Does Every Schizophrenic Patient Need Tranquilizers?

A. Hoffer, M.D., Ph.D.

Introduction

When Dr. Humphry Osmond and I began the first double blind controlled studies in psychiatry in 1952 (Hoffer, Osmond, Callbeck and Kahan, 1957), we were favoured by a number of advantages which may never recur. We were working for a government which wanted to bring the Saskatchewan psychiatric services into the twentieth century. We were working with patients incarcerated in hospitals rated as among the world's worst three. Secondly, there was no medical school, no department of psychiatry, in Saskatchewan. That is, there was no local establishment which could advise us what not to do. New ideas seldom survive the scrutiny of university establishments. Thirdly, we were so far away from psychiatric research centers we were not distracted by meetings and social visits. Finally, there was no effective treatment for schizophrenia. This made psychiatrists very patient. Insulin coma treatment required therapeutic skill and much patience. ECT required less skill and less patience but psychiatrists had few expectations of permanent recovery. Psychoanalysis also taught patience, as did psychotherapy. All treatments on any follow-up yielded recovery rates which were no improvement over natural recovery or remission rates. The most effective treatment was custodial care, which helped the community more than it did the patients. The best hospital provided decent, humane care which allowed natural remission its best chance. At least these hospitals did not make their patients worse. The majority of hospitals provided a very low standard of care, so low that it was relatively easy to mobilize public opinion against them. All one had to do was encourage people to visit these hospitals. Led by a few socially-minded psychologists, a new movement was created to which Saskatchewan contributed an idea later called the Saskatchewan Plan. It was said that the worst place in the community was better for the mentally ill than the best place in any institution. In the early 1950s the notion that the community would mean card-1. board boxes in downtown areas of cities, rundown hotels and so on had not occurred. The movement soon became a stampede with superintendents of mental hospitals competing with each other in the race to discharge patients. Huge numbers of chronic, deteriorated, sick patients were discharged (dumped) into unsuspecting communities. The results are evident in nearly every major city in North America.

Not having any treatments and knowing that psychotherapy was very slow even when effective, and free of the pressure to discharge patients before they were well enough to cope, psychiatrists were patient. They did not see nor expect responses in a few days or even weeks. We were patient when we began to use Vitamin B-3 and ascorbic acid in large doses. When we saw a response in one month, that was encouraging, and we were prepared to wait six months or several years for the final recovery.

Tranquilizers, in sharp contrast to vitamins, worked very quickly. In a matter of days or weeks one saw an astonishing effect. Violent patients became subdued and manageable. Within a matter of years the entire nature of mental hospital wards changed. After tranquilizers were introduced, one hospital reported a novel way of determining the efficacy of treatment. They installed a noise meter and recorded the noise level of the ward before and after treatment. There was a significant reduction. Tranquilizers are very effective in reducing noise and commotion in mental hospitals. It became generally accepted that this change in activity and behavior also meant that the patients were getting well. Reduction of bizarre activity became equivalent to cure. Later it became evident that such a simple equation was wrong. A decrease in abnormal behavior might or might not be accompanied by real improvement, i.e. in a real removal of the psychosis.

Because drugs acted so quickly, psychiatrists became accustomed to this and lost patience with slower treatments. They

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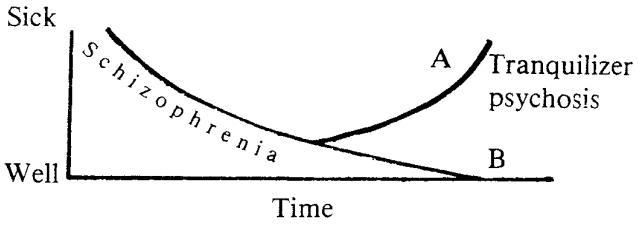
concluded that if one saw little change in a few days the treatment was not effective. This created another barrier against Orthomolecular treatment, for nutrients are gentle, slow and effective in the long term. They do not zonk patients out in a few weeks or cause the serious side effects and toxicity now associated with tranquilizers.

Most psychiatrists agree tranquilizers are very helpful but do not increase the over all recovery rate. The major achievement has been a massive elimination of psychiatric beds.

