DEBUNKING THE HEALTH CARE DEBACLE

Biting the Hand that Feeds Me

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ISBN-13: 978-1492814368

ISBN-10: 1492814369

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First Print

This material is designed to provide accurate, authoritative information within the genre herein discussed. It is to be understood that neither the publisher nor the author is engaging in medical or professional advice of any kind. This material is merely informative as to the current state of the health care industry. If health care issues are of concern on a personal level, the services of a competent health care professional should be sought.

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Preface

America's health care system is broken and nothing Congress has done, is doing, plans to do or has even debated, will fix it. The fervent arguments from either side of the isle are fallacious; for neither address the crux of the matter. It is not who should have access to health care, or even how to pay for it; the issue of concern must be the health system itself, which is grossly bloated with misallocated resources and fraudulent services. So that (and I say this without hyperbole) the vast majority of dollars spent on health care pay for an unimaginable volume of absolutely unwarranted doctor's office visits, medical tests, hospitalizations and medications that accomplish little more than to fill the coffers of service providers.

The health care system is not merely riddled with overutilization, misallocation and fraud; these are the framework upon which the entire system is built. These are the foundation of the medical economy. If taxpayers knew the extent of superfluous, gratuitous and fraudulent health care procedures and services I am certain they would force politicians to fix it. It is so bad that if politicians truly understood the degree of waste and fraud they might even be tempted to fix it themselves.

I submit that the health care system itself is sick, terminally ill. Like an irreparable myopathic heart, hopelessly destroyed by disease, no amount of money can cure this sick system. More personnel cannot cure it. Better trained clinicians cannot cure it. It needs to be replaced. It must be cut away and a new system put in its place. Herein, I suggest a viable replacement, a new system

that would provide necessary health care to all. But it will take an act of Congress; for many laws concerning medical service providers and reimbursement for medical services must be changed. The current medical system will fight it to the bitter end. So too will the medical malpractice trial lawyers, for the cash cow from which both of them suck will be removed.

One day, in my frustration at a couple of physicians admitting more patients to the hospital (unnecessarily so) and writing useless medical order for unwarranted services, I said, "If we would only admit truly sick patients to the hospital, and only provide the services that were necessary, the whole country could have affordable health care."

One of them responded, "I know, but everybody wants their money: the doctors, the hospitals, the pharmacies, everybody wants to make money. We have to do this to keep the system going." They both chuckled, brushing it off as if it were merely a game they played.

With more than four decades of clinical and managerial experience in the medical system, I am speaking out, blowing the whistle and biting the hand that feeds me. Not that I haven't spoken out before. Indeed, I've been speaking out for decades, writing articles, doing radio shows and even writing a previous book on the topic. But in light of the newly passed legislation of The Affordable Care Act, dubbed, Obama Care, I felt I had to speak up yet again. For this monstrosity of a mess is merely going to increase the already bloated system of misallocated and fraudulent medical service. I hope someone listens.

Hopefully, at the very least, this work will cast enough light on the severity of this fixable problem to get people thinking and talking about it. If we were to provide only that medical care which is necessary and beneficial, the total cost of quality health care for everyone in America would be a very small fraction of the exorbitant cost required to provide this current high volume of unwarranted medical services to the minority of the population.

Desmond Allen, PhD, MBA, RCP
Opelika, Alabama, 2013

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Introduction
My Love-Hate Relationship

As a seasoned clinical respiratory therapist and manager with an advanced degree in health care management, I have developed a love-hate relationship with allopathic medicine.

The Bright Side

I love the advanced technologies and medical interventions that can change and literally save lives. Many times, I have been part of an emergent health care team employing such advanced technologies and medical interventions in various life threatening situations. I have witnessed seemingly miraculous recoveries—people virtually coming back to life when none of us thought it possible, or at the very least, probable.

Years ago, I participated in the mechanical ventilation of a patient, who for several weeks had been virtually on the verge of death—showing no signs of cognitive function, which was confirmed by multiple unpromising EEGs suggesting irreversible brain damage. Then (and this is not typical), when all hope was gone and everyone knew it is way past time to pull the plug, a glimmer of consciousness appeared. Slowly, day by day, we watch his life return. First, his eyes began to make contact with ours. After a week or so, his eyes began to follow us as we walked about the room. Within a couple weeks his eyes began to respond to our questions. Then his head began to move and one day he mumbled a few words. Soon he was talking. Eventually, he walked out the door.

A few years before that I participated in the nearly hour long CPR of a 12 year-old girl, whom, it was believed, had an allergic reaction to anesthesia. After exhausting every possible option without results, her condition continued to deteriorate until her heart simply would not beat at all, not even erratically. At last, we were mere seconds away from giving up; the discussion to cease our efforts had already begun, when suddenly her heart began to beat with a regular rhythm. She has since grown into a beautiful young lady.

More than twenty years ago, I managed the ventilation of a middle-aged man ravaged by disseminated intravascular coagulation (DIC); it was to a degree that none of us had ever seen, consuming every limb and much of his torso. We all knew he could not survive. Days turned into weeks and somehow he was still hanging on. Then he started getting better, the DIC reversing. But after several days of promise it suddenly took another turn for the worse. Again it started to spread, though not as extensively as it had the first time. Once again his condition looked dire; and then, after several days, the DIC began to reverse again. He was eventually discharge, minus one leg. I watch him hobble to the car on his new crutches.

Many medical procedures and medications are all but miraculous; and, as one who administers some of these services, it is an honor to be part of it. I love that part of medicine. I also love the genuine compassion and personal sacrifice on the part of the caregivers. Most doctors, nurses and therapists of various disciplines, enter the medical field with a true desire to help, to make a difference in society. Through the years, I have watched many of them weep (I have wept) when faced with the realization that nothing more could be done for their patient and death was imminent.

I have heard physicians chastise uninsured patients for neglecting their office visit simply because they had no money to pay for the service. They would assure the patient that their health was more important than the ability to pay. I knew one physician who paid the cable bills for several of his nursing home patients

because they could not afford it themselves. I love that part of medicine, the human part, the empathy, the concern, the desire to make a difference.

The Dark Side

But there is also a part of medicine that I hate. It is the dark side. It is ever before us but seldom discussed; and it runs deeper, far deeper, than the benevolent bright side. It is the white collar criminal element, endemic, even intrinsic to the system. Without this element the current system would simply implode.

I hate the misinformation, the widespread misallocation of resources and the fraud upon which the system is structured. Herein, I address these problems. But this is only one aspect of this convoluted system; for it is broken at virtually every level. In the following pages I attempt to peel back these layers and expose this system for what it is. Some harsh things are said about the system and, consequently, about physicians;[1] but I want the reader to understand this is not so much a condemnation of physicians as it is the system of which they (and all of us really) have necessarily become a part.

As for the hint of sarcasm and cynicism strewn across these pages, it is not without cause. From both a professional and a personal vantage, through the years I have developed a very healthy sense of skepticism toward the dogma of allopathic medicine (Western medicine). For both your personal wellbeing and your financial stability, I would advise you to do the same. Barring a relatively few and some nearly miraculous procedures, the majority of services provided by allopathic medicine are anything but honorable, or even necessary for that matter. Not that particular services or procedures are themselves without value, but their superfluous and careless use, whereby they are employed without sufficient cause. Not only does this create additional expenditures, it fills the patient with false hope and misinformation.

Having carefully considered the many troublesome layers to

[1] Throughout this work the term physician is used to indicate both the medical doctor and the surgeon.

America's health care system, I believe I have the answer to this dilemma. The solution does not reshape the current system but replaces it all together. And I do mean altogether, the clinical as well as the fiscal elements. However, I truly doubt those legislators with the power to fix this debacle seriously want to know the cure. The cure is not a matter of resources but a matter of clinical reform. A reform that must initiated via legislation. It would be controversial legislation for it would affect one of Capitol Hill's greatest lobbying groups: the pharmaceutical industry and its plethora of dealers—AKA, medical doctors. Therefore, I suspect the cure is not welcome.

Furthermore, this work indicts the American medical establishment for its conscious and unethical neglect of promoting health; and, even worse, for actively engaging in the destruction of the same, by ignoring and even opposing proven natural therapies while promoting useless, yet profitable, medications that it might advance its own self-serving agenda of self-preservation. Although many physicians at the clinical level might be excused for unwittingly disseminating misinformation, the medical establishment which knowingly advances this misinformation cannot; and be not deceived, this medical establishment is a very real and elite society of powerful movers and shakers within, or closely tied to, the pharmaceutical industry, which is the driving force behind our health care system.

Chapter One
The Endemic Problem

The American health care system is touted as the best in the world. This is a lie. Certainly it has the resources and the potential to be the best, but the current system, on many levels, prevents this from being the case. The system is broken, spoiled, fermenting from within and drunk on its own excess. Unfortunately what Congress is presently debating, on both sides of the isle, is merely how best to fund the acquisition of more spoiled grapes, when the issue should be: How can we dispose of the rotten and yet retain the good? In its present, fermented state, the more money we give to health care, the more gluttonous it becomes.

The problem with health care is not how to fund it, or even who should receive it; the problem is what we are funding. For what we are funding is a system bloated with excess; a system that relies upon its own failure and the employment of misallocated and superfluous billable procedures.

Of course we will not hear the American Medical Association (AMA) or Big Pharma divulge this problem; at least not publicly. But behind those double doors where "Staff Only" is permitted, these issues of failure, overutilization and misallocation are well-known facts. The industry relies upon them. Overutilization and misallocation are so common that if they were to cease the fiscal foundation of the entire health care industry would crumble. Therefore, rather than expose this very real problem, the health

care industry uses its bully pulpit to cover it up; even to tout the excess as necessity and thus they cry out for even more money. Sadly, Congress listens.

A fairly recent article in The New England Journal Of Medicine (NEJM), stated, "It has been clear for some time that the primary hurdle to enacting health care reform is figuring out how to pay for it."[1] It is this argument upon which the government's The Affordable Care Act is based. I take issue with this argument, for it assumes a false premise. It is based upon the presupposition that the vast amount of health care services currently provided have intrinsic value. But this presupposition is without support; as noted by the renowned (or infamous depending upon your profession) Robert Mendelsohn, MD, who warned Americans years ago that they did not need "ninety percent or more of Modern Medicine".[2]

Until he published this opinion Dr. Mendelsohn had been a well respected member of the medical community; filling many prestigious roles beyond his pediatric practice. He had been chairman of the Medical Licensing Committee of Illinois, an instructor at Northwestern University Medical College, an associate professor of pediatrics and community health and preventive medicine at the University Of Illinois College Of Medicine, president of the National Health Federation, and national director of Project Head Start's Medical Consultation Service. Of course, even with these creditials, once he ccriticized the system, he was immediatelly ostracized.

I do, however, agree with another observation in the NEJM article, "great savings could be achievable in two areas: administrative costs and unnecessary care."[3] Where I differ is the nature and volume of the administrative costs and unnecessary care that could be purged. The article's focus is limited to extreme clinical misallocation and fraud, which is estimated at $830 billion (30%) and another $500 billion (20%) in administrative costs. I, on the other hand, focus on the routine, ubiquitous excess that drives the current medical system; that which constitutes its financial backbone, the 90% of unnecessary care Dr. Mendelsohn

discussed. Using these figures, controlling this waste could realize a savings of perhaps $2.5 trillion in clinical costs and another $2.3 trillion in administrative costs. If orchestrated effectively, the savings generated by eliminating this waste would be such that health care cost for the entire nation would be but a small fraction of its current expenditure. From this premise, it is clear that true health care reform must take place at the clinical level, not the fiscal. Reforming insurance policies and tax codes will only further propagate the problem of overutilization and fraud which are consuming our fiscal resources faster than we can produce them.

Unsustainable Model

The medical system itself is the problem. No amount of money from any source can fix it. Obama Care cannot fix it. Like so many other problems Congress attempts and fails to fix, by merely throwing money at it, this too is doomed to failure. Even worse, beyond being doomed to failure, The Affordable Care Act will most definitely exacerbate the current problem, placing a greater financial burden on the insured and multiplying the already enormous volume of unnecessary medical services, which are both the backbone of the system as well as the albatross about its neck.

The lack of money, over which Congress squabbles, is not the problem. Indeed, we might argue that an excess of money is the problem; or at the very least, it contributes to the problem. The continuous and unrestrained cash flow into health care (spawned by the virtually unregulated, convoluted pay-per-service reimbursement paradigm) has created a grossly obese cash cow, consuming every dollar it can, and begging for more that it might maintain its production for those squeezing its teats, fervently milking the system for all they can.

It is this virtually unregulated and unrestrained pay-per-service system that generates the untold volume of unnecessary care and misallocated services. In this, the NEJM article is correct when it identifies several of the issues resultant to the conflict of interest in this pay-per-service reimbursement system.

This problem results largely from the perverse incentives

> built into the health care system, in which there is a clear conflict of interest. Physician remuneration depends on the volume of patients seen, particularly on the number and intensity of the procedures performed. The need for these services is determined by the very physicians who then arrange for or perform the procedures. This is not the way a high-quality health care system should work. Unnecessary surgery and other invasive procedures may be ordered simply to augment physicians' incomes, the potential for adverse outcomes notwithstanding. Even if all physicians were highly ethical and ordered only tests and treatments they deemed truly important, it would take saints not to have their judgment skewed in favor of decisions that will provide them with financial rewards. Defensive medicine also generates unnecessary care, as do duplication of tests when data are unavailable and patients' demands for tests or treatments not in keeping with good medical practice.
>
> The dollars lost to fraud are difficult to quantify but . . . . Costs for the use of technology that has not been proved effective are also difficult to estimate but are believed to be substantial.[4]

Such conflict of interest is indeed an unsustainable model. However, this type of abuse, as mentioned, is but a small portion of the larger problem—the ubiquitous, superfluous care that is the mainstay of the system—the 90% of which Dr. Mendelsohn speaks: that routine care that is never scrutinized simply because a physician has requested it. It is this that is bankrupting the nation. It is this that is the monster at the door. Michael Chernew, a professor of health care policy at Harvard Medical School, has collected the following data concerning this monster—the rising cost of health care—in relationship to the national GDP.

> Health care spending growth in the United States has exceeded gross domestic product (GDP) growth for every 10-year period since World War II. On average, the annual gap between real per capita health spending growth and real

> per capita GDP growth from 1970 to 2008 has been about 2.2 percentage points (CMS 2010a). Projections (prior to health reform) suggested that total health care spending would consume 26%of GDP by 2035. . . . Under even favorable assumptions, the coming several decades will see health care absorb about twice the share of income growth as in past decades.[5]
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> . . . . . .
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> reasonable projections suggest that our large and rising structural deficits, largely driven by health care, will shoot us to the 90% of GDP threshold in about 2020, 110% of GDP by 2025, and to an unimaginable 180% of GDP by 2035, . . . Such a trajectory would result in economic Armageddon. Interest rates would likely soar, GDP would contract significantly leaving many out of work, and the government would have few levers to respond. Policymakers will be forced to respond to prevent this scenario well before 2025. This implies some combination of tax increases and spending cuts (relative to the projections) and those cuts will likely include health care."[6]

The forecast reminds me of the old colloquialism: "You can't have your cake and eat it too." In the current model, health care will be spread thinner and thinner; gradually everyone will merely receive poor care. Then it will implode and there will be no care at all. It will end like an ancient Greek tragedy; the appetite for superfluous health care services consuming so many resources that in the end even health care itself is consumed.

Health Care Reform is Looming

With voices speaking up nationwide, in many demographics, health care revolution is on the horizon. Beyond being extremely frustrating, the topic of American Health Care is also extremely complex. With several factions having various financial and/or ethical interests and each passionately struggling to protect their particular concern, health care in America is a volatile subject. It is just as likely to get a rise from the affluent businessman as it is from the inner-city indigent, from the health care provider as from

the health care consumer, from the insurer as from the insured, or from the politician as it is from the voter. Their views are just as diverse as their interests, with proponents from all factions plastered across the opinion spectrum; ranging from health care providers, consumers and politicians who advocate a completely private industry, to health care providers, consumers and politicians who call for total government control; and from health care providers, consumers and politicians who advocate a market driven fee-for-service reimbursement, to health care providers, consumers and politicians who call for a service-driven free humanitarian enterprise.

The divisions are such that no true end is in sight. Our government has responded by passing The Affordable Health Care Act. Unfortunately, this legislation fails to address the real crux of the matter and therefore it solves nothing. Furthermore, by addressing the wrong issues, and even making issues out of non-issues, it will quickly prove to further widen and entrench the current fiscal dilemma; thereby making matters even worse. While the objective of this legislation sounds humanitarian and reasonable (i.e. to provide more people equal access to health care), the framers have overlooked the key issue of the health care crisis, which is the health care system itself. Herein, at the clinical level, is where health care reform must take place. For it is steaming forward like an out of control locomotive. There is no engineer and the proverbial cliff is ever so near. No one but the Road Runner will survive this crash.

The Affordable Care Act solves nothing. Soon everyone, but those tied to the agenda of a specific interest group, will admit that it merely further frustrates the issues. In the end, it will exacerbate the problem of misallocation and fraud, thereby costing the country even more money. Because the broken pay-per-service paradigm will continue but with a reduced reimbursement, physicians will seek to maintain their standard of living and hospitals will attempt to keep their doors open by increasing the volume of overutilization and fraud: unwarranted billable services, unnecessary hospitalizations, etc., for this will continue to be

where the money is. It will result in a generally poorer quality of care for everyone.

If our country is to survive its currant fiscal problems: looming inflation, continued high unemployment rates and a growing deficit that is already $17 trillion, we must come to terms with the out of control cost of health care. Yet, The Affordable Care Act does the exact opposite. In 2007, the Congressional Budget Office calculated that

> financing even a 1% gap between income and health spending growth without cutting other public programs would require an increase in taxes of more than 70% by 2050, which would bring the highest tax rate to 60% and have broad adverse economic ramifications.[7]

We must seriously scrutinize the cost/benefit analysis in which, at present, the government alone is liable for roughly $1 trillion in health care services between Medicare and prescription drugs.[8] This amount will certainly grow under The Affordable Care Act; even beyond that which was calculated by the Congressional Budget Office, in that Obama Care was not constructed at that time.

Although, as yet they are given little attention, a growing number of concerned citizens are acutely aware of the unwarranted financial burden created by overutilization, as well as the subsequent insufficient clinical outcomes. Few of them, however, realize that Obama Care attempts to address part of this issue by discriminating against the elderly, thereby prohibiting their access to a vast amount of medical services due to their age. I am certain discrimination lawsuits will quickly follow, once the public realizes what they have allowed their government to implement. Has not the Supreme Court ruled against discrimination based upon race, sex, religion and age? Yet here is the scenario under Obama Care. Based upon their income, which is likely higher than the younger generation, the aged must purchase health insurance or pay a stiff penalty, i.e. tax; yet they are not permitted the same access to healthcare as are their younger counterparts, for many services will be denied to them due to their age. I do not see how

this can hold up in court. I might be a little crazy, but it seems to me that it might have been best if our legislators had actually read the The Affordable Care Act before signing it into law.

Baby-boomers are a substantial portion of society. The first baby-boomers have already reached senior citizenship. As more follow they will demand quality health care at an affordable price. The Affordable Care Act does not achieve either of these. But baby-boomers are not the only population of concern. Generation X is not the ignorant, trusting sheep of previous generations. They are more informed, have a higher education and question authority with more regularity. The rapidly growing popularity of alternative health care, coupled with easily accessible medical information, has also fueled the flames. Soon people will be demanding answers and options to this expensive and defective health care system; for they can ill-afford, nor will they tolerate the current arrangement, which not only gouges deeply into their pocketbooks, but fails, miserably, even to satisfy its marketed expectations. Soon these voices will unite and change will occur. At least, I hope this happens.

Sadly, although a grassroots health care revolution may be on the horizon, it is accompanied by no viable compromise that is likely to satisfy the majority of interests. Unless the issue is broached from a different set of values upon which the majority of parties can agree, this condition will continue to deteriorate; our coffers will continue to hemorrhage until our nation's very civility will be at risk.

I am leading up to what I believe the solution is to our health care dilemma; however, for the reader to fully appreciate this solution it is imperative to have a clear picture of just how broken the current system is; how misinformed the general population is about the current system. Thus, some very important issues of insider knowledge must be exposed before my proposed solution is even considered.

Chapter Two
Blowing the Whistle

If the health care system provided care commensurate to its fiscal appetite we might excuse its voracious hunger. Unfortunately, this is not the case. So that the volume of misallocation and fraudulent services perpetrated within this obscenely bloated system far outweigh the relatively small volume of essential and beneficial services it actually provides.

With few exceptions, we will not hear this truth from physicians. We certainly will not hear it from The American Medical Association, nor from any other physicians' group; they are too dependent upon this overutilization and misappropriation. Indeed, for the most part, it is fundamental to their livelihood. Asking their advice on health care reform is like asking a committee of foxes how to fix the henhouse. There are, however, certain physicians and other professionals who speak up from time to time; essentially marking themselves as whistleblowers. Such as Drs. Robert Mendelsohn,[9] Stuart Berger[10], Richard C. Bates[11], Guylaine Lanctot[12], Marcia Angell[13], Loraine Day[14] and other non-physicians, Lynn Payer[15], Charles B. Inlander, Lowell S, Levin, Ed Weiner[16], Jeff Forster[17] and many others.

I am one of those whistleblowers. I know firsthand how the medical community is fleecing America with countless superfluous diagnostic tests, unwarranted treatments, inappropriate procedures and the bogus hospitalizations of patients whose primary problem is simply having shown up for a routine and likely unnecessary

doctor's appointment on a day their physician had a few hospital beds to fill. The American public pays for this obscene volume of gratuitous medical service with its tax dollars and the high cost of health insurance.

This corrupt system has not been operating in darkness, but hidden in plain sight. The problem is that few individuals with the power to do anything about it have the moral fortitude or the political ambition to address it.

Stark II

Federal law, known as Stark II, is designed to dissuade nefarious practices such as kickbacks—referrals to services in which the physician or his/her family has a financial interest—or other various types of conflict of interests. About half the states have similar laws to discourage such conflict of interest being submitted to private insurers as well. However, neither the federal nor state laws have significant impact on these dubious practices. One former official of the Centers for Medicare and Medicaid Services (CMS) estimated: 95% of the more than 6,100 hospitals in the country have Stark violations due to their arrangements with the 932,700 physicians who participate in Medicare.[18]

Because hospitals generally have more funds than do sole physicians, physicians are hardly ever prosecuted. The American Health Lawyers Association has recognized this:

> Stark enforcement against physicians is almost nonexistent and there is little reason to believe that will change. Given this, it is not surprising the physicians often view Stark compliance as the hospital's problem.[19]

Even if the government wanted to end this milking of the system many, such as Rep. Pete Stark, believe it could not:

> The enforcement resources simply aren't there. There is no way that the Inspector General—with fewer than 500 investigators nationwide, can adequately police the complex business arrangements that underpin the $100 billion a year Medicare program.[20]

This problem is so pervasive no one really has a handle on it.

No one really knows how many dollars are lost to fraud and abuse. As admitted by Louis Saccoccio, CEO of the National Health Care Anti-Fraud Association in Washington, DC.

> A total of US $4.1 billion worth of medical fraud was identified by the United States government in 2011, and US $10.7 billion over the past three years. But while the Federal Bureau of Investigation (FBI) estimates that fraud accounts for roughly US $80 billion per year in America's US $2.4 trillion health care budget, no one has been able to attach a firm number to health care fraud. . . . There are a lot of estimates, but they are all just estimates. Nobody has ever done some in-depth mathematical, statistical type study of the issue. But we can safely say it's in the tens of billions of dollars. [21]

Fraud Not Addressed by Stark II

But the problem is much bigger than the blatant fraud that Stark II and these reports address. Overutilization and misallocation are the bigger problems; the more costly problems. These practices are just as fraudulent, but are conveniently hidden in plain sight under the guise of physician discretion. Absolutely unnecessary test and treatments, medications and office visits, hospitalizations and out patient procedures comprise the majority of the nation's overall medical costs.

As large as the figures are for blatant fraud, it is a relatively minor problem compared to the fraud perpetrated under the guise of physician discretion. As Levitt and Dubner contend in FREAKONOMICS, pretty much everybody cheats; from corporate CEOs to school children, "Cheating is a primordial economic act: getting more for less."[22] Medical service providers have refined this act into a fine art, so that the grotesque volume of routine, nonessential care is praised and desired. This is the 90% of unnecessary medical services of which Dr. Mendelsohn and others have addressed, yet to no avail. Putting his reputation on the line, Doctor Mendelsohn argued that when the score is settled, modern Western Medicine actually does more harm than good.[23,24]

This overutilization, which is the mainstay of abuse, is not even on the government's radar. Their action team, dubbed HEAT (a joint effort between the Department of Health and Human Services and Department of Justice),[25] merely chips away at the edges, targeting perpetrators of blatant fraudulent activity, Medicare scams and criminals veiled as health care providers. All the while, the real loss, that is, the greatest loss, stems from countless real services being provided uselessly to unwary patients.

