

Research Article

Study of the effect of “FARADARMANI” on patients in waiting list for liver transplantation: a double-blinded randomized controlled clinical trial

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Abstract

Introduction: Within the sphere of Complementary and Alternative Medicine (CAM), the most recent newcomer “*Faradarmani*” applies the interactive flow of consciousness with the energy-matter around for treating a wide spectrum of ailments with its own distinguishing hallmarks from other mind-body therapies. The present research deals with a curing experimental design for end-stage cirrhotic patients who have been on the waiting list for liver transplant by skilled “*Faradamangars*”.

Materials and methods: This is a double-blinded randomized clinical trial exerted on 70 cirrhotic patients in a period of 12 months in Shiraz Motahhari clinic with the exclusion criteria of either death or undergoing liver transplant. The objective measured variables included MELD score, CBC, LFT, PT, INR and Creatinine. Additionally, the quality-of-life measures comprised of SF-36 general health questionnaire. The data were fed into the Mann-Whitney test, Chi-squared test, and Fisher’s exact test. These were carried out by means of the SPSS software with a significance P-value of 0.05.

Results: As many as 70 patients within the age bracket of 17–66 were brought under the study of whom 39 continued to the end of the investigation (21 patients in the test group and 18 in the control group). There has been an increase in the hemoglobin (Hb) mean in the test group, whereas the control group showed a decrease in Hb mean (P-Value=0.01). Creatinine level change was very much close to the statistical significance tier (P-Value=0.058): it increased among the control patients and decreased in the test group. As for the patients’ quality of life (QoL): the test group patients gained statistically significant recovery in physical functionality (P-Value=0.005), social functioning (P-Value=0.019), and energy/fatigue (P-Value=0.028) aspects.

Discussion and conclusion: In view of the positive effects of this method of therapy, in addition to its being totally without costs and danger, over and above the fact that it never interacts with any other of the conventional treatments that the patients might have been undergoing, Faradarmani treatment is warranted to be prescribed for liver cirrhotic patients recovery.

Introduction

Complementary and Alternative Medicine (CAM) is considered to be a set of diversified medical and health care procedures, methodologies, practices, and products which are not commonly deemed part of conventional medicine as taught through normal medical academia and colleges [1]. While the “Complementary” part of the definition denotes a number of coherent practices with their theoretical background, applied alongside the established brand of medicine without totally pushing out the latter from the arena of treatment delivered to the patients, the “Alternative” segment of the said definition suggests practices (again not excluding their theoretical backdrop) exercised simply in lieu of the established conventional medicine [2].

In recent years, the use of CAM has aroused much more interest among various levels of public life. This might be the result of frustration accumulated for years on the part of patients, especially those with chronic ailments [3]. The number of those that have been somehow or other disappointed by conventional treatments is not small.

Consequently, workers in the field of CAM have been encouraged to redouble their efforts for better propounding their ideas and practices [4].

This has not always gone on without friction with the medical establishment. Sometimes, the higher-order argumentative strife has leaked down to the grass root level of the man on the street: as, e.g., in the case of anti-psychiatry movement [5].

Faradarmani as the newcomer on the CAM stage

Now, “Faradarmani” –founded by Mohammad Ali Taheri–

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has also come on the stage for three decades as yet another branch of CAM [6]. It is considered to be some qualitative medicine with exclusion of quantitative, instrumentalistic vehicles. Put another way, “Faradarmani” may well be described as a type of mind-body therapy [7]. Whereas the provenance of this arm of CAM is Iran, it has not ceased to expand its influence beyond the borders of Persia [6].

Meriting of mention would be the fact that “Faradarmani” has undergone a number of tests as to its efficacy and outcome. There is, of course, much debate going on regarding these testing procedures being fully rigorous or not. However, this has not prevented the “Faradarmani” therapists from going on treating patients and, at the same time, measuring their own statistical strength as far as significant results are concerned [8-16].

