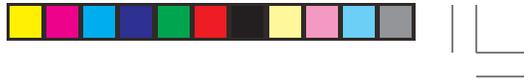




# Medical Intuition







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## Awakening to Wholeness

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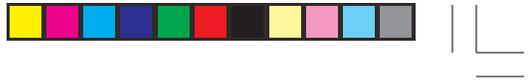
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## FOREWORD

### MEDICAL INTUITION: A SCIENCE OF THE SOUL

I do not know one person who, when describing his or her state of health, does not fail to include a profile of his or her mental and emotional status. It is, in fact, incomprehensible these days to leave out those details. Who would even think to ignore their stress patterns or their heartaches or their business or life traumas when describing how they are feeling? I can honestly say that I cannot even imagine such a conversation these days. Over the past fifty years, we have made great strides into re-awakening the Divine design of the natural order of the body/mind/emotions/spirit coordinates that support life. This inherent intelligence about the natural harmony between the soul and the body was lost over the centuries as the Age of Reason or the Enlightenment fell in love with the scientific approach to life, but we now stand on the threshold of both a Mystical and a Medical Renaissance. We have crossed the psychic Rubicon and entered into the era of the intuitive mind, the cosmic heart, and mystical consciousness. We have not yet fully arrived in this new place, make no mistake. But we have made the crossing. We are pilgrims, en route to our potential, a potential we will never fulfill in this lifetime. But we are the pilgrims who have begun the journey.



The field of holistic medicine is, of course, a central part of the energy paradigm. And the need for medical intuition to be recognized as a science within this emerging paradigm of energy, or mystical consciousness, is not an option so far as I am concerned. It is a necessity. We have years of research ahead of us to mature this field into a well-respected science that can stand alongside other sciences, and like other new fields, this, too, must earn its stripes. But that is a worthy scrutiny, as medical intuition needs to come into its own as a legitimate field. As an energy-based science, medical intuition has an enormous amount of vital data that it is capable of providing to the physical world of science, data that quite frankly makes a standard diagnosis incomplete. Yet, because medical intuition is not yet subject to the rigors of an authentic science and does not yet have an agreed upon education program for medical intuitives, much less a national board that licenses them to practice, and because we have yet to formulate controlled means to validate “energy data” or to work with it in a reliable manner, the field has not yet earned the credibility that it so urgently needs.

While Norm brilliantly addresses these concerns within the pages of this book, as a practicing medical intuitive for over two decades, I know from long experience that the field of holistic health, including the science of medical intuition, is confronting several obstacles that will take years to resolve, as they are not mere problems. Problems have solutions. What we are confronted with as we truly come to grips with the vast difference between the physical world of medicine and the philosophical core of energy medicine is a predicament—namely, a collision of realities and all that such a collision portends. And predicaments, unlike problems, do not have solutions. Rather, they call for the emergence of new perceptions in order to move forward.

Let me offer just a few examples of what the challenge is to which I am referring. What makes “science” a science is repeated research that, in turn, produces reliable data. Such data becomes a building block, a given piece of information that can then be applied to a problem toward arriving at a solution. Energy information is an entirely different type of data. It is “kairos” data as opposed to “chronos,” meaning that it is reflective of the “here and now” or having a more “timeless” quality to it, whereas physical, or chronos, data is concrete and forensic-friendly.



A person may be emotionally upset today, in the “here and now,” but not yesterday and perhaps not tomorrow. That doesn’t make the “here and now” data invalid or useless, but it does make it exactly what it is—good for the “here and now” and not measurable. A person’s energy is “off” today but “on” yesterday. Such information is valid but how exactly does that translate to hard-core healing information? People talk about the influence of attitudes and beliefs. That’s true, but which ones? Have you any idea whatsoever how many beliefs you have in that head of yours? And exactly which ones are causing you stress? Which precise negative patterns do you think are at the root of your crisis? Now that’s what I call a fishing expedition if there ever was one.

