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Letters to the Editor

Section Editor's Reply to Reciprocal Healing in Healthcare

To the Editor:

The programs and services of the Institute of Medicine, Education, and Spirituality at Ochsner (IMESO) are individually designed to integrate into the life and work of all departments at the institution. A common denominator of IMESO's programs is that they are framed in terms of *virtues and values,* resulting in the fostering of many positive behaviors that further advance institutional quality of patient care. Overall, these activities impact many aspects of professional life at Ochsner, and this is especially true when it comes to our continuum of medical education, namely both undergraduate and graduate medical education programs along with the final transition to practice once formal clinical training has been completed.

Since the institution of IMESO, our diverse medical education populations have all benefitted from an increased focus on learning to care for the individual patient which was (and still remains) a hallmark of Dr Ochsner's philosophy. It is part of what it means to be trained in the **Ochsner Way**, and this is an important aspect of the legacy that our educational program leaders have received and that they will in turn pass on to the next generation of physician staff members. The value of the Reciprocal Healing in Healthcare statement (as shared in the Letters to the Editor, 2014 fall edition of *The Ochsner Journal*) will be calculated utilizing many variables. This statement must first result in staff behaviors that are worthy of modeling. Our students, residents, and future clinical practice peers learn best from a staff (doctors, nurses, ancillary care providers, and others) who set a daily example worthy of being followed. Additional value to our institution will be measured by having more satisfied patients, a workforce where burnout is minimized, and the presence of healthcare providers who are once again experiencing the joy of being an integral part of the healing process.

Ronald G. Amedee, MD, FACS
Section Editor, Graduate Medical Education
The Ochsner Journal
ramedee@ochsner.org

Reply to Reciprocal Healing in Healthcare

To the Editor:

In a recent letter to the editor (*The Ochsner Journal,* 2014 fall edition), Rev. Anthony J. De Conciliis, Vice President and Director of the Institute of Medicine, Education, and Spirituality at Ochsner (IMESO), presented a statement on Reciprocal Healing in Healthcare. The Executive Steering Committee at the April 2014 meeting of IMESO unanimously endorsed this statement. Briefly, IMESO hopes that the statement of reciprocal healing will follow Dr Alton Ochsner's principles of individual care for our patients and also stimulate systemwide fruitful discussions and promote high-quality patient care in the workplace.

To assess the impact of the statement, I asked two practicing physicians at Ochsner Clinic, one trainee and one staff, if they were able to comment about the statement on reciprocal healing and, in addition, if they were able to abide by this statement in their daily activities. Both physicians read the statement and answered independently.

The first is a physician in training. "Very nice read! I agree with the therapeutic benefit to both physician and patient. The philosophy of treating patients as a whole and not just the disease process is extremely important. Understanding each individual patient, their beliefs, their understanding of their treatment, and their psychosocial situation is extremely important. The unfortunate truth in the current healthcare environment is that it does not always place an emphasis on the physician-patient relationship; it does not recognize the time and effort spent in establishing and strengthening the relationship. Patient satisfaction surveys reflect the reduced time spent with each patient. I feel that in looking to the future, caregiving needs to facilitate an environment in which providers can place an increased emphasis on the physician-patient relationship."

A staff physician also commented on the letter. "It is a very nice editorial piece. Sadly, it is true that nowadays many care providers treat diseases rather than patients. As physicians, we should be able to overcome this. With the current changes in healthcare, we can still be physicians who respond to the patient as a whole person. A physician doesn't need to spend 45 minutes with a patient to create a helping relationship. Medicine is still an art. Each physician comes with his own sets of skills. Communication is paramount. In 20 minutes, a physician can listen to the patient, give an opinion, and talk about life in general. The bottom line is this: If a patient is treated like family, the relationship will be fine. After reading this article, I will definitely pay more attention to my patients' needs, maybe talk less and listen more to them. Thanks for sharing a very stimulating article."

Both physicians agreed that they would be better physicians if they kept the statement on reciprocal healing in their minds and hearts when relating to patients. Although this is a small sample, reciprocal healing as part of the physician-patient relationship can play an important role in patient and physician care.

Hector Ventura, MD
Department of Cardiology, Ochsner Clinic Foundation
hventura@ochsner.org

Patrick Campbell, MD
Department of Cardiology, Ochsner Clinic Foundation
pcampbell@ochsner.org

Selim Krim, MD
Department of Cardiology, Ochsner Clinic Foundation
selim.krim@ochsner.org

Homeopathy Against Fulminant Hepatic Failure Caused by Fungal Poisoning from the Genus *Amanita*: Critical Comments

To the Editor:

The recent article by Frass et al in *The Ochsner Journal* unexpectedly reported two cases of *Amanita phalloides* intoxication successfully treated by additive homeopathy. In this paper, the authors showed that homeopathic medicine prescribed in patients undergoing allopathic therapy against poisoning from *Amanita phalloides* allowed subjects to survive without any residual pathological symptoms.[1] This evidence raises some comments whether individuals restored their own health by homeopathy or rather by orthodox therapy, as homeopathy was used simply as an additive treatment. In cases of fulminant hepatic failure (FHF), clinical symptoms are characterized by the development of severe liver injury with impaired synthetic capacity and encephalopathy in those patients with previous normal liver or at least well-compensated liver disease. Actually, the etiology of FHF refers to a wide variety of causes, often idiopathic, of which toxin-induced hepatitis is most common. In spite of specific therapeutic options in distinctive etiologies, orthotopic liver transplantation may appear as the only therapy proven to improve patient survival in the majority of patients. Obviously, the outcome is warranted by preventing complications like severe coagulopathy, infections, renal impairment, or increased intracranial pressure. Therefore, any decision for transplantation depends on the possibility of spontaneous hepatic recovery, which may be estimated by several factors. The most important variables for predicting the need of transplantation in FHF are the degree of encephalopathy, the patient's age, and the underlying cause of liver failure. Individual age should be associated to any other serum/clinical marker of FHF. Therefore, prognostic scores have been developed as decision support systems for indication and optimal timepoint of liver transplantation.[2,3] The paper by Frass et al did not report any prognostic score related to the patients undergoing the observational case study.[1] Lacking this information, the reader may be turned to trust the occurrence, though rarely, that acute liver failure may recover spontaneously and restore complete liver regeneration, eg, by activating microRNAs miR-122, miR-21, and miR-221.[4] However, each case described by the authors presented marked signs of liver injury, so to address the reader mostly to an unfavorable prognostic index, but each reported case did not appear to fulfill all the criteria for orthotopic liver transplantation, at least according to the King's College Hospital criteria for liver transplantation in FHF. Moreover, patients underwent a sustained pharmacological therapy.[2] Aside from a total bilirubin value higher than 18 mg/dL (308 μmol/L) (case report #1), a transient arterial pH $<$7.3, and age $>$40 years (case report #2), the paper did not further report important markers such as prothrombin time and serum creatinine for eligibility towards a liver transplantation decision.[1,2] Jaundice, an important hallmark to highlight encephalopathy, was observed only in case report #2, and its onset increased paradoxically following administration of phosphorus 15 cH.[1] The authors did not show if jaundice lasted $>$7 days before the onset of encephalopathy; on day 8, total bilirubin was lower than 18 mg/dL.[1,2] These comments would focus on the scanty endowment of prognostic markers the paper showed, markers able to rigorously define FHF of the reported cases with full liver transplantation criteria. Furthermore, homeopathic approaches provided the physician with a complex, poorly understandable attempt to solve complex clinical circumstances without a rapid positive outcome.[1] For example, modest or lower grades of encephalopathy, as in case report #2, make more likely spontaneous recovery in FHF;[5] this circumstance could increase the outcome due even to non–liver transplantation therapy[6-8] and therefore vanish the conclusive interpretation that homeopathy resulted in a resolutive attempt to save the lives of those people. In this perspective, we have no deeper insights, although apparently encouraging, to assess the fundamental role of homeopathy in restoring FHF in affected subjects to health.[9,10]

Salvatore Chirumbolo, PhD
Head, Laboratory of Physiopathology of Obesity
Department of Medicine-University of Verona
Verona, Italy
salvatore.chirumbolo@univr.it

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Authors' Reply to Dr Chirumbolo

We thank you for your interest in our research and for your valuable comments. With regard to patient #2, liver transplantation was rejected by our surgeons. They refused to consider this option because of the poor cardiovascular state of the patient, which included the need of high doses of epinephrine, and severe multiorgan failure (5 different organs failing), therefore making surgery impossible. Further, the described prognostic score (Gotthardt et al) was encephalopathy grade IV, and the patient's age was greater than 40 years. In total, the patient was in an extremely severe state although we should have included a MELD [Model for End-Stage Liver Disease] score. In patient #2, we have calculated a MELD score of 38. According to Lee et al, a MELD score $\geq$30 was found to be the only independent risk factor of mortality in fulminant hepatic failure patients without liver transplantation. A pitfall is that the INR is used only for patients on stable oral anticoagulant therapy. It makes no significant contribution to the diagnosis or treatment of patients whose prothrombin time is prolonged for other reasons. Our entire group of extremely experienced intensivists, along with the transplantation surgeons, agreed that the patient would not survive.

Dr Chirumbolo states there are 3 errors in our statement, "Jaundice, an important hallmark to highlight encephalopathy, was observed only in case report #2 and its onset increased paradoxically following administration of phosphorus 15 cH." First, jaundice was observed in both cases. We expected that our readers would realize that a bilirubin of 77 mg/dL (as in case #1) is accompanied by jaundice. Second, its onset did not increase following administration of phosphorus but was already present. Third, in case report #2, phosphorus CH200, not CH15, was used. We agree that the conclusion could be modified to "We suggest that homeopathy might have helped . . . ." Our intent was to encourage other colleagues to consider homeopathic remedies to complement our traditional critical care treatment options.