The conceptual basis of this mode of CAM is the interactive flow of consciousness (awareness) with the Energy-Matter milieu around (Figure 1); this means that despite the fact that consciousness (awareness) can be neither energy nor matter, the material world has been created from conscious building blocks lacking space-time curvature dimensionality [7]. In point of fact, according to “Faradarmani” therapists, there is a holistic collective awareness whose predominating influence determines the overall direction of its ingredients’ motion and state [17].

“Faradarmani” theory goes like this: human beings, animals, plants, minerals, and even molecular entities down to the level of atoms have partial awareness [7]. The field flux of the above-mentioned entities builds up into a resultant vector of consciousness. Disease, not just among human beings, but also throughout the animal and plant kingdoms, is the terminal effect of suspension of bonds between these beings’ partial awareness and the Whole Consciousness [7]. Even deformities and abnormal torsions at the cellular-molecular level take place as and when the said consciousness bond-breakage happens.

This is not to be mistaken for the homeopathy’s postulate of bringing back into a state of balance the unbalanced consciousness on the part of molecules by means of other material agents [18]. Faradarmani talks of re-establishing the broken links among entities of different types by hooking them onto the Whole Consciousness, the process being necessarily not of material nature [7].

Additionally, the remotely probable extant proximity/similarity with polarity therapy and/or energy therapy might also be nearly totally negated to the level of (almost) absolute refutation [19]. To make the point even more clear:

As for the polarity therapy: The fundamental theoretical basis in this school of CAM would be that central to polarity therapy is the concept of a life energy, which is in constant pulsation from positive to

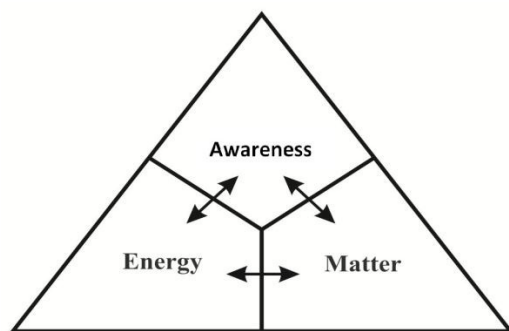


Figure 1. The constituent elements of the universe.

negative poles via a neutral position, creating fields and energetic lines of force [20]. However, when we come to “Farakolnegari”, that is to say, the treating application of Interuniversalism, as the fundamental theoretical basis of Faradarmani, we will soon realize that: here, it is the trilogy of matter+energy+universal consciousness (with the Whole Consciousness as the overruling, overmastering regulator of the other ingredients of the trilogy of existence) that influentially works as the totally balancing channel of treatment [and not the pulsation energetic lines of force or the flow thereof alone] [7].

As for the energy therapy: Energy therapy is based on the concept of connection between the physical, emotional, mental and spiritual realms of our lives found in many holistic healing methods. It uses focused healing energy to clear blocks that accumulate in the body hindering the natural flow of physical, emotional, mental, and spiritual energy [21]. This is –by its very quid nature–much more akin to the “Farakolnegari” as one of the theoretical-applicational, fundamental basis of Interuniversalism [22]. Yet again, energy therapy focuses only on the entity of energy (with its categorization of sub-branches) as the healing agent [21]. It disregards the holistic, exhaustive, so to speak, unitarian role of the Whole Awareness.

Faradarmani and cirrhotic patients

Of very many different applications of Faradarmani, this present piece of research deals with the usage of Faradarmani as for cirrhotic patients. This is actually in line with the general policy adopted by Faradarmani therapeutical researchers whereby end-stage patients are picked for the purpose of disease treatment. Faradarmani workers and students have opted for such a policy so that the tiniest amount of their treatment’s effect could, in no way, be either refuted or denied.

The second best reason for choosing end-stage cirrhotic patients as subjects of investigation was Shiraz’s being not just a major liver transplant in Fars Province, in Iran, in the Middle East, or in Asia, but in most likelihood-in the whole world [23]. This actuality paved the way much more facily for nearly all sorts of medical/pharmaceutical maneuvers, so to speak. This does not spell that Faradarmani treatment of cirrhotic patients has been in need of a variety of medications, facilities, or subspecialty clinics. Rather, it means that the concentration of a wide spectrum of almost all shades of liver disease patients has already been extant in the city of Shiraz. Moreover, tight scrutiny could well have been undertaken by an elite group of some of the most prominent experts in the field.

