

Did we study medicine or medicine?

*'Acute [diseases] meaning those of which God is the author,  
chronic meaning those that originate in ourselves.'*

- Thomas Sydenham (1624-89), physician

## The Dutch doctor's oath

*'I promise to practice medicine to the best of my ability in the service of my fellow man. I will care for the sick, promote health and relieve suffering.*

*I will put the patient's interests first and respect his views. I will not harm the patient.*

*I am listening and will inform him well. I will keep secret what is entrusted to me. I will advance the medicinal knowledge of myself and others. I recognize the limits of my abilities. I will be open and verifiable, and I know my responsibility to society. I will promote the availability and accessibility of health care. I will not misuse my medical knowledge, even under pressure.*

*I will so honor the profession of medicine.*

*I promise.*

# Content

Foreword	11
Introduction	15
1 Medicine	27
2 Rob and Terry	43
3 Insulin resistance	55
4 Low-grade inflammation	73
5 Microbiome	95
6 Immune System	125
7 Mitochondria	139
8 Stress	161
9 Toxins	171
10 Detoxification	185
11 Medicine	199
Thank you	223
Addendum	225
References	227
Register	251

# Word in advance

*by Martin Schipperus*

'S tude medicine or medicine?" asks Lieneke van de Griendt in her book to all practitioners of patients with a chronic condition or disease. This question is very topical and, fortunately, is receiving more and more attention. For example, Machteld Huber has introduced the new concept of 'positive health', in which health is no longer seen as the presence or absence of disease, but as the ability of people to cope with the physical, emotional and social life challenges to deal with.

The number of chronic patients is only increasing in recent years. In 2018, nearly 10 million patients had one or more chronic conditions. Even cancer is now considered a chronic disease - and we are getting cancer more often and earlier. Since 1990, the number of annual new cancer cases in the Netherlands has more than doubled. Currently, a man has a 45 percent chance of getting cancer during his lifetime and a woman a 37 percent. Of course, this is partly due to better diagnostic methods and screening programs, but it still gives food for thought. It seems like mopping up with the tap running and with drugs alone we will never solve this problem.

This book expertly reviews a number of important causes of chronic diseases. We are included in the story of Rob and Terry, patients who have tirelessly sought better, cure-oriented treatments for the disease Multiple Sclerosis (MS). Terry Wahls, MS patient and senior lecturer in internal medicine at the University of Iowa in the United States, eventually developed this into a scientifically sound treatment method: the Wahls Protocol. This consists of a combination of good nutrition, vitamins, minerals, supplements, exercise and strength training, relaxation and sleep.

That patients often have to find their own way through the jungle of non-regular medicine is a well-known fact. A survey of patients with hematologic disorders at the HagaZiekenhuis in The Hague, where I worked for almost twenty years, shows that more than 70 percent of them use some additional form of non-medicinal treatment. Unfortunately, only 30 to 40 percent of them share this fact with their treating physician. This is because most patients are afraid of encountering un-gripping from their physician. This is unfortunate, because patients would benefit when physicians have a listening ear for their patients and are open to a more holistic approach to the patient and his or her condition. A patient of mine once complained about the way she felt we work in the hospital these days: there was no more "surgery," in her opinion. Rather, she felt she was being broken into thousands of pieces

fragmented because it was sent from subspecialist to subspecialist. 'Whole person,' should be our motto (again), and we can achieve that by becoming more knowledgeable about functional medicine - and by training medical students in it as well.

This book provides a taste of this knowledge by going step-by-step into the pathophysiology of chronic diseases.

It is fascinating to read what the role of the microbiome can be; mainstream medicine has now picked up on this, leading to fae- cest transplants for intestinal infections, as well as influencing the immune system in diseases such as

MS. This brings us back to Terry Wahls, who was convinced that she needed more than just medicine to cure (if that is possible) her MS. Many patients, like Terry, have begun their search, but are not yet being heard enough by their practitioners. Hippo- crates (see physician oath on page 6 of this book), however, made us promise to listen carefully to our patients and also to avoid harming them. If we limit ourselves to prescribing medication, in some cases we must question whether we are still keeping this promise. Symptoms can be controlled and symptoms relieved, but a defini- tive solution pills usually do not offer.