All science evolved and inherent to the evolution of all sciences was the evolution of the vocabulary of each science. There was a time when the words “bacteria” and “infection” and “germs” and “virus” and “molecules” and “atoms” did not exist. Words are the telescopes and periscopes and microscopes of the imagination and intuition. Without an adequate vocabulary, we can see nothing. We can articulate nothing. We can “sense” that something is “out there” or “in there,” longing to makes its presence known and its significance realized, but we are helpless until we name it. Language and *naming something* are as significant a building block to any science as the discoveries are themselves. Our challenge at this point is that we lack an adequate vocabulary that carries us between the dimensions of the physical body and the full force of the energetic anatomy and all the mysteries and power of that domain. We are at a loss to find a way that actually animates in measurable, real terms the connection between First Chakra issues and their everyday fetishes or fears. For example, the influence inherited tribal superstitions have on a person’s emotional maturity are huge—not small—huge. They are as influential as the religious myths a person grows up with because they are often intertwined. Try to measure the “energetic intensity” of that subtle thread within a psyche and then delicately track that thread as it went from a superstitious thought form into a behavioral pattern that resulted in a control fetish so intense that the person becomes incapable of intimacy. Can physical medicine do something like that? Not likely.

The role of power and our relationship to power is, so far as I am



concerned, basic to a health evaluation. People hemorrhage power for all manner of reasons—power plays in relationships, low self-esteem, lack of social clout, fear of rejection, personal finances, compulsive need for approval, a chronic fear of being humiliated—it’s an endless list. And that’s the point when it comes to your health—your health is intimately connected to your sense of power. The powerless find it nearly impossible to follow a health program. The empowered get right back on track. Can a person’s sense of power be measured in a lab? Of course not. But it most certainly can be intuitively assessed by a competent medical intuitive, and through my work with Norm, we learned early on that factors of personal, emotional, psychic, and mental power were as significant to a health analysis as blood work.

I can continue to list the many obstacles I see ahead for the field of medical intuition and energy medicine—and there are many—but I can also sum them all up in explaining that the science practiced in allopathic medicine, for the most part, is objective. Lab tests are lab tests. Energy medicine and the role of the medical intuitive provide subjective data, data that has many more variables than quantifiable data in the physical world. Every memory has an emotional thread, for example, and the fact is, you alter the intensity of the emotional current that you transmit through that thread moment by moment. Thus, the significance of my earlier statement: the role that medical intuition faces is not so much as a problem within the field of science as a predicament. Its field of reality is fundamentally mystical in design. Its data is energetic and of the substance of mystical consciousness. That does not make it any less valid. In fact, if a person truly grasps the significance of this rich domain of soul dialogue, then you know you are engaged with the core of a person’s true being. But, as I say, that leads to the predicament of translating that subtle field of data into the practical world of hard-core illness and treatment. And the obstacles in that world are equally complex in that patients rarely want to do the arduous work of soul transformation. Though they want the information, they are often under the impression that such information is like a release valve, as if it’s a secret, dark memory that you unlock, and poof, health is returned. Healing just doesn’t work like that.

Yet another variable that exists within the field of the medical intui-



tive is what the client believes the intuitive can actually do. It must be understood that the maturity of the medical intuitive, the attitudes and beliefs of that person and that individual's inner discipline, play the leading role in the quality of a medical intuitive reading. An immature, arrogant, untrained person who claims to be a medical intuitive will give a person a defensive reading; that is, he or she will have to be right and will argue to prove a point lest he or she be thought of as inadequate. I've seen that more often than I can count. Clients (medical intuitives may not refer to individuals requesting their help as patients) are vulnerable people. They often make the mistake of thinking that a medical intuitive has a tech lab for a mind instead of a mere intuitive system. Clients always imagine that an intuitive of any kind can answer questions that he or she simply cannot. They want their fortunes told. They want their life problems resolved. They want all their mysteries unfolded and not just about them. They usually come with a list of family members or a lover. A medical intuitive is not a street psychic or a carnival barker who can "see the future." A medical intuitive is exactly that—a person who has the ability to interpret energetic data as it relates specifically to health-related crises. This data often includes behavioral patterns, archetypal patterns that govern the soul's path, life traumas, and then there is the presence of physical illness as well as the illnesses that are in the process of developing. A profile of the individual's relationship to power as profiled within the Divine order of the chakras provides a map of how and why and where a person is losing power. Stepping out of those parameters and discussing other relationships and what a person might be able to psychically pick up about another person or discussing investments or business dealings during a medical intuitive reading is, so far as I am concerned, "energy malpractice," a crossing of the lines of the appropriate use of one's intuitive skills. If you are a medical intuitive, you must be governed by the ethics and parameters of what "medical" means. It means you are devoting your intuitive abilities toward assisting people to heal. If you want to be a street fair psychic and do romance readings, then list yourself as such but do not call yourself a medical intuitive.