One method some physicians use to game the system is merely to order more of a particular test for which they will receive an interpretation fee. As demonstrated in a recent study of a large insurer in California, many physicians have another method to squeeze all they can from the system. In this study, a high degree of self-referrals for various tests were revealed: nearly 33% for MRI scans, 22% for CT scans, and 17% for PET scans. Furthermore, 61% of the MRI machines and 64% of the CT machines were leased on a payment-per scan arrangement.[26]

Similarly, over a six year period, Baras and Baker observed a change in practice patterns in non-radiologist physicians who began self-referrals for MRI studies. Patients with low back pain received more MRIs. Patients of orthopedists also received an increased number of low back surgeries. Among these patients, additional costs went up several times the cost of the MRI itself.[27]

Medicine is rife with conflict of interests. Matsen addressed one aspect of this issue at the 2011 annual meeting of the American Aacademy of Orthopaedic Surgeons. After analysing voluntary disclosure of conflict of interests, he realized conflicts were present in "over 75% of the presentations, 100% of the featured symposia, 80% of the scientific exhibits, 76% of the podium presentations, and 75% of the posters." The modest conclusion was: "There is growing concern regarding conflicts of interest in orthopaedic research and education."[28]

But is it not just the lonely physician scamming the system, entire hospitals and treatment centers are established to milk the system of its best fruits. These treatment centers and specialty hospitals are often owned and operated by physicians who have a

vested interest in the services provided. Orthopedic hospitals, cardiac hospitals, women's hospitals and oncology centers are among the favorite cons, for their reimbursements are very lucrative. Moore and Coddington studied about twenty percent of these specialty hospitals and found exactly what we might expect; each sharing several common features:

- Focus on the highest paying procedures.
- Market to and provide services for the healthiest and best insured patients.
- Typically perform exceptionally well financially.
- Physicians with equity in the facility redirect large numbers of patients to them.
- Certain procedures correlate with an increased overall volume and utilization.
- Procedures are generally scheduled well in advance while emergency services are refused.[29]

Gabel had similar findings. Physicians at physician-owned Ambulatory Surgical Centers were "more likely than other physicians to refer well-insured patients to their facilities and route Medicaid patients to hospital outpatient clinics."[30] Bishop arrived at this same conclusion in a national cross-sectional study of Ambulatory Medical Care Surveys. Among physician-owned specialist group practices with on-site laboratories, five common laboratory tests (CBCs, electrolytes, HbA1c, cholesterol, and PSA were the favorites) were more likely to be ordered; "potentially resulting in millions in excess health care spending."[31]

Scamming the System

There are many ways for physicians to play the system: prescribing unnecessary medications and requesting repeated and superfluous office visits, unnecessary hospitalizations, ordering various pointless yet reimbursable outpatient tests and treatments.

The majority of doctor office appointments in the nation are to address frivolous matters: post nasal drip, common cold, etc.

About half of them are to treat a cough. At the same time, the vast majority of hospitalizations are just as frivolous, even fraudulent. Far too many patients are admitted for a wide range of benign conditions that could easily be treated at home. Many are admitted simply because their physician has a few beds to fill at the hospital. These patients need to be in the hospital no more than the nurse taking care of them. At times, the nurse or therapist is sicker than the patients they care for. If you think I am making this up, you are very naïve. And if you think such incidents are rare, you are very naïve.

Just as fraudulent, are the patients hospitalized with an untreatable, end-stage condition that should be treated with palliative care at home, in a nursing home, or by the hospice system. If they survive, these patients will be discharged from the acute care hospital in virtually the same condition in which they were admitted. Although they are by no means candidates for any effective rehabilitation program, once their allotted reimbursed length of stay runs out (that is, at that point when the hospital will begin to lose money on their admission), some will be switched to a swing bed status for rehabilitation. Now they will be visited by various therapeutic departments to provide rehabilitation therapy. However, it still holds true that upon discharge these patients will be virtually in the same condition as when they were admitted. During the entire hospital stay, the physician will generate a separate, daily invoice for his/her patient visits, which Medicare/Medicaid will gladly pay.

Most of these patients (both those who are not really that sick and those at the end of their life in need of simple palliative care) will endure a series of unnecessary tests; tests that require a physician's interpretation, which, of course is another, separate billable item. Beyond the daily, billable visits from their primary physician, they are likely to get visits from various other consultants, specialist physicians who will generate yet other costly invoices.

Tip of the Iceberg

The National Health Care Anti-Fraud Association estimates

that some $60 billion a year is lost to such obvious fraud.[32] But this is just the tip of the iceberg, a drop in the bucket; for it fails to consider such practices as pointless hospitalizations, in which patients are discharged in virtually the same condition they were admitted; the gratuitous outpatient tests and treatments that serve no viable clinical purpose; the expensive interpretation fess for needless tests that will lend nothing to the clinical outcome; the voluminous unnecessary medications; or the routine subsequent office visits in which patients with multiple disease processes are scheduled different office visits for each disease.

All of these practices and more slip under the radar simply because they are sanctified by medical order. No one questions the physician's medical orders in these gray areas of clinical care where physician autonomy reigns as king.

From this unrestrained autonomy, countless unnecessary procedures are generated to account for the majority of health care expenditures. Nevertheless, the physician is virtually given carte blanche to order whatever medical services he/she desires. This unrestrained freedom generates a routine misallocation of billable services hidden in plain sight. These routine abuses are just as fraudulent as are the claims submitted for services never provided, or the overutilization among specialty facilities. Furthermore, the total cost for these routine abuses far surpasses that of the blatant fraud. It is this routine fraud upon which the system is build that is the primary source of abuse. It is this routine misallocation that is bankrupting the nation. While fraud fighters use real-time techniques to detect a minority of grotesque patterns of abuse, these routine abusive practices go unnoticed and undetected. The estimated $60 billion a year speculated by the National Health Care Anti-Fraud Association, pales in comparison to the untold billions laundered by these routine, superfluous and fraudulent medical practices; the ninety percent or more of unnecessary procedures of which Dr. Robert Mendelsohn spoke.[33]

A Few Examples of Unwarranted Care

Antidotal as it may be, let me share a few examples of routine overutilization and misallocation. However, the reader may rest

assured that whistleblowers from other disciplines (radiology, laboratory, nursing, physical therapy, pharmacy, etc.) could tell you more, far more. Of course I will use no names or dates; the privacy of everyone mentioned, but myself, is protected.

Because physicians bill a higher rate when prescriptions are provided, it is not uncommon for patients to leave their doctor's offices with prescriptions in hand. Of course, the redundant and repetitive office visits to receive refills for these unnecessary medications also generate a nice income. Not working in a physician's office, I am not directly privy to the details of this information. However, working in hospitals as I have through the years, I have seen these patients' often scandalous list of medications. So I am not exactly out of the loop. But unnecessary pharmaceuticals and redundant doctor visits are not the only means to generate income. Other misallocated billable resources are also very popular.

A physician once called me, STAT nonetheless, to initiate routine therapy for one of his elderly patients. He wanted to provide a certain treatment four times a day while the family was in the room, because the patient's daughter did not think we were doing enough for her 90 year-old mother. Of course, there wasn't much that could be done, in that she was hospitalized for generalized weakness. Not only was this therapy unwarranted and certainly of no benefit, the entire hospitalization was unnecessary. News flash! We get weaker as we age. Did I mention she was 90 years old? Although she was eventually discharged in the same condition in which she was admitted, both the physician and the hospital were able to submit their bills to Medicare for services rendered. This scenario plays out countless times every day all across the nation.

Or how about the admission/discharge nurse who fielded a call from a physician seeking a hospital bed for his patient?

"What is wrong with him?" the nurse asked.

"Hold one," the physician said. "Mr. X, what is wrong with you?" the nurse heard the physician ask the patient. Then the physician got back on the line; "He says he is just not feeling too

good."

Then there are those very common hospitalizations that serve yet another purpose: the physician's invoice. Such must have been the case with the sweet 93 year-old woman with terminal lung cancer who wanted only to go home, but was hospitalized for more than six weeks for no particular reason other than failing to thrive. She was 93 years-old with terminal lung cancer, of course she was failing to thrive, and there was nothing any acute care facility could do to reverse her condition; thus the term "terminal". After several weeks of hospitalization, an unnecessary fiber-optic bronchoscopy (FOB) was performed merely to observe the tumor for which there was no treatment. The traumatic FOB made things worse. She ended up in the ICU. Although the ICU was not able to reverse her terminal condition, it did generate a larger Medicare reimbursement for the ICU admission. The fact that the ICU admission transpired due to trauma incurred during an absolutely unnecessary procedure was of no concern to the Medicare payer, which is ultimately us, the taxpayers.

Rather than being confined to a hospital room where she did not want to be, this pitiful, dying lady should have been at home where her family (who held a constant vigil in her hospital room) could spend quality time with her. The problem with this option is that the physician was not about to make unnecessary, billable, daily home visits as he could make them in the hospital.

What is so alarming is that such pointless care is not the exception but the common practice. I could go on with situation after situation, but I will restrict my diatribe to but a few more abuses that quickly come to mind.

Every hospital has what it calls "frequent flyer"—those who are admitted repeatedly and generally for the same condition. Sometimes these patients are actually sick; but often, very often, they are no sicker upon admission than they will be upon discharged, for their hospital admission is seldom about the patient's medical condition, but about billing the insurance company for the admission and for the physician's daily visitation. Those physicians for whom this is common practice generally

have multiple patients hospitalized on any given day that they may be visited in one fell swoop. Some of these patients are hospitalized multiple times a year to help accomplish this goal.

I think of the 54 year-old drug abuser, hospitalized four or five times a year, year after year. Generally there was no particularly acute reason for these admissions. She received no intravenous fluids, no medications that she could not take at home. She merely wandered the halls, going out to smoke as needed and waiting for her physician's visit—whom, by the way, would visit six or eight other patients, each of which was also admitted with no particularly acute issue. Well, on the admission orders of each chart there would be an acute issue listed; but in reality, the condition was chronic and certainly not of the acuity that acute hospitalization was required. But this is where the fine line of practicing medicine is easy to blur.

What each "patient" had in common was the invoice their insurance provider (generally Medicare) received for their physician's bedside care . . . oh yeah; and the other invoice from "Club Med".

Then there was the 95 year-old gentleman hospitalized because he had an episode of dizziness and syncope. Upon discharge, 40 days later, nothing had been discovered or resolved. Similarly, there was the 76 year-old gentleman with the same basic story except his unresolved issue was nausea and his length of stay was more than 50 days. Sadly, in other than for-profit hospitals, these cases are not the exception. This same scenario is played out countless times in every big city and little burg across the nation. Although (due to the DRG[2] reimbursement system) hospitals have to absorb much of the costs associated with these lengthy stays; physicians, of course, submit separate bills for their daily visitations.

Some smaller hospitals routinely allow physicians to take advantage because they are so afraid of offending and losing them. The irony is that these are generally the same hospitals struggling

2 Diagnostic Related Group, in which hospital are paid a predetermined sum based upon the patient's diagnosis.

to stay afloat due to their high personnel cost, which they incur because of the extra staff needed to take care of these patients with unnecessary extended lengths of stay, for which the hospital will not be completely reimbursed. Furthermore, these physicians, which hospital administrators are so afraid of offending, most likely have nowhere else to go. It is highly unlikely they would pull up roots for having to contain their fraudulent practices; and if they did, "good riddance," the hospital is better off without them.

Or, how about this common practice? The physician who orders numerous EKGs for the days he/she is scheduled to read EKGs. EKGs will be ordered even on non-cardiac patients with conditions such as Alzheimer's, cellulites of the foot, dehydration, etc. If this physician happens to be reading EKGs for the next few days, expect these patients to receive daily EKGs. Of course this scam only works if the hospital does the billing and reimburses the physician's interpretation via a separate contract. Furthermore, because EKG interpretation is all about the measurements of voltage and millimeters per second as grafted on the tracing, modern, computerized EKG machines provide vary accurate interpretations. Thus, some physicians "interpret" the EKGs in a matter of seconds by merely reading the computerized results. How many times have I watched a physician do nothing more than dictate the patient's name and the automated interpretation provided by the machine? Without his knowledge, I once timed a physician as he "interpreted" 33 EKGs in less than three minutes. Later that day he had another stack to "interpret". This happens daily in hospitals and clinic across America. But EKG interpretation fees are the least lucrative of the many tests that require a physician's interpretation. Other studies, are also used superfluously: PFTs, EEGs, ultrasounds, MRI's, sleep studies, CT scans and numerous x-rays, just to name a few; some command hefty interpretation fees of scores or even hundreds of dollars.

Such fraudulent overutilization (for it can be called nothing else) is nationwide. Of course the fraud and abuse does not take place only in the hospital, nor do all physicians employ the scams

of interpretation fees or unwarranted hospitalizations; indeed these are likely the minority. But the unnecessary medical bills they generate are enormous. The routine doctor's office visit is the backbone for most medical practices. Here, an untold number of routine, unnecessary doctor's office visits occur daily across the nation. Here, many physicians will sustain their livelihood by such questionable means as prescribing some drug and requiring monthly office visits to obtain refills.

I am thinking of the 44 year-old lonely, depressed widow, who was told by her doctor that she suffered narcolepsy. This was the beginning of monthly doctor's office visits to get her Dexedrine prescription refilled. Twenty years later, when at last she had to be cared for by family in another part of the county, the abuse was discovered. Not only did she not suffer narcolepsy, she now suffered severe psychiatric side effects (anxiety, mania and hallucinations) from prolonged and unnecessary amphetamine use.

Or how about the young physician, in her new practice, who could not contain her excitement after having examined her first diabetic patient; the dollar signs swirled about her head as she estimated how much money she would make each year from this patient's routine visits. I could go on for hours, but these few examples are set forth just to wet your whistle.

Another scam is to perform unnecessary, billable procedures and tests in the office or clinic. Of course physicians will convince themselves that the procedures and data acquired from various tests have value; but the truth is, these results generally have little bearing on the course of treatment, which is likely to be the same no matter what the tests show. Not that these procedures have no value when used appropriately, it is their misallocation of which I speak. For example, of what value is a pulmonary function study on a 65 year old smoker with end stage emphysema? Similar to the unnecessary sleep study to document known sleep apnea (which I shall discuss later), the results are predictable, nothing has been achieved other than to document that yes, 2 plus 2 is 4, but now we have proof. Well, this is not entirely the case, for an account billable has also been generated.

Such routine, ubiquitous "health care" events are consuming our tax dollars. And because the volume is so great, this type of unregulated, unnoticed abuse is far more costly than is the nearly insignificant, blatant fraud perpetrated by providers who submit bogus bills for services never rendered; that which the government's task force chases. This is a problem, but it stands in the shadows of those physicians who provide tangible, unnecessary, albeit, billable services. This is not a small problem; indeed, it is the primary problem with the system—at least at the fiscal level. Yet this common practice is the backbone to the entire health care economy. Without it the current system implodes.

Plenty of Blame to Go Around

While the medical establishment must absorb most of the blame for this broken and fraudulent system, individual physicians, nevertheless, retain some culpability. Many (indeed most, for this is how the system is structured) are guilty in some way of the blatant overutilization of resources: encouraging unnecessary office visits, ordering superfluous tests, procedures, medications or unwarranted hospitalizations. Some do it assuming they will protect themselves from frivolous litigation. Many physicians create worthless medical orders for no reason other than the allotted reimbursement the service generates. Some do it with exuberant ignorance; for this is what they were taught and they truly believe they are providing a service. (Later, we will expose the utterly deficient education provided in medical college). Then some do it to placate; and this must not be dismissed as a rare event. They do it to make the patient, or the patient's family, think something of benefit is being done; when in reality nothing can be done in hospital for this patient that could not be done at home. There are no drugs, IV or otherwise, that can make a dying 88 year-old 22 again.

Once, while discussing this widespread practice of placation with a couple of physicians, one of them said, "There is an old Chinese proverb: the physician's primary role is to occupy while nature takes its course."

If course, I could not refrain a response, "And you are doing a masterful job at it." To which he had a great laugh.

It Need Not Be This Way

I am convinced that if we were to eliminate this fraud and misallocation of resources, we could provide affordable, quality health care for everyone. This, however, means we would provide only that care actually deemed necessary and beneficial; that we hospitalize only those patients who are truly in need of care that cannot be provided elsewhere, and whose medial condition is likely to be improved upon discharge.

This might sound logical, but I assure you it is not the current model. Using these criteria, the volume of unwarranted hospitalizations in our current model far surpasses the meager number of truly necessary hospitalizations. If we were to limit hospitalizations only to those patients whose conditions could not be treated effectively elsewhere (i.e. home or nursing home), and to those with conditions that would likely be improved upon discharge, the cost of such judicious care for the entire nation, would be a small fraction of the current cost of providing the enormous volume of fraudulent, misallocated medical services to but a portion of the population.

Chapter Three
The Physician And The System

It has been my experience that most physicians enter the field for philanthropic reasons; but once in the field, the twisted system (at both the clinical and the business level) necessarily takes control. It is a complex existence of long hours and personal sacrifice. Family time is sacrificed. Sleep is sacrificed. They can be called several times during the night and yet still have to get up and hold office hours in the morning. I have observed dedicated, exhausted physicians too tired even to drive, napping at the nursing station, in the doctor's lounge, even in their car before going back to the busy office that awaits them. And there is often an emotional sacrifice, as many build unavoidable emotional attachments with patients who they know will soon pass away due to their disease process.

Then too the physician is caught in a quandary of convoluted reimbursement methods, with laws and regulations constantly changing. Those who run an office have payroll obligations and all of them are concerned about threats of litigation. Many have accumulated great debt for school loans that will take years to repay.

The Convoluted Medical System

In the midst of personal sacrifice, emotional investment, financial obligations and the overall desire to succeed in business, the physician is thrust into this pay-per-service system in which many and various services and procedures are billable items, and

for which the physician holds the magic pen to summon such services and procedures, largely at his/her uncensored discretion. It is the only industry in the country in which the provider determines what services the customer will receive and what the customer will pay for the services; all, while the customer likely never understands what he/she received or why it was deemed necessary. While it may seem to some that a visit to your local auto mechanic is the same, there is a difference. The auto mechanic customer may choose to provide his/her own service, or may choose to have a friend or family member provide the service. Not so in medicine. Here, Congress has legislated that your physician must orchestrate your medical care; the customer has no effective voice in the matter.

Furthermore, virtually no one has oversight of these medical orders. No one on the micro level of the physician's practice is evaluating the necessity, appropriateness or even efficacy of a physician's medical orders. Even hospitals and HMO systems only get involved with a physician's practice when it starts to cost them money. Across the board, physicians are simply trusted to do the right thing.

Because they are reimbursed in a large part (whether directly or indirectly) by the various billable services and procedures summoned by their unregulated medical orders, gratuitous medical orders are not merely endemic to the system they constitute the framework upon which the system is built. As such, America's convoluted medical system is setup as if it were purposefully designed to promote dubious medical practices.

Some physicians propagate unnecessary medical orders in their attempt to protect themselves from frivolous lawsuits. Others knowingly fudged the system so their practice might survive; they justify their tweaking of the system as a means to keep their heads above water and to make payroll. Others diligently work the system, exploiting it for its spoils merely to enhance their portfolio. Not that one reason for such questionable practice is better than another; but on an ethical level, I often wonder how some of them sleep at night. Yet even to this

question I know the answer. Most have convinced themselves they are providing necessary services; at the very least, standard services. In that overutilization is so endemic to the profession it actually has become the standard, this is an easy position to take. So that the dishonorable practice of grotesque misallocation and overutilization is business as usual.

Moreover, the medical society has worked very hard to extend the physician's self-deceived self-perception to that of the public's perception of them as well. The average American sees the physician's role in society as an honorable and necessary service. As such, they trust them; they have faith in them. Speaking of this faith, Robert Mendelsohn, MD, has warned us about his colleagues and his profession, which he argued has run amok.

> Don't believe for a minute that they don't play it for all it's worth. Because what's at stake is the whole ball game, the whole ninety percent or more of Modern Medicine that we don't need, that, as a matter of fact, is out to kill us. Modern Medicine can't survive without your faith, because Modern Medicine is neither an art nor a science. It's a religion.[34]

Once the physician has a license to practice medicine, very little of his/her practice is regulated, investigated or even questioned. Occasionally, the government will make a high profile arrest of some physician who has been exposed for submitting fraudulent claims for services never rendered to Medicare or other insurers. But this practice pales in the face of the real problem, which is submitting claims for pointless services actually rendered. Herein is where the problem with America's health care system lies. This alone is bankrupting the system. And it is for more of these unwarranted, pointless services for which Congress and the White House are clamoring and which Obama Care will fund.

Stop the Madness

The life of the physician is not an easy life; but this does not justify the endemic abuse of the system, which, for many, transpires without thought, as if it were second nature. Whether these exploitations are perpetrated for survival or greed or

placation or merely because they are viewed as the standard of care, is not the real issue—at least, not in regard to solving the health care dilemma. The issue is that these exploitations are built into the system, they constitute the primary cost of health care and they must stop.

If these exploitations were eradicated we could provide health care to the entire nation at a small fraction of the current cost of providing countless fraudulent and misallocated services to a limited population. This, however, means we would provide only that care which is actually necessary and beneficial. We would hospitalize only those patients who truly need medical care that cannot be provided elsewhere, and whose medial condition is likely to be improved upon discharge. These are not the criteria for the current model in which the volume of superfluous and ineffective services far surpasses that of essential and effective care.

This pretty much sums it up. This is the crux of the matter that I hate and which is bankrupting the nation: the superfluous and unnecessary services provided on a routine daily basis by nearly every physician in the country: tests, treatments, hospitalizations, medications, surgeries, office visits, etc. An excess of services provided for one or more of three possible reasons: medical ignorance, medical fraud, or mere placation—the patient, the family, the nurse, the physician, whoever it might be that feels something should be done, even if there is really nothing of value that can be done.

I reject the argument that "You are not a physician; you cannot make the judgment as to whether these patients need to be tested, treated or hospitalized." I am not a professional auto mechanic either, but I have given the car a tune up; I have even rebuilt engines. I can tell when the car needs new tires rather than engine repair. I am not the computer technician, but I can tell when the computer is having memory problems versus monitor problems. Likewise, although I am not a physician, I can determine that when hospitalized patients merely receive the same medications and care they receive at home, the system is being

worked. One need not have a degree in a certain discipline to ascertain misuse or fraud; especially when one is an intimate part of the process and has considerable knowledge of the topic. Indeed, in some areas of cardiopulmonary medicine, I am confident I have more knowledge than does the typical physician.

I am not the physician prescribing the care, but I am the therapist providing much of the care that is prescribed; and I know (even better than most physicians writing the prescriptions) the effectiveness, the benefits, and the proper utilization of these therapies. Beyond the extensive study of these treatments, I am with these patients before, during and after these treatments. I do tests to ascertain the effectiveness or ineffectiveness of these therapies. I am fully capable of observing inappropriate and fraudulent utilization. Furthermore, beyond my allopathic credentials as a respiratory therapist, I also have a doctorate in naturopathy as well as a doctorate in health management. Therefore, all I am asking is that the reader continues with an open mind, for I do not expose these practices or set forth my critic lightly.

Where Not to Seek a Solution

As for solving our health care quandary; physicians are hardly the group from which to seek advice. They are necessarily biased on two counts. Even those with the purest of intentions have a clouded view of reality. First, they have been indoctrinated by medical school to provide unnecessary procedures; and secondly, they have a vested interest in the current process. Making changes that might disrupt their financial status is not in their best interest. As such, seeking their opinion to resolve the health care dilemma is like asking the fox how to secure the chicken coop. And I am telling America at large; the fox is in the henhouse while the hounds on Capitol Hill are baying at the moon.

Furthermore, allopathic physicians are not the only game in town. The conflict has been around for years—this quarrel between allopathy and other, holistic, medical philosophies, often referred to as alternative or traditional health care. The battle is as old as modern allopathy itself.

For thousands of years physicians had held a holistic view of health and health care, wherein the body was considered a single unit—each organ or body system necessarily affecting other body systems and consequently the whole body. Then in the 1600s the early works in physics, chemistry and pathology paved the road to allopathy. With the advent of advanced pathological techniques came the ability to provide a more technical approach to medicine. It became possible to isolate body parts, to dissect and perform micro-examinations on organs and body systems, which lead to a better understanding of the function and the disease processes of each.