The liver cirrhosis

Cirrhosis is a medical condition whose precise definition has to do with histopathology. The manifestations of cirrhosis are not always the same, nor are its resultant complications. Under certain circumstances, there is likelihood of its being lethal. Despite the fact that it was previously thought to be an irreversible condition, recent studies show that fibrosis’ reversibility is possible conditioned the underlying cause has been taken away: The best success as for removing the main cause of fibrosis and, thus, reversing cirrhosis damage would be the treatment of chronic hepatitis C [24].

World Health Organization’s report informs us of an annual death rate of 800000 as a result of cirrhosis. The same rate as for the United States is around 27000. This causes cirrhosis to known as the twelfth-ranker death cause there [25].

Although the only surefire treatment for advanced liver dysfunction is deemed to be liver transplant, the shortage of livers to

be transplanted onto patients in addition to the increasing trend of advanced liver ailments pushes the specialists in the field to put forward some immediate, effective remedy [26]. For instance, liver donation in the United States has actually doubled in the time period of 1991-2007 while the liver transplant waiting list sum total have jumped up tenfold for the same time bracket [27].

Another facet to the liver transplant issue is the economic effects and side effects at individual, familial, and societal level: effects that start to show up even before the surgical operation to long last afterwards. This is true in almost all countries of the world [28,29].

In Iran, Shiraz has started to be the only center for liver transplant operations since 1993 where 40 transplants have been carried out up to 2000. Between the year 2000 and 2007, the transplant rate came to the ceiling of around 400 [23]. In spite of much effort having been spent in Iran for increasing both the quality of life and the life expectancy for the patients, only one fifth of the total number of those in urgent need of transplant receive the needed liver [30]. As a result, the death rate does not show any sign of abating in Iran, as elsewhere in the world [31].

CAM is expected to step in and play a major role at a satisfactory level especially in a nation-state like Iran whose long-lasting ancient history of traditional medicine is well known even by laymen. It is right here that Faradarmani shows up to perform its self-accepted responsibility for cirrhotic patients.

Materials and methods

Materials Applied

The patients on whom the experiment was conducted were of the age bracket of 17-66. Their average age was computed to be 47.2 for the test group and 36.3 for the control group. The gender distribution was 86% male and 14% female for the test group; as for the control group males and females were respectively 39% and 61%. From the point of view of education level, types of job, and marriage status, there was not any significant difference between the test and control group according to Fisher's exact test.

The patients picked for conducting this experiment were end-stage cirrhotics on the waiting list for liver transplantation in the organ transplant center in Shiraz Namazee hospital. The inclusion criteria were:

a. diagnosis of liver cirrhosis in addition to falling in Child Class B or C category

b. non-usage of any other kind of CAM therapies

The exclusion criteria were as follow:

a. occurrence of death

b. the carrying out of liver transplant

The sample population consisted of two 40-member groups on whom randomization was done on the spot.

Naturally, the conventional treatment the testees received depended upon the type of etiology, complications, side problems of the symptoms, etc. none of which was to be considered or discussed by Faradarmani experimenters throughout this survey.

However, it is of absolute necessity to mention the fact that the patients were totally free to undergo liver transplant as and when the

central office of organ transplant called on them; no intervention or prevention was ever done by Faradarmani therapeutical experimenters as far as transplant was concerned. The only action taken by Faradarmanists on such occasions was to withdraw such patients' names from the list of those on whom the test was being performed. Many a time, the very exercise of Faradarmani on the cirrhotic patients led to considerable alleviation and/or the patients not any longer needing transplant operation.

While at the beginning, the experiment was to be limited to patients only from Fars province, later on, in the course of actualizing the test, patients from all over Iran were brought in. This broadened the scope of the experiment from a local one up to a national one.