Here comes the next logical question: Can people be taught to do medical intuitive readings with that same precision? First, the false be-



lief that intuition is a gift needs to be completely shattered. Intuition is not a gift. Everyone is naturally intuitive, beginning with our inherent survival gut instinct, which operates in us as a function of our animal nature—not our higher consciousness, but our lower one. However, as a second point, let me say that our intuitive senses evolve not because we are gifted with them but because we seek an inner life. The trigger mechanism or launch pad for the beginnings—and note I said beginnings—of sharp intuitive abilities is to develop a strong sense of self-esteem. By that I mean a sense of who you are without being controlled or influenced by the fear of being humiliated. If you can get a grip on that one fear—the fear of being humiliated—then you will have the courage to hear your intuitive voice, the deep, clear, Divine voice that is not driven by your fear of survival. That’s the beginning of mystical intuition, the core of what it takes to be a master medical intuitive.

Norm addresses a chapter of our history together and our effort to train a group of devoted students in the science of medical intuition. From that came Norm’s brilliant idea to found the American Board of Scientific Medical Intuition. His intention in creating ABSMI was to establish a national standard of excellence. I say “his” because, even though I am on the Board, the fact is, it was Norm who envisioned the need for the creation of the American Board of Scientific Medical Intuition. It was Norm who first realized years ago that we had entered the energetic age, an age that would call forth practitioners of the energetic arts of healing. Up until now, we have named ourselves without testing, without having to prove these abilities to a Board of qualified authorities who, in turn, would grant us a license to practice our science. Through such a process of standardization, this intuitive skill is matured into an energetic healing science. This is the route medical intuition must follow in order to emerge as a mainstream science. So far, very few medical intuitives have stepped forward to be tested. Hopefully, that will change in the years to come. Hopefully, medical intuitives will feel confident enough in their skills to believe that they qualify to step up to the ranks as members of an emerging science. Hopefully, that time will come soon.

Norm’s book on medical intuition is a textbook on this new science, a book that combines his history as a scientist examining this skill and



as a physician urging the common sense of personal health care. Energy medicine and allopathic medicine are teamwork, but neither compensate for negligent health habits, as he is quick to point out. Norm Shealy has always been a visionary in the field of medicine and human consciousness, and I have been blessed to be a part of his life's work. I would not have become the medical intuitive I am today had we not met so many years ago. And I can also say that it was precisely because of my skill as a medical intuitive that the inner world of human consciousness opened up to me. I know that this is a science, but it is a science of the soul, not the mind. And it requires the utmost inner training on the part of the practitioner to become a precise instrument. I was more than lucky in finding Norm as my mentor; I was blessed. And this I know to be true above all else—you cannot walk into the territory of the soul unescorted. A mentor is essential. I am grateful my mentor wrote this book.

Caroline Myss  
Oak Park, Illinois  
September 2009





# 1

## MY JOURNEY FROM PARAPSYCHOLOGY TO NEUROSURGERY AND MEDICAL INTUITION

While I was growing up my mother visited a little black lady outside our town, Lil Brown, known throughout the southeast as an excellent psychic. Supposedly, she had been consulted by our governor and various prominent people. Her technique was to have a client tell the problem. Lil would then dream on the solution and come up with a passage from the Bible. She then used that passage to give a practical answer. A remarkable use of scripture as a metaphor! In fact, just before I left for college, my mother had Lil do a “reading” for me. Lil told me, “You will be well known, but you will never be president of the United States.” I do not remember ever wanting to be president! Indeed, I cannot understand why anyone would want that position.