The more advanced these techniques became, the more artificial methods were devised to micro-manage and manipulate each organ and body system. With each new method allopathy grew further estranged from viewing the body as a whole unit and from the holistic philosophies of health. The tension between the two philosophies increased rapidly, as did the bitter competition for patients. But it was not until the early 1900s that allopathy was launched into its present popularity and legislatively mandated dominance.

Although the two systems seem to tolerate each other a little more cordially today than they did a century ago, little has changed. If anything, the philosophical divide has grown even wider. While holistic systems still see the body as a unit, allopathy has grown increasingly fragmented with most medical doctors actually specializing in the treatment of a specific organ or body system. That their therapies often, ignorantly neglect other organs and body systems is of little or no concern to an institution mesmerized by laboratory findings and the tabulation of endless and generally meaningless data.

Arthur L. Murphy, MD, has acknowledged in the Story of Medicine that allopathy does not agree with the holistic view of the body as a unit. Speaking of the holistic physician, Hippocrates—whom even allopathy considers the father of medicine—Murphy says,

To Hippocrates all diseases were general; they affected the

> body as a whole; therefore studying the varied tissues and structures of the organism was to little purpose. A faulty belief, this, as were many others he held. But a poor working basis is better than none.

Although Murphy rejects the holistic concept of health he concedes that Hippocrates "made theories and what if many were wrong, the accuracy of his practical conclusions are all the more remarkable." [35] What Murphy seemingly refused to entertain is that perhaps Hippocrates was right and allopathy is wrong, and that perhaps this is why Hippocrates had better outcomes than does allopathy.

A primary belief of Hippocrates, as with all holistic physicians, is that nutrition is paramount to health. But regardless of the current patronage by most allopathic physicians, allopathy is not comfortable with the holistic concept of health based on nutrition. Some modern allopathic physicians seemingly try to incorporate select alternative health care methods (such as nutrition and lifestyle) into their practice, but mostly their efforts are necessarily futile; their emphasis must be on pharmaceuticals. This is their reason for existence. Without the power to prescribe medications their livelihood is severely compromised.

Ultimately the two philosophies are not likely to ever unite, for they are diametrically opposed to each other; even, to some degree, mutually exclusive—one relying upon natural therapies and the other upon artificial. In the holistic philosophy the body, as a living being, is dependent upon other living organisms for its sustenance and health. Allopathy however, believes that synthetic substances can bring health and even cure metabolic disease. This difference is far more significant than many want to acknowledge.

Woodson Merrell, MD, professor of medicine at Columbia University College of Physicians and Surgeons and executive director of the Beth Israel Medical Center's for Health and Healing, has pointed out that, "for many in the medical field, nutrition continues to occupy a back seat in their awareness. Maybe a treatment based on nutrition can never hope to achieve the same fanfare as a drug that's often heavily promoted."[36]

Certainly, this is an accurate assessment. Understanding its philosophy will answer the question as to allopathy's continued neglect of nutrition and its adamant opposition to holistic philosophies in general. For its very survival, the allopathic community cannot accept holistic methods, cannot include nutrition among its treatment options. The implications are too threatening. If nutrition and holistic methods work then many allopathic methods are largely displaced. Its power and perceived value are compromised. Stripped of its prescription pad allopathy loses its significance; it loses its very purpose for existence. Consequently, allopathy has a decided opposition to anything that suggests a cure can be achieved without prescription drugs or heroic intervention.

Nevertheless there is some common ground, slight as it may be, between allopathy and holistic philosophies. Both agree on basic cytology: that cells are bathed in a nutritious extracellular environment and that potential invaders (bacterium, fungi, virus, carcinogens, etc.) are ever present, lurking, seeking opportunity to attack. But here the two philosophies part company—each having different answers to the fundamental questions of: How do these invaders strike? How do we defend against them? And how do we repel them once they have invaded? It may sound trivial but the schism is deep with diverse and far-reaching implications.

The fundamental theory of allopathy is one of intervention and heroics. The invaders must be killed, inhibited or excised. After a differential diagnosis an intervention is prescribed: a medication, radiation, surgery, etc. What evoked this cellular invasion is of little or no concern. The primary issue is to get rid of the invader.

Because of its fundamental philosophy, allopathy relies heavily upon synthetic drugs to inhibit or in some way alter the body's natural biochemistry. Accordingly, Benjamin Rush—the famed professor of medicine at the University of Pennsylvania from 1769 to 1813, taught that physicians must use "powerful and painful remedies in violent disease."[37] This philosophy has not changed.

Conversely, holistic philosophies—as practiced by

homeopathy, naturopathy, botanical, Chinese and ayurvedic medicine—believe these same invaders have taken advantage of the cell's weakened defense system. A defense weakened by an imbalance, or deficient supply, of necessary micro-nutrients within the cellular environment. Barring exceptional circumstances, this philosophy believes that cells necessarily have the ability to defend against these invaders. But they must be supplied the proper nutritional ammunition to accomplish the task.

In this view, the poisonous flu vaccine, as discussed earlier, is an enemy; it is not the ally allopathy envisions. But it is not the concept of immunization that is at issue, for indeed, the law of similar as practiced in homeopathy is based upon an immunization of sorts. It is the poisonous substances with which the pharmaceutical companies insist upon polluting the vaccines.

Political Maneuvers

During the 1800's the struggle between these philosophies and for the patient population, grew quite heated. The new field of licensed allopathic practitioners was growing and although botanical medicine and naturopathic practitioners were present, homeopathic physicians were also licensed and therefore posed a significant threat. They also had a greater patient population at that time than did allopathy. In 1846, two years after the American Institute of Homeopathy was founded, the American Medical Association was established, largely to compete with homeopathy. A series of events and shrewd political transactions transpired throughout the latter part of the 1800's and early part of the 1900's that, politically and culturally, virtually brought homeopathic and other holistic systems to their knees. Simultaneously these maneuvers—none of which were medical or scientific in nature—exalted allopathy to its present, albeit ill-gotten fame and glory.

To meet the urgent demand for medications during the Civil War, allopathic surgeons (who had previously prepared their own medicines), began using the pre-concocted products of the newly established pharmaceutical companies, whose subsequent post war prominence proved to be a demonstration in marketing genius.

These young companies grew rapidly with traveling sales representatives riding the circuit, informing and educating local physicians of the latest compounded miracles at their disposal. As Dr. Atkins points out, for many physicians the "drug salesman became the key method of staying up with medical research."[38]

Seemingly overnight allopathic practitioners and drug manufacturers developed an inseparable bond. With drug stores popping up all across the nation, doctors could simply send their patients to the local druggist with a prescription. If the druggist did not have a prepackaged product available he would simply concoct what the doctor had ordered. To this day the bond has not weakened. Drug reps and drug advertisements are still the physician's primary means of continuing education, with the drug industry at large virtually controlling the medical profession.

Just after the turn of the century, with the struggle between allopathy and holistic methods at its climax, the political fervor was kicked up a notch when the Carnegie Foundation, in association with the allopathic society of the AMA, commissioned Abraham Flexner to submit a critical evaluation of the country's medical schools. The results, released in 1910, kindled a number of significant changes in clinical medicine. Two were particularly important to the expansion of the allopathic agenda and the eventual demise of holistic teachings. Although the Flexner Report critiqued the entirety of medical education as rather poor, as might be expected, it strongly favored the allopathic of the AMA over the non-allopathic schools. As a result, the bulk of the funds from the coveted Rockefeller grants were given to the allopathic schools while the homeopathic schools went without.

Even beyond the money, which was crucial, the report had another potentially more significant result. Understanding this consequence is key to understanding the staunch, aggressive opposition that allopathy still holds toward other medical philosophies—including nutrition.

Before the report, medical schools were small, unregulated and often less than academic. The Flaxner Report had acknowledged this dearth of academia (even within the allopathic

schools) as a nationwide problem and thus recommended that medical training be moved to the universities and given "a proper theoretical foundation."[39] However, as Harding observed some twenty years later in a 1929 article, this move to the universities brought very little change or improvement to the non-academic climate of medicine.

> Medicine, as a profession, is not distinguished for the high mentality of its members. Anyone can easily point out exceptions to this statement, but—all due respect to them—the run of the medical school mill does not show many exceptionally brilliant individuals. Their average intelligence is lower than that in perhaps any profession . . . and physicians of standing have publicly acknowledged this in commenting upon intelligence testing as applied to doctors.[40]

Despite failing to significantly improve its academic standing, once it became nominally associated with the universities the allopathic philosophy became chiseled in stone. What transpired was a universal medical education that followed the interventional methodology of allopathy and dogmatically opposed the empirical methods of holistic philosophies. This anti-holistic, even militant mind-set was galvanized into each student; Kool-aid drinking, blind faith in the allopathic philosophy of heroic intervention was demanded. Any physician who broke rank did so at great peril. Those who dared even to consult with homeopaths were shunned by their peers, ostracized and often expelled from their medical societies.[41,42] Even as recent as the late 20th century those who actually prescribed alternative, non-allopathic therapies did so at the risk of losing their license to practice medicine.[43] This was a greater offense than misdiagnosis or even killing your patient with the wrong amount or even wrong allopathic medication.

To this day the battle is waged on many fronts. Medical colleges are still dogmatically opposed to holistic philosophies. Nutrition is still not a part of the average medical education. Allopathic physicians tell their patients to avoid natural remedies. Drug manufacturers do all they can to block the sale of natural

supplements. Legal battle lines have been drawn and even as I write the pharmaceutical industry is trying to get supplements (vitamins and herbs) regulated so the signature of one of their drug dispensers (AKA physicians) would be required to purchase them. In this way Big Pharma would bring supplements into their tent, control them and subsequently make a lot of money.

One of the most persistent and effective battlegrounds is in the media. Allopathic naysayers frequently write manipulative attack articles—often called white papers within the industry—which are designed to spurn alternative therapies. Generally the article is written by a member of the medical specialty that is economically threatened by the natural remedy.[44] Published in prestigious medical journals, these editorial analyses are written with the express purpose of dissuading readers from further investigating certain alternative therapies. Their readers (largely physicians who have already been brainwashed by the allopathic system) accept these articles as if they were Holy Scripture. For allopathy, medical journals are the final authority. They stand above intuition, above personal experience, above proven clinical outcome, even above reason.

Some of these white papers are so extreme in the pursuit of their agenda that they actually defy logic. For example, an article published in a major surgical journal questioned the necessity of good micronutrients for the critically ill. Although the author admitted "critically ill patients are hypermetabolic and have increased nutrient requirements," he also argued that it is only "assumed that nutritional support is beneficial for these patients. . . . There are no well designed clinical trials to test this hypothesis." He continued, although "the administration of specific micronutrients and specialized supplements has attracted attention . . ." the studies are "limited because of poor study design."[45]

Despite being incorrect about the nature and number of well-designed clinical trials proving the importance of micronutrients for the critically ill, still the article was published. One must wonder what the research scientists at the Mayo Clinic[46] and the

Shriners Burns Hospital[47] thought of this attack article and its blatant disregard for their works, which methodically prove the necessity of such nutrients. Even spokesmen from the prestigious Harvard School of Public Health have timidly admitted that such nutrients play a significant role in a patient's recovery.[48]

Considering the vast scientific documentation and the intuitive logic that people must eat to maintain health or recover from illness, it is amazing that anyone, especially a physician, would argue against the importance of nutrition for the critically ill. It is amazing that is, if one does not understand the allopathic mindset and its philosophical aversion to any method of healing other than intervention with synthetic substances.

The Religion of Allopathy

Although few members of this fraternity ever admit it, allopathic medicine is a belief system indoctrinated with and directed by the circular logic of tradition. Some within the industry have even referred to it as the medical priesthood. [49] Robert Atkins, MD, has made the charge that,[50]

> Orthodox medicine has entrenched itself within a formalized structure that is surprisingly codified. Centered around the teaching hospital, this structure includes ritual, pomp and ceremony, a hierarchy, a belief system, and a profound faith in those beliefs. It is very like a religion.
>
> . . . . . .
>
> But as a religion it promotes a blind emotional attachment to its tenets and, consequently, a blind antipathy to what it perceives as heresy. As in a strong church, anything that is not orthodox is heretical.
>
> Not unlike most religions, medical orthodoxy believes in proselytizing the uncommitted. In this endeavor it has succeeded, and most of the general public has been converted to its beliefs.

For this reason, a significant number of physicians have jumped ship. Having realized the futility of the allopathic philosophy and

the ineffectiveness of synthetic drugs for attaining or sustaining health, they have converted to the forbidden holistic philosophy. Robert S. Mendelsohn, MD, was one such defector.

What makes Dr. Mendelsohn's defection so painful to allopathy is that he was not just one of their own but, as mentioned earlier, a leader in the field. A medical authority with significant influence had who served as the national medical director of Project Head Start, the chairman of the Medical Licensure Committee of the state of Illinois, associate professor at the University of Illinois Medical School, and the director of Chicago's Michael Reese Hospital. In the world of allopathy, he was royalty. Yet, after decades of clinical practice and leadership in the medical community he concluded that modern medicine is "neither an art or a science. It's a religion."[51] A religion, in which he confessed he no longer had faith.

Allopathic medicine is not and never has been an exact science. It is a never-ending experiment and we, the public, are its research subjects. Decades ago Harding expressed his amusement at the AMA for posing as a scientific avenger and working itself into a perfectly self-righteous wrath to debunk what it called "quack healing." What he found so amusing was that approximately half of the drug therapy in his day, employed by the ordinary physician and advertised in their most respected journals, as he put it was "of the quack quackery in so far as it involves the dosage of human beings." After very imperfect diagnoses the doctor routinely prescribes "simple or compound medications or agencies of unknown physiological effects (or perhaps lacking any at all) upon human organisms." He found it comical that physicians want to be considered as scientists yet they experiment in a manner that the trained laboratory worker and research investigator would consider empiric in the extreme. Although research investigators and scientists would not think of experimenting upon even so simple an organism as a rat unless they had it under rigid control, the physician experiments "upon complex human beings with their intricate idiosyncrasies and environmental differences while he has his experiential animals

under vary imperfect control indeed."[52]

New and Useless Technologies

Although Harding wrote this in 1929, ample evidence shows this practice has not changed. At least 22,500 heart attack victims in the United States receive the wrong dose of clot-busting drugs every year, which results in some 1,500 deaths.[53] The Journal of Health Care Management reported that incorrect physician orders account for 56% of all medication errors.[54] Darrell Abernethy, MD, PhD, clinical director of the National Institute on Aging,[55] has stated that "adverse events related to drug therapy continue to be common" among nursing home residents. Often physicians merely guess at what dose to give their patients. This is especially common among the elderly demographic in that few studies exist to ascertain optimal dosages for them.

As for using human for their experiments, many clinicians have a certain fascination with new technologies, which draws them even deeper into the lair of this twisted, tangled system. So that in a circular fashion, to a large degree, the advent of advanced medical technologies, coupled with the dearth of regulations and clinical guidelines for their use, has spawned a population of often inadequately trained practitioners who routinely overutilize and misallocate technologies to which they are enamored and by which a quick profit can be made. In the end this overutilization and misallocation of resources makes no significant contribution to overall clinical outcome. The primary accomplishment is merely to generate revenue at the expense of both the patient's health and pocketbook.

For example, although many cardiologists argue for Medicare to widen their coverage for carotid stenting (an increasingly popular invasive intervention intended to prevent stroke), Anne Abbot and others have warned these procedures are overutilized, have enormous risks factors and provide poor outcome. Despite putting the patient at a much greater risk for stroke, ninety to ninety-five percent of these procedures are performed on patients who have no symptoms. On the up side, from $1 to $2 billion is made in the process.

> The current situation regarding CEA and CAS [Carotid Artery Angioplasty/Stenting and Carotid Endarterectomy] for patients with asymptomatic stenosis in the United States is unjustified and outdated. Up to about 90% to 95% of these procedures are being performed for asymptomatic carotid stenosis, exposing patients to unnecessary risk and causing unjustified expenditure of at least 1 to 2 billion US health care dollars each year at a time when the health care costs need to be justified. . . . Extending the approved indications for CAS will open the floodgates for widespread CAS and expose patients to unnecessary risk and greatly increase unjustified health expenditure. Broadening the indications for CAS reimbursement for SYMPTOMATIC carotid stenosis is also inappropriate. . . . Unfortunately, the actual CREST data, most other randomized trial data, meta-analyses, and registry data do not justify this presumed equivalence of CAS and CEA for symptomatic carotid stenosis. In symptomatic patients, CAS, overall, is associated with about double the 30-day, 120-day, 6-month, and/or 4-year risk of stroke or death compared to CEA…. Carotid angioplasty/stenting is also associated with a much higher periprocedural risk of brain-imaging-detected ischemic lesions than CEA and a higher incidence of carotid restenosis. No studies have shown CAS is better than CEA in preventing stroke in patients with symptomatic carotid stenosis and procedural costs are significantly higher with CAS.[56]

Nevertheless, despite these realities (as to the ineffective, potentially harmful outcome and unnecessary cost) the employment of Carotid Artery Angioplasty/Stenting to prevent stroke is on the rise. Buyer beware. Of course, if you are a potential consumer your cardiologist will deliver a convincing sales pitch so that having the procedure will seem the only logical thing to do.

Temporal artery biopsy, used to diagnose giant cell arteritis is another overutilized and outdated procedure. A recent study by

Brent and Chung, concluded that of those "patients who underwent biopsy, 78% could have been excluded from the procedure based upon individual diagnostic criteria."[57]

Intensive glucose control in critically ill ICU patients was another bandwagon that cost many lives. After a series of lectures by the author/sales representative, Greet van den Berghe, many ICUs "rushed to create protocols, buy pumps, train nurses, and print posters to meet this new metric." [58] Intensive glucose control in critically ill, non-surgical patients was the "in thing to do" in the early 2000s.[59] It became a widespread practice until a few years later when the awful reality was revealed: patients on intensive glucose control therapy were more likely to die. In hindsight, investigators concluded the following:

> Patients with severe hypoglycemia (glucose < 40 mg/dL) were twice as likely to die compared to patients without hypoglycemia (adjusted hazard ratio 2.1). Those in the intensive control group were ten times as likely to have severe hypoglycemia (n~200 vs~20). Those with moderate hypoglycemia (glucose 40-70) had a hazard ratio for death of 1.4, and 82% of these patients were in the intensive-control group.
>
> Those patients with moderate hypoglycemia had a 5% absolute greater risk of death (28% vs 23%) than those with no hypoglycemia. There was a dose-response relationship between hypoglycemia and mortality — those with more than one day of low blood sugars were more likely to die than those with one day of hypoglycemia.
>
> Hypoglycemia was also associated with longer ICU stays, and can be confounded by severity of illness. . . .[60]

Many other medical and surgical procedures fall into this category of being employed merely because the physician or surgeon has a facination for new technology and/or they provide a nice reimbursement. The all but defunt Swanz/Ganz Catheter is another such technology. Despite its dangers, physicians have used it extensively in ICUs for the last few decades to measure a

patient's pulmonary artery pressure. A catheter (with a balloon on the end) is inserted down a large vein into and through the patients heart so that it comes to rest in the pulmonary artery. Periodically, the balloon is inflated to be wedged in a small pulmonary vessel. A reading is then collected which indicates pressure in the left atrium. Treatments are determined from this data, which may or may not be correct, depending upon the technique used to collect it and the person interpreting it. Furthermore, the treatments set in motion due to this information may or may not be correct; often the treatment is too aggressive and even harmful. After decades of collecting this potentially inaccurate and basically useless information, which has not been shown to improve outcome, finally the industry is beginning to doubt its benefit.[61]

Indeed, the history of allopathic health care is littered with one new technology after another that was all the rage until the industry finally admitted it did not work. This is not something that happened years ago, it continues to this day. If there is money to be made, the technology, the medicine, will be utilized until its ineffectiveness is so blantant the industry must reject it.

Allopathy's experimentation on human organisms has certainly not changed since Harding's time. As you recall, just a few pages back we learned of the double dose flu vaccination experiment the CDC sanctioned to be performed on pregnant women during 2009 and 2010, which resulted in a 4,250 percent increase in the number of miscarriages and stillbirths. It is not without cause that I have developed a healthy skepticism toward anything the physician recommends for my wellbeing. I will listen, but I will also research the issue for myself.

Duping the Masses

Even if we accept the premise that allopathic medical research is based on sound science (a premise I am not willing to concede), the implementation of these findings in clinical allopathic medicine is by no means scientific. Although many scientific underpinnings exist and some science even makes its way into medical practice, clinical medicine in general is a more a practice of tradition and

belief than it is science. Upon realizing this truth, many of its once committed practitioners abandon it. Indeed, it is quite telling that although many allopathic physicians have converted to the holistic philosophy, to my knowledge, there are no holistic practitioners who have wholeheartedly converted to the allopathic philosophy.

At its best medicine is a wonderful institution. Every year an untold number of lives are significantly changed by brilliant techniques of orthopedic surgery, sight restoration, cleft palate repair and the like. And I marvel at the heroic procedures that cheat death: emergent vascular repair or the repair of gross wounds caused by violent trauma, and the ability to dissolve blood clots or breathe for those temporarily unable to do so for themselves. It is truly awesome. I stand in reverence to the men and women who devote their lives to learning and perfecting these important skills.

On the other hand, while select procedures can work wonders in certain situations, allopathy knows very little about and does even less for achieving or maintaining health. Nothing in pharmacopeia can reverse metabolic disease processes and promote health. At best these medications temporarily disrupt or merely mask disease symptoms. Yet, ironically, providing these drugs is the mainstay of allopathy's financial success.

But health and the promotion of health are simply not the forte of allopathic medicine. Heroic procedures? Yes. Health? No. By recalling his own education, Stuart Berger, MD, sheds light on the typical procedure-oriented medical education that knows nothing of health. It might give us pause to consider that he trained in some of the most prestigious institutions in the country: Tufts Medical School, New York's University Hospital, Bellevue Hospital and Harvard School of Public Health.

> The system believed it was important that we know how to drive a sharp, hollow needle (trocar) into a person's living chest without anesthetic in ten seconds in an emergency room, but never taught us how to help our patients live so that they would never be brought into that emergency room. We learned how to use scalpels, deadly drugs, and radiation

> beams to destroy cancer, but not how the right foods and life-styles could help prevent cancer in the first place."[62]

I caution the reader to beware. Our society, which is easily persuaded by charisma and grandiose promise, has been exploited, coerced by a series of shrewd legislative maneuvers designed to convert us to the religion of allopathy. To minimize defectors we are duped, conned, browbeaten and even legislatively forced into submission to their religion. Millions are literally doped by the allopathic drugs, which are virtually forced down their throats. But this coerced conversion of the masses does not make allopathy a superior or even effective medical philosophy. It does, however, speak to its very effective marketing strategies and its very powerful lobbying voice in Washington—the voice of the movers and shakers of allopathic medicine, the voice of Big Pharma.

Chapter Four
What No One Wants To Hear

No longer considered a luxury, the routine utilization of copious medications and advanced medical technologies has become common practice; an expectation for clinicians and patients alike. The public has come to believe there is almost nothing medicine cannot fix with its magical gadgets, sophisticated procedures and all-powerful drugs. Of course, the medical industry does not openly make such a promise, but neither does it deny it, at least not with conviction. And for good reason; this mindset is actually part of its philosophy. Dr. Rene Dubos, professor emeritus at Cornell Medical College, referred to this as the doctrine of specific etiology: the belief that for every disease there must be a specific cure.

Although not overtly articulated as such, nevertheless, this expectation is a primary feature of western allopathic medicine's appeal. Since the founding of the American Medical Association in 1846, a concentrated effort has been made to promote public faith in this concept. That the doctrine is yet to be demonstrated is of little concern. This small detail is overshadowed by the extremely successful promotional campaign; which, perhaps, has been too successful in that it has created expectations that simply cannot me met.

Without qualification, the primary issues that have driven the nation's health care costs so high are directly linked to this doctrine of specific etiology. For it has opened the floodgates of

overutilization and misallocation. Every day, all across the country, physicians, like thespians, don their white coats to pen one futile medical order after another, pretending their medicines and procedures are necessary for health. But, as one physician learned from the guest speaker at his graduation: "Most of your patients will get better on their own, but for goodness sakes, do something so you will get the credit."

The blatant misallocation of clinical resources is beyond common place, it is expected. This then creates a huge gray area, which leaves the doors wide open to habitual fraudulent overutilization that goes absolutely unchecked. Neither the government nor the insurance industry questions those medical orders within the gray zone; yet these unnecessary medications and procedures account for the overwhelming majority of America's health care costs.