Ultimately, an integrative approach to the many factors underlying the onset of chronic disease will offer a greater chance of true cure than the mere administration of drugs. That is the cure-

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art and science to which Lieneke is striving with this book and others. This is not only a beautiful and commendable endeavor, but actually a must for any self-respecting physician.

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# Introduction

**P**athologist Prof. Marco de Vries was an exceptional man who, at the end of the last century, dared to conduct scientific research among his very rational-minded colleagues into what in human life could contribute to "spontaneous" recurrence of cancer.<sup>1</sup> Thanks to his lectures on General Theory of Disease, which I took in the first year of my studies in Medicine, I now look at my patients and their chronic diseases with a broad view. It is partly due to this seed he sowed in my brain so many years ago that I am now beginning to see the big picture. Also, his courage to go against the established entering into order inspires me.

In those days, the 1980s, a serious (a chronic or fatal) illness was something that just happened to you, without us wondering too much about what caused it. Bad luck," was the answer I once heard from a specialist when I asked him about it. The genes, in particular, were held responsible. Now we are discovering that environmental factors, of which nutrition is one, also play an important role. If we look at cell biology, biochemistry and physiology and see which vitamins, minerals and trace elements are needed in the many enzyme reactions of our metabolism, it is actually

very logical. Unfortunately, we learned little about it at the time.

My biochemistry textbook from that time mentions something about vitamins on fifteen of the thousand pages, and a number of important minerals I also see mentioned here and there. I don't remember that we learned in which foods we can find the micronutrients - which are necessary for the optimal functioning of our body and thus for good health - and that taking a nutritional history is therefore useful.

### **The doctrine of medicine**

In contrast, we were taught extensively about pharmacology: the doctrine of medicine. So the central question we ask ourselves every time as doctors is: how can we intervene in the patient's biochemistry and/or physiology with a drug or intervention so that the symptoms disappear?

Acute conditions (a wound, fracture or infection) can be treated well with this approach. But what if the patient develops a chronic disease? Can we eliminate it even with the help of a drug or intervention?

As with the acute complaint, we ask questions, we do physical and possibly blood tests, and perform X-rays or other imaging tests. Then, based on the results, we make a diagnosis and then ... we often prescribe a medication. The patient takes the medicine, (sometimes) gets rid of his symptoms, and the blood results improve. But after discontinuing the drug, the same symptoms return, or new ones arise. If, as a general practitioner, you no longer know how to proceed, you refer the patient to a specialist.

your patient to a specialist. The specialist does more research and then prescribes more or different pills. Pills that quite often give side effects, for which we then give another pill. Meanwhile, the original disease is still not overcome. Before he knows it, the patient is stuck on medication for life, and we see the patient adding more diagnoses - and medications - over time. For example, it starts with chronic fatigue and an irritable bowel, then we see increased blood pressure and slightly elevated sugar levels, then the thyroid slows down, depression sets in, or the patient suffers an autoimmune disease, osteoporosis, heart attack or stroke on top of it. And so the already chronically ill patient goes from rain to drip.

It is the same with complaints that cannot be diagnosed. If the recurring or long-standing complaint does not yet fit within a diagnosis, we call it an SOLK: a *somatically unexplained physical complaint*. In other words: we do not know the cause and there is not much we can do about it.

The patient notices that neither GP nor specialist can help him get rid of this complaint and, after going back three times for the same complaints, feels "a nag. And the doctor, in turn, becomes frustrated because he realizes that he has not been able to cure the patient, as he keeps coming back.

On Jan. 1, 2016, the Ministry of Health determined that 8.8 million people in the Netherlands had one or more chronic disorders; by Jan. 1, 2018, the figure was 9.9 million. This corresponds to 52 percent and

58 percent of the Dutch population! In fact, 95 percent of people aged 75 and older have a chronic condition.

### **Medicine or medicine?**

I've been watching this pass by me for about 20 years, and I'm slowly wondering: what's going on here? Were we studying medicine or medicine? I cannot conclude otherwise than that we doctors are not very good at curing a patient with a chronic complaint or disease.

