September 1997 Issue | Dr. Christiane Northrup, M.D.

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Welcome to *Functional Medicine Update* for September, 1997. Last month in discussing paradigm shifts, I gave some examples of the great scientific and cultural changes that are occurring in healthcare delivery and research-based medicine. This month we will keep that theme going, but from the perspective of women's health issues. We will be focusing this entire issue on women's health issues. Our Clinician of the Month, Dr. Christiane Northrup, is an important supporter of the concept of a changing paradigm in women's healthcare delivery.

What is happening at the forefront of medicine? A recent issue of the magazine *Managed Healthcare* (1997;7(6):14-18) described the changing times with regard to managed care and medical delivery systems, integrating what previously was called alternative medicine. Some people call it comprehensive medicine, integrated medicine, or functional medicine.

Consumer demand is forcing managed care organizations to evaluate and implement alternative, comprehensive, or functional medicine in their health plans. It is a driver that has created a great dynamic of opportunity for a learning system to develop. I am borrowing a term from Dr. Peter Senge's book, *The Learning Organization*, in which he describes a learning organization as one that has engaged in the process of its own self-discovery and forward evolution through a shared learning experience.

We are seeing that process right now in the healthcare delivery system. Case studies and empirical observation from patients who have been given access to integrative functional medical therapies are showing that these therapies result in better patient feedback, satisfaction, and improved outcome. The consequence is greater subscription to health plans, which means greater business, greater profits to shareholders, and so on. There is an economic market driver that is presently creating an environment for this paradigm shift of integration.

Are we developing and providing therapies that result in people's having lowered utilization in the long term and allowing them to extend their health span, reduce morbidity, and prevent premature mortality? That question is raised in the *Managed Healthcare* article, which also asks what markers, determinants, and benchmarks are there to indicate that these integrative therapies are, in fact, delivering the goods, beyond just feel-good, that they are also producing improved outcome and benefit.

There is some question about how alternative care will be delivered and what it will look like in the future. Most healthcare finance forecasters predict it is here for the duration, as the baby boomers age, experience the decreased vitality that comes with middle age and beyond, and look for ways to hold on to the edge, preventing premature disease, and not ending up as many of them have seen their parents end

up. Most of the forecasters believe that trend will stay with us. Andersen's consulting group on health care predicts that as many as 60 of the largest health organizations will make a strong play within the next few years to integrate comprehensive, functional, or alternative care into their plans, similar to what the Oxford Health Plan has already done. Healthcare providers on the East Coast have already been offering that as an opportunity for their subscribers.

These developments raise questions about how we develop an understanding of competence in this area and apply it to specific segments of the healthcare consuming public, such as women who are going through menopause, the focus of this women's healthcare issue of *FMU*.

The best way to get into that topic is first to discuss what functional medicine is, since this tape series is called *Functional Medicine Update*. Many of you may still wonder how functional medicine differs from preventive medicine, integrative medicine, or comprehensive medicine. I'd like to describe how I think functional medicine is framed and then apply that model to the women's healthcare arena.

Dr. Buck Levin, Dr. Michael Schmidt, and I recently wrote a book chapter titled "Functional Approaches in Natural Medicine," in which we commented on the underpinnings of this paradigm shift in medicine and its relationship to functional medicine. The book, Churchill Livingstone's *Textbook of Natural Medicine*, was edited by Bastyr University President, Joseph Pizzorno, N.D. We wrote:

"Historically, students of science and medicine in the United States and other countries have learned anatomy and physiology from a systems cause-and-effect type approach. We have learned organ systems, individual organs, tissue, cells, and subcellular spaces as separate entities that interact with one another to form their function. The better one understands anyone's system or entity by this model, the more skilled he or she will be in treating dysfunction of that entity."

INTERVIEW TRANSCRIPT

Clinician of the Month:
Dr. Christiane Northrup, M.D.

Women's health issues are our focus this month in *Functional Medicine Update*. What better way to celebrate this topic than to have Christiane Northrup, M.D., as our Clinician of the Month? Many of you are familiar with Dr. Northrup's contributions as a graduate of Dartmouth Medical School, a diplomate on the American Board of Obstetrics and Gynecology, the Teacher of the Year in 1979 at Tufts Medical School, the cofounder of the Woman to Woman Innovative Health Care Center in Yarmouth, Maine, the author of *Women's Bodies, Women's Wisdom*--a book whose clarity and vision had an impact on most of us, and as the editor of the very successful monthly newsletter *Health Wisdom for Women.*

Dr. Northrup's accomplishments in the area of women's health field are significant. She is presently an assistant clinical professor of obstetrics and gynecology at the University of Vermont College of Medicine, and she is actively involved in a private practice, writing, and serving as a teacher and guide for all of us.