Billable items loom before physicians like ripe fruit in an orchard where the caretaker is never seen; and what makes their plucking so appealing is that everyone expects physicians to pick a bushel or two—to order a plethora of tests, treatments and medications. The necessity or effectiveness of these procedures is seldom considered relevant; it is the doing that is important. Herein, is the problem that must be addressed if our nation is to survive our sickened health care system.

Who to Blame

While we are quick to blame the insurance companies, the trial lawyers and even the illegal immigrants for our rising health care costs, we have overlooked the real culprit, the superfluous activity of the health care system itself. This system is not the benevolent enterprise we have been lead to believe. Indeed health care is a misnomer, for the system has less to do with health than it does with disease management and profit.

Undeniably, there are marvelous procedures and treatments that correct defects and arrest certain diseases; but they benefit a relatively small sector of the population. The overwhelming majority of health care services (from pharmaceuticals and advanced technological procedures to hospitalizations and routine

doctor's office visits) are unnecessary events. Often, these events have no effect on clinical outcome; they are employed merely to create an accounts receivable invoice for the provider or to placate the patient or the patient's family. Often, patients could provide these services for themselves if given the opportunity, but legislation will not allow it.

Tell me what business a physician has admitting a dying 90 year-old (who is suffering multiple system failures and has a signed "Do Not Resuscitate" request) to the Intensive Care Unit on a mechanical ventilator when she develops sudden respiratory failure. When asked, "What do you want us to do?" of course the children say, "Do everything you can!" But the fact is, she is dying and nothing can stop it. The physician cannot stop it; but he/she can placate. The family should never have been put in this position to answer such an emotionally charged question when the physician knows full well that nothing beneficial can be done. The physician might think he/she is being thoughtful, but this loaded question does nothing but prolong and increase the family's pain. It is unethical. Although the truth is far better, placation is easier; but this placation comes with a price.

A large tube will be stuck down her throat and her breathing mechanically controlled. To remove the constantly accumulating secretions, another tube will frequently be inserted further into her lungs after several cc's of normal saline have been injected into the breathing tube to loosen her mucus. It will make her gag and cough uncomfortably. She will spend much of the time sedated and likely be tied to the bed so she doesn't pull the tube out of her throat. Another tube will be inserted into her stomach to keep it empty of all gastric contents, and another into her bladder to collect her urine. Of course she will not be able to eat or drink anything. Various medications and nutrients will be pumped into her stomach and veins. Multiple monitoring wires will be attached uncomfortably to various places on her body. Because communication is likely not possible due to the tube in her throat, the sedation and the restraints, she will defecate on herself and the bed sheets; but she will be rolled and cleaned with frequency. Her

veins and arteries will suffer numerous needle punctures from various blood draws day after day, sometimes several times a day. Discolorations—contusions from the needle sticks—will appear and multiply. A probe will be inserted into her anus every four hour to get a core temperature. She will not be able to talk with her family, only look at them with her sad eyes, wondering why they are doing this to her.

After a week or so she will be taken to surgery for a tracheotomy tube. In time, due to various complications, her blood pressure will begin to drop. Vasopressor medications will bring the blood pressure back toward normal, but the side effects of their long-term use are unavoidable. Her circulation in the extremities will begin to shut down. At length the medications will exhaust their effectiveness, her blood pressure will drop below a life sustaining pressure and CPR (which she had said she did not want, but was overruled once the family said, "do everything") will be initiated. It is very likely a few ribs will be broken and all but certain the CPR will not work. It virtually cannot work in this situation.

She will die having spent her last days in complete misery and having paid the price she did not want to burden. If, perhaps, the experience does not progress to CPR and she actually survives the ICU, she is still the same terminally ill person she was before the torture; still she dies a few days or weeks or months later. But everyone else is satisfied: the family, the doctor, the care givers, everyone knows they "did all they could".

This harsh reality of modern medicine could all be avoided if the doctor would simply be honest with the family. "She is 90 years-old. She is terminally ill. There is nothing we can do for her but to make her as comfortable as possible. You should treasure your last days with her."

When I started my career in health care we used the term "No Heroics", which precluded all this unnecessary for-show activity. Unfortunately that term has been replaced with "Do Not Resuscitate" (DNR), which has an entirely different connotation. Now the door is left open to many futile heroic procedures.

Unfortunately, our advanced technologies and their miraculous persona (as touted by the medical industry and understood as gospel by the general public) create ethical issues concerning their appropriate utilization, which most physicians are not willing or prepared to address. So placation is the easiest route. Of course, there is always the additional reimbursement that occurs when she is admitted to the ICU, and another when she is placed on the ventilator, and yet another when she receives her tracheotomy.

End-of-life Health Care Costs

Because of scenarios like the one just mentioned, the end-of-life health care costs are enormous; so that over 50% of Medicare's budget is spent on those who will die within two months.[63] The crime is that this enormous expenditure is completely unwarranted, for it pays for pointless procedures. Other than the occasional intervention with a certain medication or advanced technology to temporarily compensate for or correct a life threatening condition, there is nothing medicine can do to stop people from dying. We are born, we get old (if we are the lucky ones), and then we die.

Is it not (as Albert Einstein once observed) insanity to keep doing the same thing over and over only to achieve the same failed results? Yet when it comes to the aged and dying, we keep doing it, achieving nothing but the ostensible placation of the loved ones. Assuring them that we are doing everything we can; when the truth is nothing of benefit can be done. Neither the ventilator nor any amount or kind of medication will cure terminal cancer, heart disease, kidney failure, etc. And CPR will certainly not cure them. What we are doing when we say we are doing all we can for these terminally ill patients is merely putting on a sideshow, a performance to placate the family and society at large. But this placation comes at a very high cost; a cost that will eventually bring about the financial death of the nation.

Such end-of life placation has been taken to a whole new level in many medical communities. A recent study of the medical costs for the last six months of life in Southern California highlights this

madness. Dying patients in Los Angels had an average of 64 visits from 10 different physicians, while those in San Diego had 35 visits from 9 different physicians; each physician, of course, referring the dying patient to another specialist.[64] This is not quality care. It even goes beyond placation. This is cold heartless fraud, milking the system for it can before the patient dies.

Perceived Need

Beyond the futile end-of-life procedures, the overwhelming majority of billable medical procedures performed from coast to coast are not dissimilar to the infamous unnecessary mechanical repairs suffered at the hands of an unscrupulous auto mechanic. Much of medicine is nothing more than white-collar crime, an elaborate sideshow designed to relieve you of your money, or in some cases (as just discussed) to placate, which you will pay for as well. The continued financial success of the current health care industry is directly related to its continued clinical failure and persistent overutilization and misallocation of billable resources. Everyday in America an endless stream of unquestioned, unwarranted, unregulated medical procedures and hospital admissions occur in every little burg of the country.

We have been conditioned to trust that whatever the doctor prescribes is for our best interest, and this is where the scam begins; for if physicians only prescribed those tests, treatments, medications and hospitalization that were truly necessary for their patients' health, their fat cow would soon be little more than a skeleton. The bottom line is that the array of health care services, to which we have grown accustomed, are less a necessity for our health than for our perceived need, which has been created by the savvy marketing campaign of this venerable enterprise that ostensibly has our welfare in mind.

The health care system is primarily a for-profit industry cleverly disguised as a necessary public service. Because it is a for-profit enterprise with a legislated monopoly on the market, it operates to excess and without censor. Like any good scam, just enough truth and good outcome is provided to make the entire system appear legitimate. But behind the white coats and closed

doors, at both the administrative and the clinical level, is a world of deceit, overutilization, fraud and generally poor clinical success. While the overutilization is not overtly illegal (most of it anyway), it is definitely overtly unethical. Although most of the physicians have not blatantly conspired to perpetrate this scam, they are aware of their involvement nonetheless. Because it is their livelihood, many have convinced themselves they are providing a valuable service by overlooking the unwarranted excess and focusing on and accentuating what little benefit they might actually achieve. No doubt this helps them sleep at night.

Indeed, overtly illegal activity is hardly necessary in that the current reimbursement process actually encourages numerous legal, albeit unwarranted, scams within the industry. Access to countless billable items (medications, procedures, diagnostic tests and hospitalizations) is unrestrained; and because these fiscal fruits can be summoned with but the whimsical stroke of the wizard's pen, these golden apples are plucked as prime pickins.

The Vast and Complex World of Medicine

The world of modern western medicine is complex. Here, I am not referring to clinical medicine so much—which is actually quite mechanical and algorithmic in nature—but to the world of the business of medicine. The medical industry is much larger than most might imagine; and the business end (i.e. non-clinical side) of this industry plays many important roles at several different levels.

In the world of medicine, clinical medicine has a primary role to be sure. Certainly it is the most visible. But it is merely a fraction of the many industries that comprise the vast, complex health care system. The relationship between clinical medicine and the business of medicine is a strange one. Clinical medicine has all the prestige and takes all the credit, while the business of medicine has most of the power and takes most of the blame. As such, clinical medicine is necessarily influenced, often even controlled, by the business of medicine. To fully appreciate any aspect of the modern health care system, a basic knowledge of the business of medicine is required.

Behind the curtains of every front-line health care institution, in every large and small town in America, are many players other than the clinical staff: engineers and maintenance crews, medical records personnel, housekeepers, coding and billing agents, CPAs, food services workers, security personnel, administrators and a host of middle managers, a human resources staff and others. Even a small hospital of less than 200 beds can easily employ well over 1,000 people. Beyond this, entire industries exist solely to support the center stage performance of front-line clinical health care. Or, perhaps more accurately to some degree, much of the center stage performance of clinical health care takes place merely to support the peripheral industries. It is defiantly a symbiotic relationship.

The number of peripheral health care industries is enormous. So too are their profits, many far exceeding the profits of clinical medicine, with some wielding considerable political clout on Capitol Hill. Beyond the profits and political clout they employ multitudes. There are medical equipment and drug manufacturers—each having clinical technicians, marketing departments, salesmen, research and development branches, security, housekeeping and maintenance personnel, administrators, secretaries and middle managers, lawyers and boards of directors. There are middle marketing companies that sell medical equipment and others that simply rent it. They too have technicians, salesmen, clerical and administrative personnel, lawyers and boards of directors.

There are consulting firms for clinical, administrative and regulatory roles—each with their professional consultants, marketing staffs, clerical and administrative personnel, lawyers and boards of directors. Then there are institutions of higher learning. They have professors, researchers, marketing departments, clerical and administrative personnel, lawyers and boards of directors, maintenance, housekeeping, security and food service personnel. And we must include the insurance agencies. They too have their share of clinical consultants, marketing departments, salesmen, clerical and administrative personnel, investigators, lawyers and

boards of directors.

But that is not all. There are many organizations specifically designed to address particular medical conditions: the American Heart Association, the American Lung Association, the National Cancer Society, the Red Cross, the National Heart, Lung and Blood Institute, ad infinitum. All of them have clinical personnel, clerical and administrative personnel, lawyers and a board of directors.

Then there are the national, state and private professional associations that service the various members within each of these many health related professions. There are organizations for educators, administrators, insurance agents, nurses, dieticians, medical device engineers, financial personnel, physicians and physician assistants, managers, laboratory personnel, therapists of various kinds, record keepers, radiation personnel, regulatory officers, again ad infinitum. Each of these organizations has a technical staff, marketing staff, clerical and administrative personnel, lawyers, and a board of directors.

But this too is not the end. There are publishing companies with clinical and technical consultants, marketing departments, salesmen, editors, clerical and administrative personnel, lawyers, and yes, boards of directors. And there are private regulatory bodies such as JCAHO, CAP, CARF, CHAP and others that oversee, accredit, license or otherwise ostensibly legitimize numerous institutions. Each has technical consultants, marketing departments, field investigators, clerical and administrative personnel, lawyers and a board of directors.

There are federal governing agencies as well, such as the FDA, HCFA (now CMS), OIG and OSHA. Each of these agencies has a tremendous number of employees: technical consultants, field investigators, clerical and administrative personnel, middle managers, maintenance and security staffs, and lawyers. Then each state has its own similar regulatory bodies employing another tremendous number of personnel. And there are organizations of national authority such as the NIH, HHS and the CDC. Each of these employs a significant number of technical consultants,

researchers, field investigators, clerical and administrative personnel, middle managers, maintenance and security staffs, and a board of directors.

It is ironic that we have all the oversight and quality performance agencies but none of them preside over the physician's practice. The one entity that drives the entire system, the focal point through which all patients must flow, is virtually unregulated. Oh, the wisdom of it all, but I have diverted, for there are still more industries that rely on the medical system. There are contract companies that provide continuing education to the many specific professions: from technicians to physicians and administrators, and from performance improvement personnel to insurance agents and the many disciplines in between. Each of these companies has educators, a marketing staff, clerical and administrative personnel, lawyers and a board of directors. There are companies that supply animals for research. Others that provide billing services and others still that transcribe medical records. And there are companies that recycle medical devices and others that dispose of medical waste. These also constitute a sizable work force.

Finally, although we have certainly not exhausted the list, there are the labor unions to deal with; they represent a considerable portion of all these workers, especially those who work within the government. Medicine is big business and although very little of it is clinical in nature the clinical aspect is the fulcrum with major health and economic consequences for every medical consumer. Business medicine sets the tone. It determines (in a broad scale) current and future practice and often decides what procedures are utilized in a micro scale. But clinical medicine is the point of contact through which business medicine and the peripheral industries access the patient. Therefore, not only is clinical medicine center stage for the patient, it is the focus of the entire peripheral health care industry. Because clinical medicine is the focal point for all concerned, it is paramount to all aspects of the industry that it has the public's trust.

Chapter Five
White Collar Corruption

With so many industries and people, in both the clinical and the peripheral businesses (as discussed in the previous chapter), relying on clinical medicine to sustain their livelihood, it should come as no surprise that much of clinical medicine is nothing more than white collar crime. It is rife with corruption; a prime target of fraud and overutilization. The continued financial success of the entire health care industry is directly related to overutilization and misallocation.

Although several examples of overutilization and misallocation have been presented, here is yet another: the common practice of right heart catheterization. Untold millions have undergone this largely useless procedure, which is routinely employed to monitor patients during high-risk non-cardiac operations. James E. Dalan, MD, of The University of Arizona Health Science Center, concedes that although this procedure has been used extensively for over thirty years, "little evidence exists" to demonstrate its benefit. In the same issue of JAMA, Carasi A. Polanczyk, MD, and his associates, found that patients who undergo this catheterization are three times more likely to have a major postoperative cardiac event. The authors point out that such increased monitoring has led to "overly aggressive corrective treatments that may harm patients."[65]

Another example can be observed at any medical center in America. Although cancer treatment via chemotherapy carries

substantial side-effects with very poor outcomes, these drugs generally account for more than half of a medical center's pharmacology budget. At the same time, although successful alternative therapies for many cancers would cost the medical center little more than one full time employee and a small budget for education materials, they are neglected, even shunned by medical specialty groups.

The reason is hardly a medical issue. It is a matter of money and philosophy. Both the allopathic medical philosophy and the medical reimbursement system demand pharmaceutical intervention. Behind it all is the powerful pharmaceutical lobbyists who seek to insure that allopathic medicine (its drug dispensing body) remains the primary health care provider by legislation. In this way they insure their merchandise is sold.

Anticoagulant medications are another good example. The pharmaceutical industry makes no money when people opt for inexpensive natural anticoagulants such as fish oil, green tea, garlic, vitamin E, willow bark, ginger, red clover, ginkgo biloba, chamomile and cayenne pepper. Therefore, your physician is not likely to recommend these treatments, nor will he/she know much about them, other than to tell you not to use them once you start using one of the patent powerful poisons. On the other hand, the pharmaceutical industry cleans house with its manufactured, poisonous anticoagulants. One of the new oral anticoagulants can cost the patient up to $300 per month.[66]

The sad truth is that allopathic medicine is the mainstay because of political legislation not clinical outcome. Therefore, Medicare and other payers reimburse for elaborate ill-effective chemotherapy, but they will not reimburse for non pharmaceutical alternatives, regardless of their effectiveness. Thus, to stay in business, to make a profit, the physicians and the medical centers are forced to follow the money, regardless of pitifully poor clinical outcomes.

Virtually Worthless Exams

Many medical tests and the testing facilities that provide these tests are virtually worthless. That is, they are worthless in the

context of being inappropriately and unnecessarily utilized—providing redundant data of no added value to the patient's known condition or course of treatment. Two examples of such scams are the Sleep Lab and the ill-equipped Cardiac Catheterization Lab; both of which largely exist to meet the needs of service providers, not the patients.

The Sleep Lab, used to determine sleep apnea, could be a poster child for unnecessary utilization. Obstructive sleep apnea is very real, many people suffer from it and the sleep study is definitely capable of identifying sleep apnea. The caveat is that nearly anyone can watch a suspected sleep apnea sufferer sleep and detect obstructive sleep apnea, add a $50 pulse oximeter and the diagnoses is exact. Indeed, the patient's spouse, or someone else, has likely already observed and diagnosed the obstructive sleep apnea, which is why the patient sought treatment. However, why would we rely on this primary knowledge when we can be reimbursed for two useless sleep studies, each costing thousands of dollars apiece: one to confirm sleep apnea, and the other to observe the predictable effectiveness of the Continuous Positive Airway Pressure (CPAP) machine, with which sleep apnea is treated very effectively by its auto titration feature that dynamically adjusts to the patient's immediate need?

Decades ago, as scientists sought to understand obstructive sleep apnea versus central sleep apnea these studies had value. But today there is no clinical reason for them to continue. The sole function of these lavishly designed Sleep Labs, which record EEG and pulse oximitry readings is to provide a revenue stream for the provider and for the physician interpreting the superfluous pages of redundant data documenting what is already known. The results do not alter the course of treatment in the least.

It is nothing less than an elaborate side show, a scam perpetrated on the American public. If legislation would allow it, those suffering from obstructive sleep apnea could simple walk into a medical equipment retail store and fit themselves for a CPAP machine like they would a pair of shoes; but the lobbyists work hard on behalf of The American Academy of Sleep

Medicine to make sure this is not an option.

Even worse than the Sleep Labs are the multitude of minimally equipped Cardiac Catheterization Labs scattered throughout the county. I say minimally equipped because many of them are not prepared with either the necessary equipment nor personnel to provide subsequent intervention should the test find it necessary. In these facilities the procedure is merely exploratory; but still very dangerous. If a condition is found that needs treatment the patient must be sent, often by ambulance, to another facility where the procedure is repeated. Needless to say, few of the staff or their family members, at these facilities would consider having this procedure at their own little lab. They would go straight to the facility that could treat them.

There is no clinical reason for these satellite labs to exist. Indeed, it could be argued that in an emergent situation the use of such a facility merely delays the patient's needed treatment, thereby increasing the likelihood of a poor outcome. The only reason these satellite Cardiac Catheterization Labs exist is to make money for the facility and especially for the cardiologist performing the procedure. Very effective lobbying efforts on Capitol Hill have worked hard to maintain and even expand this scam.

Then there is the ritualistic, mostly useless and always expensive, heroic CPR procedure that nearly every dying person must endure. This is not so much a scam designed to make money, but to perpetuate the concept that medicine can fix anything. While this procedure can work quite well on certain patients, it does not work for everyone, not even most everyones. The fact is, it seldom works on anyone. But this information is not broadcast. It is important for the medical community to garner public's trust, to maintain its image. It is important that the public continues to believe their doctors can fix anything.

On those rare occasions when CPR does work, it is generally a relatively healthy patient who happened to suffer a sudden injury or medical mishap. It definitely does not work well on those with advanced degenerative diseases in multiple body systems,

especially if they are elderly. In the end, the extraneous and misallocated use of this procedure is a gruesome and unethical process that does little more than offer cruel and false hope to patients and their loved ones.

Modern technologies can be amazing; but just because the technology exists does not mean it is appropriate for everyone. We must come to grips with the fact that these technologies need not be employed in futilely, simply because we have them. As amazing as they are, they cannot stop the dying from dying. We are born, if we are fortunate we grow old; then we die. No technology in the world will ever change this.

Tell The Truth, The Whole Truth

Unfortunately, what physicians tell patients is not always, or even usually, the whole truth of the matter. "The rest of the story" as Paul Harvey would say. A research team from The University of Wisconsin Medical School captured this practice of partial truth and misinformation in action. After analyzing the survey results of chemotherapy patients and their physicians, they realized that although patients appreciated the risks involved in chemotherapy, they did not have a clear understanding of its benefits or of possible alternatives to the chemotherapy.

Some 65% of the patients believed the chemotherapy was a cure, while their physicians consider it merely palliative. Even of the 35% in which both patient and physician agreed on the goal of the therapy, the patients had a higher expectation of success than did their physicians (82% vs. 59%). Unfortunately, such an unrealistic expectation of advanced medical technology is common; and even more unfortunate, this misinformation is encouraged.[67]

Considering the extremely poor risks to benefit ratio of chemotherapy coupled with the physician's financial interests, this lack of information borders on criminal activity. Certainly it is ethically reprehensible. That a physician would treat a cancer patient with largely ineffective yet extremely toxic, even deadly substances, without giving the patient all the information needed to make an informed consent is unconscionable. It is especially

condemning when you consider that highly effective, inexpensive and non-toxic alternative options exist in the form of detoxification, nutrition and nutritional supplements.[68,69,70,71,72,73] Granted the allopathic physician is not an advocate of those alternative therapies that threaten his or her livelihood, but it is the patient's life at stake and the patient has a right to have all the information available to make an informed decision as to his or her care.

Still another alarming example of both misallocation and patient danger is the overutilization of routine x-rays; although the AMA has yet to admit it. The report comes from some of the top physicists in the world who have repeatedly warned of the dangers involving common diagnostic radiation. Non other than the renowned John Gofman, PhD, MD (Professor Emeritus of Molecular and Cell Biology at the University of California at Berkeley and founder of the Biomedical Research Division for Livermore National Laboratory as well as a participant in the Manhattan Project and a holder of various patents in nuclear physics) has stated that "Medical radiation is a highly important cause (probably the principle cause) of cancer mortality in the United States during the Twentieth Century." Yet, even in light of such concerns, few physicians refrain from ordering unnecessary x-rays, CT Scans, fluoroscopes, etc.

On the anecdotal side, I once knew an x-ray technician who shared his complaints about the increased volume of CT Scans. For more than 25 years he had done countless CTs on patients with migraine headaches and in all those years he had never encountered one that was positive for a cerebral hemorrhage, which is what the CT is ruling out in this situation. Of course he had observed hemorrhage in various other cerebral conditions, but never in a patient with a migraine. Yet the CT is ordered on a routine basis. No doubt it too is revenue driven. While we are on the subject of CT Scan overutilization, I will share another of his stories; a young women in her mid-twenties who came to the emergency room regularly (when the appropriate physician was working) to get pain medication for her non-obstructive kidney

stone. He knew she had a non-obstructive kidney stone because he had done many CTs on her, in one year alone he did as many as seven. Always it was the same result.

After they got their new CT scanner the volume of CTs hit the roof. Where he used to do 3 or 4 a night he was now averaging 10 CTs every night, and for the most mundane things. Of course, even more CTs were being done during the day shift. Little children and women of child bearing years were having CTs for conditions that could have been examined by other less dangerous means, a simple x-ray, an ultrasound, etc. But this did not make any difference to the physicians; they wanted the CT.

Simultaneously, there is the pressure to tow the party line—to prescribe certain pharmaceuticals for particular conditions (regardless of how ineffective a medication might be). Even if the physician might prefer an alternative approach, he/she is restricted by convention, for there are industrial pharmaceutical expectations that must be met.

A prime example of this is the most likely useless, and often harmful, flu vaccination. Although many physicians do not agree with the industry's push to have as many people vaccinated as possible and, secretly, do not take the flu vaccination themselves, still it is their job to push the program on their patients. If they were to instruct their patients to get plenty of sunshine and vitamins D and C, and Omega-3 fatty acid, and exercise, and to wash their hands frequently, they would be considered heretics; unless, of course, they also pushed the flu vaccination.