Methodology and procedures

The present investigation was conducted within the boundaries of a fully randomized clinical double-blind procedure during the years 2012-13. The shortest time period for any one subject of experiment was set at 3 months. Withdrawal, during the experiment, was 14 patients from the test group and 17 from among the controls. Taking into consideration these dropouts, as many as 39 patients (21 in the test group and 18 in the control group) continued to be scrutinizingly studied down to the end of the investigation.

The demographic variables to be considered comprised of: age, gender, education level, occupation, weight, marriage/singleness status, Body Mass Index (BMI), background ailments, and individual habits. The laboratory variables thereof were: Liver Function Test (LFT), Complete Blood Count (CBC), Prothrombin Time (PT), International Normalized Ratio (INR), and Creatinine (Cr). Yet another parameter of measurement was Model for End Stage Liver Disease (MELD) score, which is the most significant score to determine the transplant priority.

The quality of life on the part of the patients in both groups was delved into by the standard questionnaire of SF-36. Additionally, cirrhotic patients specialized tailored questions were put to the subjects of the investigation in order to get at more details of their life quality. Accordingly, the physical examination as for pitting edema, ascites, and jaundice was carried out to know in full detail specifics that might be deemed peculiar to cirrhotic.

Statistical toolkit

The statistical data coming out of the experiment were fed into the Mann-Whitney test, Chi-squared test, and Fisher's exact test for proper statistico-mathematical comparison, collation, and analysis. These were carried out by means of the SPSS software (version 18). Enough care was dedicated to each and every single piece of datum as far as its measurement, double checking, and placement within the necessitated table were concerned. The statistical sensitivity, that is to say the P-values of various analyses was set at 0.05.

Further elaboration on methodology

No lost data recovery was conducted throughout the investigation. Those variables regarding (previous) background ailments, the consumption conventional drug dose, in addition to personal habits were not measurable or analyzable. This was the consequence of shortage of information in the aforementioned trilogy.

How Faradarmani therapists intervened

Patients were chosen according to the inclusion criteria. The interviewer, not herself being a Faradarmani therapist (Faradarmanist),

but having gone through conventional medical education to become an intern, started to put the experimentees through the following steps:

- a. Signing the inform consent
- b. Filling out the questionnaire
- c. Being physically examined for symptoms related to cirrhosis (as cited before)
- d. Being referred to lab technicians for sample-taking
- e. Receiving explanation as to how and when to be linked

The interviewer, then proceeded on to send (through E-mail) all the patients’ names, phone numbers, and the 3 Ettesal (linking)s hours chosen by the patients themselves to the randomizer. The randomizing person, again herself not being an interventionist and/or a Faradarmani therapist, had the responsibility to just randomize the experimentees into two groups of test and control. She managed to, later on, onforward the two groups’ members either to a Faradarmani therapist (as for those chosen into the test group) or to a non-Faradarmani (as for those chosen into the control group).

Upon receiving the names list, each one of the followers contacted the first contact (by phone) onto the patient. Elucidation was once more given to the intended patient as to how she should proceed on along with the investigation. This manner of following the experiment to encourage the patients to continue cooperating went on approximately weekly down to the end of the experiment.

Shedding more light on the manner of intervention

It should be made absolutely crystal-clear that the only job performed by the Faradarmani therapist for any patient is to just will the process of Faradarmani for the intended patient: no incantation, mantra, meditation, transcendental epi-hypnosis, or bodily touch is to be exercised. Just the intentionality on the part of Faradarmani therapist focused on towards the patient’s healing is done [7,22].

The result of such a modality of intentionality would be to link, or : hook on, or : bond, the patient to the Whole Awareness of the Universe. The initiation of the said Ettesal(linking)s would, by the norm of Faradarmani, lead to the Scanning on the part of the Whole Awareness of the all known and unknown functional/dysfunctional dimensions of the patient [22]. This is not the conventional-treatment scanning as applied in the terminology of modern medicine. Rather, it is some process to be carried out by the Whole Consciousness (not, even, by the Faradarmani therapist herself), meaning that: all the various component parts of the human under treatment are comprehensively scrutinized by the Universal Awareness [7]. Thus, without any intervention by instruments or therapist’s visualization, past, present, and future maladies, malfunctions, ulcers to the interior or to the exterior, disorganization of organs down to the cellular level, etc. are all recognized by the so-called process of scanning before any curing could take place. The same Universal Consciousness goes to extent of prioritizing which disorder(s) ought to come top on the list of healing [7,22].

