

**INTEGRAL  
COHERENCE MEDICINE**



# INTEGRAL COHERENCE MEDICINE

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THE FORTY-EIGHT FIELDS OF LIFE AND THE  
SIX PILLARS OF INTEGRAL HEALING ARTS

A Quantum-Biophysical Framework for Physicians,  
Alternative Practitioners, and Therapists

by

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## Target Audience and Purpose

This book, “Integral Coherence Medicine — The Twelve Fields of Life and the Six Pillars of Integral Healing Arts,” is a specialist textbook aimed at licensed physicians, licensed alternative practitioners (Heilpraktiker), licensed psychotherapists, and qualified health and therapy professionals practicing within the scope of their respective professional regulations. It serves the professional presentation and discussion of a therapeutic method — the Integral Coherence Medicine developed herein — within the context of integrative and complementary medicine.

The book is explicitly not intended as a guide for medical laypersons, not for self-treatment of diseases, and not as an alternative to qualified medical or alternative practitioner care. Individuals with symptoms are explicitly advised to seek qualified medical assistance. In acute medical emergencies, the emergency physician or an emergency room must be contacted immediately.

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The Integral Coherence Medicine developed in this book is an independent therapeutic framework. It is founded on professional work involving the therapeutic conversation, individual case history (anamnesis), psychotherapeutic and emotional

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Therapists who additionally work with technical applications such as frequency or information field systems — including the methods scientifically discussed in Chapter 26 — do so outside the methodical framework of the six pillars and under their own

legal and professional responsibility. The coherence-medical method, as presented here, makes no claim whatsoever to specific devices or products and bears no responsibility for their selection, implementation, results, or legal assessment.

### **Application within the Scope of Respective Professional Regulations**

The application of the methods described in this book is subject to the currently applicable professional regulations of the practicing therapist. This applies in particular to the German Alternative Practitioners Act (Heilpraktikergesetz), the Federal Medical Regulations (Bundesärzteordnung), the Psychotherapists Act (Psychotherapeutengesetz), and the respective model professional codes of conduct. Performing diagnostic or therapeutic measures that are reserved for licensed physicians or licensed alternative practitioners in Germany is not permitted for non-licensed professionals; this applies independently of the methodical options presented in the book.

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The application of the methods presented in this book takes place under the sole professional and legal responsibility of the practicing therapist. The author and publisher assume no liability for damages arising directly or indirectly from the application or non-application of the contents presented in this book.

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### **Confidentiality and Anonymization**

The case studies used in this book are prototypes constructed from many years of clinical experience. They do not represent individual real patients. Specific details have been altered and recombined to illustrate the respective methodical points. Identification of individual real persons is neither possible nor intended. Professional confidentiality has been fully preserved in all cases.

### **On the Spirit of This Book**

The foregoing legal notices are necessary. They are not intended to intimidate readers, but rather to outline the clear framework within which reading this book is meaningful. Integral Coherence Medicine, as developed in this book, is a serious therapeutic tradition in the making. It is carried forward by therapists who have learned their craft, who respect the legal frameworks, and who work for the well-being of their patients. The book is written in this spirit; may it be used in this spirit.

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# Preface

## A Medicine on the Threshold

The medicine of our time stands on a remarkable threshold. On the one hand, it possesses a precision that has never before existed in the history of healing. Molecular biology has described cascades, receptors, enzymes, and signaling pathways with an accuracy that would have seemed like magic to the medical eye a hundred years ago. Genomic analyses allow for statements regarding individual predispositions. Medicinal interventions can address cell types of whose existence previous generations were entirely unaware, utilizing meticulous dosages. Diagnostic procedures render structures visible that are hidden deep within the body's interior. Surgical techniques permit interventions that would have been unthinkable a generation ago.

On the other hand, this very same medicine, despite all its precision, has become increasingly helpless when confronted with what most individuals encounter in practice: chronic conditions without a clear single diagnosis, functional syndromes that yield no organic findings, multimorbid aging processes that manifest as the sum of many unresolvable individual problems, psychosomatic disorders that are shuffled back and forth between disciplines, post-infectious fatigue states that do not subside for months or years, and diseases at the interface between the immune system, nervous system, and metabolism that are not fully captured by any clinical guideline.