So what did we learn during our studies? We learned to recognize and name the symptoms that belong together: *hypothyroidism* (thyroid gland working too slowly), *cardiomyopathy* (heart muscle disease) and *osteoporosis* (brittle bones), for example. The names sound expensive and intelligent, but really only indicate where the problem is. The name says nothing about why the problem arose. For example, we determine that the thyroid gland is working too slowly and, at best, get no further than to say that the cause is an autoimmune reaction. Why that reaction occurred, we don't know. We then learned how to suppress the symptoms of this diagnosis with pills. Our study was also called the Study of *Medicine* in the 1970s and 1980s for a reason.

Prescribing is a logical consequence of how our profession has evolved. Traditional healers and shamans used plants and herbs for their beneficial effects, and Western science built on that. We discovered how to extract the medicinal part from the plant.

isolate or imitate. By giving this to a large group of people and comparing it to a group that does not receive this drug, it can be said whether a significant portion of this group experiences a positive effect from it. We call these studies *randomized controlled trials* (RCTs). The results of these RCTs allow many to live longer and, in some cases, even reduce disease. For the chronic diseases, however, it is usually the case that medication must be taken for life, especially for the diseases that the general practitioner supervises: diabetes, cardiovascular disease and lung disease. Thus, patients can never stop taking their medication. In other words, with the medication we suppress the symptoms of the chronic disease, but cannot make the disease itself disappear with it.

### **Suppression of symptoms**

Once we have made a diagnosis, we do not then investigate the question with the patient: why did the disease arise? Of course we know a bit: it will have something to do with lifestyle, nutrition or stress, but with chronic abdominal complaints, eczema and thyroid disorders, for example, we quickly lose track. And when diagnosing psoriasis, alopecia, multiple sclerosis and rheumatoid arthritis, we are completely lost. We then prescribe something that relieves the symptoms and suppresses the symptoms, but do not actually help those with a chronic disease to get rid of it.

I'm having more and more trouble with that.

## **Research**

Of many chronic symptoms and some chronic diseases (such as autoimmune and neurodegenerative diseases), we still do not know exactly how they come about. They probably involve many causes at once, which may be different for different individuals but lead to the same disease. That means we will have to do countless large RCTs - and meta-analyses from them - to get one small step closer to the truth. Such outcomes may take 10 to 20 years to emerge, if those studies are ever done at all. In fact, doing research on such a complex disease in humans involving many different causes is extremely difficult and also often ethically impracticable. In addition, these studies require a large financial investment, but if they are not linked to something that can then be sold, they yield nothing. The patient with a disabling chronic disease has no time at all to wait for all this. And one might ask: doesn't that patient simply have a right to hear what we do know, even if it is somewhat premature for a broad-based scientific consensus, so that he can decide for himself what to do with this knowledge?

## **Blue Zones**

Now that we know that there are regions of the world (called Blue Zones<sup>2</sup>) where almost everyone reaches old age in good health, we can no longer ignore them. Research into the success factors of these Blue Zones show

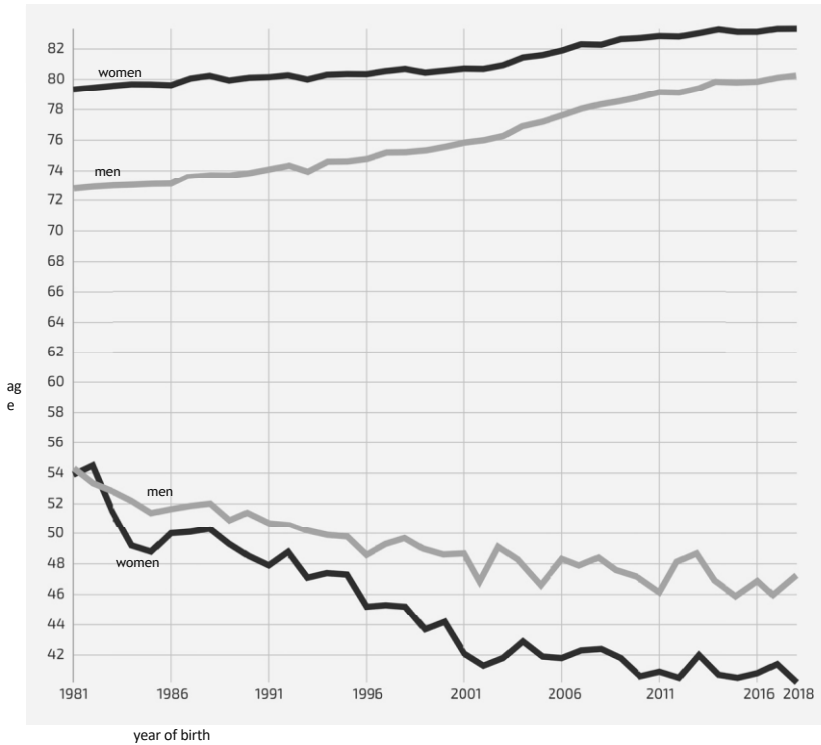
that the way we live affects the health of our bodies. The Blue Zones show us that being part of a community, having loving relationships and a purpose in life (*ikigai\**), getting enough exercise, living and working in a reasonably toxin-poor environment, and eating unprocessed, varied foods are important to growing old healthily.