Beyond the likelihood that "experts" will fail to correctly predict the flu virus that might occur in the next season, according to Anne Marie Helmenstine, PhD, Chemist, there are several reasons the vaccination might not even prevent the flu, even if the coming virus is correctly predicted. By the time the flu season arrives, the virus may well have mutated beyond recognition; or your immunization may have been too soon or too late for your immune system to respond to the virus appropriately. Your immune system may simply be overwhelmed by an extremely high level of virus exposure; or your immune system may not have

produced enough antibodies in response to the vaccination.[74]

But the potential futility of the vaccination is but a minor issue. There are very real dangers associated with the vaccination. Although several years ago multitudes spoke out against the use of the neurotoxin, mercury, in these vaccines (and the industry agreed to stop its use), mercury, in the form of Thimersol, is still widely and routinely used by major manufactures, with each vaccine containing 25 micrograms of mercury; 250 times what is considered toxic waste.[75,76] In the end it was determined, "Removing the mercury from vaccines would cause a major disruption in the manufacturing and supply of vaccines."[77]

The side affects of mercury toxicity are many: "depression, memory loss, attention deficit disorder, anger, oral cavity disorders, digestive disorder, anxiety, cardiovascular problems, respiratory issues, thyroid and other glandular imbalances, and low immune system" and more.[78] Furthermore, as Sheryl Walters points out, these vaccines also contain antibiotics designed to eliminate stray bacteria found in the mixture; but they also eliminate the body's good bacteria necessary for optimum health. "Antibiotics ironically lower the immune system and cause Candida overgrowth."[79] Walters, further explains:

> Vaccines contain Polysorbate 80 as an emulsifier. This highly toxic agent can seriously lower the immune system and cause anaphylactic shock which can kill. According to the MSDS sheet at Science lab.com, section 11, polysorbate 80 may cause reproductive effects, cancer, and may be a mutagenic, (change the genetics), in animals. . . . neonatal rats that were injected with small doses of polysorbate 80 had serious damage to their reproductive organs, often resulting in infertility. Imagine that they are recommending this for young girls! It's no wonder that the infertility rate is skyrocketing each and every year.
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> There is growing evidence that flu shots cause Alzheimer's disease due to the aluminum and formaldehyde combined with mercury since they are even more toxic together than they are alone. Some research suggests that people who

> received the flu vaccine each year for 3 to 5 years had 10 times greater chance of developing Alzheimer's disease than people who did not have any flu shots.[80]

Although vehemently denied by the powers that be, vaccinations laden with mercury have been linked to autism and narcolepsy as well other disorders such as fetal mortality. Jeffery John Aufderheide provides the following astonishing report:

> On September 27, 2012, the Human and Environmental Toxicology Journal (HET) published a study by Dr. Gary Goldman reporting a 4,250 percent increase in the number of miscarriages and stillbirths reported to VAERS in the 2009/2010 flu season. That year the Centers for Disease Control (CDC) had recommended the double-dosing pregnant mothers with two flu shots spiked with mercury. In his abstract, Goldman said: "The aim of this study was to compare the number of inactivated-influenza vaccine–related spontaneous abortion and stillbirth (SB) reports in the Vaccine Adverse Event Reporting System (VAERS) database during three consecutive flu seasons beginning 2008/2009 and assess the relative fetal death reports associated with the two-vaccine 2009/2010 season."[81]

When I read this I immediately thought of the Tuskegee, Alabama, syphilis experiment conducted by U.S. Public Health Service from 1932 though 1972. I though of the poisons the U.S. government (via the Treasury Department) laced alcohol with in the winter of 1926/7, in their attempt to stop people from drinking. I thought of the government's bioweapon experiments in which they dropped 300,300 mosquitoes over Georgia and 300,000 rat flies over Utah in 1955; then another 600,000 mosquitoes over Florida in 1956. I thought of the U.S. troops exposed to radiation during nuclear testing and those exposed to various toxic biochemicals during Vietnam and the Gulf War. It only takes one high ranking bureaucrat to wreak havoc on millions of citizens. Health care is no different.

But flu vaccination scam gets even worse; for those

bureaucrats behind the push to vaccinate are well aware of the extremely dangerous risks verses the virtual lack of benefit. Consider Aufderheide's comments concerning the following quotes.

> Much of the evidence on the toxicity of Thimerosal was swept under the rug at a secret meeting held by the Centers for Disease Control in Simpsonwood, Georgia. I'd like to invite you to read a few quotes from the meeting. I think you will see why the Centers for Disease Control want to keep the lid on Thimerosal. Here are three important quotes from the Simpsonwood Document:
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> "…the number of dose related relationships [between mercury and autism] are linear and statistically significant. You can play with this all you want. They are linear. They are statistically significant." – Dr. William Weil, American Academy of Pediatrics. Simpsonwood, GA, June 7, 2000.
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> "Forgive this personal comment, but I got called out at eight o'clock for an emergency call and my daughter-in-law delivered a son by c-section. Our first male in the line of the next generation and I do not want that grandson to get a Thimerosal containing vaccine until we know better what is going on. It will probably take a long time. In the meantime, and I know there are probably implications for this internationally, but in the meanwhile I think I want that grandson to only be given Thimerosal-free vaccines." – Dr. Robert Johnson, Immunologist, University of Colorado, Simpsonwood, GA, June 7, 2000.
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> "But there is now the point at which the research results have to be handled, and even if this committee decides that there is no association and that information gets out, the work has been done and through the freedom of information that will be taken by others and will be used in other ways beyond the control of this group. And I am very

> concerned about that as I suspect that it is already too late to do anything regardless of any professional body and what they say, . . . My mandate as I sit here in this group is to make sure at the end of the day that 100,000,000 are immunized with DTP, Hepatitis B and if possible Hib, this year, next year and for many years to come, and that will have to be with Thimerosal containing vaccines unless a miracle occurs and an alternative is found quickly and is tried and found to be safe." – Dr. John Clements, World Health Organization, Simpsonwood, GA, June 7, 2000.[82]

No Room for Dissenters

As one might ascertain, the flu vaccination has less to do with the flu than it does profits for Big Pharma; and, being the minion of Big Pharma that it is, the medical community falls into step as ordered. Even in the face of all this evidence, many medical service providers are now insisting that their employees get the flu shot. Those who refuse are made to suffer by wearing a surgical mask while at work. Of course the mask has nothing to do with the flu; the flu is largely transmitted my contaminated hands touching mucus membranes, or by someone with the flu coughing droplets into your eyes. You would have to be very intimate with a flu victim to catch the flu from his/her breath. However, as everyone in the medical workforce knows, donning this surgical mask has nothing to do with catching the flu. It is purely a punitive measure, a scarlet letter to mark the offender, the non-conformist to the religion of western medicine.

Sadly, there is no viable system in place to which the medical bureaucrat or the clinical physician must be held accountable. The physician's word is gospel and all payers and patients are expected to obey with due reverence. For who out there has the knowledge or the right to question the necessity of a dangerously invasive heart catheterization on their 87 year-old grandmother with advanced Alzheimer's? One needs a medical degree to contemplate such things. Or who can second guess the surgeon's decision to perform a coronary artery bypass graft on the 76 year-old dialysis patient in end stage renal failure? Who, without a

medical degree, has the audacity to inquire about the validity of daily EKG's on the 48 year-old with ulcers?

Why should the 34 year-old admitted for a routine hysterectomy (which had been suggested by her surgeon) need to know that her surgeon does four or five of these surgeries every week in their little community of but a few thousand people? Why should the 22 year-old giving birth for the first time (by C-section, on Thursday, because her physician suggested it) need to know that the majority of her physician's patients give birth by C-section on Thursdays? Who indeed? And this is why the abuse of our medical resources flourishes.

"Flourishes" is too mild; for such widespread practices of routine overutilization and misallocation are raping the nation, robbing us of our financial resources. These few examples do not even scratch the surface of the ICD-9 and CPT Code reimbursement books filled with page after page of legal medical procedures and treatments that command a handsome reward. In these pages, health care providers find item after item with which to legally scam the system. Talk about a kid in the candy shop. But I assure you, as evidenced by your doctor's wonderful bedside manner; they do it in love, out of concern for our health.

But we must not think physicians are the only perpetrators in this scheme. While they are certainly the primary offenders there are other players as well; players who are more devious and overtly out to work the system in anyway they can. Certain DME companies for example. Because the reimbursement requirement to qualify a patient for home oxygen is set so low, many people who really do not need home oxygen easily qualify for it. Select, deviously managed home oxygen companies are masters at seeking out and qualifying such customers. And then Medicare compounds the issue by renting the oxygen equipment month after month and year after year, rather than simply purchasing it for an amount equivalent to a few monthly payments. It may sound trivial but this issue alone accounts for billions of lost dollars every year.[83]

Do not misunderstand; this is not an effort to discredit

medical technology, nor is it an argument in favor or against any specific medical procedure. Given the proper circumstance, modern medical science is capable of truly miraculous feats. This cannot be denied, nor is it to be marginalized. But neither can we point to the occasional good these procedures accomplish to justify their widespread misallocation. Although dazzling, and potentially very effective when utilized appropriately, far too often these procedures and devices have little to no substantial effect on a particular disease process or the clinical outcome. Their overutilization accomplishes little more than securing a nice profit for the service provider.

Seeking Solutions

Herein lies the single most important issue for resolving America's health care crises: putting an end to the overutilization and misallocation of services: the frivolous offices visits, the unwarranted hospitalizations, the unnecessary diagnostic procedures and the unwarranted use of advanced technologies must come to an end. While these services can be essential at times, the vast majority of their employment is unwarranted, useless and fraudulent.

Based upon the understanding that the widespread overutilization and misallocation of medical technologies and unwarranted hospitalization has merely increased overall health care costs without commensurate clinical benefit, the solution seems simple: The reallocation of public and private funds from the current overutilization and misallocation of advanced technologies and unwarranted hospitalizations toward the allocation of necessary health care services. But this is easier said than done.

I am certainly not the only one to address these problems. A growing number of researchers and physicians are acutely aware of both the unwarranted financial burden and the poor clinical outcomes of many advanced medical practices. A study by Project Hope a few years ago concluded the key challenge facing the health care market is to develop a policy that requires cost-benefit examinations of new technologies and recommends altering the

reimbursement structure so that cost-effective and ineffective technologies are easily distinguishable.

These problems are well-known and have been known for many years. Some time ago The National Roundtable on Health Care Quality made this dismal observation:

> Serious and widespread quality problems exist throughout American medicine. . . . Very large numbers of Americans are harmed as a direct result. Quality of care is the problem, not managed care. Current efforts to improve will not succeed unless we undertake a major, systematic effort to overhaul how we deliver health care services, educate and train clinicians, and assess and improve quality.[84]
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> The burden of harm conveyed by the collective impact of all of our health care quality problems is staggering. It requires the urgent attention of all the stakeholders: the health care professions, health care policymakers, consumer advocates, and purchasers of care. . . . Meeting this challenge demands a readiness to think in radically new ways about how to deliver health care services and how to assess and improve their quality. Our present efforts resemble a team of engineers trying to break the sound barrier by tinkering with a Model T Ford. We need a new vehicle or, perhaps, many new vehicles. The only unacceptable alternative is not to change.[85]

Clinical Practice Guidelines Versus Physician Autonomy

Although it would not address our problems entirely, a certain degree of reform could be accomplished by adherence to strict clinical practice guidelines based upon proven clinical data, which are designed to "guide decisions and manage conditions by linking evidence with clinical judgment. Their contribution to standards of care presumes that they represent impartial expertise for the good of physician–patient decision making."[86] While this process would not resolve the overutilization it might at least direct physicians toward correct treatments.

We already use such guidelines for certain critical medical conditions; for example, when a cardiac arrest arrives in the emergency room every person there from doctors to nurses and therapists and medical assistance, even security personnel, knows exactly what there intervention will be. It has been drilled into them with a simple algorithm of Boolean logic: "if this then that" and they know it by heart. The algorithms are even age specific.

There is no reason clinical guidelines could not be constructed for nearly every medical complaint a patient might present. No reason other than widespread physician objection; for it would compromise their prized clinical autonomy. They already argue there are too many regulations placed upon them by the payers. Physicians will never go for it; they value their autonomy too highly.

For some, their autonomy seems more important than is their patient's well-being. Often, their autonomy is necessary to continue the clinical behavior patterns they have been practicing their entire career; even if current evidence shows it ineffective. How often have I given an absolutely unnecessary treatment with a bronchodilator medication (which is designed to relieve bronchospasms) to someone who is coughing, has a cold, has the flu, is in fluid overload from congestive heart failure or renal disease, has atelectasis, pneumonia, plural effusion or, even worse, has completely clear lungs? There is absolutely no clinical reason to give this medication for any of these conditions. But I know from discussing this issue with many physicians that each of these inappropriate, even nonsensical, medical orders stems from one of two reasons: either physician medical ignorance (that is, they do not fully understand the purpose of the bronchodilator medication), or the desire to placate the patient—thereby providing some unnecessary service to make the patient think something is being done.

Sometimes even the placation becomes dangerous. Is this not the case with the over-prescription of antibiotics? The patient presents with a respiratory illness, which is likely a virus; and although the physician suspects it is a virus, he/she prescribes an

antibiotic to make the patient feel like something is being done. However, as pointed out in The Annals of Internal Medicine, this creates yet another problem.

> Overuse of antibiotics is a vexing problem in biomedicine. Antibiotic use, especially broad-spectrum antibiotics, is increasing around the world, and a substantial proportion of prescriptions in the United States and other countries is used for viral illnesses that do not respond to these drugs. Antibiotic overuse is costly and contributes to bacterial resistance, but unnecessary prescribing is commonplace.[87]

Patient placation is irritating, but a physician's medical ignorance is scary. I cannot help but to speculate: if physicians do not understand the correct application for a bronchodilator medication (in which the application is clarified in its name), how can they understand the application and contraindications of those more complex and dangerous medications they order for their patients? Sadly (and I believe the facts agree), they generally do not have a real grasp on these either. The many unnecessary and often contraindicated medications prescribed to the elderly provide ample evidence.

Over half of all prescription medications are given to patients over 60 years of age. More than 90% of these seniors who are not in an institution take at least one prescription medication. If they are seen in the doctor's office they generally take from six to eight prescriptions, and one in five of these patients will be taking something that is potentially inappropriate. One out of every six hospitalizations of the elderly is due to an adverse medication event. For those over 75 year of age it is one in three. While in hospital, one in six will suffer another adverse medication event. Despite our knowledge of the physiological change in the elder and that these changes affect medication interactions, still "the effects of medications in older adults are not often studied adequately."[88] Furthermore, as Hitzeman and Belsky report, an increase of polypharmacy (four or more medications) also increases the risk of adverse events.

> The risk of adverse drug events in patients 65 years and older increases as more medications are prescribed: 13 percent with two medications, 58 percent with five medications, and 82 percent with seven or more."[89]
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> In the end, the most common causes of adverse drug events in older patients may be right under our noses. . . . Warfarin (Coumadin), insulin, and digoxin accounted for one in three of these visits [i.e. emergency room].
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> We can reduce the rate of adverse drug events by using validated risk calculators for bleeding in patients taking warfarin, . . . setting less stringent goals for A1C levels in older patients with comorbidities, and avoiding high doses of digoxin or use of the drug without proper indications."[90]

Nevertheless, despite this knowledge, physicians continue to over medicate the elderly.

Sometimes the physician's clinical autonomy is necessary to set in motion medical services in which he/she has a particular financial interest. For example, based up the same information, two highly regarded organizations, The U.S. Preventive Services Task Force and The American Academy of Pediatrics arrived at entirely different conclusions as to lipid screening in children. The AAP (whose physicians provide this service) "recommended screening in children two to 10 years of age with risk factors for cardiovascular disease or a family history of premature cardiovascular disease or hyperlipidimia." The USPSTF (which has no financial interest in this procedure) advised "there was insufficient evidence to recommend routine screening."[91] Such is the practice of medicine. Although the patient trusts the physician to know and do what is best; pretty much, physicians often just fly by the seat of their pants and, if given the option, do that which affords the greatest personal profit.

Neither in our current broken system, nor in the recently legislated Affordable Care Act, will there be Clinical Practice Guidelines established to reform the health care. Rather, unnecessary procedures and misallocated resources will continue

to run amuck as physicians remain unleashed to exercise their coveted clinical autonomy. The Affordable Care Act will place some restrictions on certain treatments, especially for the elderly (which I suspect will not hold up in court in that it is blatant discrimination); however, the gray area of routine low acuity care, in which physician autonomy thrives and which is bankrupting the nation, will remain un challenged.

But given the physician's pitiful performance with an historic and persistent overall misdiagnosis rate of 40% to 60%[92] (no better than it was more than a century ago, even despite the advance technologies), dare I say, a few hours of reading at the library or on the internet and one's self-diagnosis is likely to be just as accurate. Furthermore, considering (as shown in one prominent study) that as much as 71% of prescriptions are potentially inappropriate,[93] the persistent conflict of interests, and the reimbursement paradigm, which is directly related to the volume of pay-per-service activities, if we are going to retain the current health care model (which is not my solution to our problem), I vote that the physician's voice be given little credence; and physician autonomy be chained to Clinical Practice Guidelines. Indeed, it is because we have listened to their voice for so long that we are in the current dilemma.

One aspect of the solution that I will eventually propose is to allow consumers to seek alternative means of health care; to seek advice from practitioners other than allopathic physicians. Allopathic medicine currently has the corner on the health care market; not because of proven outcomes but because of its powerful voice on Capitol Hill, which has granted it a monopoly. It won a political battle about a century ago, which (to the demise of the nation's health) has simply never been challenged. In truth, the clinical outcomes of allopathic medicine are nothing to brag about and traditional alternative health practitioners often have far more to offer. We need to let, even encourage, consumers to seek medical advice from other health care practitioners. Years ago The National Roundtable on Health Care Quality advised as much: "Individual patients must have the opportunity and the

information they need to participate in their own care and to take responsibility, where necessary and appropriate, for their own health."[94]

To be fair, I must acknowledge that many physicians knowingly order superfluous diagnostic test and unnecessary treatments because they are concerned about litigation, if, perhaps, they might be accused of overlooking something. This is arguably a somewhat legitimate concern on their part; however two qualifying points must be made. First, if clinical guidelines were implemented, this would not be an issue. Secondly, (and I admit this is a different issue) if medical schools, including our most prestigious medical schools, provided a thorough medical education this would not be a concern. Unfortunately, much of the physician's learning comes after medical college, in on-the-job training positions, which (because the learner is already a licensed physician at this point) necessarily carries additional professional burdens that a true student would not incur. On-the-job training is a poor process for garnering primary, academic information; for the learner is limited to his/her mentor's knowledge (which may not be correct), and the stress and responsibility of being a worker/learner hinders the learning process.

Chapter Six
Something Is Not Right

I started my career in health care forty years ago. Early on, I knew something was wrong. Although I was pretty sure of what that something was, as a young respiratory therapist I was too naïve, too trusting of the system, to seriously consider exposing what I suspected the problem to be. I quickly realized this trouble was an internal matter, not to be discussed outside the sacred halls of the institution and certainly not to be discussed with anyone outside of health care.

Medical Incompetence

From the beginning I worked with many seasoned physicians who could not read electrocardiograms, decipher x-rays, correctly interpret or make appropriate use of even basic laboratory results. I soon realized that although medical doctors were the alleged experts, the teachers of medicine, many of them knew less than I did about certain rudimentary body systems, their diseases and the accepted treatments for each.

For example, the mechanical ventilation of certain patients is a vital aspect of critical care medicine. Being in charge of the patient's care, the physician is generally in charge of selecting the very important and potentially very dangerous mechanical ventilator settings. While this may sound logical to those unfamiliar with critical care medicine, the problem arises in the fact that very few physicians have a clear understanding of these settings.

Unless they have participated in a post graduate residency in pulmonology (which is very unlikely) they will have but a minimal understanding of just a few of the many complicated settings available on these sophisticated machines. An excellent analogy would be a ridiculous scenario in which a 16 year old is placed in charge of the family car's total care. He passed drivers education and received his driver's license, but he knows little more about the car than where the gas and brake peddles are located. Nevertheless, for some crazy reason he is in charge. When the car needs mechanical repair, the 16 year old will instruct the mechanic what needs to be fixed and how to fix it. Suppose that car needs front tires. Although the car has 13 inch rims, the teenager wants 14 inch rims in the front because it looks cool. That this is a dangerous setup, throwing the balance and center of gravity off kilter, is of no concern; this is what the mechanic must do because the ignorant teenager is in charge. The mechanic will attempt to explain the situation to the teen, to talk some sense into him; sometimes it will work but frequently the teenage is offended and stubbornly insists upon his ridiculous decision. For those of you who place your trust in your physician's hands; welcome to modern medicine.

You will likely think I am making it up when I tell you some physicians do not even know how to use the stethoscope correctly. Stethoscopes (at least quality stethoscopes) are anatomically designed to fit the forward angle of the external auditory canal. If placed backwards the stethoscope's ear pieces rest at opposing angles to the auditory canals, thereby making it most difficult, if not impossible, to hear.

I recall a certain physician, a house resident, called upon to assess a possible abdominal aortic aneurysm—a very serious, potentially lethal condition in which the artery could burst open and the patient bleed to death within minutes. The physician arrived with a stethoscope that looked like a toy, with which he had trouble hearing the telltale throbbing in the patient's lower abdomen, which two nurses and I could hear with clarity. When I handed my nice, professional style stethoscope to him, he looked

at it carefully, examined the angle of the ear pieces (seemingly, at least, knowing there was a correct and an incorrect position) and proceeded to place them in his ears backwards. He listened, or attempted to listen, for the possible aortic aneurysm. He moved the stethoscope about until finally, making a funny face, he stood erect and sharply removed the stethoscope from his ears. For a second time he examined the angle of the ear pieces then preceded again to place them into his ears backwards; but this time he did so with confidence. After listening once again, he pronounced there was no evidence of an aneurysm.

I am thinking also of another physician with whom I worked for a few years—a board certified internal medicine specialist who evidently did not fully comprehend that renal failure leads to metabolic acidosis. Now, I am sure that anyone reading this with even the slightest understanding of medicine or basic physiology is thinking that I must be making this up. If I had not personally discussed this with him I am not sure I could have believed such ignorance was possible by a physician, much less by one who was board certified in internal medicine. But as the years passed I have encountered one physician after another that cannot properly understand arterial blood gases (ABGs), the test that indicates such conditions.

For readers without a basic understanding in physiology this ignorance may not sound too alarming, so let me put it in perspective. Acid/base balance is a fundamental concept in human biochemistry. It is measured via the arterial blood gas test. Those of you who have had this procedure will remember it very well, for it generally hurts like the dickens.

Normal metabolic cellular function continuously produces waste in the form of hydrogen ions, which combine with water to form a toxic acid. The body deals with this excess acid in different ways. It buffers some of the acid with various biochemicals; it breaks down some of the acid, expelling the by-product from the lungs as carbon dioxide; and it excretes excess hydrogen ions, the source of the acid, through the kidneys.

If the kidneys fail to function properly, excess hydrogen ions,

and therefore acids, accumulate, resulting in a condition called metabolic acidosis. Depending upon the severity of the metabolic acidosis it can cause various problems, not the least of which is death. This is as basic to understanding bodily function as understanding the normal structure of a simple declarative sentence is to the English language. Can you imagine having an English teacher who did not understand the concept of subject, verb, object? Yet, this physician seemingly did not fully comprehend that renal failure results in metabolic acidosis.

Although years later I came to realize just how such ignorance was possible, at the time I could not understand how he had ever passed a licensing exam, much less how he had actually graduated from medical school. And I shuddered to think there were others like him. Sadly, he was not the only physician I have encountered who does not have a clear understanding of ABGs. The fact is I long ago stopped counting the number of physicians I have worked with who do not have a clear grasp of these values.

I do not want to bore or confuse the reader with to many details, but let me provide a brief overview of ABG interpretation. Three important measurements are made: pH (the acid/base balance), $PaC0_2$ (the partial pressure of carbon dioxide), and $Pa0_2$ (the partial pressure of oxygen). The $Pa0_2$ is easily understood, for it is one number expressing one entity, oxygenation. It is the correlation between pH and $PaC0_2$ with which so many have trouble. From these two measurements other entities concerning acid/base balance (i.e. bicarbonate concentration and base excess) are calculated; they are predictable values that directly correlate to the relationship of the pH to the $PaC0_2$.

The $PaC0_2$ predicts the pH. If the prediction holds true, yet the values are other than normal (i.e. either acidotic or alkalotic), an acute change is present, which is either respiratory or metabolic depending upon the abnormal $PaC0_2$ value. If the $PaC0_2$ fails to predict the pH, the abnormality is other than acute and there must be a metabolic component at work, which is expressed by the calculated bicarbonate concentration and base excess. The degree of metabolic involvement is determined by the degree to which

the $PaC0_2$ fails to predict the pH. Ergo, knowing the $PaC0_2$ and pH is critical to ABG interpretation.