Anyone sitting in a consultation room as a physician, alternative practitioner (Heilpraktiker), naturopath, or health consultant knows these conditions well. They fill the waiting rooms. They leave behind patients who, after years of consultations, have received neither a clean diagnosis nor an effective therapy — but certainly the conviction that something is wrong with them that no one can name. The medical system often reacts to these patients either with symptomatic pharmacotherapy, which does not touch the actual dysregulation, or with a friendly but ultimately resigned recommendation to move more, have less stress, and eat healthier — recommendations that are correct, yet so unspecific that they rarely lead to substantial change.

This is not the fault of medicine. It is the consequence of its fundamental methodical choice. Twentieth-century medicine achieved its greatest successes where a disease could be traced back to a defined molecule, a receptor, or a pathogen. It shaped its language and its

tools around this assumption. Whatever is not addressable in this manner almost inevitably eludes its structures — not out of ignorance, but due to structural causes.

## What Underlies This Book

The Integral Coherence Medicine developed in this book does not view itself as an opposition to scientific medicine, but rather as an expansion of it by a dimension that has not yet been explicitly formulated within it: the dimension of organismic coherence. It is based on a precise, mathematically elaborated quantum-biophysical description of living systems, which has been formulated over the past two decades under the name *Quantum Blueprint Formalism* (QBF).

The QBF is not an esoteric system. It is a formal theory that has unfolded in over ninety peer-reviewed papers and relies on established physical terrain: dissipative quantum field theory, as mathematically elaborated since the 1970s by Hiroomi Umezawa, since 1992 by Celeghini, Rasetti, and Vitiello, and since then by many others. In this theory, open systems — systems that continuously exchange energy and information with their environment — are treated as quantum field theoretical objects. This is not because they are quantum-like in the popular sense of uncertainty and tunneling, but because the formal structure of quantum field theory is the only one that consistently brings together dissipation, irreversibility, and memory formation.

The central thesis is that the living organism is precisely such a system. It is open, it is dissipative, and it carries its identity through time by means of processes that mathematically correspond to the ordered vacua of dissipative quantum fields. This approach is neither metaphor nor speculation; it is a legitimate and by now well-elaborated application of physical formalisms to biological systems. What makes it interesting for the clinic is not its physical depth as such — which understandably does not interest the patient — but the fact that it provides a precisely defined concept of coherence that becomes clinically addressable.

## What This Book Aims to Be — And What It Does Not Aim to Be

This book is not a treatise on devices, frequencies, or so-called information fields. Such applications exist, possess their own systematics, and are presented elsewhere. Coherence medicine, as developed here, is an independent therapeutic framework that operates without technical mediation. Its interventions are psychotherapeutic, emotional-integrative, energetic in the classical sense of meridian theory, homeopathic, biochemical-orthomolecular, and lifestyle-related in nature. They can be supplemented by devices — which is a separate matter — but in their fundamental structure, they are grounded in the therapeutic space between practitioner and patient, in the conversation, in manual intervention, in the prescription, and in the guidance of a lifestyle.

A note regarding the dietary orientation of this book: The recommendations for nutrition and supplementation given in the following sections are consistently vegetarian. Where classical accounts of integrative medicine specify animal products such as fish, meat, bone broth, or animal collagen, plant-based alternatives are proposed here — such as algae oil as a source of preformed omega-3 fatty acids, amino acid complexes with proline, glycine,

and lysine instead of collagen peptides, plant-based vegetable and herb broths instead of bone broth, and legumes and fermented soy products as high-quality protein sources. This orientation corresponds to the author's conviction and, at the same time, to a now broad epidemiological evidence base for plant-forward dietary patterns (Adventist Health Studies, Mediterranean diet in its vegetarian form, Ornish programs). Those who must deviate for medical reasons can translate the recommendations accordingly; the overall logic of coherence medicine remains unaffected by this.

The book is neither a merely popularizing work, nor is it a closed-off specialist text for experts. It aims to build a bridge. It presupposes that the reader is willing to learn a new language — a language in which the organism is no longer understood primarily as a sum of molecular events, but as a dynamic coherence architecture. This language is systematically introduced in the first part of the book. The presentation is designed so that any reader with a high school science background can follow it — the demanding concepts of modern physics are developed using images, analogies, and step-by-step explanations, so that no specialized knowledge is presupposed. Those who wish to study the formal side in greater detail will find the mathematically complete presentations in the references to the QBF corpus.