Psychiatrists have become reconciled to the lack of efficacy of tranquilizers. In recent reviews (Davis and Andriukaitis, 1986, and Schooler, 1986), there is a thorough and useful account of the results of tranquilizer treatment, but nowhere is there any reference to the most important human statistics: how many became normal, how many were better, how many unchanged, and how many were made worse. Any intelligent reader must assume that when results of treatment as measured by recovery are avoided so carefully, there are very few if any recoveries. Tranquilizers have made it possible to manage patients at home who thirty years ago had to be treated in mental hospitals, but the major psychosocial and economic costs to patients, their families and society have not been added up. The total economic cost per patient over the duration of the illness remains the same whether treated with tranquilizers or not treated at all. This I have estimated will be about $1 million per patient over the next forty years.

Tranquilizers are quickly effective in controlling behavior and in reducing the intensity of hallucinations and delusions, but they do not cure. In fact it is impossible for anyone to be well while taking tranquilizers because tranquilizers replace the original psychosis by another. To understand this idea one needs to accept two facts: (1) tranquilizers are effective in reducing intensity of psychoses, (2) a normal person can not function under the influence of tranquilizers. The best drugs or treatments are those which are curative and have no detrimental side effects. Xenobiotic molecules are generally less benign than Orthomolecular substances because the body has had no experience with them and has to improvise ways of eliminating them. Natural molecules normally present are dealt with by processes which have evolved over many years. Thus, when a tranquilizer is used it has two effects. The beneficial effect helps move the patient from schizophrenia toward normality, but the closer one comes to being normal, the more active does the drug become in creating the new psychosis which is the drugged stated. A good example is the "zombie" state of complete apathy and indifference. This means that we can only go so



A — Schizophrenic
B — Normal

far with tranquilizers. The closer we get to being well, the more abnormal we become from the tranquilizer. The two main detrimental effects are: (1) the massive dependence on community and family created by the drugged state, (2) tardive dyskinesia, which may be the forerunner of new neurological diseases still seen only dimly. This therapeutic dilemma can be illustrated in the figure below.

This diagram illustrates that the patient can not become well although they may approach it so they can function as a well-adjusted chronic psychotic, on welfare, requiring nursing and medical care, totally dependent and often on the verge of relapse as they resist continuing to take the medication.

Most psychiatrists know only one way of dealing with this problem. They slowly decrease the amount of tranquilizer, hoping that so little is required that the tranquilizer psychosis is almost unnoticeable. Or that the patient can remain well without any tranquilizers. Of course many do, but it is doubtful whether natural recovery rates are exceeded. From long term follow-ups I have concluded that natural recovery rates are closer to 15 percent than they are to the usually given figure of 35 percent.

Orthomolecular psychiatrists use nutrients in optimum amounts. These work slowly but with time they become more and more

effective. This contrasts with the placebo effect which decreases with time. But even more important, they *do not* create a new psychosis. They allow a patient to recover and to remain well. By combining nutrients and drugs one can take advantage of both. Drugs will work rapidly to help control the disease while the nutrients are slowly healing the patient, and as healing continues the drugs can be slowly withdrawn. The pathway to recovery is more like line B in the illustration.

Of course, not every patient will recover. No one has yet reported a 100 percent cure rate, but in general orthomolecularly treated patients much more frequently follow line B, while almost all tranquillized patients follow line A.

Tranquilizers are therapeutic as long as they are present in the body. When they are no longer present there is no further activity except for the tardive dyskinesia, which may remain forever if the patient is not treated with vitamins and manganese. There is no long term post-treatment beneficial effect. In sharp contrast, Vitamin B-3 treatment does have a prolonged effect. If a group of patients treated with Vitamin B-3 is followed after treatment is terminated, the beneficial effect is maintained up to five years. This prolonged beneficial effect resembles the action of nicotinic acid in prolonging life and decreasing mortality from coronary disease. The huge national Coronary Drug Project followed patients for a decade after treatment with nicotinic acid had been stopped. They had been on this vitamin about nine years to lower cholesterol levels. Other groups were given placebo, thyroid, estrogens or Atromid (clofibrate). Over the nine years post treatment, only the vitamin group benefited by an 11 percent decrease in mortality and a two year increase in longevity. None of the other groups were better than placebo and the Atromid group suffered an increase in mortality. When treating patients with coronary disease Atromid acts like tranquilizers in schizophrenics, while nicotinic acid is beneficial for both, even long after treatment is stopped.