As simple as this is, many physicians immediately zero in on the bicarbonate concentration, as if this is the sole value of merit. Armed with this calculated value (and seemingly not concerned with how this value was calculated via the correlation between the $PaC0_2$ and pH), they inevitably proceed to misinterpret the ABGs. This then often leads to incorrect treatment. How often have I had a physician want to place a patient on mechanical ventilation because he/she did not fully understand the blood gases? Too many, that's how many.

In cases of severe metabolic acidosis the calculated bicarbonate concentration has merit; albeit it is largely academic. It is necessary to calculate yet another value (the anion gap) to document the potential cause of the acidosis. However, this is largely done for the chart in that the physician should already know if the acidosis is due to some condition such as diabetic ketoacidosis versus something like hemorrhage.

I never cease to be amazed at how many physicians do not understand ABGs. Predictably, these are the physicians who order the test most frequently. If you have ever had this painful test (unless you were extremely ill at the time), it was very likely completely unnecessary. Aside from the misallocation due to physician ignorance, do not think I am lying when I tell you; at times this test is performed on emergency room patients who come in for non-emergent conditions. I have worked with frustrated physicians who will order this painful test merely to punish the patient for having taken up their time with some mundane condition that could have been seen at the doctor's office or even treated at home.

Unwarranted Procedures

Beyond the widespread abject ignorance, I also noticed how many physicians would readily send patients for dangerous and expensive procedures without even considering logical alternatives. I remember a grossly overweight female in her mid twenties with mild chest pain on whom we performed a rigorous

cardiac stress test. It showed nothing significant. However, rather than discuss diet change, weight loss and exercise with this young woman, the physician dutifully opted for heroic intervention. I was still in the room as he (a board certified internal medicine physician) told her he wanted to schedule her for cardiac catheterization and evaluate her for coronary artery bypass graft surgery.

I remember many of these unwarranted and extreme treatments. I recall a particular situation that involved a cardiologist, the cardiac cauterization laboratory and a frail, elderly woman in her late 80s suffering end stage terminal lung disease and thus not a viable candidate for any type of follow-up surgical procedures regardless of the test results. But, because such logic does not concern heroic intervention, she too was strolled through the sacred halls to undergo a completely unnecessary and extremely dangerous exploratory procedure from which, I vividly remember, she did not survive.

I remember another elderly gentleman whom I saw immediately post-op from a coronary artery bypass graph. It was my job to manage the mechanical ventilator during recovery. He was in his late 70s with a history of two prior coronary artery bypass graph surgeries. He was also a diabetic and a victim of chronic renal failure with frequent visits from the dialysis team. Even if he would have survived, other than his insurance coverage, he was hardly a viable candidate for a coronary artery bypass graph.

Many Allopathic Deserters

Almost daily I questioned the necessity of the endless tests and inappropriate treatments, but generally it was all to no avail. I was a mere pickaxe striking at the Rock of Gibraltar. At first I had assumed these incompetent physicians had simply slipped through the cracks. I assumed they were the exception, the bottom of the bell curve. But the incompetence was so prevalent that in time I began to question the entire institution of medical education. Could it be that it was simply inadequate?

When finally I fell ill myself and the recommended treatment

did not work, I turned to alternative therapies. They did work; and thus began a new chapter in my health care experience. Heretofore, I had learned that the philosophy of holistic health care was nothing but quackery and, like any well-trained, institutionalized learner, I abided by it. But now that it was my health on the line, suddenly the philosophical became practical, and the known failure of western, allopathic medicine became a personal reality.

To my great surprise, behind this door of holistic health care I discovered other allopathic has-beens, including many allopathic physicians, who had come to the same realization. While some still struggled with their roots, trying to combine the heretofore heresy of holistic health care with their allopathic philosophy, others had published books expressly denouncing their profession's ignorance.

Other new horizons unfolded from my formal study of naturopathy, which I pursued primarily to better understand my own health. But it was during my previous studies in business that I came to fully understand why so many physicians were so incompetent, why the system allowed it to continue, and why so much of western medicine is a failure.

At Last I Understood

Decades earlier I had realized that beyond the obvious ignorance, many medical procedures were performed merely for the profits they generated. The institution providing the procedure, the physician performing the procedure and even the physician interpreting the results, when applicable, received generous reimbursements. But what I had not realized was that the entire western medical economy with its many and various industries, relied heavily upon the excessive use of these mostly unnecessary procedures, and that it equally relied upon its continued failure to cure the diseases it purported to treat, thereby insuring return business. This answered some very troubling questions: Why is the medical education so inept? Why is rampant incompetence allowed to continue? Why are superfluous, expensive and useless tests and treatments routinely ordered?

Why do completely unnecessary hospitalizations take place? I came to realize that each question was answered by one simple word: economics. Modern, allopathic western medicine thrives upon is own failure to promote health and health care. What I learned is that a true cure is not welcome.

The failure to provide quality health care to the American public is neither an issue of available clinical resources nor adequate funds for these resources. That the medical profession fails to provide quality health care even to the wealthiest individuals who patronize the country's most high-tech facilities illustrates the veracity of this statement. The failure to provide quality health care to the American public is the requisite outcome of the absolutely inadequate education and the biased, myopic philosophy of allopathic medical practitioners.

By in large, medical doctors cannot provide quality health care because they do not understand quality health care. What they can provide (although few truly have the expertise) is disease investigation. Almost all medical doctors take part in this quest, and some do it with great fervor. The proficiency of their investigative skills is of little concern. Whether the hunt is warranted or not makes no difference; it is their duty to investigate and to write prescriptions, which preferably are medications created by the nerve center, Big Pharma. But this lucrative disease hunting process is not the same thing as the promotion of health or the practice of health care. Indeed, the preeminence of this disease-hunt is directly related to the lack of quality health care and its promotion. At best, the disease investigation process of allopathic medicine is the flip side of health care, the negative pole to the positive; and it has developed a life all its own.

It is only under the wings of the lucrative post Civil War pharmaceutical industry that allopathic medicine has managed to dominate our current medical system. And this was achieved by legislation rather than accomplished clinical outcome. Sadly this system of disease investigation is designed for, and thrives upon, its own continued failure.

Chapter Seven
The Medical Doctorate

Practiced by many, practiced well by a few, mastered by even fewer, medicine is an ever-changing, never-changing philosophy dogmatically devoted to its myopic tradition of heroic intervention, yet relentlessly confronted with and mystically bedazzled by discovery. The result is a confused society of physicians held captive to a perpetual dichotomy—one foot rooted in perceived truth and tradition, the other stepping into the future where discoveries displace these truths and new therapies betray tradition.

Tradition is Safe for the Insecure

Although the forward ground is increasingly firmer, it is hard to leave the familiar; and although outcome and discovery continually disprove current practice, the goal of allopathy remains constant: heroic intervention is, by necessity, more important than health or cure. Intervention is the hallmark of allopathy; this, its tradition, yields credibility regardless of the outcome. If the patient does not get better it is because the illness is beyond medical technology, but at least the physician intervened in everyway possible. If the patient does get better it is only because of the physician's skill and intervention.

Beyond the perceived credibility conjured up by the tradition of intervention, the flip side of this tireless adherence to a proven faulty tradition is personal insecurity. Although some are certainly sharper than others, one thing they all have in common is a lousy

education. The physician's absurdly inept academic education results in a community of undereducated, ill-prepared practitioners indoctrinated by a fraternal order and threatened by change. Unleashed upon society, having little understanding and even less confidence in their own abilities, a sense of insecurity is pervasive; for them, there is safety in tradition. Insecurity in all forms finds comfort in tradition.

Physicians Recognize the Problem

This fundamentally inferior education does not go unnoticed; the lack of sufficient education is occasionally discussed in medical publications. Incompetent physicians, rendering poor care so permeate our society that it is often a subject of discussion in the medical journals. Of course the medical journals refrain from actually addressing the institution of medical education, focusing instead on the multitude of incompetent medical practitioners. And of course they never mention that these incompetent practitioners come from the same medical programs as the supposedly competent practitioners. Nor do their solutions ever include the restructuring of the education format that graduates such ineptness. For regardless of the medical school, whether prestigious or obscure, the medical program is virtually the same. A prominent AMA spokesman has admitted that today's medicine is increasingly complex with more intricate procedures and therapies that create an inherent potential for error;[95] nevertheless, medical college lasts no longer today than it did 150 years ago. Thus, because of their education all physicians must be considered incompetent until proven otherwise, which I submit seldom happens.

Although these articles, written by physicians, seldom use the term incompetent, and seldom do they actually address the real cause of the problem—that is their inept education, they do acknowledge that a problem exists and, in a general sense, that physicians need better training.

Sometimes they come up with rather curious solutions to the problem. For example, an article in one JAMA article entitled Managed Care Is Not The Problem, Quality Is,[96] the author, a

physician, suggests that perhaps critical x-ray films should be read independently by two physicians "to reduce observer variability"—a gentle way of saying error without actually admitting it. The author reasoned that this would result in greater value to the public for their investment.

Now I fail to see the logic in this solution. The problem being addressed is that physicians are very likely to misinterpret critical x-ray films. If the first physician is likely to misinterpret the x-ray, by what reasoning do we assume the second or third will not do the same? These physicians would have received the same medical education and passed the same licensing exam as the first. True, statistically the odds of at least one of them being correct are improved—like flipping a coin three times is more likely to yield heads than is a single flip; but somehow this is not a very reassuring scenario for supposed scientific tests. At least with the coin you can see the heads, but how are we to know which physician's interpretation is correct? Or indeed, if any is correct?

The idea of actually teaching physicians how to interpret the films properly in the first place might be a novel solution. This would provide both quality care and efficient utilization of resources. Not only would the job be done correctly but a job designed for one could be performed by one rather than two or three individuals.

A Typical Medical Education

Physicians may speak of twelve and even twenty years of education, but the truth of the matter is medical school consumes a mere four years—some, only three. In both, the academic portion constitutes only of the first two years. In that absolutely all the medical schools in North America must comply with the licensing body, they all have a fairly comparable curriculum. Basically, medical college consists of a meager two years of academic medical education followed by a series of clinical clerkships crammed into one year or stretched out over two.

Admission requirements for many medical colleges are minimal at best. When I last investigated this several years ago (and I seriously doubt much changed has transpired) only eight of

the one hundred and twenty-five medical colleges required a thesis, and a master's degree was not a requirement for any.

While most medical students have an undergraduate degree, even this is not requisite in many medical colleges. Except for a dozen or so medical colleges that actually admit students directly from high school, admissions requirements generally include: a few years of college with an ever so modest GPA that would not even qualify for most master degree programs (in some schools a GPA of 2.0 is sufficient); the completion of five or six prerequisite courses; and an undetermined competitive grade on the Medical College Admissions Test (MCAT).[97] A requisite minimal GPA for graduation is virtually nonexistent, in that most medical schools have converted to a simple satisfactory/unsatisfactory grading system.

While a master's degree is not required for any medical college, students can actually enter many six-year programs directly out of high school. When I wrote A CURE IS NOT WELCOME – America's Successful Failing Health System at least thirty medical schools, including some of our most prestigious schools such as Tufts University, Boston University and Robert Wood Johnson Medical School, offered accelerated programs to grant a BS/MD combo. A mere high school graduate enters one of these programs and emerges with a medical doctorate in six short years. Keep in mind, this includes the two years of job shadowing . . . I mean clinical clerkships. In all, this equals two years of undergraduate work, two years of academic medical school and two years of job shadowing.

In essences, all of the medical colleges follow the similar curricula. The primary difference between well known research medical institutions/colleges verses lesser known medical schools is the cost, not the extent of the education. Another difference would be the admission requirements; with the more prestigious schools having very competitive criteria. But all, including the Ivy League schools, follow the same pitiful curriculum. I am sure some readers will doubt the veracity of these minimal qualifications (a response itself that further illustrates the way we

have been deceived into believing the MD is of a superior intellect and education); but I invite all with interest to simply log onto the website for the Association of American Medical Colleges where information for each medical school is easily accessed.

While there are some very skilled physicians and surgeons, they are not the norm. They are indeed the minority among their peers. Those who have advanced skills and knowledge will have gained it after medical school, not during it. The bottom line is that medical college provides an incomplete education. The medical doctorate, MD, is the only doctorate one can receive in any academic field and yet not be proficient enough upon graduation to teach that subject at university level. The irony is that doctor means teacher; yet somehow the physician, who holds the only doctorate that is not qualified to teach, has seized the moniker doctor, so that society has come to associate doctor with the clinical physician.

Sadly, this inept education leads to the common practice of medical misdiagnosis, erroneous medical treatments and, far too often, injury or even death. Aside from the physical and emotional damage, it costs the nation tens of billions of dollars every year.[98]

It is not merely the aforementioned ill-equipped, cardiac catheterization labs that health care workers "in-the-know" will avoid when seeking their own personal medical treatment; they are likely to avoid the majority of physicians with whom they work. In many facilities, if said health care workers have a serious medical condition, they might avoid the entire medical staff and seek treatment elsewhere. Unfortunately, they are not allowed to alert or warn patients with their inside knowledge. No matter how inept a patient's physician might be hospital employees must bite their lip, put on a good face and promote confidence in the physician. This is mandated by the facility. The stress of this daily thespian role (especially when the patient's health and possibly even his/her life is at stake) causes many nurses and ancillary health care workers simply to leave the medical field altogether.

In his 1910 report, Abraham Flexner detailed the pitiful state

of the medical education in America. Not only is the general population unaware of this scathing report, they are also unaware that little has changed since his report. Due to his report numerous medical schools closed while the remaining schools were attached to the universities, thereby, presumably, allowing students to first receive a proper university education. Unfortunately, although the university education was added, very little of the actual medical education has changed. Despite the major advancements in the science of medicine and the high tech equipment, medical college lasts no longer today than it did more than 150 years ago (even before surgeons realized they should wash their hands between surgeries).

Although medical knowledge has advanced far beyond what was known when Flexner submitted his report the medical education has not kept pace; but other disciplines have. In today's world the physical therapist has a doctorate degree with more postgraduate academic education than does the medical doctorate. So too does the pharmacist with his requisite doctorate. Nurse practitioners are also soon to hold doctorates. It seems everyone is getting more education but the physician. Yet, merely due to legislation and certainly not expertise, the MD continues to control health care at the clinical level; and, as previously mentioned, in a virtually unregulated manner.

Because the primary purpose of the medical degree is to train pharmaceutical gatekeepers the current education model satisfies the system: diagnose, prescribe a pharmaceutical, bill for services. Correct or incorrect, the diagnosis and prescription seem secondary to the act itself. As a result, litigation (which is not all or even mostly frivolous) is rampant. Often, this litigation is for good cause. Medical error is one thing; medical incompetence is another, and medical incompetence abounds.

For example, and on an admittedly anecdotal note, I once suggested to a physician (who, by the way was certified in critical care medicine) that we ship his very sick middle-aged patient to a medical center that would be better equipped to deal with the patient's quickly advancing Adult Respiratory Distress Syndrome

(ARDS) –a potentially deadly acute disorder. He replied, "No, it wouldn't make any difference, we (i.e. physicians) are all just guessing, none of us knows what we are doing." Now you might think this is an isolated case, but from nearly forty years of experience I can tell you, other than the use of the superlative modifier "none", he was largely correct. Fortunately, there are some physicians scattered around the country with established strategies that certainly increase the ARDS patient's chances of survival; however, it is true that most physicians are clueless as how best to treat this disease. Needless to say, this particular patient was not one of the survivors.

The Credentials Are Meant to Fool You

Do not be fooled by the credentials. Despite the fact that not one of these graduates has mastered medicine and much less could be considered a teacher of the subject—which is what doctor means—upon graduation from these short programs, the degree Doctor of Medicine (MD) is granted and (after a nominal exam) each becomes a legally, licensed medical practitioner. It is due to the inferior and incomplete nature of the medical education that graduates are necessarily incompetent; and sadly, most doctors seldom bother to learn much more than that which was required of them in medical school and their initial on-the-job-training.

These newly licensed physicians will complete a yearlong hospital internship, in which they are abused and dumped on by more senior physicians. Even the non-physician professional staff will give these interns the what for. They will work very long hours with little sleep and even less supervision. Any supervision they do get is not likely to come from a seasoned professor of medicine but from a nurse, a therapist or a resident—a mere senior fellow who has recently completed his/her year of similar servitude. The internship is little more than a fraternal hazing ritual at the expense of unwitting human guinea pigs.

After surviving internship, physician will serve a few more years of residency—an extended transitional training process, in which they learn to act more like senior physicians. But keep in mind, during both the internship and residency they are licensed

physicians, receiving salaries (albeit ever so meager) for their services. Stuart Berger, MD, tells us of his experience.

> I soon found myself beginning my internship, the brutal rite of passage that tempers all physicians. Every doctor knows the terrified feeling of showing up on the wards the first day, knowing he or she is expected to help people, but not having the first clue as to how. I had never taken a pulse, inserted a catheter, sutured a wound, drawn a blood sample, even taken an accurate history. Neither I nor my classmates knew even the rudimentary skills of doctoring. We were expected to learn as we went, on the run, using our patients as human workbooks. In theory, older doctors were there to guide us; in the grim practice of the wards, we were on our own, left to fend and figure as best we could.[99]

Our culture has a term for this type of education. It is common to many industries. We call it on-the-job-training or OJT. Employees are paid a salary while they learn their craft by trial and error under some degree of supervision. However, no industry but medicine makes the pretense that their OJT is an academic education. Dr. Berger speaks more of his OJT.

> Through those endless days and nights of our training process, we knew something was wrong—but we never had time to ask what. We were so concerned about packing in all the information we were given; mastering the overwhelming rush of data and facts, knowing how to put the pieces together, that it never occurred to us that there might be things we were neglecting altogether.[100]

Earlier, he had commented,

> In the excitement and rush, we had little time to stop and reflect or to ask the obvious questions: We were learning immense amounts—but were we learning what we should? We were becoming doctors, to be sure, but were we becoming better healers?[101]

An Academic Shame

The medical doctorate is a shame, an embarrassment to academia; no master's degree, perhaps a bachelor's degree, a mere two years of postgraduate academic education, which largely is not even graded beyond the pass/fail system, another one or two years of job shadowing and presto, the degree Doctor of Medicine is granted. This hardly compares to the academic requirements for other doctorates.

Consider the requirements for a Doctor of Theology (ThD). Upon completing a requisite bachelor's degree, students must complete a full four-year academic, Master of Theology degree (ThM), which generally requires a GPA of 3.5 for admission and a dissertation for graduation. Then, if the grades are high enough (again, a GPA of 3.5), is the candidate granted admission to the ThD program, which is another four years of grueling academics and another dissertation.

Once considered the ultimate education, today the ThD lives in near obscurity receiving little acclaim from a society that has been converted to the religion of allopathy. Nevertheless, anyone wanting to achieve this degree must still complete the rigorous academic requirements; and rightly so. Doctors of Theology deal with philosophical and theological ideas that ultimately affect the whole of society. They should be well educated. But then so too should the medical practitioners. They too have a significant impact upon society. I submit that the academic standards for achieving the MD should be no less than those required for the ThD. Academia should demand it. Society should expect it.

A Profitable Franchise

Although some medical doctors will truly master their craft it is not required or even expected. Too many are content simply to build a busy but comfortable and lucrative practice dispensing meaningless prescriptions, ordering useless test and resting on the laurels of their supposed superior education.

For too many physicians, the medical license is little more than the key to a profitable franchise—a license to write drug prescriptions. And, like so many other regulatory licenses, it is a

license retained merely by paying the price. Knowledge has very little to do with it. Once a physician receives a medical license—barring a series of major screw-ups—he or she is set for life. Despite the ever-changing nature of medicine, there are no re-certification exams and less than half of the states even require physicians to complete continuing education credits to keep their license current.[102] Inlander has addressed this issue with clarity.

> What a medical license gives a doctor is what a Senate confirmation gives a Supreme Court justice nominee: a practically unassailable job for life. There is a difference, though. The Supreme Court justice has had to go to law school, pass a bar exam, get a job, do well enough at it, attain a position of high standing—a judgeship, say, or a place in academia—do well enough at it, and catch the eye of a person in a lofty government office. It's a long haul. One usually gets a Supreme Court job for life only after one has paid his dues.
>
> On the other hand, a physician has merely to get through four years of medical school, pass one licensing exam (with an average passing score of as low as 75 out of 100, and in some states with an even lower score), successfully complete an internship somewhere, and 'possess acceptable personal attributes,' whatever that means. And that's it. Minimal qualifications. Job for life. The only dues a doctor has to pay are the annual kind for license renewal—if he happens to be practicing in a state that even requires an annual fee. Some don't. Simply being alive and having once passed a licensing exam is all that's needed to have carte blanche in the field of medicine. . . . it is only in rare instances that proficiency or experience are prerequisites for getting a license, or competent or successful work conditions for keeping one. Short of killing someone (or, more likely, a string of someones), once a doctor always a doctor. [103]

The primary clinical objective of allopathic medicine is threefold: to diagnose disease, to treat disease symptoms and to

stave off the inevitable (death) for as long as possible. The entire clinical setting revolves around these virtuous challenges with various interventions and heroic measures routinely employed, at nearly any cost; even regardless of predictable, ineffective outcome, which is acceptable because it is being done under the banner of "doing good".

Beyond this facade another script is being performed with similar intensity. Medicine is a very competitive business that generates billions and billions of dollars every year. There are far more players behind the curtain than one might imagine, powerful players with self-serving agendas. Entire industries revolve around western allopathic health care: medical device manufacturers, sales firms, consulting firms, educational facilities, research groups, publishing companies, grant recipients and vying for the top of the list, pharmaceutical corporations and their minions—the physicians who link them to their market, the patient.

The financial success of both clinical medicine and the supporting industries is completely dependent upon clinical failure. Each of them needs the threefold objective to remain center stage. Anything that threatens to change or to somehow diminish their market, their patient base, is not welcome. Traditional and alternative therapies such as nutrition and nutritional supplements, in spite of effectiveness—indeed especially if they are effective—are not welcome. They disrupt the status quo and cast suspicion on the lucrative methods of proven failure.

Do I mean to indict the entire allopathic industry? No, I do not call for the complete discard of allopathy, merely its reform. Much of modern allopathy is helpful, nearly miraculous at times—especially in the area of trauma and reconstructive surgical procedures. But to understand and promote health is not its genius.

I call for the reform of the medical education: the pitifully inferior academic content, its neurotic obsession with intervention, and the embarrassingly short timeframe in which the medical degree is earned. One cannot learn medicine with a mere two years of classroom studies and another year of two of job

shadowing.

Chapter Eight
The Code of Silence

> We are drawing near to my proposed solution to our country's health care dilemma. However, please bear with me as I continue to expose just how pitiful our physicians, at large, really are; for knowing this is integral if the proposed solution is to be fully appreciated.

"Doctoring must be very easy to do since doctors always bury their mistakes." Stated in 1947 by Fred Raber,[104] sadly, there is more truth than satire in the statement.

Doctoring easy? Oh yes, quite. Good doctoring? Now that is a different issue. No, good doctoring is not easy. Indeed it is very demanding. Good doctoring requires physicians to be perpetual students—ever studying to master every aspect of the procedures they perform and the diseases they hope to control. But mere doctoring? Well, for this a physician needs no more than his/her original, inept medical education. There are far too many incompetent physicians practicing medicine to argue otherwise. The country is littered with medical practitioners who make one wonder how they ever made it through medical school, much less how they ever passed the licensing exam.

Not only is the medical education minimal at best, the license to practice medicine does not signify either initial or continued competence. But even if the initial education was stellar and the licensing exam a real challenge, in the fast-paced ever-changing world of medicine, as Inlander pointed out in the last chapter, of

what good is a twenty-year old diploma if there has been no learning since?[105]

Since The Institute of Medicine published its November 1999 report entitled To Err is Human: Building a Safer Health System, medication errors have been at center stage. This is a good thing. It is imperative that the public finally take note of these issues. However, it has not decreased the events. The 1999 report revealed an estimated 98,000 deaths per year in hospitals due to human error; in a subsequent study, from 2000 through 2002, the number had increased to 191,000 per year.[106]

It is imperative that physicians finally be held accountable for their incompetence. Errors are one thing, incompetence is another. Even the best clinical practitioner will make occasional errors, but incompetent physicians (which I submit are the vast majority) do not merely make errors they practice by them.

Error and Misdiagnoses is the Norm

Multiple studies have demonstrated the medical profession's consistent inability to make correct diagnose. Even despite multiple advanced medical technologies, diagnostic accuracy is no better today than it was a hundred years ago. In fact, incorrect diagnosis is so prevalent that it is now considered routine. It is for this reason that patients are always encouraged to seek a second or third medical opinion. Why do you think physicians themselves seek another's opinion? They do not treat themselves because they are well aware of their personal inability to diagnose correctly. They hope the other guy has learned more since graduation. It has been this way since allopathic's conception.