Above all, it is a practical book. This means: it aims to provide the reader with a tool. Anyone who reads it to the end should be able to listen to a patient in the language of coherence, structurally locate their coherence disturbances, design an integral therapy plan that coordinates the use of multiple therapeutic pillars, and guide the course of treatment in such a way that the coherence architecture is restored instead of being symptomatically suppressed.

## Who It Is Addressed To

This book is addressed to therapists of diverse educational backgrounds who work with chronically ill individuals and are looking for a language in which they can integrate their observations. Licensed physicians who struggle with the limitations of the purely molecular approach. Alternative practitioners (Heilpraktiker) who wish to combine their traditional experience with modern scientific language. Psychotherapists who want to grasp the physical entanglements of psychological processes more precisely. Osteopaths, physiotherapists, acupuncturists, homeopaths, orthomolecular physicians — all those who work within one of the six pillars of integral healing arts and are seeking an overarching language of mutual understanding.

The book is likewise addressed to interested laypersons — to the growing number of people who want to understand their own health without settling for superficial guidebooks. In the first part, they will find intellectually demanding reading that will not overwhelm them, however, because every term is carefully introduced. In the second part, they can look up the subfield that best describes their personal situation. In the third and fourth parts, they will understand which therapeutic pathways exist for which constellation — and can draw conclusions from this for their own life choices.

What the book is not: it is not a self-help book in the usual sense. It does not replace therapeutic guidance. It does not supply a five-part, step-by-step blueprint for healing. Anyone searching for simple promises will not find them here. Coherence medicine is demand-

ing, both in its theory and in its practice. This is the consequence of the depth into which it ventures — and simultaneously the reason why it can work where shallower approaches fail.

## The Structure

The book is divided into six parts. The first part — Foundations — develops the theoretical basis of coherence medicine. Six chapters lead the reader from the paradigm shift to the quantum biophysics of the living, the master equation and the twelve fields of life, the Biological Coherence Index, and finally to the geometric theory of therapeutic intervention.

The second part — Cartography of the Forty-Eight Subfields — is the encyclopedic center of the book. Each of the twelve fields of life receives its own chapter, in which the four subfields of that field are described according to a uniform scheme: biological significance, quantum biological substrate, symmetry breaking, time scales, clinical manifestations, diagnostic indicators, therapeutic approaches from the six pillars, frequent couplings to other subfields, and a typical clinical vignette example. This part is intended as a reference work and allows individual subfields to be consulted specifically.

The third part — The Six Pillars of Integral Healing Arts — unfolds the therapeutic disciplines from which coherence medicine draws: the psychological pillar, the emotional-integrative pillar, the energetic pillar (acupuncture, TCM, Ayurveda in the classical sense), the homeopathic pillar, the biochemical-orthomolecular pillar, and the lifestyle-related pillar. Each pillar is honored as an independent tradition in its own chapter and simultaneously presented in its embedding within coherence medicine.

The fourth part — Diagnostics, Therapy Planning, and Follow-up Observation — describes the practical methodology of coherence medicine. How is an anamnesis conducted in the language of coherence? How does one identify the three to five key subfields that are relevant for a specific patient? How does one differentiate between the four types of intervention — tangential, normal, metric, and topological interventions? How does one structure a multimodal therapy plan that utilizes the pillars in a coordinated manner? How does one recognize the course, success, and failure of treatment?

The fifth part — Longevity and Life Phases — applies coherence medicine to aging. Which changes in the coherence architecture characterize healthy aging? Where lie the levers for a longevity medicine that is more than the extension of the lifespan — namely, the extension of the healthspan, of lived coherent time?

The sixth part — Practice and Ethics — gathers case studies, indications and contraindications, reflections on the ethical dimensions of coherence-medical practice, and an outlook on the open research questions that will require further work in the coming years.

A recommendation for reading: For those who wish to read the book in a first pass, the author advises: Begin with the Preface and Chapter 1. Then read Chapter 2 at a relaxed pace without insisting on every detail — the most important concepts will reappear later and deepen upon re-encountering them. After Chapter 4 (the twelve fields of life), skip directly to the second part and read two or three of the subfield chapters that interest you most. Then return to Chapters 3, 5, and 6, which will now be clearer. In the second pass, you can study the book in its sequential order with a significantly deeper understanding. This two-stage reading process has proven successful for many readers.

## A Personal Remark

The development of coherence medicine is, for the author, the result of a journey spanning more than thirty years. It began with the study of physics, which took a turn upon encountering the writings of Hiroomi Umezawa and Giuseppe Vitiello: at the time, the formal tools of dissipative quantum field theory seemed to me to be made not primarily for solid-state physics, but for the description of the living. This intuition matured over years.