Not every patient needs tranquilizers. Before they were introduced, most acute patients treated with nutrients recovered without tranquilizers. Our first double blind studies were completed without any tranquilizers. Patients who are early in their illness may not need tranquilizers and will even refuse to take them. I have treated many who found the tranquilizer psychosis so unpleasant they would not continue with them. Instead, they demanded nutrient treatment. Patients who do need these drugs are agitated, paranoid, anxious, fearful and should be treated with these helpful drugs.

Psychiatrists who have not studied Orthomolecular literature have a number of misconceptions based upon what they have been told by their teachers. They are equally innocent of this information and fall back on the APA Task Force Report on megavitamins which is a treasure of misinformation. For many years they told their patients that if they went to an Orthomolecular physician they would have to give up the tranquilizers which were providing some relief. Today they maintain that it is the tranquilizers used by Orthomolecular physicians which work, that the nutrients have a placebo effect, even though the tranquilizers alone had not previously helped that patient. There appears to be a common idea that Orthomolecular physicians can impart a mystical therapeutic effect to tranquilizers not seen by others.

I have been challenged by psychiatrists to demonstrate schizophrenic cases who have recovered on nutrient treatment only. Many years ago, when Dr. M. Lipton was freely attacking our work, he challenged me to produce one schizophrenic who had recovered on vitamins only. He added he would then look at our work more seriously. This was at a time when he invoked the holy double blinds as the only certain source of the truth. In this report I will describe a number of these cases in two groups: (1) those who have never taken any tranquilizers, (2) those who have not responded to tranquilizers in the past and have not required any after undergoing Orthomolecular treatment. I will not record patients who suffered from cerebral allergies or toxicities to foods or other environmental factors, for their treatment must be different.

Patients Never Tranquillized

The first three cases are the first ones ever to have received large doses of Vitamin B-3 for their schizophrenia. Number 1 was a patient at Saskatchewan Hospital at Weyburn, Saskatchewan, under Dr. Humphry Osmond's care. This patient, just over 21

years of age, was catatonic, having failed to respond to either ECT or to a series of insulin coma treatments. In 1952, I had just received a free supply of nicotinic acid, nicotinamide, ascorbic acid, thiamin and riboflavin from Merck & Co. (now Merck Sharp & Dohme). We were starting preliminary studies to discover whether large doses of vitamins were safe, how much could be given, for how long, and what side effects we might expect. We decided to begin with Vitamin B-3 and Vitamin C and leave the other two B vitamins for future study.

I had driven from Regina, Saskatchewan, where I worked, to Weyburn to deliver the vitamins to Dr. Osmond. As we were making our plans, Dr. Osmond was informed by a senior staff psychiatrist that this patient was dying and his relatives should be called immediately. Catatonic deaths thirty years ago were not uncommon, and this patient was going to be another. Dr. Osmond and I agreed neither we nor the patient had anything to lose by giving him nicotinic acid and ascorbic acid. We promptly went to the ward, inserted a stomach tube and poured in a solution containing a large amount of these two vitamins. That day he received 10 grams of nicotinic acid and 5 grams of ascorbic acid. The second day he was able to sit up and drink the vitamin solution. After thirty days he was well. He was still well when seen many years later. When I presented this case in 1966 at a meeting in New York, a psychiatrist angrily claimed he must have had pellagra. The food in our mental hospitals was more nourishing then than it is today as very little processed food was then used. The hypothesis that he was a classical case of pellagra without: (1) a history of malnutrition, or (2) any stigmata of pellagra, i.e. a case of pellagra sine pellagra, was highly unlikely. The other two cases did not respond as quickly and therefore were even less likely pellagrin. They were treated at the Munro Wing, General Hospital, Regina, under my care.

One, a woman in her mid-forties, had suffered three major psychotic episodes beginning two years before she came under my care. The first time she was given a series of ECT and was better for a few months. When I saw her she was very paranoid, having a delusional system of ideas relating to her employer, and she was depressed. Because she had not responded long enough to ECT, I started her in 1952 on nicotinic acid, only 1 gram three times per day. After one month she was less depressed, less delusional and was discharged. I saw her once each month. She continued to improve. After several months she was ill once more. She had stopped taking the vitamin. I persuaded her to start again and once more she responded. She discontinued medication once more with another relapse. Finally in 1957 she had been well about two years and wanted to try again without the nicotinic acid. I agreed she could try. She remained well thereafter.