By the turn of the Twentieth Century (i.e.1900), the Mayo Brother's Clinic—already a medical Mecca—had been widely praised for its amazing 42% diagnostic accuracy.[107] After reviewing 3,000 medical records at Massachusetts General Hospital in 1912, Cabot's well-publicized study reported the clinical diagnostic accuracy to be about 60%.[108] According to Dr. Charles Mayo, by 1927 the diagnostic accuracy at the clinic had improved to 50% while he taunted that the accuracy of the mere lone practitioner remained, at best, a dismal 20%. T. Swann

Harding recounts Dr. Mayo's boast before a surgical Congress in Washington, D.C.

> The Mayo Clinic had attained the phenomenal record of fifty percent correct diagnosis. . . . It is probably a high mark for all time. Certainly few would contend that the snap diagnosis of the average general practitioner working alone is right in more than one case of five.[109]

Twenty-five years after Cabot's study, Gall examined another 1,000 cases at Massachusetts General Hospital and found no change from the Cabot's original figures. [110] Nor did he find any changes in 1960's after reviewing another 1,000 patients at Cincinnati General Hospital.

Another study in a 1993 edition of the Journal of Nursing reported that thirty consecutive postmortem examinations revealed an incorrect clinical diagnosis of 33%.[111] The author concluded that in 23% of these cases, the correct diagnosis would have dictated a different treatment. A more recent study, published in the February 2001 edition of the prestigious medical journal CHEST, reviewed 91 postmortem examinations of 401 deaths in the MICU and discovered a 20% incorrect clinical diagnosis. Of these, it was determined that 44% would have been treated differently if the correct diagnosis had been made prior to death.[112]

Other researchers have routinely reported similar results. In 1996, a major university hospital admitted that when the sum of all diagnostic errors for the year were tallied they ranged between 40% and 60%—similar, the author confessed, to those in the aforementioned surveys of Cabot and Gall. Although the report modified this damaging data by discussing differential categories of misdiagnosis, at last it conceded, "despite the increased scope and improved quality of diagnostic technology, the frequency of misdiagnosis has not decreased appreciably."[113]

Mum's the Word

For the most part, medicine is a self-regulating body. Although the process of peer review exists to address those who

practice with blatantly questionable skills, it is seldom enacted. When it is enacted it is mostly a nominal process at best that rarely does more than to wag its proverbial finger at the accused. It is extremely rare that someone is actually held accountable for his or her poor performance. As a rule, physicians do not speak out against each other and non-physician complaints are not taken seriously. In fact, non-physician complaints largely fall on deaf ears.

State-licensing boards view non-physicians as less educated, less intellectual than physicians. In their view a non-physician is not capable of making accusations against someone so highly educated as a physician. And certainly a non-physician cannot understand anything about medicine—after all they have not experienced the fraternal hazing of internship.

That physicians bury their mistakes is common knowledge; true both literally and figuratively and practiced routinely, both individually and with group participation. That physicians allow their peers to continue maiming and even killing patients without speaking up is unconscionable; but it is a permanent part of medicine—consciously built into the system. Upon graduating from medical school and before beginning his/her career, every physician openly pledges the oath of Hippocrates to "first, do no harm." But in secret a more compelling oath has permeated the hallowed halls, an unspoken oath in which it is understood that "one never accuses a colleague."

But occasionally this code is offended. As in the case of the notorious Dr. John Nork, an orthopedic surgeon who finally admitted to maiming at least thirty patients, mostly during botched laminectomies. It was bad enough that Dr. Nork had been performing these unnecessary surgeries simply to make money; even more alarming was that his colleagues knew all about it and let him get away with it for at least nine years. When finally exposed, the Honorable B. Abbott Goldberg, a judge in the Superior Court of the State of California characterized Dr. Nork as an "ogre, a monster feeding on human flesh." The judge described the evidence against him as a "Grand Guignol of

medical horrors."[114]

A Case of Iatrogeny

Sadly, few of these ogres are ever exposed publicly. Once they are exposed to their peers they merely resurface in another facility, or even another state. Incompetent physicians (albeit not as overtly heinous as Dr. Nork, but incompetent none the less) are not the minority. Such practitioners are far more prevalent than the public is aware; but largely due to the fraternal code of silence, few are ever exposed. Those who are exposed are victims of betrayal and it is very likely that something far beyond mere incompetence—which seems to be a norm for the profession—caused the code to be broken.

I cannot refrain recounting my first two known exposures to this unspoken oath of silence. In the first I said nothing; in the second I spoke up but no one listened. It was the mid 70s. I was a young respiratory therapist, in my first years of practice. Each incident took place in different hospitals in the Northwest.

Of the first I remember little, other than the surgeon, Dr. "W"—a young man perhaps in his late 30's with movie star features who always, yes always, had about four or five women ranging in age from 18 to 80, hospitalized recovering from a hysterectomies. And I remember that the hospital staff used to joke amongst themselves that he hated women and kids.

Literally being the new kid on the block (for this was my first fulltime job in the field), I did not say anything or attempt to expose what seemed to be an extraordinary practice, which he had been practicing for many years. However, I am somewhat pleased to report that about ten years later, I heard on the nightly news that Dr. "W" had lost his license to practice medicine in that particular state for performing unnecessary hysterectomies. I say "somewhat pleased" because it took so long for him to be exposed. I cannot help thinking of all the women who needlessly lost their ability to bear children. By my rough and conservative calculations, over the many years he had been doing this dastardly deed he easily could have removed more than 10,000 uteruses: r each week for twenty years. Just as depressing is that after having

lost his license in that particular state it is very likely that he merely moved to another state, acquired another license to practice medicine, and resumed his practice.

The second incident is an even more vivid memory. It has haunted be for decades. I was in my second year of practice, working in a small rural hospital. One afternoon a man in his late 40s arrived via ambulance with an acute myocardial infarction (MI) in progress. After emergent treatment he was admitted to our small Intensive Care Unit.

Later that afternoon he arrested—an abrupt burst of tachycardia (an extremely rapid heart beat) suddenly turned to asystole (no heart beat). We performed CPR and within minutes a normal sinus rhythm resumed. Although he appeared stable a few hours later it happened again, the same scenario. As the hours passed and night became morning, it had happened again and again and again. By the time the physician finally arrived, just after daybreak, we had "coded" this gentleman at least five or six times, and I had long since inserted an intubation tube into his throat and placed him on a mechanical ventilator.

Throughout the night I had grown increasingly curious as to what was happening. What was causing this repeated bizarre scenario? I reviewed his chart looking for clues. Having performed the EKGs, I knew they showed three abnormalities: an acute MI (damage to the heart muscle due to impaired blood flow), a left bundle branch block and a 1st degree AV block (each an electrical conduction problem within the heart). When I checked the medications the physician had ordered upon the patient's admission from the emergency room at once I realized what was happening.

The physician had prescribed a certain cardiac antiarrhythmic drug that was actually contraindicated for not one but all three of these abnormalities. According to the Physician's Desk Reference—literally, the physician's bible for prescription drugs—this medication in the presence of any one of these abnormalities could cause sudden tachycardia followed by asystole.

I showed the evidence to the nurse in charge of administering

the drug. She agreed. I told the head nurse. She also agreed. When the physician finally arrived I told him as well. He did not agree and he ordered for the medication to continue. It did; so too did the cardiac arrests.

Later that morning I consulted another physician. He agreed that the medication was causing the problem. I asked him if he would do something about it.

"No, he's not my patient."

I asked if he would speak to the attending physician.

"No, I cannot interfere," he said.

Before noon, I had consulted three other physicians. Each agreed that the medication was the problem and each refused to do anything about it. By the next day I had consulted three more of campus physicians, two cardiologists and one internal medicine specialist, to whom we sent our cardiograms form interpretation. They too agreed that the medication was the problem and they too refused to do anything about it.

Somehow, as the acute injury slowly healed over the next several days, the cardiac arrests became less frequent and finally subsided. After nine days the patient was discharged and we all breathed a huge sigh of relief. He had survived in spite of blatant and stubborn incompetence.

Then two weeks later the gentleman returned to the emergency room, again via ambulance; only this time he was DOA. In his possession was a bottle of the offending antiarrhythmic drug. The physician had sent him home on a rather large daily dose. Although the acute MI had healed he still had the two chronic, contraindicated electrical conduction abnormalities: the left bundle branch block and the 1st degree AV block. Evidently the toxic substance had slowly accumulated to the level that caused a sudden onset of tachycardia followed by asystole; only this time no code team was present to revive him.

I pleaded with each of the physicians with whom I had earlier consulted to report this to their state licensing board. Each refused to do so. One of them told me that three of them had report this physician a few years earlier and that they were basically

chastised by the state licensing board for having done so, for having broken the unspoken code of silence.

I struggled with telling the family. Should I let them know what had happened? Would anyone listen? I had already been very vocal and it seemed only to fall on deaf ears. In the end I let it drop. I did not tell the family and I have wondered to this day if I did the right thing. Nothing was ever done about it. It was soon forgotten and the physician in question continued his incompetent practice, no doubt hastening the death of many other victims, or as they are called in medicine, patients.

These are but a couple of the numerous events by numerous incompetent physicians that I have witnessed in the clinical setting. Unfortunately the code is strong, even hovering over the nursing and ancillary health care professionals. Ironically, for both the physician and the non-physician health care worker, it is insecurity that maintains their silence. Both the nursing and the ancillary health care professionals are taught to stand in reverence to the all-knowing, almighty physician who is bigger than life and greatly honored by society. "Who are you to question such an icon?" On the other hand, the physicians, knowing this is but a facade, are all too aware of their personal incompetence. The universal protective, prevailing wisdom of the incompetent is that it is not wise to shine light on another's faults, for someone might then shine light on your own.

Medical Incompetence Goes Unpunished

Not only does medical incompetence abound and go largely unreported, it also goes virtually unpunished. Even when physicians report a colleague it is extremely likely that nothing significant will come of it. And those physicians who are disciplined are likely to suffer minimal repercussions.

Some time ago The New York Times ran an investigative story on how difficult it was for disciplined physicians to find work. Disciplinary records and hospital admitting records revealed that over the previous eight years more than 75% of the 285 physicians punished for clinical care issues simply resumed work almost immediately following the state's action against them.

Either they continued working at the hospitals where their problems occurred or were simply hired at another facility. This was especially true of those physicians who generated a lot of money for their institution. Ironically, doctors with disciplinary problems are often among the top third moneymakers at their particular facility. In 1999, thirty-two of the hospitals in New York State employed physicians with disciplinary records who were among their top revenue generators.[115] By December of 2003, consumer advocates of this state claimed that as many as eighteen lives per day were being lost because of the "state's lax enforcement of medical misconduct." [116]

The State Health Department was criticized for failing to revoke more medical licenses; officials merely responded a "complicated disciplinary system" makes that action difficult; although no policies exists among the state, the federal government, or JCHO, on hospitals handling this problem, they all argue that hospitals themselves are obligated to weed out bad doctors.

But this puts hospital administrators in a difficult and perhaps unrealistic position. They are not part of a regulatory agency, they are businessmen charged with making a profit for the investors. In today's world, a physician can bring in more than $1.5 million in business to the hospital.[117] Therefore, administrators eagerly view the state's refusal to revoke a medical license as a vote of confidence that the physician is fit to continue practicing. Furthermore there is the code of silence; both the business administrators and those key administrators who are actually physicians themselves are reluctant to punish one of their own.[118]

National Practitioner Data Bank

The medical profession is well aware of its incompetence. Years ago, a rash of publicly exposed episodes of physician incompetence sparked public interest in physician safety records. Advocates for full disclosure of these records argue for public access to the National Practitioner Data Bank—a cohesive national repository for all instances of disciplinary action against physicians.[119] Although their voices were heard on Capitol Hill on

the September 7, 2000 and culminated in the proposal of The Patient Protection Act, it was little more than placation on the part of the government. There is a major obstacle perhaps even a conspiracy, to prevent the collection of this data, much less its dissemination.

Of course physician groups strongly oppose The Patient Protection Act; claiming inaccurate records are unfair indicators of physician performance. They have recommended as an alternative that information on physician credentials and disciplinary actions be obtained from state-run data banks. But this too is a failure. Although many states have some form of publicly accessible data the profiles can be sketchy at best. Few states supplement the files with information on disciplinary actions, medical malpractice, or criminal convictions.

A report issued by the General Accounting Office described much of the data in the NPDB as "incomplete, inappropriate, inconsistent, and inaccurate." Nearly all medical malpractice records were incomplete. In addition, about one-third of the reports containing clinical restrictions against individual physicians were also missing important information.[120] This is hardly surprising considering that during the many years the data bank has been in operation mechanisms to ensure the quality and accuracy of reported information have never been put into place.[121]

Everyone But the Patient Knows

Unfortunately medical errors are not uncommon. Seemingly it is known to nearly everyone but the patient. A survey by The Robert Wood Johnson Foundation, conducted in the spring of 2001, questioned 600 physicians, 400 nurses and 200 senior hospital executives.[122] Herein, 95% of physicians, 89% of nurses and 81% of senior hospital executives admitted to having witnessed serious medical errors firsthand. The study also found that,

- 58% did not consider the U.S. health care system excellent or even very good at providing safe and effective treatments.

- 72% said the system needs fundamental change.
- 61% accepted common errors as routine practice.
- Only 45% believed perfection should be pursued.
- And only 29% believed they could provide leadership to improve the system.

This problem is very real. However, I contend its prevalence is due not to the occasional error committed by those few who know what they are doing, but to the host of incompetent physicians whose very practice is erroneous. Having available funds for expensive drugs and diagnostics procedures (even if they worked) is a moot point when physicians are not adequately prepared to utilize them.

A young physician friend of mine (who admittedly struggled with the realization of inadequacy in certain areas of practice) once confided to me that one of the more senior physicians on staff had given this advice, "I doesn't matter that you don't know what the patient's problem is or how to treat it, just be very nice to the patient and everything will be fine."

Medical incompetence and therefore medical error is rampant and the cause must lie at the feet of the American medical establishment. They have set the tone. They have paved the way for failure. They have sanctioned the inept medical education that sends necessarily ill-prepared physicians into clinical practice and, despite the known harm to society, these allopathic leaders continue to allow and even encourage incompetent physicians to advance their practices. Desperately hoping to keep the tradition of heroic intervention alive they—this elite society of medical magnates—continue to discourage alternative and holistic health philosophies and greedily encourage the treatment of metabolic disease by mostly ineffective synthetic substances.

Chapter Nine
Your Physician, Your Local Drug Pusher

We are a drug-ridden nation. Not illicit drugs so much as prescribed pharmaceuticals, which are far more prevalent and devastating. Illicit drug use is a factor to be sure; but it is merely a symptom of, and pales in comparison to, the bigger, government-regulated problem. Although illicit drugs claim a number of lives and cause crime rates to soar, generally the users are willing, promiscuous individuals. However, prescription drugs are literally forced down the throats of an unsuspecting innocent population. Many of these drugs do little more than provide temporary relief; or even worse, simply mask disease symptoms at the expense of the victim's future health. In the meantime the primary objective is met: pharmaceutical dividends accumulate and their stocks grow and divide.

Just as the medical education is the greatest shame in academia the booming pharmaceutical industry is the greatest business scam of all time. Once ridiculed as the "snake oil" salesmen of the 1800's, drummed out of town for their false claims, now they are subsidized and regulated by the federal government. Every year they peddle many billions of dollars of unnecessary synthetic chemicals to the American public.

The Most Profitable Industry

The pharmaceutical industry is by far the most powerful and wealthy of all the industries associated with the medical community. Its dominance is preserved as evermore drugs are

approved at an alarming rate.

The FDA approved 86 new drugs in 1992. By the year 2000, that number had jumped to 106. At the same time, they decreased the average approval time from more than twenty-four months to less than twelve.[123] There are "tens of thousands of brand name and generic drugs currently on the market."[124] Not that this volume is necessarily a bad thing but industry insiders know the driving factor behind these new drugs is not to affect cure or even to provide more effective products; the primary reason for most of these new drugs is to generate sales, to improve the company's bottom line.

In recent years new drug approvals have increased by about 30%. The cost of the federal drug prescription program has increased as well with some analysts predicting a cost of $1.2 trillion in the next decade.[125] While this fiscal matter is definitely very important, factor in consumer safety, along with the lack of clinical necessity for many of these new drugs, and suddenly it is very much a matter of ethics.

Government Mandated Drug Use

Beyond the FDA's participation, legislators have also gotten involved. Stringent government regulations as to the type of medical services and therapies that are reimbursed virtually necessitate public compliance with allopathic pharmacopoeia. An obscene amount of tax dollars is spent on drugs for Medicare and Medicaid recipients. Many patients might prefer alternative therapies for some of their ailments but the government will not allow it. Public participation in this drug scam is mandated. This, despite the fact that the known side effects for many of these drugs are very dangerous; and despite that fact that other health care philosophies and many scientists argue that it is absolutely impossible for inorganic synthetic chemicals to supply organic tissue the necessary nutrients for health and life.

Furthermore, as we have seen, it is very likely patients do not need many of the drugs their physicians have prescribed. But if patients want their physicians to write scripts for those medications they actually might need, they have to comply with

the unwarranted medications as well, or their physicians will likely refuse them service.

Even though the drug companies admit their products are harmful toxins, physicians continue to prescribe them haphazardly as if they were ingredients for their favorite Food Network recipe. A prime example of this careless practice is the simple antibiotic. Penicillin seemed to work miracles when it was introduced only a few decades ago. But in a very short time, due to misuse, the bacteria had adapted to this miracle. Not to be dissuaded, we manufactured other antibiotics. And for the same reason, the microbes adapted to them as well. So we created more and more still; but the resilient bacteria would not give up. Now, due to the physician's overutilization and misallocation, on some fronts, these new super microbes are on the verge of actually winning the war.

Antibiotic-resistant bacteria are on the rise. Many years ago the Centers for Disease Control warned that excessive and unnecessary use of antibiotics would lead to the evolution of superbugs. They also warned us these superbugs would be difficult and expensive to treat. Prior to 1980, in the U.S. more than 99% of all streptococcus pneumonia was sensitive to penicillin. This is no longer the case. Today we face a growing community epidemic of streptococcus pneumonia from an increasing percentage of penicillin-resistant pneumococcus. The percentage of pneumococcal illness caused by bacteria resistant to three or more classes of antibiotics is on the rise.

What is the cause for these resistant bacterial strains? Physicians. Despite years of multiple warnings from the scientific community, clinicians continue to prescribe antibiotics for medical conditions upon which they have no affect.[126] It has been estimated that more than half of all antibiotic prescriptions are unnecessary. An article in JAMA some years ago, reported that 51% of patients with colds, 52% of patients with upper respiratory infection and 66% of patients with bronchitis are given antibiotics.

Another study found that in the state of Kentucky, 60% of the patients with common colds and 75% of the bronchitis patients were prescribed antibiotics.[127] Not that Kentucky is to be

singled out as a prime offender, this just happens to be the state in which the study was performed. I would be more than surprised if this did not reflect the situation in the rest of the nation.

The same edition of JAMA reported that "Physician focus groups say the major reason is unrealistic patient expectations, coupled with insufficient time to discuss with patients why an antibiotic is not needed."[128] But I reject this excuse. The only expectation the patients have is that which the medical community has coxed them into believing and expecting; that is, that physicians have a magic pill for every disease.

One must wonder if physicians are more concerned with the promotion of health or the promotion of product. At the very least, it would seem the primary task of the modern medical doctor is not to teach health to their patients but to peddle the products of their master, the pharmaceutical industry—from whom their power and ultimately their sustenance comes.

Although there is yet another issue for this misuse, which was discussed earlier; it is that of competence or rather, the lack thereof. Dr. Schwartz speaks directly to this matter when he says, "Although less readily admitted, physicians' inadequate knowledge of the respiratory symptoms and signs and natural history of respiratory illnesses also contributes to antibiotic overuse." Ironically, despite the average physician's ignorance of respiratory illnesses, one study concluded that about half of the doctor's office visits in the country are to treat a cough.

It is but an easy copout to claim "insufficient time to discuss options with patients". And it is a convenient way to ignore the real issue that many physicians are too busy making money, cranking patients through the system, to actually stop and play doctor with them; and furthermore, as Dr. Schwartz has pointed out, many of the physicians frankly don't understand the diseases. They are simply ignorant of the symptoms of a common colds, bronchitis and simple upper respiratory infections. If nothing else, this is a very scary thought to realize that perhaps half of our physicians know less about a common cold than our grandmothers. It also begs the question: what then do these

physicians understand if not these common illnesses?

Writing Prescriptions is a Business

The medical license is the physician's key to the franchise, a guaranteed distributorship. The franchise is drug distribution and the business is writing prescriptions. This is why physicians are so opposed to other health professionals having the authority to write prescriptions, or for medications to become unregulated, over the counter items. Neither public health nor public safety is the issue. The issue is simple economics.

Writing prescriptions is the physician's bread and butter and they are writing more than ever. Physicians learn early on, some even while in medical school, that if they write a prescription for their patients during a routine office visit, they well be able to submit a larger reimbursement invoice to the insurance company. And of course, it is the routine prescription refill that keeps the patient coming back month after month.

One physician study group revealed that physicians know the almighty prescription is the reason patients come to see them. On average the elderly were given about twenty prescriptions per year in 1992; in the year 2000 they received about twenty-nine prescriptions and it was predicted to be about thirty-nine prescriptions per year by 2010;[129] this, despite the fact that few of these drugs are actually necessary.

Writing drug prescriptions is tradition and those who break from convention are subject to peer ridicule as David Morris, MD, of the prestigious Hebrew Home for the Aged discovered. After a methodical evaluation of each patient's drug regimen—giving special attention to medications for diabetes, hypertension, high-cholesterol, depression and other chronic illness—he began to wean his patients (average age of 88) off the unnecessary medications. The reaction from other physicians and even some of the patient's family members was described as "vehement opposition to his unusual crusade."[130]

Creating a Need

Physicians are simply the middlemen through which drug companies peddle their product. Drug manufacturers can sell

drugs only if people are convinced they need drugs.[131] As evidenced by the aforementioned incident at the Hebrew Home for the Aged, the pharmaceutical companies are succeeding quite well. The industry uses several strategies and spends billions of dollars a year to convince us we need their lethal synthetic substances. While many marketing pitches are geared to creating a consumer desire for their product based upon want, the drug industry purposefully aims for a consumer desire based upon need, or rather perceived need; and it is a very successful tactic.

First they must convince us that we are sick. In general, this is an industry wide effort.[132] Then each company must convince us their product is the only, or at least the best, agent of cure. To assist the pharmaceutical industry in achieving their goal, President Clinton allowed the removal of certain obstacles. Federal regulations were loosened in 1997 thereby permitting the drug industry to provide more direct-to-consumer advertisement. Access to the mass media, once highly regulated, became an open door. The drug industry seized the opportunity and immediately turned their attention to television, radio and magazine advertisement.

Although nothing happens until the doctor writes the prescription, marketing experts know that physicians will comply with a patient's request for a specific medication about 70% of the time.[133] This marketing strategy was validated by a report in the Associated Press. "Drug companies were promoting their top-selling prescription medicines with the same tactics used by mass merchandisers: coupons and, in some cases, money-back guarantees."[134] Obviously the drug companies are expecting physician compliance, for they are the gatekeepers, the peddlers who ultimately must write the prescriptions.

Pandering

Pandering is a considerable portion of the pharmaceutical budget. Big Pharma spends from $30 to $60 billion a year marketing to physicians. Residents are especially targeted because they have long hours, low pay, and a lack of experience that makes them hungry and vulnerable. Perhaps more important, they have a

lifetime of writing prescriptions before them. The drug companies know that the earlier they bring these "prescription writers" into their stable the more money they will generate.[135]

It is not uncommon for a drug company to be entangled in somewhat questionable relationships. Several years ago, one company blatantly offered physicians $100 dollars for simply reading their literature which encouraged the use of a highly toxic drug that had not yet been approved by the FDA. Another company offered a researcher $20,000 if he could publish a "seemingly responsible—and positive—study" in a major medical journal.[136]

Unrestrained marketing practices in the name of education are another common expenditure. Billion of dollars are spent on "education" symposiums.[137] Although advertised as educational seminars, many of these gatherings are little more than elaborate sales pitches at which physicians are wined and dined at the very least. Often far more is included.

Physicians who speak at these educational seminars are paid a handsome fee for their services. That is, as long as they are promoting some drug. Lynn Prayer recounted Dr. James Sanders' invitation to speak about his topic of expertise: drug and alcohol abuse. When asked what drugs he would be discussing so the organizer could find a drug sponsor, he responded that he was "trying to get addicted people off prescription drugs, rather than on them."[138] With this his speaking invitation was revoked.