Parallel to this, I immersed myself in the classical traditions of integral healing — Vedic medicine in the Sanskrit sources, classical TCM in European training programs, and homeopathy in its Hahnemannian rigor. Meeting the great teachers of these traditions was formative. They showed me that the ancient healing systems must be taken seriously structurally — not as folklore, but as systematic descriptions of human coherence dynamics expressed in their own terminology.

The *Quantum Blueprint* Formalism, as it has developed over the last two decades, is the attempt to bring both together: the rigor of modern mathematical physics and the clinical richness of traditional medicine. It is the language in which, thirty years after those university studies, I can mediate between both worlds.

The clinical application with which this book deals is a layer of its own. The author is a physicist and theorist, not a practicing therapist; the clinical bridges presented here were not gained from my own practice with patients, but were worked out in an exchange conducted over years with clinically active colleagues — physicians, alternative practitioners, psychotherapists, homeopaths, acupuncturists, and orthomolecular physicians, whose observations, case reports, and feedback tested and shaped the translations between formal theory and therapeutic events. The present work is therefore not a theoretical textbook nor an empirical report from personal practice, but rather the attempt at a synthesis: the theory, insofar as it is necessary for clinical understanding; the clinical translation, insofar as it is supported by the colleagues who stand in day-to-day therapeutic reality.

I thank my teachers in the various traditions, without whose patience this book would not have been possible. I thank the colleagues from the clinical professions who entrusted me with their experiences from daily work with patients — the courses of treatment described, the critical feedback, the patient work of translation between theory and clinic. I thank the colleagues from the various disciplines who have wrestled with me in recent years for the right language. Finally, I thank those readers who are now entering into this book — may it become a useful tool for them, in the depth and dignity that the living human being deserves.

**Marcus Schmiede,**  
**Schloss Kränzlin, in the Spring 2026**



# The Paradigm Shift: From the Molecule to Coher

## 1.1 What This Chapter Is About

Before we dive into the theoretical depths of coherence medicine — the quantum-biophysical description of living systems, the master equation, the twelve fields of life, the coherence index, the geometric view of healing — it is worthwhile to take a step back and clarify the central question from which this entire book proceeds. This question is: Why do we even need a new approach to medicine? What is it that established molecular medicine cannot achieve — and what would an alternative or complementary language have to provide?

This chapter answers these questions. It demonstrates what molecular medicine has accomplished and where its limits lie. It introduces a concept that forms the key to our entire endeavor — the concept of coherence. It outlines what distinguishes a coherence medicine and how it relates to existing medicine. And it intimates why a dedicated language is necessary for all of this.

By the end of the chapter, you will possess the fundamental understanding from which the subsequent chapters become intelligible. You will then know why this book had to be written and what it claims to achieve. The formal mathematics will follow after this, in Chapter 2. Here, in Chapter 1, the focus is on the motivation and the conceptual framework — on that which a therapist or a thoughtful patient can and should understand even without mathematics.

## 1.2 What Molecular Medicine Has Accomplished

Before we can speak about the limitations of the molecular approach, we must appreciate what it has accomplished. It is a common misconception among certain alternative healing disciplines to dismiss molecular medicine as reductionist, as if its success were a mere misunderstanding. The opposite is true: over approximately one hundred and fifty years, molecular medicine has achieved the greatest advancements in healing in human history.

Anyone today who survives past their fortieth year, who no longer dies of bacterial pneumonia, puerperal fever, infant mortality, tuberculosis, diphtheria, or sepsis, who enters a hospital with a myocardial infarction and walks out alive, who does not succumb to peritonitis within a few days from appendicitis, who does not receive a diabetes diagnosis as a death sentence, who can be operated upon and restored after an accident — all these individuals owe their survival to molecular and surgical medicine. No holistically oriented healing art in the world could have brought about these successes, because it operates on a different methodical foundation.

Molecular medicine has celebrated its greatest triumphs where a disease can be traced back causally to a single molecule, a pathogen, a receptor, or a mutated gene sequence. Robert Koch demonstrated that tuberculosis is caused by *Mycobacterium tuberculosis*. Alexander Fleming discovered penicillin. Frederick Banting and Charles Best isolated insulin. Jonas Salk developed the poliomyelitis vaccine. The discovery of the double helix by Watson, Crick, Franklin, and Wilkins founded genetic medicine. The deciphering of cellular signaling pathways has enabled a pharmacological precision that is second to none.