The third patient gradually became psychotic and developed a bizarre delusional system involving the Canadian army. During the war in Europe, he and a couple of other soldiers were approaching the German line, collecting parachute silk. They were discovered by the German soldiers. While running back the patient was wounded but his friends were killed. After the war he returned to his father's farm in Saskatchewan and later married. He was able to cope with the vicissitudes of farming in Saskatchewan with no difficulty. However, in 1951 when everything was going well, he slowly became quiet and withdrawn. Soon he suspected the whole community was talking about him. He began to wonder why only he of the three had been spared. Eventually he concluded that the whole episode had been staged by the Canadian army to test him and that in truth his two friends were still alive. This satisfied him for a few months. Then he received a copy of his regimental history where his friends were listed as killed in action. He became extremely anxious and upset and was admitted to hospital. I started him on nicotinic acid 1 gram three times a day. One month later he was slightly better, after three months he was clearly better, and after six months he was well. He then discontinued the vitamin but remained well in spite of a series of severe financial reverses and his wife's major illness.

It is possible, even if highly unlikely, that schizophrenia was more benign thirty years ago and thus more apt to respond. Certainly malnutrition was less of a problem then. However, the patients treated in the past seven years in a different province responded similarly.
The fourth patient had been a chronic patient

in the mental hospital at Weyburn for thirteen years. She had been admitted in 1952 when she was seventeen. Her admission diagnosis was mental retardation (imbecility) with psychosis. During this admission she received every treatment then known, including Metrazole injections to induce convulsions, insulin coma and repeated series of ECT. She required a series of ECT once or twice a year. In 1952, shortly after we had begun our research program, I asked Dr. Osmond to select one of his more difficult patients. We would bring her into our home where she would work for us for the going pay of that year ($40.00 per month plus, of course, room and board). One month after she came to our house she tried to kill herself. The next day I started her on nicotinic acid 1 gram three times a day. Her history is given in more detail in our book, *How To Live With Schizophrenia* (Hoffer and Osmond 1966). She remained on this vitamin more than two years. She has remained well ever since and has been gainfully employed on the cleaning staff of University Hospital. Every two or three years she visits us in Victoria. Her recovery saved the province of Saskatchewan $750,000, for had she not been treated she would undoubtedly have remained in hospital from 1952 until now.

Patients Who Did Not Respond to Tranquilizers Alone

The next series of patients were treated more recently but have responded as well after failing to get well on tranquilizers alone. The first patient, a man born in 1960, was first seen July, 1980. He became ill at age 15, was treated with vitamins and acupuncture and recovered. Three years later he began to act in a bizarre way. He became interested in pornography, became paranoid and began to carry a gun. On one occasion he invaded his neighbour's house and ordered the woman to undress, but was persuaded by the woman this was wrong. He was admitted to a university hospital for six weeks and placed upon thioridazine 400 mg per day. Early in 1980 his mother started him on a moderate vitamin program.

When I saw him, he still felt unreal at times, was paranoid but less so than before and remained very nervous and depressed. He was started on a comprehensive vitamin program but needed to be readmitted October 3/80 while still on the same dose of tranquilizer. In hospital during his absence a colleague was called to see him and found him to be "...an agitated young man who had a marked degree of thought disorder and was obviously acutely schizophrenic." He was certified so we could treat him with a series of ECT. He was discharged November 12th after seven ECT. On the first follow-up, December 2/80, he was much improved but still was paranoid. He followed his program carefully. This included Nozinan* 600 mg per day, Haldol 15 mg per day, and vitamins. But two months later I had to increase the Nozinan to 600 mg per day. Since then the medication has been decreasing gradually as follows:

	Nozinan(1)	**Anafranil(2)**
May 19/81	450	75
June 18	450	75
August 25	200	75
November 19	50	75
April 6/82	75	75
June 8	50	
November 1/84	—	—

(1) Methotrimeprazine
(2) Clomipramine

When last seen July 10, 1985, he was normal.

