

A Medical Cure found by Remote Viewing & My last "I bet you can't Remote View it" bet!

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By John L. Turner, M.D. Neurological Surgeon

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My Last "I Bet You Can't Remote View it" Bet!

In December I was at the mid point of my TRV training with Joni Dourif. Prior to training, I had studied the history of RV in depth and had followed PSI TECH's recommendations by reading Sheldrake's The Presence of the Past. I was pleased to be able to experience remote viewing during the training, just like it was advertised. However, the day my wife lost her small medication bottle, and Joni said she could easily "remote view" the location, I laughed and doubted her. In fact, I bet her that she could not do it!

Finally, after enough laughter from me, Joni asked for pen and paper. I gladly gave it to her as we had a bet on. I watched her begin with two random four-digit numbers attached to "the target location of missing medication bottle."

Joni quickly finished the initial stages and produced a sketch of a rectangular device, a transparent window of some sort and what appeared to be a piece of spongy material. Then I watched in awe as she analyzed the drawing, went to the kitchen sink, fixated on the dish washing sponge. About a foot away from the wet sponge was the toaster oven with a glass lift-up door.

"I wonder.." said Joni as she peeked behind the toaster. There was the missing medication bottle!

Not only did I lose the bet, but also I had to endure Joni's laughter directed at me. I did not doubt Joni's TRV competence after that.

Dr. John L. Takeuchi Turner  
Neurological Surgeon

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Here is an example of how I used Technical remote viewing to enhance my medical practice

"Mr. W.D./cause of current pain problem"

By John L. Turner, M.D.

After Dr. Turner's Technical Remote Viewing training, he performed the following diagnosis on a patient using TRV as a significant aid:

(To view articles with photos go here:  
[http://www.psitech.net/news\\_sl\\_042602.htm](http://www.psitech.net/news_sl_042602.htm) )

Background Information:

Mr. W.D. is a 58 year old male who was first seen on April 10, for complaints of left leg pain, left foot numbness and weakness. He failed to respond to conservative treatment. CT on 4/11 scan revealed a soft tissue mass in the left lateral recess at the L4 level of the lumbar spine. MRI on 4/12 clearly showed an extruded disc fragment at the L4–5 disc level with cephalad migration to the left. The L5–S1 disc had a mild bulge.

4/18: Left L4–5 hemilaminotomy with microdisectomy and excision of free fragments. A disc bulge was palpated at L4–5 of mild to moderate degree. Since the MRI had clearly shown a superiorly migrated fragment, laminotomy was performed superiorly and several disc fragments were teased from the ventral surface of the dura. There were no fragments extending along the L5 root. The disc space was entered and only small pieces of disc material could be removed.

Post–operative course:

Mr. W.D. improved and returned to his home state with mild persistent weakness of dorsiflexion of his left foot and residual numbness. He was reinjured when falling from a Captain's boat chair followed by a twisting injury when working in the engine compartment of his boat. Repeat MRI scanning with and without contrast agent showed scarring and extruded fragment at L4–5 and an increase in the bulge at L5–S1. His left leg pain had returned.

12/9: Left L4–5 hemilaminotomy, medial facetectomy, L5 neurolysis with removal of disk fragments. Left L5–S1 hemilaminotomy and microdisectomy.

Considerable scar tissue was found as expected at the L5–S1 level with small fragments of disk embedded and extruded within the scar tissue. This required performing a medial facetectomy and foraminotomy to free the L5 root. At the L5–S1 level, which appeared to be transitional, a hard bulging disk was found. There were no other pertinent operative findings.

Post–operative course and inclusion of Remote Viewing:

Following surgery, his leg pain was completely relieved. He complained of back pain during the first post–operative week. This slowly led to fluctuating leg pain, left greater than right. Some days, he would be pain free. He remained afebrile and the incision remained intact and normal in appearance.

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He was sent for physical therapy with heat, massage and ultrasound with minimal relief. Caudal epidural steroid blocks did not change his pain. On 1/11 he complained of bilateral anterior leg pain and bilateral calf pain. There was no evidence of deep vein thrombosis. Straight leg raising was negative.

### Medical Technical Remote Viewing Session (By John L. Turner, M.D.)

The viewer perceived the origin of pain within the brain and the source of pain in the lumbar (low back) region. Stage six sketch showed a 'tubular structure' with a helical flow pattern and an obstruction to the flow by a 'reddish-brown' material. This material appeared to be of fluid consistency.

#### 1/13: Examination and MRI:

Patient was afebrile, back and incision appeared normal. Patient describes an area in the left paralumbar area that when pressed upon, would cause a radiation of pain to his left leg.

#### 1/14: Repeat MRI:

An isolated pocket of suppuration or, perhaps, cerebrospinal fluid can be seen 2 cm below the skin surface and extending to the level of the L5 nerve root. Needle aspiration yielded 4 cc of reddish brown material. The patient was taken to the operating room where a loculated area of reddish-brown pus was found as expected. Cultures showed growth of coagulase-negative Staphylococcus and the patient was started on appropriate antibiotics and twice daily wound packing and irrigation. He has made a good recovery with the wound healing by second intention.