This methodical achievement rests on a specific assumption regarding the nature of disease. The assumption states: disease is the result of a concrete, localizable molecular aberration. If we identify the molecule, we can address it. If we know the receptor, we can block or activate it. If we determine the pathogen, we can eliminate it. This assumption is not false. For a large class of diseases, it is simply true.

An illustration of how powerful this approach is: Imagine a patient with acute bacterial pneumonia. One hundred years before our time, he would have in all probability died — the effective agents against the bacteria were lacking. Today, a correctly chosen antibiotic treatment suffices, and the patient is cured after a few days. We owe this turn of events to the molecular identification of the bacteria and targeted pharmacology. It is a triumphant success of a clearly defined approach.

### 1.3 Where Molecular Medicine Reaches Its Limits

The difficulty begins where the disease cannot be traced back to a molecule, a receptor, or a pathogen — not because the diagnostics are inadequate, but because the disease is structurally different.

Chronic fatigue syndromes are the prime example. Patients with Myalgic Encephalomyelitis, with Post-COVID Syndrome, with fibromyalgia, with chronic Lyme disease symptomatology, with functional gastrointestinal disorders, with irritable bladder, with tension headaches, with multiple chemical sensitivity, with complex PTSD, with chronic insomnia, with functional pain syndromes — they all share a common characteristic: there is no unambiguous single finding that could explain their symptomatology.

This does not mean that they are imagining it. On the contrary: many of these patients are objectively, measurably impaired. Their laboratory values often show subtle anomalies — slightly elevated inflammatory markers, borderline hormone levels, altered autonomic patterns, reduced heart rate variability, micronutrient deficiencies, atypical microbiome compositions. None of these anomalies, taken by itself, is dramatic enough to justify a specific diagnosis. But their sum constitutes a state in which the system as a whole no longer functions, while the individual parts elude description.

An analogy may clarify this. Imagine a car that is not driving properly. It starts with difficulty after several attempts. It pulls to one side. Fuel consumption has increased. The transmission jerks occasionally. The heater does not get properly warm. When a mechanic inspects the car, he finds no obvious defect in any individual component. The spark plugs are not entirely fresh, but still usable. The tires have different pressures, but no flat. The oil is slightly darker than optimal. The brake pads show wear, but are not completely worn down. If the mechanic fixes each of these problems individually, the car still does not drive well. Only when he perceives the entirety of all these small findings as one system — as a car that is overall no longer in an optimal state — can he perform a fundamental maintenance that addresses all areas simultaneously.

The chronically ill patient in the consultation room is rarely someone who has one molecule too many or too few. He is someone whose manifold regulatory systems no longer coordinate well with one another. His immune system no longer speaks cleanly with his endocrine system, his autonomic nervous system stands in chronic dysbalance with his metabolic processes, his sleep is fragmented, his emotional regulation works against his physical regeneration, and his attention is consumed by continuous somatic stimuli. Nothing about him is acutely life-threatening. Everything about him is chronically derailed. And precisely for this, molecular medicine possesses no adequate language.

In such cases, it often treats symptomatically — an elevated blood pressure with an antihypertensive, a depressive mood with a serotonin reuptake inhibitor, a pain syndrome with an analgesic, a sleep disorder with a hypnotic. Every single one of these medications can be very helpful in certain situations. But taken together, the picture that frequently emerges is one of polypharmacy, which admittedly smooths the symptom surface but does not touch the underlying dysregulation. Patients are medicated for years without their fundamental vitality ever returning.

This is not the fault of the practicing physicians. They do what their training and the clinical guidelines prescribe. The difficulty lies deeper: the language of molecular medicine is not suited to describe dysregulation patterns that cannot be pinned down to a single molecule. And he who has no language for something cannot treat it in a targeted manner.

## 1.4 Man Changes His Molecules — What Remains?

It is worthwhile at this point to take a step back and reflect on a remarkable biological fact that is hardly ever themed in clinical education, even though it is fundamental. The human organism continuously exchanges its molecules.

The cells of our intestinal mucosa are completely replaced approximately every three to five days. Red blood cells live for four months. Skin cells of the epidermis renew themselves in a cycle of about four weeks. Bone cells over a period of seven to ten years. The proteins in our muscles are newly synthesized within days to weeks, depending on their type. Even in neuronal cells, which are largely post-mitotic and are preserved for a lifetime, membrane lipids, proteins, and neurotransmitter receptors are constantly being remodeled.