The second patient, born in 1950, was first seen in January 1977. In 1972 he had had a severe attack of panic. That initiated five years of chronic anxiety unresponsive to any medication except Librium and later alcohol. Soon he needed 26 ounces of alcohol each day. When I saw him he was clearly schizophrenic. He suffered from visual illusions including feeling unreal. He felt removed from everything. He was very paranoid with delusions of being poisoned and he was very tense and often depressed.

He was started on a vitamin program while continuing his Librium at 25 mg three times a day. By May 1977 his alcohol intake was 9 ounces per day. I then added a combination of Amitriptyline and Trilafon to his program. By September 1977 he had cut his drinking to two bottles of beer per day and

* Methotrimeprazine

his Librium to 50 mg per day. May 1978, with encouragement he joined Alcoholics Anonymous. By August 1978 he was taking Librium about five times per week. By December 1981 he was symptom-free but required 25 mg of Amitriptylene and 2 mg of Perphenazine at bedtime. He has been well since. In July 1985 he had completed an electronics course and was employed. He remained on the same vitamin program plus the same evening medication.

The third patient, born in 1957, was first seen in January 1985. He first became sick in 1979 after which he was treated for 2 1/2 months in a Calgary psychiatric ward. After that he received a variety of medications. Eventually he began to live the life of a hermit in a cabin in the backwoods, where he slowly starved because of some delusional ideas. He was referred after his family physician became very concerned over his health.

When I examined him he described visual and auditory hallucinations. He saw spirits of people and heard God's voice give him messages. He believed people were plotting to kill him, suffered typical schizophrenic blocking and was depressed. He was then started on a vitamin program plus Amitriptyhne 50 mg and Perphenazine 4 mg at bedtime.

He was too ill to follow this program and was admitted February 5, 1985, on two certificates. In hospital he was maintained on vitamins and given Nozinan 200 mg at bedtime. On discharge, March 27, 1985, he was better. When last seen July 3, 1985, he was free of symptoms and required only 50 mg of Nozinan at bedtime.

The final patient, born in 1957, was first seen in 1983. DC was ill for ten years, deteriorating slowly from an outgoing, happy, good and popular student to his present psychotic state. A major deterioration occurred in 1981 and he was admitted to a psychiatric hospital. He was very delusional, convinced about a minister being in league with Satan against him. After discharge on medication he took part in a day program and bioenergetic treatment.

When I saw him he still saw visions of the devil and discussed his vision of God. He heard the devil laughing at him. He was very paranoid, especially about people staring at him. He was started on a vitamin program while continuing on trifluoperazine 5 mg three times per day.

One month later he was thinking more clearly. The following month he began to see the world visually as he had before he became ill. In June, 1983, I increased his niacin to 6 grams per day but later had to decrease it to 4 1/2 grams. In October I decreased Trifluoperazine to 10 mg per day, adding Chlorpromazine 50 mg at bedtime. November 1983 he was started on Fluanxol 10 mg i.m. Chlorpromazine was replaced by Nozinan. By August 1984 he was well. When last seen in June 1985 he was well, requiring Nozinan 10 mg and Trifluperazine 10 mg at bedtime, and Fluanxol 1 mg three times per day. He was instructed to decrease the amount of tranquilizer slowly.

These cases represent a very small sample out of the thousands of patients I have seen since 1952. They were not selected to illustrate the best or the worst, but they do illustrate, first, that schizophrenic patients do not always need tranquilizers, and secondly, that many respond when there has been no response to tranquilizers alone.

Discussion

The patients described here all recovered on vitamin treatment, even those who had failed to do so on tranquilizers alone, as have over 100,000 patients in the U.S. and Canada treated by several thousand physicians and several hundred psychiatrists. But is vitamin therapy the main factor? In my opinion, there is no other explanation, for other explanations invoke factors which are much less likely. One can invoke the following explanations: (1) that these patients were in fact no better, but that I and my colleagues who observed them were deluded, fraudulent or simply totally inexperienced. This hypothesis would imply that there is a monstrous conspiracy by hundreds of Orthomolecular psychiatrists and thousands of patients and their families to persuade the public that patients are well when, in fact, they are not. It takes a high degree of paranoia to sustain such a belief. (2) That a natural recovery or a placebo reaction was responsible. This is the explanation most often invoked, but those who believe so have failed to answer the question why should the natural remission come on only after the vitamins are started, when it had failed to occur while patients were on tranquilizers. One