This scanning (in addition to the commencement of the healing process) may sometimes result in symptoms such as: warming, cooling, lightening, numbing, sweating, stinging(pain), or [in any other ways, means, or manner] changing of the normal routine bodily sensation in a limb or the whole organism. There are, of course, instances where none of the aforesaid occurs [7,22]. Contrary to common expectation, the occurrence or non-occurrence of these cannot again affect the

recovering process of Faradarmani.

Noteworthy would be the fact that Faradarmanists themselves have not fallen into the habit of atomizing their own healing process into sharply bounded stages, steps, or strata. This is part and parcel of the holistic approach of the Universal Consciousness’ uplink that cannot be teased out into discrete disparate segments according to the core theory of Faradarmani behind all these.

Such an ability on the part of the Faradarmanist has been obtained by her going through a course of Faradarmani. Gadgetry, instruments, gear, medications, or any other apparatus would be of no avail either during the process of Faradarmani course learning, or : afterwards, when the Faradarmanist exercises her ability to thus heal [7].

Results

As a bird’s eye view, we have first brought in the following table to lay out the general information concerning the population under study (Table 1).

According to table above, the two groups (test and control) have been statistically significantly different from one another from the point of view of the variable of age (P<0.01). In addition, the BMI has not been significantly different from the control to the test group (P<0.05).

It is worthy of mention that the discrepancy in between the test and the control group from the standpoint of the variable of age has NOT been the result of any pre-determined and/or purposeful “cherry-picking”: It has simply come out as a result of the normal routine randomization that takes place in any RCT.

Almost vitally necessary is the fact that the outcome of the aforesaid randomization process does not in any ways, means, or manner push the agenda of Faradarmanists or Faradarmani therapy. On the contrary, it has actually laid out a (very) rough ground for Faradarmani therapists to prove the validity of their own therapy, simply because the treatment group (the test group) has turned out to be consisting of patients with higher age, which is not normally considered to be a favorable parameter for any practitioner.

Table 3 shows the lab variables standard error(s) in addition to mean(s) on the part of the population under study. A number of issues to be raised as of table 3 are the following:

- As observed throughout the data laid out in Table 3, the primary MELD mean score as for the test group was 14.8 while that of the control group was 13.5. This vindicates a worse situation on the part of the test group at the initial commencement of the investigation. Towards the end of the study, changes in the MELD score [i.e. , the MELD delta(or: MELD differentiation)] were calculated both for the

Table 1. Age distribution.

Variables	Control Group		Test Group		P-Value
	Mean	Standard error	Mean	Standard error	
Age(years)	36.3	3.2	47.2	2.8	0.01
BMI (Kg/m ²)	24.6	1.07	23.5	0.5	0.5

Table 2. Gender distribution.

Gender	Control Group		Test Group		P-Value
	Mean	Standard error	Mean	Standard error	
Male	39%	0.11	86%	0.07	0.002
Female	61%	0.11	14%	0.07	

test and the control group: they turned out, respectively, to be 1.55 and 1.85. This computation simply spells that the level of “worsening” in the test group has been less than that of the control group at the end of the study.

- The hemoglobin mean has shown an increase in the test group, while the same mean has shown a decrease in the control group: these changes have been statistically significant (P<0.01).

Table 3. General laboratory findings.