One can comprehend this fact from a simple calculation: the human body contains approximately thirty-seven trillion cells. If on average three to four million of these are replaced per second — which is a common estimate — then in the course of about one year,

so many cells are renewed that one can say: on a material level, after about seven to ten years, the body is almost entirely a different one.

And yet: the person who existed ten years ago is the same person who exists today. He remembers. He carries his personality. His scars reside in the exact same places. His face is recognizable. His voice belongs to him. His illnesses take a chronic course — which means they possess a structural continuity that persists across the exchange of molecules.

This is an astonishing fact. If the molecules are exchanged — what carries the identity? What is it that preserves the continuity of this specific human being from one year to the next, from one decade to the next?

An everyday analogy may help to deepen this thought. Imagine a vortex in a river — at a spot where the water flows around a stone, a standing vortex forms. This vortex has a specific shape. It has a specific size. It looks almost exactly the same today as it did yesterday. And yet: the water forming the vortex today is completely different from yesterday. What remains is not the water, but the form. The vortex is a stable structure in a flowing medium — and its stability lies not in the water molecules, but in the relationship between them.

In a similar sense, the human organism is a stable form in a flowing medium. What remains over the years is not a specific matter, but a specific pattern — a specific configuration, a specific architecture, a specific relational structure between the components.

The classical biomedical answer to the question “what remains” is: it is the DNA. It is passed down, it determines which proteins are built, it carries the program. But this answer is insufficient. Firstly, because while DNA encodes the building blocks, it does not encode their organization. A heart and a brain possess the exact same DNA and are yet completely different organs. Secondly, because the DNA itself is epigenetically modified, and these modifications to a significant extent are not even passed on via DNA inheritance, but through cellular and tissue states. Thirdly, because DNA alone does not explain why a specific pattern — such as a chronic tension in the shoulders — sits in the exact same place for years, even though the muscle fibers carrying this tension have been exchanged a hundred times.

What we are seeking is a variable that remains stable across the exchange of molecules — a level of organization that lies not in the molecules themselves, but in their configuration. This variable is what we call coherence in this book.

## 1.5 What Coherence Means

The term coherence has different meanings in different disciplines, which admittedly relate to one another but are not identical. In colloquial language, coherent means something like consistent, interconnected, cohesive. In linguistics, it designates the logical connectedness of a text. In philosophy, the term plays a role in epistemological discussions.

In physics, coherence has a very precise meaning: coherence is the property of waves to maintain a fixed phase relationship to one another. Two light waves are coherent if their phases are linked with each other; they can then interfere — that is, form patterns together. A laser beam is a laser beam precisely because its photons are coherent: they all oscillate synchronously, in the exact same phase. A superconductor is superconducting because its electrons are coherently coupled. A Bose-Einstein condensate is the coherent ground state of a multitude of atoms that behave like a single object at the lowest temperatures.

An illustration of this: Imagine many people clapping in a hall. If they clap randomly — each whenever they want — you hear a uniform rushing noise. That is not coherent. If, however, all people clap to the exact same beat — all bringing their hands together simultaneously — you hear sharp, rhythmic impacts of great volume. That is coherent. The individual claps did not amplify themselves; rather, the synchronization created a pattern that is more than the sum of the individual claps. Precisely that is coherence.

This physical concept of coherence can be transferred to biological systems if one undertakes a certain generalization. In doing so, it is not about light waves or electrons, but about the coherent coupling of many regulatory processes in an open, dissipative system. A living organism is coherent in this sense when its regulatory systems stand in stable phase relationships to one another: when the immune system works in the correct rhythm with circadian cycles, when the autonomic nervous system oscillates in a healthy balance between the sympathetic and parasympathetic branches, when mitochondrial energy production is cleanly coupled to cellular demand, and when emotional regulation does not work against physical regeneration.

Coherence, therefore, does not mean rigidity and does not mean uniformity. A system in which all parameters were constant would not be coherent, but dead. Coherence means: living variability within a stable overall structure. The healthy organism pulsates, it oscillates, it responds, it adapts — but it does so within a pattern that carries its identity. The diseased organism has either lost its variability (it has become rigid, one-sidedly dominant, one-sidedly cold, or one-sidedly hot) or its structural cohesion (it has become chaotic, fragmented, without a beat).