JB: With that condensed biography, welcome to *Functional Medicine Update*, Dr. Northrup. I will ask you the question I have asked nearly all of our Clinicians of the Month this last year. What events in your personal and professional life led you into the kind of practice and teaching that you now are involved with?

CN: The events started with the home setting where I grew up, in which we were interested in natural foods, organic gardening, and that sort of thing. My father was a dentist, and now I realize he was very preventive in his focus, using the latest technology to help people restore their teeth. I grew up with this kind of feeling, and then I went to medical school, which I call my anesthetic years, where I forgot a lot of what I already knew.

The big wake-up call for me was having my first child, trying to breast feed her all the time -- meaning breast milk only -- while trying to simultaneously be in private practice as an obstetrician/ gynecologist and be up all night delivering babies. Believe it or not, I really thought I would be able to do both of those things full time, which is crazy when you think about it. But I came of age as a woman physician in the 1970s, with the women's movement, and there was a powerful energy of "I can do anything."

I ran into a structure in place by society that made it virtually impossible to nurse a child and be fully functional as a doctor and a surgeon at the same time. As a result of that, I got a huge breast abscess and pretty much did an automastectomy on the right, and I began to realize that the dilemma of trying to balance my life between my nurturing function as a mother and my drive to do women's health in a new way were at odds with each other. I also realized that same thing was happening for many women.

Balancing our imbalanced lives was at the core of most of the illnesses I was seeing, ranging from PMS to menopausal symptoms and even pre-eclampsia. Women who came in with high blood pressure in pregnancy were often working in jobs they hated and for longer hours than they should have been. We were all in the midst of the turmoil of having a society that saw us as production units instead of human beings.

As a result of that, I realized we needed a different approach. We cofounded Women to Women in 1985 so we could help women use their own inner balance to do something about it. In other words, it wasn't enough to say society is doing this to me. That is a powerless, victim position. So I thought, you'd better put your money where your mouth is, and if you think the structure of medicine needs to change, you'd better try to do that yourself. It's easy just to sit there and blame the system. It's quite different to do something about it.

JB: I am intrigued by your rich experiential history, and to learn that during this period of time you were also voted Teacher of the Year at Tufts in 1979. How do you feel students in the 1970s and today have responded to this message, which is balance of the reductionistic model and the experiential model?

CN: The beauty is this: Every human being has both a right hemisphere and a left hemisphere, and even though it's been shown experimentally that the left hemisphere denies the existence of the right, the fact is that experiences like going to movies, listening to music, or gazing at a child you love activates the right hemisphere, so you know, deep within you, the truth of what I'm saying. There is more to life, and this balance -- that which moves us to tears -- is enormously important.

The students in 1979 and the students 20 years later are the same, although I would say the students now are more open than they were then. I was asked to give the graduation address to the University of Vermont College of Medicine this past spring, and since the commencement speaker was chosen by the students themselves, it was a great honor for me. It was also an affirmation that the people coming into medicine now, the healers, are in the field because they are interested in true healing. They know they might not even be able to pay back their student loans, so the financial interest that perhaps was there in the 1970s and 1980s is simply not there any longer. We have a different group of students.

JB: You said something about your history and how it has formed your professional contributions today, about balance in our lives, and how that relates to manifestations of physical function. What is your opinion of the way medicine is looking at hormone balances, either as a pharmacological problem and just replacing those things that are low, or looking at an integrated balance?

CN: I am aware that when we are in our 20s and 30s, if we do not get adequate nutrition, enough sleep, and so on, we are usually able to pull that off, because our bodies are set up to function optimally. I think, of course, our bodies are set up to function optimally for at least 100 years, but by not following the principles of replenishing what's missing -- the same as with the soil -- we keep trying to get more and more out of our bodies by putting in less and less.

Many women enter the menopausal transition with depleted adrenal glands, and if you look at the way things are set up in nature, as ovarian function changes, the adrenal function is all set up and ready to take over, if we have adequate amounts of vitamin C, rest, protein, physical activity, and so on, and that often doesn't happen. Also, one in three women enters menopause through drugs or surgery, or from autoimmune problems such as premature menopause. So you take what should be a normal transition, with the body fully supporting it with enough steroidal components, and you've already been beating your adrenals, let's say for 15 years.

I certainly had been doing that by the time I got into my 40s. It took me about five years just to recover from being up all night and that sort of thing, and I had a lot of awareness about health. So if I think about the average woman out there who is maybe raising kids, working 60 hours a week, not eating properly, not exercising, and not resting, I can see where there would be a need for exogenous hormonal steroid support from the outside. However, we need to realize that the body was probably designed to make this transition quite well without outside support, as long as we replenish the soil, fertilize it, and so on.