Variables	Control Group		Test Group		P-Value
	Mean	Standard error	Mean	Standard error	
MELD 1	13.5	0.76	14.8	0.85	0.39
MELD 2	15.4	1.52	16.35	1.38	0.44
Delta MELD	1.85	1.23	1.55	1.13	0.72
TPRO 1	7.57	0.20	7.46	0.18	0.58
TPRO 2	7.32	0.18	7.50	0.19	0.56
Delta TPRO	-0.25	0.21	0.04	0.18	0.50
ALB 1	3.60	0.13	3.32	0.13	0.38
ALB 2	3.68	0.15	3.59	0.14	0.84
Delta ALB	0.08	0.10	0.27	0.07	0.15
GLO 1	3.97	0.13	4.14	0.14	0.51
GLO 2	3.63	0.20	3.89	0.18	0.50
Delta GLO	-0.33	0.22	-0.24	0.14	0.87
AST 1	57.57	8.74	62.38	8.26	0.66
AST 2	52.64	9.23	67.7	10.77	0.36
Delta AST	-9.41	5.11	5.31	5.66	0.10
ALT 1	43.42	5.98	43.95	5.38	0.59
ALT 2	37.21	5.95	46.15	6.49	0.41
Delta ALT	-8.58	4.07	2.20	4.71	0.10
ALP 1	364.92	108.83	586.1	130.22	0.14
ALP 2	426.07	157.71	486.85	66.97	0.06
Delta ALP	12.35	57.56	-99.25	81.37	0.63
TBILLI 1	2.47	0.44	3.35	0.53	0.20
TBILLI 2	2.70	0.49	3.11	0.53	0.31
Delta TBILLI	-0.07	0.47	-0.23	0.28	0.47
DBILLI 1	0.88	0.36	1.16	0.31	0.17
DBILLI 2	1.30	0.44	1.37	0.30	0.11
Delta DBILLI	0.27	0.43	0.21	0.25	0.62

Table 4. Quality of life’s dimensional comparison between the test and the control groups.

Quality of life’s aspect	Control Group			Test Group		
	Mean	Standard error	P-Value	Mean	Standard error	P-Value
Physical functioning 1	72.77	28.60	0.937	61.90	24.77	0.005
Physical functioning 2	72.77	21.01		76.90	25.32	
Role limitations due to physical health problems 1	37.5	40.44	1	42.85	37.20	0.211
Role limitations due to physical health problems 2	37.5	33.48		55.95	35.27	
Role limitations due to personal or emotional problems 1	47.22	35.81	0.833	45.23	33.39	0.116
Role limitations due to personal or emotional problems 2	45.37	37.83		62.69	36.09	
Energy/Fatigue 1	47.22	21.43	0.049	52	22.32	0.028
Energy/Fatigue 2	58.61	23.37		63.5	22.07	
Social functioning 1	58.33	34.29	0.548	64.37	20.38	0.019
Social functioning 2	52.77	26.96		77.5	21.3	
Bodily pain 1	63.47	37.87	0.569	69.16	25.28	0.23
Bodily pain 2	70.41	23.02		76.90	25.3	
General health perceptions 1	49.16	24.80	0.694	53.25	21.53	0.211
General health perceptions 2	46.38	22.34		59.75	59.23	
General mental health 1	48.88	18.43	0.102	62.8	16.05	0.359
General mental health 2	57.33	25.03		67.7	22.04	

- The creatinine changes in the form of decrease in the test group and increase in the control group, though not statistically significant, have been highly considerable and very close to the level of significance (P=0.058).

- As for other laboratory variables under study, significant differences were not observed between the two control and test groups.

- Table 4 introduces various life quality dimensions besides their comparison in the two control and test groups. This is according to the Wilcoxon signed-rank test.

❖ According to Table 4, the physical functionality quality in the lives of the testee patients, i.e. within the test group, has significantly improved (P<0.01) (P value=0.005). Against this and in the same background, no changes have been detected in the control group’s quality of life (physically).

❖ Within the social functioning life quality, a significant increase has actually been traced (P<0.05) (P value=0.019) whereas some decrease of social functioning has been witnessed in the control group.

❖ Despite the fact that the energy/fatigue dimension index of the quality of life has moved toward some sort of recovery, the said recovery has been statistically significantly higher among members of the test group.

❖ No statistically significant differences were observed in the other quality-of-life indices and dimensions.