Three years later, while I was an undergraduate at Duke University, I was asked by the director of “The University Players,” to write a radio skit on Dr. J.B. Rhine’s work in parapsychology. I spent three months interviewing this first professor of parapsychology and observing in his lab. I was convinced that he had exhaustively proven that individuals could “guess” correctly the contents of closed envelopes, precognitively know what was coming next, and do psychokinesis—influence the rolling of dice. The work was fascinating but left me frustrated—why did he not do something *useful* with this parapsychological wisdom?

1



The terms used in those days were *psychic*, *clairvoyant*, *psychokinesis*, *viewing*, and *precognition*—all anathema to “academic” psychologists!

The skit was produced in the spring of the year, and I went on to medical school in the fall of 1952. For the next eighteen years I was preoccupied with medical school and graduate training in neurological surgery and my beginning clinical practice. Actually, I chose that field because I thought somehow it would help me understand the brain-mind. In medical school I had two major experiences with what I later would recognize as intuition. In my sophomore year, in Physical Diagnosis class, I made a diagnosis, which was correct, but which the professor felt I should not have been capable of making! He accused me of cheating and wrote a scathing report for my student file. Two years later, he apologized and asked me to intern in the Department of Medicine. He said he had withdrawn his earlier report from my file. In my junior year, I made a diagnosis of sarcoidosis of the pituitary gland in a patient who had entered the hospital over the weekend. Sarcoidosis is an autoimmune disorder that can be very serious, especially when it involves the brain or master gland. The professor of endocrinology was shocked when I presented my diagnosis and said to me, “You are a medical student. You can’t make such a diagnosis.” It was the first case of sarcoidosis of the master gland seen at Duke, and Professor Engel and I wrote a definitive paper on the subject.

Meanwhile, my research throughout medical school was investigating the physiology of the amagydala of the cat. The amagydala is strongly tied to emotions. Then, during my neurosurgery residency, I developed interest in the physiology of pain and continued that when I joined the faculty at Western Reserve Medical School. There I discovered the physiological foundation for pain mechanisms, a paper for which I was given the first Harold G. Wolff Award for Research in Pain. Remember this event, as it later became one of numerous *synchronicity* aspects of my life, a concept or term which, at that time, would have had no meaning! I met, at that meeting of The American Headache Society, Dr. Janet Travell, President Kennedy’s physician, and a leading expert in myofascial pain. Out of my work came also my first two inventions—TENS, Transcutaneous Electrical Nerve Stimulation, and DCS, Dorsal Column Stimulation—both now used worldwide. Again, a be-

ginning of what I would later know as *intuition* at work!

From age sixteen, I had planned to be a professor of neurosurgery. In early 1966, I was offered an opportunity to be interviewed to take over a major department of neurosurgery. As I had experienced by that time major meetings with a large number of chairs of Departments of Neurosurgery, I suddenly realized that I really did not like many of them. They were often arrogant, rude, or alcoholics and not individuals with whom I wanted to socialize! In fact, neurosurgeons had a reputation from the early days in the twentieth century of being the rudest of all specialists! I phoned Dr. Talmage Peele, my mentor since I entered medical school; I had done my amgydala research in his lab; and his response was, "Junior, you are ruining your career."

Suddenly, I made a critical decision—to leave academia. I took a position as chair of the new department of neuroscience at the Gundersen Clinic in LaCrosse, Wisconsin. The Gundersen Clinic was at that time the tenth largest private clinic in the United States. One of its founders had been president of the American Medical Association, and my position at Gundersen Clinic would allow me an opportunity to be clinically active but do some continuing research. Over the next five years, I was by far the busiest I have ever been, often working eighteen-hour days and seeing hundreds of patients with the broadest variety of neurosurgical problems. During that time our department expanded to include three neurosurgeons, three neurologists, and a neuropsychologist. I was able to have wonderful laboratory assistants who could carry out the research protocols that I developed. I even worked with a palsied orangutan, Shakey, in whom I demonstrated that electrical stimulation could indeed control tremor. In collaboration with Dr. Ted Tetzlaff, a neuroscientist at the University of Wisconsin, LaCrosse, we demonstrated electrical control of seizures in rats as well as control of penile erections in monkeys.

