inadequate dopamine-cell death theory. Over the next several years, recovery symptoms answered more questions. The recovery symptoms led us to propose the set of channel reconfigurations that could account for all the symptoms of Parkinson's and the recovery symptoms. Once we knew what to look for, we saw evidence of these channel aberrations in all the PDers. Also, some of the more arcane teachings of Asian medicine, such as the Law of Midnight/Midday (the two hours periods of increased Qi in any given channel) suddenly became meaningful.

Most importantly, by merely treating the foot injury, some of our PD patients made a complete, easy recovery from Parkinson's disease.

¹ Of course, in advanced PD, the problem may eventually affect all five toes. And there are a few PDers whose feet are so damaged that they haven't been able to move any of their toes since their college days. Still, we were basing our generalizations on the situations seen in most early- and mid-stage PDers.

² The reason that dopamine-enhancing drugs improve movement in rigid areas is that they mask pain. If neck muscles are rigid, a person will refrain from turning his head from side to side because of the tension and pain. Under the influence of pain-masking dopaminergic drugs, he will not feel pain. He may move in whatever manner he wants to. When the drugs wear off, the pain in the rigid area resumes, possibly even increased by the movements that were done while he was under the influence.

The antiparkinson's drugs do not resolve any of the symptoms. They mask the symptoms.

Partial recovery and the discovery of the mental/emotional component

PDers who got stuck in partial recovery added a new dimension to the mystery. They no longer had no physiological symptoms of Parkinson's and had experienced some of the recovery symptoms, and yet they were emotionally susceptible to "attacks" of Parkinson's symptoms.

Working closely with these patients, and with the patients with psychogenic parkinsonism, we uncovered the shocking commonality of dissociation from the heart and an inability to feel safe. In the early twenty-first century, new research using mice proved that feeling safe is the trigger that causes an initial surge of dopamine release in the substantia, which then leads to seeking behaviors which then leads to further dopamine release.

Putting this all together with the foot story, we created a model that could explain all the symptoms Parkinson's disease. The model required two pathological patterns: a foot injury and dissociation from either the foot *or* the foot and the heart. The dissociation could be either held in place all the time or selectively activated in situations in which the PDer did not feel safe.

By treating both of these problems, the foot and the dissociations, we were able to eliminate Parkinson's disease in *some* partially recovered PDers, but not all.

Many patients dropped out of the program when they learned that they would have to change some of their mental habits. Others dropped out because they were convinced that they could *never* change their mental habits. Others felt that when we included the self-induced mental component to our theory of Parkinson's, we were "blaming the victim." We got some heated correspondence accusing us of inventing the idea of a mental component so that we could explain away those PDers who did not recover even after their foot injuries were gone and they'd experienced the foot-related recovery symptoms.¹

But we have stuck to our guns: one of the commonalities in recovered PDers is their conviction that they have become a "different person." In cases involving people who were stuck in partial recovery, the "different person" did not emerge as a *result* of recovery; by *becoming* a "different person," the PDer was able to recover.

One new idea

The reader may be wondering if all of my ideas about channel rerouting of Rebellious Qi are supported by Asian medical theory. The answer is "almost."

But first, remember: modern Asian theory did away with the existence of channels. Even so, many practitioners of Asian medicine have observed proof of channels and some of the older doctors secretly still make use of channel theory.²

Historically, learning about channels was the traditional starting point for any study of Asian medicine. Therefore, honoring tradition, some of the old channel theories are still taught, even though they are usually taught as historical relics. As for channels flowing backwards,

¹ When I first received hostile correspondence, I was surprised. But my son reminded me that paradigm shifts go through three stages. In the first, the new ideas are mocked. In the second stage, they are met with open hostility. In the third stage, they are accepted as self-evident.

² Twice in one year I attended classes taught by highly respected teachers of Asian medicine. Both of them made a statement at some point in the lecture to the effect that "it's OK if you don't needle the acupoint in the exact right place, as long as you get the needle on the channel." Both of them, when asked after class whether or not channels actually exist, said that they did not believe in the existence of channels: they followed the party line.

failing to flow, or flowing into other channels, those ideas are not my invention. Those are old, established ideas.¹

I did not invent any of the basic concepts presented in our hypotheses except for one, the jaw shunt. For the rest, if I accepted the idea that Qi is real, that channels are real, and that channel Qi follows the rules of electrical movement, then all of the aberrant channel flow seen in Parkinson's could be explained both in terms of Asian medicine and in terms of basic western physics.²

The only new idea that I had to add to my training in Traditional Chinese medicine was the idea of a Qi shunt on the jaw that served to prevent Stomach channel Qi from running backwards over the face and into the Du channel. Nothing in the traditional literature suggested that such a shunt system does exist. Even so, this shunt *does* exist: in PDers, it was palpable by hand.

Though it was not in the literature, I could feel the shunt on the jaw in my PD patients: the Stomach Qi in their necks ran backwards, up to their foreheads. It did *not* retreat back up the face path of the Stomach channel all the way to the point between the eyebrows. I had to hypothesize that, when Stomach Qi runs backwards, it is shunted away from the face. This built in shunt makes sense to me: surging, backwards-flowing Qi through the midbrain can cause death.³

With the jaw shunt in place at ST-6, Rebellious Qi from the Stomach channel, should it occur in response to any serious foot injury, is redirected up to the corner of the face where it should either cause headache or healing sleep. In mild cases of Rebellious Qi in the Stomach channel, Qi pools up at ST-8 and causes a headache, hopefully forcing the injured person to take a nap. In response to more serious injuries, the large amount of rerouted Qi building up at ST-8 may short circuit over into GB-4. When this takes place, a person may want to drop into a

¹ Even the newest student of Asian medicine is probably familiar with the principle of Wood Attacking Earth, in which the upward flowing energy in the Liver channel gets jammed up at LI-14 and palpably shunts over into the Stomach channel, thereby disrupting the downward flow of Qi in the Stomach channel. Though the word "channel" has been removed from the phrase "Liver channel attacking the Stomach (or Spleen) channel," a quick feel of the channels in the vicinity of LI-14 will show that the physical problem is the channel rerouting that occurs at acupoint LI-14. Channels have been removed from the nomenclature, but the classic pathologies usually imply the pathological action of Qi in the channels.