Michael Frass, MD
Department of Medicine I, Intensive Care Unit
Medical University of Vienna, Austria
michael.frass@meduniwien.ac.at

Alan David Kaye, MD, PhD
Departments of Anesthesiology and Pharmacology
Louisiana State University Health Sciences Center
New Orleans, LA, USA
akaye@lsuhsc.edu

Comments on Your Recent Publication About Homeopathic Treatment of *Amanita Phalloides* Poisoning

To the Editor:

In a recent issue, your journal published a paper reporting the management of two cases of *Amanita phalloides* poisoning.[1] First of all, I want to congratulate the authors on the success of their hard work. But unfortunately the conclusion they draw from their success hardly seems warranted. Their statement "combining homeopathic medicine with conventional treatment is beneficial" has no foundation in the information given in the paper for 3 reasons:

1. The authors do not disclose how they verified that homeopathy played any role at all. The patients received silibinin as part of their treatment. While it is true that there are no PCTs about silibinin in amatoxin poisoning today, there are some papers, including a retrospective study on 18 cases, that imply that silibinin may well be able handle such situations alone.[2,3] There seems to be a fairly good chance that homeopathy did not have anything to do with the course of events.

2. The process of the remedy-selection is reported for one of the two cases only. From this we learn that the criteria for selection yielded more than one remedy, but the authors selected just another one that was not named there. On the second run, the process yielded still another remedy. The similarity to the patient's symptoms is limited to the liver issues only, no 'holistic approach' to the rest of her condition or her poor prior health status at all. So even if the homeopathic law of similars would be for real, the arbitrarily selected remedies would hardly fit in the picture and thus would hardly work.
3. The authors give us no reliable data that indicate that the additional homeopathic treatment has had any benefit at all. What would have happened without the additional homeopathic treatment? Are there any statistics—say from the clinic's records—how many patients died although they received additional homeopathic treatment or how many patients survived without? Without such data, the claimed benefit can only be an assumption.

Of course, this paper is to present two cases only and is no PCT, but the authors should have kept this in mind while formulating their conclusion. The most they could have done is to formulate the hypothesis that homeopathy may have had anything to do with their success, but this has to be proven elsewhere.

Norbert Aust, PhD
Schopfheim, Germany
drnorbertaust@t-online.de

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Authors' Reply to Dr Aust

We thank the author for his positive comments about the use of homeopathy in these two cases of fulminant hepatic failure. We wish to clarify the comments and respond:

1. The cited papers refer to light/mild cases of *Amanita* poisoning, which are not comparable to our presented cases. For example, the paper by Hruby et al did not include any prognostic scores as requested by the other comment of Dr Chirumbolo. In both papers, patients did not exhibit failure of 5 organs. Patient #2 in our manuscript exhibited severe 5-organ failure, which is obviously associated with a high mortality rate.
2. We have identified all homeopathic remedies presented in our manuscript: in case #1, phosphorus, and in case #2, arsenicum album, phosphorus, and *Helleborus niger*. For nonhomeopaths, remedy finding appears implausible. Choosing the correct remedy as in our extreme cases is only possible after extensive training and knowledge in the science of homeopathy. In an acute situation as these challenging cases, the holistic approach would be limited as the treatment of acute cases differs significantly from treating chronic cases.
3. Asking for statistics is difficult: the only way to prove any therapy is a double-blind study. However, if Dr Aust would help us find volunteers consuming *Amanita*, we are ready to perform such a study. If colleagues treating patients with *Amanita* poisoning would participate in a double-blind study, we would be interested to participate in such an investigation.

We agree that the conclusion could be phrased with more caution. We thank Dr Aust for his positive comments because with minimal costs, about $65 [USD] for the entire homeopathic treatment, it could be therapeutic for patients in such severe situations without harm and without appreciable side effects. As compared to the daily costs in an intensive care unit of approximately $2,500-$10,000 [USD] or higher, we believe that it is justifiable to consider the addition of low-cost homeopathy. It should be noted that our entire healthcare team was extremely surprised by the survival of patient #2. Furthermore, the acceptance of homeopathy is very high in our population, and several metaanalyses suggest that homeopathy is an effective medical treatment strategy.

Michael Frass, MD
Department of Medicine I, Intensive Care Unit
Medical University of Vienna, Austria
michael.frass@meduniwien.ac.at

Alan David Kaye, MD, PhD
Departments of Anesthesiology and Pharmacology
Louisiana State University Health Sciences Center
New Orleans, LA, USA
akaye@lsuhsc.edu