### **Increase in chronic diseases**

The World Health Organization (WHO) says the following about a number of chronic diseases<sup>3</sup>: 'Cardiovascular disease, cerebral infarction, cancer, diabetes and chronic lung disease together account for nearly 70% of over-suffering worldwide. It has been established that the rapid increase in occurrence of these diseases is mainly due to four main causes: smoking, alcohol, unhealthy diet and insufficient exercise.' And in 2009, at the Dahlem Conference in Berlin, 37 experts agreed that not only the so-called *hygiene hypothesis* (see box on next page) is probably responsible for the increase in certain chronic diseases, but also exposure to pollutants such as exhaust fumes and particulate matter, altered diet and use of antibiotics<sup>4,5</sup>.

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*\*One of the Blue Zone islands studied is Okinawa; this is where the term ikigai comes from.*



*Figure 1 - Graph of life expectancy for men and women (top two lines) and life expectancy without chronic diseases (bottom two lines), as of birth year 1981. While we are getting older, we are also getting chronically ill sooner. Source: CBS, 2019*

## True health

Shouldn't we physicians be working on this? The patient with chronic complaints deserves our comprehensive attention and customized care. And by that I mean: identifying together what the cause of the complaints is, and then treating this cause to-



catch and take away. Medication we can then quite often reduce or even phase out altogether. That is the way to true health.

### **Old knowledge, new insights**

In this book, I tell how, thanks to listening carefully to my patients - as I promised to do when taking the oath - and many hours of study, I gained a new perspective on health and disease. I immersed myself again in some of the basic subjects such as biochemistry, physiology, endocrinology and immunology. But this time, not as during my studies from the question: what medicine fits this? but: what does the body lack in raw materials? What do the cell components and systems of our body need to function optimally and what can actually harm them? If we know this, we may not have to wait for the results of large RCTs to be able to give simple and safe advice that can contribute to better health.

When treating a chronic complaint or illness, instead of just following existing guidelines, let us start thinking again and ask the question: Why is the patient unable to lose weight? Why is the immune system attacking the body's own tissue and why does the patient have irritable bowel?

And let's combine our old knowledge with new insights: so much more is now known about what the body needs to stay healthy!

## **A world of difference**

This book is not a blueprint for how to do things differently. I see it as the physician's job to adequately inform and be able to advise the searching patient. Therefore, I want to see my colleague's enthusiasm to go beyond diagnosing a diagnosis, to consider what may underlie the diagnosis, for example, metabolic chaos, low-grade inflammation, dysfunctional mitochondria, a hyperactive immune system, detoxification problems, or combinations of these things. Then from there, the link can be made to their cause, such as hyperinsulinemia, an increased permeable intestinal wall, inadequate micronutrients, a disrupted microbiome, chronic stress or exposure to toxins. The patient can then - if he wishes - be informed about what is going on and what causes may be involved. He will feel heard and seen and can make his own conclusions and decisions accordingly.

From experience, I have found that it makes a world of difference to patient motivation if the doctor can explain exactly how things are. This may sound easier than it is, because the topics we encounter on this path are entirely new subjects for most doctors. That means we get to study again to master the new insights.

So get to work!