In dissipative quantum field theory — and thus in the QBF — this concept of coherence possesses a precise formal definition. It designates the selection of a specific ordered vacuum from an infinite manifold of possible vacua. Exactly what that means will be unfolded in Chapter 2. For the moment, the intuitive concept suffices: coherence is the property of an organism to function as a structured whole whose parts are attuned to one another and whose identity is preserved over time despite the continuous exchange of its material constituents.

## 1.6 What Constitutes a Coherence Medicine

If we accept coherence as a fundamental level of organismic order, a very specific therapeutic approach emerges, which differs from the molecular one in several aspects. Let us go through these differences in five points.

First, the focus shifts from the molecule to the relation. A molecule is a thing; a relation is a connection. Someone working within coherence medicine does not ask first: Which molecule is missing or is too abundant? — but rather: Which coupling is disturbed? Which relationship is out of balance? Which beat is lost? The intervention then aims not at supplementing or inhibiting a single molecule, but at restoring a relationship.

Second, the focus shifts from the acute event to the trajectory. A molecular finding is a snapshot. A coherence disturbance is a course-of-treatment disturbance. It has a prehistory, it has a current dynamic, it has a tendency, it has a possible future. The coherence practitioner asks: In which direction is the system moving? Where is the journey heading if we do nothing? What would be a fork in the road that leads back into coherence?

Third, the focus shifts from the diagnosis to the pattern. The classical diagnosis names a disease that is defined in a registry. The pattern describes the specific configuration of this one single patient. Two patients with the same diagnostic label can have entirely different coherence patterns — and thus require completely different interventions. Conversely, two patients with different diagnoses can display very similar coherence patterns and benefit from similar approaches.

Fourth, the focus shifts from elimination to restoration. Molecular medicine often thinks in categories of removal and replacement: eliminate the pathogen, replace the missing molecule, block the pathological receptor. Coherence medicine thinks in categories of restoration: Which conditions must be created so that the system can reorganize itself? The organism is not a machine to be repaired, but a living being that finds its own coherence again under the right conditions.

Fifth and finally, the focus shifts from control to guidance. Molecular medicine exercises control: the physician decides, the patient is treated. Coherence medicine is guiding: the therapist creates conditions, the patient actualizes them, and coherence returns or it does not. This makes coherence medicine more demanding — for both sides. It demands patience, precision, and the tolerating of uncertainty from the therapist. It demands active participation, personal responsibility, and the willingness to work on the conditions of one's lifestyle from the patient. Where these conditions are not met, coherence medicine remains ineffective.

## 1.7 The Relationship to Existing Medicine

From what has been said so far, a misconception could arise that shall be explicitly rejected here: that coherence medicine is a competitive enterprise to established medicine, that it rejects or wishes to replace its approaches. None of that is true.

The correct stance is complementary. Both approaches have their place, both have their limits, and both complement one another where a patient requires both acute biomedical treatment and structure-oriented coherence work. A patient after severe sepsis requires intensive care medicine first, then coherence work for long-term restoration. A female patient with breast cancer requires oncology, then potentially coherence-oriented guidance for the integration of the illness experience and the restoration of organismic balance. A person with type 2 diabetes may require pharmacological adjustment and at the same time deep lifestyle and coherence work that addresses insulin resistance at its metabolic and autonomic roots.

Coherence medicine thus understands itself not as a replacement, but as a necessary supplement to a medicine that remains irreplaceable in its molecular precision, yet alone does not suffice to do justice to the whole human being. In practice, this means: anyone working within coherence medicine sends their patients for cardiological clearance, oncological diagnostics, or neurological imaging if suspicion warrants it. He maintains an overview of established medical findings and integrates them into the coherence-medical picture instead of ignoring or undermining them.

## 1.8 Why a New Language

The great therapeutic traditions that have dealt with the human being as a whole for millennia — Traditional Chinese Medicine, Ayurveda, European naturopathy, classical homeopathy, schools of depth psychology, phytotherapy, Anthroposophic medicine, Hildegard medicine — each possess their own rich descriptive systems. These systems are clinically proven, they have refined their procedures over generations of healers, and they carry an immeasurable treasure trove of experiential knowledge. But they remain largely untranslatable for modern, scientifically oriented medicine as long as no common foundational conceptual framework exists.