Discussion

This whole plan of RCT was conducted for the purpose of showing the effect of Faradarmani on cirrhotic patients, in waiting list for liver transplantation. Never before had a scientifically organized testing schedule been designed and carried out to prove the efficacy of Faradarmani as a registered complementary genre of medicine. Of course, a number of other studies and investigations had been published on Faradarmani therapists’ works on patients with asthma, drug addiction and general health problems [8-10]. In addition, yet other works had been done in the field of psychiatry, including: depression, anxiety disorder, sleep disorder, mood disorder, bipolar disorder and schizophrenia [11-16].

The accord has, of course, been established with other studies of Faradarmangars. This is, no doubt, reaffirmation to the core idea of complementary and alternative medicines being sufficiently helpful (and, in many cases, much more than simply helpful) in treating diseases of psychic, somatic, and psychosomatic origin. Still, focus has certainly been on Faradarmani itself as the center of attention for acting out the role of a comprehensively working complementary medicine up to the notch of a systematic RCT.

Thus, there remains very little room for the established medicine practitioners to disagree with a narrowed-down numerical report of the workings of Ettesal(linking)s inside the boundaries of Faradarmani. On the other hand, Faradarmangars, as shown throughout the protocol of our investigation, do never resist the idea of (partial/total) application of conventional medicine, either.

Worthy of mention would be the fact that there has occurred NO transformation of data throughout the very little statistical operations conducted within the domain of our research study. There are a number of research designers and a smaller number of statisticians who show of themselves some signs of frowning disapproval whenever it comes to such data coding as additions, subtractions, multiplications, log straightening, etc. [32]. There are, in addition, a group of laymen who (without, of course, justifiable scientific base) regard as "factitiously fictitious" any changing of the original data by the abovementioned coding-transformation operations. They simply consider this to be means for purposes of "cooking" numerical when researchers are *a priori* inclined to arrive at a certain predetermined conclusion [33]. This whole matter remaining to be fully teased out and discussed by students in the field notwithstanding, the truth of the matter is that no such coding's have been executed in our Faradarmangars' research study.

Bringing the routes of our roadmap investigation into some state of briefing abridgment, so to speak, the double-blind pilot study of ours on the cirrhotic patients HAS been able to show how the correlation between the exercise of Faradarmani Ettesal(linking)s and physicalistic improvement in the state of patients does exist in full coordination with all the four preassumptions of analysis of variance; that is to say: Normality, Randomness, Independence of error terms within the numerically additive digital value of variates, and Homogeneity of variances [34].

The truth of the matter is that nearly three decades of all but successful treatment and healing on the part of complementary/alternative Faradarmani practitioners has roughly been semi-isolated from the rigorous cosmos of researchers by what appear to be relatively impervious bulwarks for no totally justifiable reasons. Nevertheless, the cause of fully working Faradarmani cannot remain forever as a non-follower of evidence-based medicine [35]. There is very little doubt that the "scientific" establishment itself is responsible for clouding some sphere of ambiguity around what Faradarmani pieces of research are obliged to come up to in order to meet their own, or possibly, unbiased spectators' standards.

Bearing the holistic nature of the Universal Consciousness's treating practice methodology in mind, tailoring has long been due since the initiation of Faradarmangars into the realm of practice. Tailoring, that is, of those areas and niches within the borders of Faradarmani where overlapping is best observable with conventional medicine academia so much so that the Faradarmani can best bring itself out as "orderly rational" [36]. Although it was previously mentioned in this present investigation that measuring research had been done by

other Faradarmangars, the type of query most frequently pushed into the face of our practitioners' community by the mainstream paradigm researchers is almost precisely and comprehensively answered by the approach adopted in this research into objective observations among cirrhotic patients with recorded academia mainstream medicine.

Thence, quest as to causation, and: the level of the treatment efficacy is answered, applying scientific methods.

An alternative suggestion for statistical analysis: Bayesian prospect

In addition to the normal routine ANOVA that is most commonly applied in whatever has to do with biometry, there also exists the Bayesian Paradigm with its own (usually neglected) superior advantages over the "frequentist" paradigm in mathematico-statistical analysis of data in medicine [37]. The future horizon for Bayesian inference from the present data of our Faradarmani investigation appears to be all but brilliant. Of course, it is true that the most popular choice for statistical work on medical data would naturally be the hackneyed frequentist one-way, two-way, multiple-way, nested split-block ANOVAs etc as they hardly ever clash with the trodden way chosen by the majority of biometrists: the computer software to carry out such models of analysis are already present to make the job even more facile for the common medical researcher [38,39].