#### Discussion:

This represents a case of post-operative infection which was a diagnostic dilemma due to atypical symptoms and a fluctuating course of shifting pain in the back and both lower extremities. The surgical incision gave no clues about the loculated deep infection. A remote viewing session focusing on anatomic features revealed obstruction of flow due to an abscess cavity which communicated with the epidural space and may have impeded normal flow of cerebrospinal fluid. The RV findings did not suggest a recurrent herniated disk, but rather, a reddish-brown fluid as the etiologic agent. This was confirmed by MRI scanning, needle aspiration and surgery.

Remote Viewing shortened the delay in diagnosis and decreased medical costs of continued physical therapy in this patient with an unusual presentation of post-operative infection.

John L. Turner, M.D., F.A.C.S.

To view the article with photos go here: [http://www.psitech.net/news\\_sl\\_042602.htm](http://www.psitech.net/news_sl_042602.htm)

Dr. John L. Takeuchi Turner, A retired Neurological Surgeon on the big Isle of Hawaii who was trained by PSI TECH as a Remote Viewer to help assist his specialized science with alternative possibilities for quicker cures.

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## **What is Remote Viewing & Why do Remote Viewers abhor being referred to as "Psychics"**

**By Jonina Dourif**

What is Remote Viewing & why do Remote Viewers abhor being referred to as "Psychics"

"Lay back and tell me what you see," says the psychic.

"Move fast and stay in structure," says the remote viewer.

One is passive and the other is active.

The Remote Viewer actively participates, using a pen, paper and a specific recipe, which allows for passive information to accumulate. The breakthrough discovery occurred when it was realized that by using this conscious processing system (called TRV) an alert mind could manage its mental attention to access direct knowledge – accurate information on a consistent basis and we don't even have to believe that it works. It will work despite our disbelief!

Sounds dry? It is dry and simple.

People have traditionally romanticized psychic experiences and made the unknown mysterious. Remote Viewing wrecks all that fun. We cut right to the chase and make a point of striving for accuracy and consistency. Remote Viewers learn the specific protocols and then they work to accomplish increasingly better results. Like any skill, the more we do it the better we get at it.

Sound like work?

It requires effort and discipline but Remote Viewers end up loving the work.

There's nothing else like it out there.

There is not an accurate comparison for Remote Viewing.

Professional remote viewers shy away from calling it "an experience" because there is nothing else like it. People who do not know better, cut and paste other psychic practices on the term "Remote Viewing". The fact is that there is not a comparable descriptor. Remote Viewing is not like automatic writing, channeling, out of body experiences (OBE's) or astral projection. It is not lucid dreaming or playing with Ouija boards or tarot cards. Remote Viewing is a trained skill, similar to language. Everybody has the innate ability and anybody who puts in the time and effort, can learn it. Once upon a time man could only make noise and grunt – now we talk and communicate in a refined way and think nothing of it.

Many psychics who have become known by sticking the sign "Psychic" on their door do not like the idea of Remote Viewing. We have destroyed their specialty. We have yanked the pedestal out from under them and obliterated their mysterious unique ability. Now, it's not only "the gifted ones" who get to enjoy the power of their mind. A trained Remote Viewer is more consistently accurate than the world's best untrained psychics. And we just keep getting better. Our boundaries see no limits. The longer a remote viewer sticks with it – the more amazed and astounded he or she becomes.

The world becomes an infinitely more interesting place and life becomes more intriguing. Discoveries

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that were once only vague guesses or chosen beliefs may become realities or falsehoods under the scrutiny of a practiced remote viewer. The remote viewing protocol naturally teaches our mind to recognize imagination from direct knowledge. Our minds learn to scrutinize information and separate out accurate data from imaginary information. We become naturally more in tuned with what's real in the world and in our lives, and our possibilities multiply as our horizons expand.

Does it sound to good to be true? Too unbelievable to be real? Remember, that not that long ago being able to travel and fly or communicate via the airwaves was considered a fantasy and impossible. Most people did not believe it possible until they repeatedly witnessed it. Today generations of people exist who have never known a world without phones and planes.

Someday Remote Viewing will be integrated that way. A generation will be born who will instantly know truth from fantasy and it won't just be a fleeting instinct – they will know. Knowledge will be an experience as real as touch, sight, sound and taste.

Isn't that how we are supposed to be?

So, even if you choose to wait and see about this technology – the next time you hear a person spout "I've been remote viewing my whole life" ..pinch yourself.. to remind you that you're still in the past, but pat yourself because you are already way ahead of the pack.

The future is yours by making more of the present.

<http://www.psitech.net>

A professional remote viewer, Jonina (Joni) Dourif was one of the first civilians trained in this formerly Top Secret technology. Joni was asked to commercialize PSI TECH and Technical Remote Viewing® for the civilian sector in 1993. In 1999, the company's founder retired and Joni took over the helm as President. She continues to lead PSI TECH into the future on the cutting edge of PSI and mind technology. <http://www.jonidourif.com/>

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