A Chinese physician speaks of Qi deficiency, Yang emptiness, heat in the liver, cold in the spleen. An Ayurvedic physician speaks of Vata imbalance, Pitta overheating, Kapha stagnation. A classical homeopath speaks of miasm, constitution, the law of similars. An Anthroposophic physician speaks of the etheric body, astral body, fourfold human nature. Each of these languages captures something real. Each is coherent within itself. Each has experienced clinical verification in a certain sense. But none of them can be directly connected to the language of scientific medicine — not because one is right and the other is not, but because the terms originate from different conceptual landscapes.

What has been missing until now is a mediating language. A language that is precise enough to be interfaceable with scientific medicine, and at the same time rich enough to absorb the insights of traditional healing arts without reducing them to their molecular equivalents. Coherence medicine is an attempt to provide such a mediating language.

This succeeds because the concept of coherence operates on a level that is neither purely molecular nor purely metaphysical. It is mathematically grounded — which means it possesses a formal precision that allows for scientific communication. It is relational — which means it can contextualize the holistic insights of traditional healing arts without turning them into flat biochemical correlates. It is dynamic — which means it captures processes, rhythms, and developments that are characteristic of the living.

When we speak of the twelve fields of life in the further course of this book, these fields correspond neither directly to the five elements of Chinese medicine, nor to the three doshas of Ayurveda, nor to the constitutions of homeopathy. But clinical experience shows that the ancient systems can be translated into the language of the fields of life — not one-to-one, but in a kind of multi-perspective illumination. The kidney meridian of TCM, for example, addresses aspects of the first field of life (Foundation), but also aspects of the seventh (Renewal) and the eighth (Blueprint). These multiple correspondences are not a deficiency of the translation, but a refinement: the ancient systems were right when they recognized connections that modern medicine is only painstakingly rediscovering. Coherence medicine offers a language in which these connections can be formally expressed.

## 1.9 What Awaits Us in the Following Sections

In the next five chapters of this first part, the theoretical foundation will be unfolded step by step. Let me give you a brief preview so that you can visualize the journey ahead.

**Chapter 2** introduces the quantum-biophysical description of living systems. It will show why open, dissipative systems demand a formal framework that goes beyond classical physics, and why dissipative quantum field theory is the appropriate framework. You will

become acquainted with the “dance partner” concept of doubled degrees of freedom, the iron magnet as an illustration for the family of ordered vacua, and the laser as an image for the condensation of collective modes. The chapter is the only one in the book with demanding physics; it is conducted in such a way that it remains comprehensible even without a mathematical background.

**Chapter 3** develops the master equation — the fundamental equation of the dynamics of the living — and shows how the life equation on the twelve-dimensional coherence manifold follows from it. It will introduce the three forces of the living — drift (the attraction into stable states), diffusion (random fluctuation), and circulation (inner cycles) — and the three clinical dynamic regimes in which a patient can live.

**Chapter 4** presents the twelve fields of life as coherence sectors. It explains why exactly twelve — and not ten, not fifteen —, organizes the fields into four levels with three fields each, and describes the coupling architecture that connects the fields into a single organism. It introduces the four subfields per field and thus the forty-eight subfields that form the backbone of clinical practice.

**Chapter 5** defines the Biological Coherence Index as a summarizing measure of total coherence. It will specify what this index measures and what it does not measure — a distinction that is clinically crucial in order to avoid falling into the trap of a false objectification. You will learn how the BCI is utilized for the longitudinal tracking of therapy.

**Chapter 6** finally unfolds the geometric theory of healing. You will get to know health as movement along an optimal path — the geodesic —, disease as a deviation from this path, and aging as a gradual drift of the geodesic itself. Above all, however, you will learn about the four types of therapeutic intervention — tangential, normal, metric, and topological —, which are the most important conceptual tools of coherence medicine.

Anyone who has worked through these six chapters will possess the conceptual tools with which the complete cartography of the forty-eight subfields becomes accessible in the second part — and along with it, the concrete therapeutic work toward which all later parts of the book are aimed.

Coherence medicine is, let it be said once more at the conclusion of this first chapter, not a new doctrine of salvation. It is an attempt to establish a language in which the interplay of different therapeutic traditions becomes intelligible and in which the limits of molecular medicine can be bridged not with resignation, but with a more precise language. Whether it proves helpful will be decided not by the elegance of its theory, but by the experiences that practitioners and patients have with it. This book is an invitation to try it out.