All the said ease extant for analytical work on medical data with frequentist paradigm notwithstanding, the Bayesian SURVIVAL analysis enables us to make extremely precise inference for any sample size without need to resort to asymptotic computations [40]. For instance, survival rate guesstimation usually requires asymptotic arguments, quite complicated to derive in many models. Moreover, there is almost always the issue of whether the sample size is large enough for the frequentist survival rate approximation to be technically valid [41]. In contrast, the Bayesian paradigm is able to incorporate prior history of the patients in a most natural method: something which the asymptotic-frequentist statistics is normally unable to do [42].

Thence, the Bayesian paradigm proves to be a mighty tool for the quantification of patients' prior history data over and above the actuality that frequentist inference can also be got at as a special case of Bayesian inference [43].

Conclusion

The main comparison, here in this article, comes to be between the two groups of end-stage cirrhotic patients, on the waiting list for liver transplant. Of the two, one has received Faradarmani over and above the conventional medical treatment. The other group has remained to act as the "controls", normally present in all biometry and medicine test and experimental design.

Contrary to established medicine's current inculcating view, this branch of CAM applied within the boundaries of the present investigation, causes no impinging interference into the routine treatment used for end-stage cirrhotics. Faradarmani does not interfere with conventional medicine's therapy either in a quantitative or in a qualitative manner [8]. The minimal point of emphasis to be highlighted here is that NO bodily and/or mental harm is directed towards cirrhotic patients as and when they commence to undergo the CAM Faradarmani treatment down to the end of the process of their healing.

The evidence directly backing the efficacy of Faradarmani as applied to end-stage cirrhotics has been brought out in full detail throughout the body of this present research. Objectively speaking, doubt, in any form, shape, or manner is-in actuality-removed when the final result of statistically significant change in the level of Hemoglobin is confirmed as shown above. Furthermore, the quality-of-life indices (physical functionality, social functioning, and energy/fatigue dimensions) at the close of Faradarmani treatment are the yet more densely colored stamp of confirmation on the effectiveness of what our Faradarmangars had done with their test group patients.

We are morally and honestly duty-bound to assert that one of the important markers of improvement in the physical state of an end-stage cirrhotic patient would naturally be some decrease in the level of Creatinine. Such a change has, undoubtedly, taken place among our test group patients. However, there is a borderline Δ delta numerical difference to be the moot point of dispute when it comes to the significance of Creatinine decrease which is something like 0.008 (deviant from the standard P-value of 0.05) while the control group patients have shown a remarkable increase in their Creatinine level. The closely asymptoting, but not tangencing, Creatinine level decrease of the Faradarmani-treated patients down to the level of 0.05 significance might well be the result of not-up-to-notch cooperation on the part of the test group patients with our Faradarmangars' procedural treating protocol besides the kind of follow-up that was possible to not have been close enough to bring about 100% certainty of the full correct performance of the intended Ettesal(linking)s.

No unwanted complications arising from the execution of Faradarmani treatment having been observed, it is to be added that no extra charges, costs, and economic burden have been involved with (or: have been the result of) Faradarmangars' healing. Again, no additional energy or time has been spent (bodily/mentally) on the part of the patients undergoing Faradarmani: in contrast, at least in a number of patients, improvements have been observed in psycho and somatic aspects of their being.

The whole point of the present piece of research is to objectively prove the point and pave the way for more prospective in-depth study of the influential effect of this branch of CAM on treating almost all kinds of human ailments in future plans of research and investigation. As Faradarmani does not demand immediate direct access to patients' presence, the avenue is now widely opened for those epidemiologically enclosed enclaves and pockets of disease where shut-in patients or rural people cannot be instantaneously and/or directly accessed [7, 22].

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