² I have received queries, sometimes hostile ones, from acupuncturists who were taught that Qi only runs in the lines that are taught in the basic textbooks. I always ask them to start feeling the Qi flow in their patients. They will soon have proof that, to paraphrase Tolstoi, "All people with healthy bodies in parasympathetic mode have channel Qi flow that moves in the same way. All people with injury and illness, including mental illness, have at least some portion of channel Qi that flows in its own, unique way."

³ I had seen a demonstration of this principle by accident. I was using gold and silver needles on a patient who had lack of focus and depression. I was trying to stimulate the Du channel through the head, so I put a gold needle on her forehead and a silver one on the back of her neck. The use of two different metals creates a small electrical current. By using one gold needle and one silver needle, I can make a very low powered "battery" that sends a current between the two needles.

I made a mistake. I should have put the gold at the back of the neck and the silver on the forehead. Instead of generating a current from the midbrain to the forehead, I was generating one that ran backwards through the head. At first, my patient said that she felt weird. Then she said, weakly, that something was wrong. As she started to pass out, I saw what I had done and removed the needles. I reversed the needles and within seconds she returned to full alertness.

healing sleep and take some time to live slowly, nursing his wounds. This jaw shunt is an excellent built-in safety/health mechanism for a normal person. It is the only Qi flow item that is original in our hypothesis. And I strongly suspect that it is not “original,” but was known by other doctors before my time.

SUMMARY

I have shown the extent to which nearly all the well known and lesser-known symptoms of Parkinson’s are located on just two channels of the body: the Stomach and Large Intestine channels. By showing that the *nature* of the symptoms corresponds to Rebellious and Deficient Qi patterns, I have shown that these symptoms may correspond to an unhealed injury and the ensuing pattern of Rebellious Qi in the Stomach channel, complete with the shunts and short circuits described in chapter five xxx.

Asian medical theory explains *how* these channels changes can lead to non-channel symptoms such as the inhibition of dopamine-release and the decline in dopamine producing cells.

The mental/emotional blockages known as dissociations, which have been widely studied by psychologists and psychiatrists, can explain the symptoms of Parkinson’s that are affected by mood, thoughts, and situations.

Another point that makes itself clear while looking carefully at the full list of recognized symptoms and auxiliary symptoms is that the current paradigm, the “dead dopamine cell” theory, simply does not match the limited locations or the mixed natures of the symptoms of Parkinson’s disease. Even the few symptoms that eventually become body-wide, such as slowness and depression, symptoms that might conceivably be caused by a systemic disorder such as dopamine deficiency, also happen to resemble a healthy response to severe injury *and* a selectively-induced dissociation-from-the-heart response.

The Big Four symptoms in Parkinson’s disease don’t have any logical connection. Also, the tremor and balance problems – two of the four – do not necessarily improve even if a PDer takes dopamine-enhancing medications.

Oppositely, the symptoms of sustained Rebellious Qi in the Stomach channel because of an unhealed injury make perfect sense – if a person is aware of the electrical schema that courses through the body and which provides instruction to every cell in the body from the time of conception.

Throwing away the dopamine theory for failing to fit the facts, we can say just this: Parkinson’s disease causes anatomical and physiological changes. The cause is unknown. Long-maintained Rebellious Qi in the Stomach channel due to unhealed foot injury creates the same changes. The cause is known.

IN CONCLUSION

Parkinson’s disease is the same illness as sustained Rebellious Qi in the Stomach channel From an Unhealed Foot Injury.

Many of my readers mistakenly think that Rebellious Qi *causes* Parkinson’s disease. No. Sustained Rebellious Qi in the Stomach channel and its inevitable shunts and short circuits is the

same exact thing as Parkinson's disease. They are both names for a syndrome that manifests itself as a particular collection of symptoms.

This bantering over a name is actually very important. The name "Parkinson's disease" is associated with incurability. One patient told me, "The day the doctor said the words 'Parkinson's disease' to me, the world changed."

As another example, I was examining a recovering patient and noticed that the Qi was finally running correctly in his legs. By his own admission, his symptoms were nearly gone. I said to him playfully, "Oops! Looks like you were misdiagnosed!" A few minutes later, he said to me, "The moment you said that, that I was misdiagnosed, I felt a shift go through my whole body. I felt a glow inside that I haven't felt since I was told I had Parkinson's. It's as if, in that moment, when you said that, that's when I really recovered. I know it's just a name, but until then, even though my symptoms were mostly gone, I could feel there was something wrong inside."

There is power in a name. Since Parkinson's is defined as incurable, doctors should be very careful in giving out that diagnosis. For myself, I'm reluctant to work with patients who have Parkinson's: Parkinson's is incurable.

I prefer to work with people who have Rebellious Qi in the Stomach channel From Unhealed Foot Injury, with possibly some Dissociation from the Heart on the side. That disorder is curable. The two syndromes are exactly the same.