JB: This is a bit of a leading question, because I've read your book and followed your newsletter, so I think I have some sense of what your answer might be. When a woman tells you she is confronted with having to take estrogen and asks what type of estrogen she should take, how do you address that issue with her in consideration of the fact that she may have been brought up and acculturated to the pharmacological model?

CN: Most people who live in our culture think of their body as a machine that isn't working and they need something from the outside to fix it. There's no way, in a 30-minute office visit, that you are going to change that perception, but what you do is work with little bits of a perception, so I would suggest to the patient that we check her levels, perhaps with a salivary test, just to see where she's starting, and then the replenishment I would use, if it's necessary, is a naturally occurring hormone.

I would not use Premarin. Premarin is natural for a horse. I would use a naturally occurring hormone in the female body manufactured from soybeans or yams, and bring her up to physiologic levels, which may take six months. You're trying to replace what she doesn't have. Then, at the same time, or on a subsequent visit, I would talk about improving diet and exercise, and then gradually, over a year or two, I could re-discuss the hormone issue with some experimentation of cutting back or giving a little more of one thing and a little less of another.

You also need a holistic approach with hormone replacement, because if we're replacing hormones, why do we just focus on estrogen? We need to look at progesterone, the androgens such as DHEA and testosterone, and perhaps even a little pregnenolone.

All of these things figure into the replacement decision, but we must also remember the body has the ability to make all those things in the enzymatic pathways if you have the zinc, magnesium and all the other stuff that you need. So it's a constant little tightrope walk where you see where the patient is and then try to replenish and rebalance and help her where she

JB: Women who come through our research facility here in Washington state frequently ask if when we give them various hormone replacements or hormone precursors we are not also increasing their risk of cancer? We try to explain processes related to detoxification of hormones and their proper elimination. Is part of the message you give to your patients related to how the hormones come in and how they go out?

CN: Well, yes. My feeling about cancer, particularly breast cancer, is that when we are using something like equilin and the other equine estrogens, these estrogens are not native to the female human body. Some studies show they have a more toxic effect on the liver than the naturally occurring hormones. They are often not balanced with adequate progesterone, So, in fact, it is not surprising that we see an increased risk of cancer with synthetic hormone replacement that has not been adjusted to physiologic levels, and which we are giving to women like M&M's.

Unfortunately, we're taking something that can be very beneficial, like hormone replacement for some women, and by using it in an unnatural way, we actually create problems. You have to keep coming back to what I call a partnership with nature and the wisdom of nature, with the human not being a parent/child with nature, but a partner. I know some stuff; nature knows some stuff. How are we going to put these two things together in a sane way? But you can't ignore one.

I think women's bodies and women have been equated with nature, wild and out of control in the natural world, needing to be tamed, and so forth. We need to see what the wisdom of nature is and somehow recover from our ideas about nature as being out of control and needing to be reigned in and tamed. Let's just use it as a partner.

JB: Let's say a new patient comes to you and is trying to figure out exactly what strategy you're going to employ with her, and she is going to own that strategy. How do you move into this integration of tradition, experience, and the scientific method in addressing the woman's health issues?

CN: If she's coming to me for PMS, which I think is a wonderful model, she may come in saying her hormones are out of control, it's wrecking her life, and she would like Prozac. I would acknowledge that her hormones are out of control, and that this is related to her life. But we would start with something I

learned from Elizabeth Kubler-Ross. She said that when someone is in pain, give him morphine. I'm talking, of course, about real post-op pain, that kind of pain. So I start by making the person comfortable, doing what works to get her comfortable, using the entire pharmacopoeia if I need to. Then I come back and say to her, at the same time I may be giving her natural progesterone for the PMS, that I want her to keep a journal and tell me what comes up for her in the premenstrual time. What are the issues?

The next time she comes back -- and if I can enlist her husband or family members, it's great; they'll all help out -- she may say things like she noticed that premenstrually she always wants to go back to college and she doesn't want to clean up the house. Then I tell her that the premenstrual time is a time of heightened sensitivity to what she really needs to be doing; that our lives are actually set up in that cyclic way, like nature, and the premenstrual time is a time when the tide is out and you're left out to put up with the garbage that you put up with during the rest of the month, so it's premenstrual reality check time.

Once she knows that, she can begin to appreciate that her body has wisdom and she can trust it. The natural progesterone has been the bridge she can cross to understanding that. Knowing that probably into her 30s and 40s, her premenstrual time may not be the most Doris-Day-laughing-up-and-coming time in her life, but it will be a time that teaches her the most about her life. She can use medicine, but she should take notes at the same time.