could, of course, postulate that tranquilizers prevented natural remissions in the same way they prevent full recovery. It is illogical to ascribe a natural recovery only after vitamins have started, for if it did, it is exactly the same as saying vitamins increased the ability of the body to heal itself, which of course is what they do. (3) That these patients were not schizophrenic to begin with. Diagnosis is based upon the clinical description of the patient and not upon the response to treatment. If diagnosis is made only after treatment, we may as well dispense with any diagnoses. When Vitamin B-3 first became available and was tested in a few southern U.S. mental hospitals, it was soon found that a number of schizophrenic patients recovered very quickly. They were promptly rediagnosed pellagra. In fact, the pellagra psychosis is one of the schizophrenia syndromes. The result of this practice was that no schizophrenic was ever allowed to become normal on Vitamin B-3 because if they did get well, they had not been schizophrenic in the first place. This effectively prevented any serious examination of the role of Vitamin B-3 in treating schizophrenia. Instead of denying schizophrenia was present, it would have been scientific to conclude that a variant of schizophrenia did respond and then to try to determine how the variant or pellagra syndrome differed from other schizophrenia syndromes.

If a person with Ewings sarcoma recovers on vitamins, one should not say there had not been a Ewings sarcoma. One should say we have a case of Ewings sarcoma who recovered; how does this case differ from others who do not recover? In this way progress will be made in developing better treatment. Changing the diagnosis because of a preconceived notion that the treatment could not have worked is a complete denial of the scientific method. If a diagnosis is changed it must be done on clinical descriptive grounds, e.g. discovering a patient hearing voices (which helped make the diagnosis) was in fact hearing a freak radio transmission via metallic amalgam fillings in his mouth.

Diagnoses change frequently: depression to schizophrenia, less often schizophrenia to depression, but the decision to change the diagnosis must be made on rational criteria, not on the outcome of treatment. (4) That only patients with good prognoses were selected for treatment, even if they were still treatment failures. They had not given up the battle against disease as indicated by their desire to seek an alternative treatment. This may be true of a few, but many had no choice in treatment and none of the early patients had any choice in who would treat them. Nor was there any public demand for this treatment. The public demand started in 1966 following a report in *The New York Times.*

The facts are simple. These patients became well, i.e. they had an illness which disappeared only when given Vitamin B-3 in optimum doses. I have concluded they were schizophrenics who responded to vitamin therapy. The patients, their relatives and friends agree they were once ill and are now well.

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Letters

To the Editor,

On May 21, 1986, I was called to see a patient suffering from severe upper abdominal pain that radiated into his back. J.L. was a 37 year old Black man from Detroit, Michigan, who had experienced two prior episodes of this same pain; two weeks ago and a month ago. Both times he had been given Demerol injections which had eased the pain but did not completely relieve it. His second attack had required two Demerol injections, and his condition was diagnosed as acute pancreatitis. He was told that the laboratory studies done on the two prior occasions didn't show any marked abnormalities. The past medical history revealed he was being treated for hypertension since 1974 and that he presently took hydrochlorthianide 50 mg in the morning and minipres 1 mg at night. His blood pressure prior to treatment was 160/120 and had been well controlled with medicine. There was also a history of migraine headaches and opiate addiction which had been treated with methadone from 1978 to 1981. He had been maintained on 45 mg of methadone daily which did not control his drug urges and he had used Tylenol with codeine 4 with increasing frequency prior to cessation of methadone in 1981. The opiate abuse had orginally been heroin snorting; he denies injecting of heroin and has no needle marks.

The present episode began at noon with severe upper abdominal pain which seemed to be deep and went into the back. He had anorexia and nausea associated with the pain and had spent the day in bed unable to get comfortable in any position. When I saw him at 9:00 p.m. he was a patient in distress with hands over the upper abdomen as he lay on his back. There was marked tenderness to palpation of the upper abdomen. Because of my experience investigating the problem of subclinical or unrecognized niacin deficiency I decided to try niacin 250 mg by mouth as a clinical trial. The patient had three different diseases which I had successfully treated with niacin therapy in other patients; namely, migraine headaches, opiate addiction, and hypertension. It is also well known that pancreatitis is a common problem in alcohol addicts and alcohol addiction also is relieved by niacin after treatment with 250 mg niacin twice daily for several weeks. The patient was given 250 mg niacin orally with water; within one half hour the patient had complete relief of pain and slept well that night. In the morning he complained of slight pain again and was given niacin 250 mg again with a full glass of water and had no further problem with his pain.