Meanwhile, my research with chronic stimulation of the spinal cord in cats and monkeys had proven successful enough that in 1968 I presented my work at the American Association of Neurological Surgeons in St. Louis. The paper was so controversial that physicians jumped up on the stage and grabbed my microphone. The paper was the first ever given at that meeting that was turned down for publication in the *Jour-*



*nal of Neurosurgery* as too controversial. It was subsequently published in *Analgesia & Anesthesia*. Two years later, I presented my first eight cases of DCS in human patients with advanced, incurable pain. Suddenly neurosurgeons wanted to jump on the bandwagon and do the procedure!

I had developed the original equipment with Tom Mortimer, who had done his master's and doctoral research in my lab. When he graduated, he joined the faculty at Case Institute of Technology and went on to become a famous biomedical engineer. He suggested that I invite Medtronic, the leading manufacturer of pacemakers, to manufacture the Dorsal Column Stimulator (DCS) devices. They agreed initially to support the Dorsal Column Study Group, a consortium of neurosurgeons who planned to operate on a total of five hundred patients and follow up on them, over five years, before we made the procedure publicly available. I tried from the beginning to interest Medtronic also in TENS, but they refused until one of their research engineers left the company and began manufacturing the first TENS devices. Two weeks later, his replacement at Medtronic produced a smaller device, using the electronics I recommended! As so often happens in industry, greed crept in. Another company started advertising DCS to the neurosurgical community and Medtronic followed suit. The study group had barely inserted stimulators in 480 patients, but few followed five years. And, unfortunately, the design of the electrode was changed from my initial design. That led to many complications and forced me to abandon the approach. Forty years after my first DCS patient, I was invited to receive a "Lifetime Achievement Award" for the creation of DCS, even though I have not inserted a DCS since 1973!

Meanwhile, in the fall of 1969, my family moved to a farm outside LaCrosse and began our work with Appaloosa horses. My wife has been the major force in that work, but our involvement with horses opened the door to my old, dormant interest in psychic phenomena! In October 1970, I flew to Colorado to visit Sun Appaloosa Ranch, where the owners were retiring and had some champion horses for sale. I drove down from Denver to Castle Rock, and when Joyce Cannon opened the door, I knew her at a deep soul level! We spent a couple of hours discussing psychic phenomena and even past lives, which I had never before even



thought about! I wound up purchasing eight of Ralph and Joyce's horses, and we became good friends.

Two weeks later, I received *Psychic Discoveries Behind the Iron Curtain* from Joyce. *Wow!* That really did the trick. I was excited to see how far parapsychology had come in eighteen years. Another week passed and Joyce sent me Shafica Karagulla's book *Breakthrough to Creativity*. Here was proof of *practical* application of clairvoyance! I wrote to Shafica and asked for an address of Kay, who had been mentioned in the book as highly accurate in making medical diagnoses just by seeing the patient. She told me to "find your own psychic." I was disappointed but began asking colleagues if they knew any good psychics! I was lucky to stay out of the insane asylum.

In November 1970, on my monthly visit to the University of Minnesota, where I had a teaching appointment, I said to one of my colleagues, "Pain is the most common symptom that takes patients to a physician, but no one has specialized in pain management." His response was, "An interesting idea, but who would ruin his career doing that!" I was immediately convinced that I should found a comprehensive pain management clinic. Over the next nine months, the idea incubated. In July, I visited Dr. Wilbert Fordyce at the University of Washington to see his five-year-old Behavioral Modification, or Operant Conditioning, Program. Working with just one hundred patients in the five years, he hospitalized them for two months. His program was what I would call passive behavioral modification. But he had a 60 percent success rate doing little but ignoring their pain and weaning them from drugs, as well as a modicum of physical activity. He felt that if he had only a 10 percent success rate with these chronic pain patients, then society would break even. The cost of these patients to the medical system is enormous! In August 1971, I made the decision to leave Gundersen Clinic, as I needed space in which to develop my ideas. I went across town to St. Francis Hospital, where I was allowed to take over an entire floor in the oldest part of the hospital to develop an inpatient pain management program. Not being born Catholic, little did I suspect at that time how strongly I would be attracted to St. Francis—and have been for many centuries. More about that in a later chapter.

I was already being sent four hundred chronic pain patients from