Bibliography

1. Austin S. When is allopathic medicine useful in the treatment of invasive breast cancer? *J Naturopathic Med.* 1996;6(1):44-47.
2. Beard JL, Dawson H, Piñero DJ. Iron metabolism: a comprehensive review. *Nutr Rev.*1996;54(10):295-317.
3. Beresford SA, Weiss NS, Voight LF, McKnight B. Risk of endometrial cancer in relation to use of oestrogen combined with cyclic progestagen therapy in postmenopausal women. *Lancet.* 1997;349(9050):458-461.
4. Burns A, Murphy D. Protection against Alzheimer's disease? *Lancet.* 1996;348:420-421.
5. Cohen LA. Re: breast cancer risk in rats fed a diet high in n-6 polyunsaturated fatty acids during pregnancy. *J Natl Cancer Inst.* 1997;89(9):662-663.
6. Edlin M. Changing their ways to keep up with the times. *Managed Healthcare.*1997;7(6):14-18.
7. Fackelmann K. The birth of a breast cancer. Do adult diseases start in the womb? *Science News.* 1997;151:108-109.
8. Gullette EC, Blumenthal JA, Babyak M, et al. Effects of mental stress on myocardial ischemia during daily life. *JAMA.* 1997;277(20):1521-1526.
9. Hilakivi-Clarke L, Onojafe I, Raygada M, Cho E, Clarke R, Lippman ME. Breast cancer risk in rats fed a diet high in n-6 polyunsaturated fatty acids during pregnancy. *J Natl Cancer Inst.* 1996;88(24):1821-1827.
10. Karpf DB, Shapiro DR, Seeman E, et al. Prevention of nonvertebral fractures by alendronate. *JAMA.* 1997;277(14):1159-1164.
11. Kushi LH, Fee RM, Folsom AR, Mink PJ, Anderson KE, Sellers TA. Physical activity and mortality in postmenopausal women. *JAMA.* 1997;277(16):1287-1292.
12. Mancia G, Sega R, Milesi C, Cesana G, Zanchetti A. Blood-pressure control in the hypertensive

population. *Lancet.* 1997;349(9050):454-457.
13. McCarron DA. Role of adequate dietary calcium intake in the prevention and management of salt-sensitive hypertension. *Am J Clin Nutr.* 1997;65(2S):712S-716S.
14. Mittleman MA, Maclure M. Mental stress during daily life triggers myocardial ischemia. *JAMA.* 1997;277(19):1558-1559.
15. Osborne CG, McTyre RB, Dudek J, et al. Evidence for the relationship of calcium to blood pressure. *Nutr Rev.* 1996;54(12):365-381.
16. Pearson TA, Myerson M. Treatment of hypercholesterolemia in women. Equality, effectiveness, and extrapolation of evidence. *JAMA.* 1997;277(16):1320-1321.
17. Psaty BM, Smith NL, Siscovick, et al. Health outcomes associated with antihypertensive therapies used as first-line agents. *JAMA.* 1997;277(9):739.
18. Rizzoli R, Bonjour JP. Hormones and bones. *Lancet.* 1997;349:sI20-sI23.
19. Schneider DL, Barrett-Connor EL, Morton DJ. Timing of postmenopausal estrogen for optimal bone mineral density. *JAMA.* 1997;277(7):543-547.
20. Schow DA, Redmon B, Pryor JL. Male menopause. How to define it, how to treat it. *Postgrad Med.* 1997;101(3):62-79.
21. Sukumar S, McKenzie K. Breast cancer prevention strategies for the twenty-first century. *Mol Med Today.* 1996;2(11):453-459.
22. Tang MX, Jacobs D, Stern Y, et al. Effect of oestrogen during menopause on risk and age at onset of Alzheimer's disease. *Lancet.* 1996;348:429-432/
23. Walter T, Olivares M, Pizarro F, Muñoz C. Iron, anemia, and infection. *Nutr Rev.*1997;55(4):111-124.
24. Whelton PK, He J, Cutler JA, et al. Effects of oral potassium on blood pressure. *JAMA.*1997;277(20):1624-1632.
25. Whiting SJ, Wood RJ. Adverse effects of high-calcium diets in humans. *Nutr Rev.*1997;55(1):1-9.
26. Wynder EL, Cohen LA, Muscat JE, Winters B, Dwyer JT, Blackburn G. Breast cancer: weighing the evidence for a promoting role of dietary fat. *J Natl Cancer Inst.*1997;89(11):766-775.

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