I have studied the medical literature and biochemical literature back to 1935 and know of no other instance when acute pancreatitis has been treated successfully with niacin. The patient was well pleased with his relief of pain and stated that niacin 250 mg gave better relief than injected Demerol had during his prior two episodes. He was continued on 600 mg time release tablets once daily to build up body stores of the coenzymes NAD and NADP which are made in the body from niacin. In my experience it takes 3 or 4 weeks of niacin 500 mg or more per day to restore depleted body stores of the coenzymes. A lower dose given for long term maintenance will prevent relapses and I find 50 to 250 mg per day is effective after the first month at the higher dose of 500 mg or more.

Sincerely,
John P. Cleary, M.D.

To the Editor,

Homeopathic Doctors are being harassed "coast to coast" and battles are being lost, and meagre resources are being wasted by fighting the entrenched establishment.

We, in Arizona, want to share with you a much better way to achieve total freedom in the way we practice.

It is the purpose of this letter to outline the necessary steps for achieving our own independent licensing Board.

It is the story of the steps to take to organize Doctors committed to being licensed as Homeopathic Physicians; it is the story

of the Arizona Holistic Medical Doctors and the great event which occurred on April 16, 1986.

The first thing to do is to have a cadre of dedicated physicians working together united in purpose.

Next, you need a central coordinator, to be in constant touch with an Executive Director and with your Lobbyist. The coordinator needs to attend every single meeting with every Legislator that must be seen. It will be your responsibility to collect funds in order to pay all of your expenses. It will be your responsibility to make sure that every Legislator is covered (more on this later.) For the next year, the work will become all consuming and leaves little time for anything else.

In our case, the second step was to hire an Executive Director, a woman who was a Homeopathic patient and totally dedicated to our cause. She was extremely bright, capable, talented, innovative and dedicated. She was instrumental in helping to write the response to the Auditor General's report as well as drawing up format letters for patients.

The third step, hiring of a Legislative Lobbyist, became most important, without which all else would possibly have failed. In our case, it was an attorney, a full-time Lobbyist in our Legislature. He had many personal friends — key Senators and Legislators and this helped to be the key to our survival.

Our Executive Director provided instructions to our patients as to who to write to, as well as an idea of what to write. We did not allow form letters to be written.

In Legislative hearings, we were well-prepared for each hearing knowing necessary facts, not attacking any opponents. We negotiated from a position of strength, gave away nothing, but showed them we were willing to work out any problems that might arise if a physician chose to be licensed by both boards in a State.

We utilized patient contacts with Legislators.

Finally, on the 17th day of April, 1986, the Governor of Arizona signed the Homeopathic Bill which renewed the Homeopathic Board for another ten (10) years. This Homeopathic Board not only allows us to practice Homeopathy and General Medicine but includes prescriptions; also Acupuncture, Orthomolecular Medicine, Neuromuscular Integration and Chelation.

To be licensed by the Homeopathic Board in the State of Arizona, one must fulfill the following requirements:

1. Have an active M.D. or D.O. licence in the U.S.A.
2. Obtain three (3) letters of reference from Physicians who have known you.
3. Pass a Homeopathic exam. This exam may be waived by the Board if you are already a practicing Homeopath. For those Holistic Doctors who are not yet into Homeopathy, courses are given by the National Center of Homeopathy in Washington, D.C. which would allow a candidate to pass this exam, and there are also similar courses given around the country.
4. Must appear for a personal interview with the Homeopathic Board.

We encourage all holistic Doctors not to wait until they are under investigation to obtain a Homeopathic license in Arizona. The problem is, that if you lose your Allopathic license, you are unable to get the Homeopathic license. We appeal to you to have the foresight to protect yourselves in advance. Once you have obtained your Homeopathic license in Arizona, you can obtain a similar Homeopathic license in Nevada by reciprocity.

There is also a Homeopathic Board in Connecticut.

I have a much longer submission available for distribution to anyone who wishes to write to me to obtain this.

Thank you.

Sincerely,
Abram Ber, M.D.
President
Arizona Homeopathic Medical Assn.

August 26, 1986