From the results of a conflict of interest investigation, concerning physicians and the pharmaceutical industry, Norris and other realized an extensive financial connection. 373 physicians received $52,600,624, an average of $141,020 per physician. Of these, "147 of these physicians authored a total of 134 publications in the first quarter of 2011." While 103 publications disclosed a conflict of interest 69% of them did not mention the money that had exchanged hands.[139]

Big Pharma, the driving force behind modern medicine, does not take kindly to non-Koolaid-drinkers, especially when it is one of their own, whom they have trained to tow the line. (Please

excuse the mixed metaphors; I couldn't help myself). Payer also tells us of Dr. Ralph Lach's experience. Although he was the Director of The Adult Cardiovascular Training Program at Mount Carmel Medical Center, he had been critical of high cholesterol medications. He explained that dissenters, like himself, were suppressed in a passive fashion. There is no forum for his anti-medication viewpoint. When he speaks of the lack of clinical evidence as to the benefit for cholesterol-lowering drugs his honorarium is nonexistent. Meanwhile, advocates for cholesterol-lowering drugs are readily supported by the pharmaceutical industry.[140]

Such is the case with L-Arginine, a known, natural anti-cholesterol agent. Who is going to sponsor a speaker for this topic; especially when cholesterol-lowering medications are among the top selling drugs?[141] The subject of L-Arginine and low cholesterol is not likely to appear at any "educational" symposiums in the near future. L-Arginine is a simple amino acid that cannot be patented. Therefore an outlandish markup is not justifiable. But the ineffective, even dangerous, anti-cholesterol drugs are patented and thus able to demand the obscene markup. Modern medicine is a simple economical arrangement. The pharmaceutical companies pitch drugs to the physicians and the physicians peddles them to their patients.

Dr. Atkins concluded the drug industry has seduced the entire medical profession. Physicians, who at one time were "open to any therapeutic system that appealed to a rationalist's intellect," now assume the only answers are pharmaceutical in nature.[142] Many of his colleagues would seemingly agree, each having written their own book on similar alternative health care methods: Robert Mendelsohn, MD,[143] Guylaine Lanctot, MD,[144] Loraine Day, MD,[145] Rudolph Ballentine, MD,[146] and Stuart Berger, MD,[147] are but a few.

Chapter Ten
Lies and False Advertisement

OK, this is the last chapter of exposing the corrupt nature of the American medical community before we get to the proposed solution.

The world of medical journals is a curious thing in clinical medicine. Although everyone is aware of potential bias, once an article is printed in a respected medical journal of The Index Medicus it is gospel. Authors and articles are referenced as authoritative, if not infallible. At the very least they are referenced to justify one's own bias.

For the physician, once the medical textbooks are set aside nearly the entire scope of health and medical knowledge revolves around the pharmaceutical sales rep and medical journals.[148] The journals are where physicians keep up on current findings, new procedures, discoveries and most important new drugs. It therefore comes as no surprise that medical journals are tremendously important to the pharmaceutical industry. Major pharmaceutical companies have a great deal to say about what these medical journals print. Aside from sponsoring authors, funding studies, perhaps even owning some of the journals, the pharmaceutical industry supports nearly all (if not all) of these journals with advertisement dollars.[149]

The issue of medical journals having financial ties to private industry is not new. In the 1870s, Parke-Davis actually purchased several successful medical journals—each headed by leading

physicians or professors at prestigious medical schools. Even before the dawning of the 20th Century many prominent medical leaders were salaried by the drug industry. By 1906, all but one of two-hundred and fifty medical journals was supported by pharmaceutical advertisements.[150]

Unfortunately, as a direct result of this conflict, the studies reported in various medical journals are not necessarily trustworthy. In 2012, Giovanni A. Fava submited the following report as to the reliability of clincal findings within the pharmaceutical industry.

> The reliability of reports of studies funded by the pharmaceutical industry has been seriously questioned. Researchers with financial conflicts of interest are more likely to publish articles (original investigations, editorials, systematic and non-systematic reviews, meta-analyses) that support the products of the companies with which the researchers have financial ties. Simple disclosure of financial conflicts of interest is not regarded as sufficient for original studies funded by pharmaceutical companies, and strategies for minimizing biases have been suggested, such as ensuring that at least one author who is not employed by a commercial firm has full access to all of the data and the use of an independent biostatistician. Surprisingly, however, little has been proposed to minimize bias in other types of papers, and particularly meta-analyses. When these latter papers have been supported by the industry, by means of funding or authors' ties, they have been found to reach conclusions that favored sponsors' interests more than independent meta-analyses. Furthermore, Rosemanetal, found that only 7% of meta-analyses concerned with pharmacological trials reported the funding sources of the studies that were selected for analysis, despite the fact that about two-thirds of all trials are industry funded. This is interesting given the fact that meta-analysts are expected to assess the risk of bias related to various aspects of the trials they select for analysis and to exclude unreliable

> investigations. The reader trusts that this check has indeed taken place, but it is difficult to believe that it has if conflict of interest in the trials was not even reported in the paper."[151]

Advertisement Dollars and Ethics

Despite the stated ethical standards, which are common to every medical journal, and the ostensible commitment to true science, Big Pharma's multi-billion dollar budget for journal advertisements wields considerable power over what is and is not printed. For example, a certain major pharmaceutical company once pulled its advertising from JAMA for having published an article that cited its competitor. To placate this powerful drug lord the journal published an appeasement—a make-up article.[152]

Some of the most prestigious medial journals openly shop for additional pharmaceutical advertisement funds. The Association of Medical Publications has argued that advertisement in their journals delivers a higher return than other marketing tactics, including physician visits, promotional events and direct-to-consumer advertising. Their contention is that advertisements in professional journals are where physicians learn about the drugs they prescribe.[153]

Pharmaceutical advertisements are simply out of control. I understand the logic for placing these ads in professional journals (although I do have ethical issues with the practice); but what I find so bewildering, so non-scientific, is the direct-to-consumer advertisements. Anyone who has watched television for more than an hour has seen them. They are all of the same formula. First comes the absurd hook. On the screen is an attractive model or two partaking of some pleasurable activity. The prospective drug taker (you) is told of all the wonderful benefits this particular drug offers. The implication is that your life could not possibly be complete without it. Then comes the incongruous passionate plea for you to solicit your physician for a prescription. And finally the small print—the soft, rapidly spoken warning that this drug could kill you. Now my question is twofold: if this drug is the new miracle cure for a certain disease and if physicians are the all

knowing masters of medicine; why must the patient beg the physician to prescribe this wonderful cure?

Research Bias and Drugs Companies

The mere publication of a research article does not, in itself, prompt rank and file physicians to implement the findings. Most physicians will not employ new therapies until the go-a-head is given by the elite powerbrokers of medicine (CDC, journal editors, Big Pharma spokesmen, FDA, etc.); and this go-a-head is not given to anything that threatens to compete with the pharmaceutical industry, even if a journal article has been published.

Such is the case with the voluminous research of the amino acid, L-Arginine, to treat such cardiovascular disorders as hypertension, high cholesterol, congestive heart failure and impotence. The medical community is guilty of ignoring decades of scientific research concerning the beneficial biological effects of nitric oxide and its biochemical precursor, L-Arginine. Certainly it is not overlooked due to a lack of data. Although a seemingly endless number of research articles explain its clinical benefits, there is a dearth of literature directed toward rank and file clinicians—articles couched in terms they can understand in a practical sense. Articles that simply tell them to "prescribe L-Arginine for . . . ."

Am I saying that physicians cannot understand scientific articles? Not exactly. But I am saying that few will make the connection between the scientific research of non-pharmaceuticals and their clinical practice. At least they will not lead the way. Most of them simply will not make the research part of their clinical practice until a major spokesman—a clinical guru—tells them to do so. This is how medicine works. Rank and file clinicians do not break from pharmaceutical tradition until directed to do so by a recognized spokesmen of the medical establishment. Those who do break rank face the danger of malpractice accusations within the world of Big Pharma.

For allopathic medicine, the primary problem with something like L-Arginine is the enormous potential it possesses to help heal

a nation sickened by cardiovascular disease—an outcome that would drain the very life blood from the medical industry that desperately needs to treat cardiovascular disease to keep itself alive. Without cardiovascular disease and its comorbidities the industry crumbles.

Thus, regardless of extensive research that has astounding outcomes (some of which even won the 1998 Nobel Prize for Science and Medicine), a void of information concerning L-Arginine persists among medical doctors and their patients. Physicians neglect this research for a few reasons: (1) It is not promoted by the pharmaceutical industry, which will never indorse it because it is a micronutrient from which the industry gets no income. (2) Because it is not a drug (a regulated substance), no prescription is necessary, which is the symbol and means of the clinical physician's significance. (3) Most physicians do not understand nutritional cures. It is not part of their training. And finally (4) the movers and shakers, closely tied to the pharmaceutical industry will continue to issue white papers, which are little more than sales pitches deriding natural cures and hyping synthetic pharmaceuticals.

Medical Journals

Knowing they are the primary source of physician education, medical journals pride themselves on being fair and scientific. Each publication has an ethical policy that, theoretically, avoids bias and conflicts-of-interest. However, in the practical world bias often makes it to print; sometimes fraudulent, sometimes philosophical, but bias is printed.

Although it is seldom made public, many within the industry know outright corruption is commonplace. For example, one pharmaceutical company offered $20,000 if a particular researcher would publish a seemingly responsible and positive study on their drug.[154] Even when knowledge of such corruption leaks, it is a soon forgotten and business resumes as usual.

Several years ago, The Los Angeles Times revealed that editors of the prestigious New England Journal of Medicine routinely approved drug review articles despite knowing the

authors had received research support from the pharmaceutical companies through their perspective academic institutions. An internal audit identified nineteen offending articles, totaling nearly half of the drug review articles published in recent years.[155] The Editor-in-Chief at that time, Dr. Marcia Angell, who had fought against this unethical practice, finally resigned her position in frustration.

The outspoken Editor-in-Chief was replaced in May 2001, by a doctor who just happened to be an author of one of the review articles criticized for a conflict-of-interest. The new Editor-in-Chief defended himself saying that NEJM editors knew of his financial ties to the drug company and, he confessed, it is difficult to find colleagues who do not have such ties to the drug industry. Concern that the new editor was too closely tied to the pharmaceutical industry raised to a new level when it was discovered his salary came largely from the pharmaceutical industry. The Chicago Tribune felt this ethical crisis was such a significant threat that perhaps it could even "destroy medical research".[156] Certainly, one would think that the exposure of such conflict-of-interest within one of America's most prestigious medical journals should at least give cause for concern; for, by extension, it implicates the entire medical industry. Of course, nothing ever came of it; few even raise an eyebrow and conflict-of-interest articles continue—business as usual—to this day.

It came and went without notice; largely overlooked by the media very few Americans learned about it. Not that the public would have cared, had they known; for they have been trained to trust the medical community, to trust their physician, to believe their physician knows all and always has their best interest in mind.

That one of medicine's most eminent publications was caught red handed in unethical conflict-of-interest publications is more than an embarrassment, it is sufficient reason to suspect this unethical practice exists throughout the industry. How are we to know when we are reading balanced scientific reporting verses biased pharmaceutical hype? Having this very concern, Dr. Angell eventually called for an independent national advisory panel

composed of distinguished experts who have no stake in the powerful pharmaceutical industry. She hoped the panel would evaluate industry practices, make non-binding recommendations and generate reform.[157] As far as I know, this has not happened.

On June 21, 2001 Dr. Angell and Dr. Relman wrote in The Washington Post, "Few Americans appreciate the full scope and consequences of the pharmaceutical industry's hold on our health care system." They cautioned that as Congress considers Medicare prescription drug issues there must be a "thorough understanding of the industry's behavior . . . It's time to take a hard look at the pharmaceutical industry and hold it accountable. . . . We can't think of a more urgent investigative assignment for the Senate Committee on Health, Education, Labor and Pensions." However, without public outcry their plea merely fell on deaf ears. The drug industry has the largest lobby in Washington D.C., contributing sizeable sums to many political campaigns.[158]

Aside from the legal issues and the allegations of dirty money changing hands, there are clinical implications to this corruption. By their own admission these medical journals are where physicians learn about the drugs they prescribe.[159] It is bad enough that the journals are filled with skewed information in the form of advertisements but we now have evidence that physicians are also indoctrinated by skewed, biased scientific research. Springing forth from this fraudulent information is an untold number of unnecessary and even harmful drug prescriptions, costing the nation both dollars and lives. It is this fraudulent industry to which The Affordable Care Act wants everyone to have access. This legislation is doing neither the patient nor the country any favors.

More Misinformation

Beyond the contrived pharmaceutical studies to make their products appear more beneficial and less harmful than they actually are, another form of misinformation is disseminated by the medical establishment concerning nutrition and nutritional supplements. The importance of proper nutrition is typically brushed aside as an annoying, unimportant element of medical

concern.

Nutrition is something simply not on the radar of allopathic physicians; and for good reason. Allopathic medicine is purely pharmaceutical driven. This is where the money is; not merely the inflated cost of pharmaceuticals, but the largely bogus billable item of the doctor's visit, which is required to receive the physician's prized signature to permit the acquisition of the largely unnecessary pharmaceuticals. There is a symbiotic relationship between the costly pharmaceuticals (which keep the drug industry afloat), and the billable office visit (which keeps the physician afloat). Unregulated nutrition and nutritional supplements do not fit into the scenario; they only dilute the money pool. That is why nutrition is virtually a non-subject in medical school.

It is for this reason that promising nutritional cures and treatments are suppressed while the pharmaceutical industry fervently attempts to concoct a synthetic substitute. The synthetic version is then regulated so that it requires a physician's prescription; thereby becoming a profitable revenue stream. The natural micronutrient brings them no income; even worse, it competes with their synthetic product, threatening a loss of potential income.

Addressing cures for cancer, Allan Spreen, MD, a member of The Health Sciences Institute Advisory Panel and the author of TOMMOROW'S CANCER CURES TODAY, explains the following (although what he says is also true of other profitable, pharmaceutically-treated, diseases).

> When a natural substance shows promise against cancer, the drug companies invest all their time and money into developing a synthetic version of it that can be patented. More often than not, it just doesn't work. But letting the public know that there's a cheap, natural cure would mean missing out on cold, hard cash. So what happens to all those study results? . . . The Big Pharma bigwigs and the government powers-that-be skew the results and sway public opinion away from the natural cure. Half truths, misleading data, manipulated results . . . For all the underhanded tactics

> the mainstream uses against natural remedies, these miracles may as well be under lock and key.[160]

Even potential cancer cures are neglected because allopathic medicine needs cancer almost as much as it needs cardiovascular disease. In the following passage, Dr. Spreen speaks of the effectiveness of HZ (a nutritional treatment for cancer) on a BBS radio show.

> The most powerful cancer agency in the world has spent the last thirty years frantically trying to keep a lid on this breakthrough therapy. You won't believe it when you hear about the underhanded tactics they resorted to . . . . But what makes this cover up even more despicable is the fact that it's not the first time it's happened! Are you willing to die for their deadly sin?
>
> I've spent the better part of my career researching what nature has to offer in terms of cancer treatments. And the disturbing truth is, when it comes to natural cancer breakthroughs, the mainstream (including some of the most prominent health organizations all over the world) has a habit of botching studies, skewing results, and hiding the truth about Nature's cancer-curing potential; . . ." as in "a 2006 survey sent by the Union of Concerned Scientists to nearly 6,000 FDA scientists. Those scientists that responded to the survey (about 1,000 of them) made some pretty shocking admissions . . . almost 20 percent admitted that they had been 'asked explicitly by FDA decision makers to provide incomplete, inaccurate, or misleading information to the public, regulated industry, media, or elected/senior government officials.' Less than 50 percent agreed that the FDA 'routinely provides complete and accurate information to the public.' 47 percent admitted of being aware of instances 'where commercial interests have inappropriately induced or attempted to induce the reversal, withdrawal or modification of FDA determinations or actions.' That last admission gets right to the heart of the matter . . . . It all

> boils down to one of the deadly sins—greed. The FDA will sell you out and pocket the change![161]

The orchestrated misinformation, generated by the movers and shakers of Big Pharma and the FDA, naturally trickles down to clinical physicians. Especially since nutrition is not a significant part of their medical training. In the following, extended passage, Russell L. Blaylock, MD, explains the dichotomy between nutrition and pharmaceuticals at the clinical level as such:

> I tell my patients that every major medical journal and surgical specialty journal contains at least one nutritional-based article in virtually every issue. The problem is that doctors do not read them. Instead, they focus on articles concerning the newest surgical techniques, diagnostic tests, or expensive drug treatments. My theory is that nutrition articles are ignored because doctors simply don't understand them, especially if there is a lot of biochemistry involved. In addition, nutritional treatments will not increased a doctor's sagging income the way an exorbitant new procedure can.
>
> . . . . . .
>
> They only time doctors ever learn anything about biochemistry or nutrition is in connection with a pharmaceutical drug's mode or action or a very focused review of a disease process. Actually applying biochemical/nutrition knowledge to patient care was and is as rare as hen's teeth. Nutrition is essentially biochemistry, and medical care devoid of nutritional considerations is like a care without wheels. It goes no where.
>
> Take something as simple as a common infection. When most doctors see a patient with an infection (e.g. pneumonia), their first thought is to culture the organism, identify it, and specify an antibiotic appropriate to effectively treat it. This is basic medicine, . . . But simply giving the antibiotic leaves a huge gap in properly treating the patient. It is rare in my experience that doctors will place such a patient on probiotic organisms and prebiotic support

nutrients to assure the growth of friendly organisms.

We all learned in medical school that broad-spectrum antibiotics both pathogenic disease-causing organisms, as well as beneficial colon bacteria, and that an overgrowth of pathogenic bacteria caused by the antibiotic can lead to the often fatal condition called pseudomembraneous colitis. But, we were never taught what to do about it. We were also not told that one of the most common secondary problems with frequent or prolonged antibiotic usage is yeast overgrowth (Candidia albicans) and that it can lead to numerous and severe long-term complications.

We were not taught about the importance of nutrition in immune function, and the antibiotics work better when we utilize nutritional non-specific immune stimulation. In addition, most doctors do not seem to understand that certain foods, particularly fats, can severely impair the immune system, causing antibiotics to fail and an infection to spiral out of control. Few doctors know that iron supplements can cause existing infections to become deadly and uncontrollable—all of this despite the numerous studies that have appeared in peer-reviewed medical journals emphasizing the importance of nutrition in controlling infections. These are articles that they skip over to read about the latest prescription drug.[162]

All About the Money

The pharmaceutical industry (and by extension its child, allopathic medicine), is all about making a profit. Health is not really their forte. Allopathy needs America to be sick; for sickness is how it makes a living. Health and wellness are more than foreign concepts to allloplthy, health and wellness are the enemy.

To insure a solid bottom line, the drug industry has several successful tactics. The corruption of scientific research, strategic maneuvers in the courts and the filing of frivolous patents are but a few of the many tricks up their sleeves. They also have some of the most powerful lobbyists on Capitol Hill to make sure allopathy

retains its monopoly on health care and to insure Big Phama continues to receive government subsidies and huge tax breaks. Strong, direct to consumer marketing (made possible by legislative decree under Bill Clinton) is another arrow in their quiver. Then too, of course, is the ever increasing number and cost of prescriptions.

Aside from milking the federal government of subsidies and substantial tax breaks the pharmaceutical industry is holding hostage our senior citizens. Several years ago Dr. Suresh Madhavan, of West Virginia University's School of Pharmacy, explained to the Senate Health and Human Resources Committee that while part of the spending increase is the result of an increased number of recipients some of it is because the number of prescriptions per recipient has almost doubled. Dr. Madhaven explained that two factors for this increase are the aging population and direct-to-consumer advertising.[163] The drug industry, of course, asserts this increased spending is a result of more advanced, more effective drugs that could cost far less in the long run by helping patients avoid more costly interventions.[164] However, John Brown, a lobbyist for Pharmaceuticals Research and Manufacturers of America, has conceded that the industry is simply doing more advertisement.[165]

Are All These Drugs Necessary?

Beyond the high cost of drugs, the poor quality of care generated by the plethora of drugs is even more alarming. While physicians bemoan clinical standards and defend their autonomy, it seems clear, for the purpose of public safety, that exactly the opposite is warranted. Both society and the legislators have been duped. Despite the insane idea that metabolic disease can be cured by drugs; despite the absurdly excessive medical orders for them, and despite the disabling and deadly side effects so many of them possess; still the population clamors for more.

I submit that before subsidizing the costs of these lethal and mostly useless substances, the government should entertain the mounting evidence that shows these medications are used excessively and unnecessarily? Dr. Madhavan has suggested as

much, warning that the more drugs a person takes the more likely that person will develop problems caused by the interaction of the different drugs. According to Mark Beers, MD, a geriatrician and Editor-in-Chief of the Merck Medical Manuals, "a person taking seven medications is roughly 14 times more likely to have an adverse reaction than a person taking one."[166] These problems also contribute to higher medical costs: more doctors' visits, more hospital admissions and even more drugs to address the ill effects of previous drugs.[167]

In the JAMA study mentioned earlier, "71% of newly licensed family practitioners prescribed potentially inappropriate medication to their elderly patients"."[168] The author went on to audaciously question whether a passing grade of 50% on the physician's board certification exam was high enough. Now there's a novel idea. What a progressive thought. Make physicians actually achieve passing grades before granting them certification in a particular specialty.

Considering that each of these drugs works by blocking, or in some way inhibiting, normal body chemistry, merely substituting one imbalance for another,[169] how can either the drug pushers or the drugs themselves be classified as promoters of health? And why do we continue to follow this trail of disaster? Why indeed? Largely, it is human nature to trust those in authority. To trust that physicians know what they are doing. But we trust them to the point that we throw logic to the wind and follow like sheep. Physicians understand this, and milk this trust for all it is worth. But even beyond the trust issue, is the issue of government mandate. Granted, some of these medications do have a place in certain people's well-being, but so many of the drugs physician's prescribe are all too often simply not warranted; nevertheless, for Medicare, or even a private insurer, to pick up the tab patient's must follow the allopathic path of pills and more pills. Alternative methods of wellness and nutritional supplements are not on their approval list.

Synthetic drugs are not the answer to the majority of the nation's health problems. Although they realize great profit and

support many economies, they do not and cannot support life at the cellular level. Some of these drugs can affect some benefit to be sure, but they are few, very few, and they are mostly available in generic form. Overall, society would be far better off without most of Pharmacopeia.

Health Care, Drugs and Crime

Health care is inextricably intertwined with the drug industry; while the drug industry (both the legal and the illegal) is equally entangled with crime and poverty. Poverty, because so many spend their scarce resources to purchase either illicit drugs or the even more expensive and usually just as unnecessary medications their pharmaceutical-happy physician has prescribed. Crime, because so many of those addicted to illicit drugs commit crimes to get money to buy their drugs; and of course, those manufacturing and selling the illegal drugs are criminals by definition.

But most disturbing is that over the last few decades the pharmaceutical industry, and many the physicians who peddle their products, have actually become the progenitors of a specific and violent criminal behavior. I speak, of course, of the multitude of sociopathic murderers they have unlashed upon society by feeding antidepressant medications to multitudes of unwary followers. These drugs harbor well-known psychotic side effects—the side effects are aired countless times every day over the radio waves and television. The joyous and emotionally charged commercials seek to entice listeners into asking their physician for one of these poisons. As it draws to an end, a soft, rapid speaking voice warns of its dangers. But these dangers are not to be taken lightly as the soft, rapid voice would imply. Suicide and murder are very real life ending events.

Antidepressants inhibit the reuptake of serotonin, one of the brain's most important biochemicals. Serotonin levels have critical significance to many functions such as appetite, mood swings and sleep. A lack of serotonin can be expressed by moodiness, depression, compulsively eating or gambling and insomnia. But you can also have too much serotonin. In Health and Nutrition

Secrets, Dr. Russell L. Blaylock writes,

> It is also known that these medications increase brain levels of the neurotransmitter serotonin, which, in high concentrations, can also act as an excitotoxin.[170]

Elevated serotonin levels due to these antidepressant drugs, creates a condition similar to mental illness that is expressed by many dysfunctions, not the least of which is homicidal or suicidal thoughts and behavior.[171]

Antidepressants are the pink elephant in the room that no one in government will address; at least not seriously. So many of the mass murderers in recent years, and virtually everyone who murders multiple members of their own family or coworkers or fellow students is a user of these medications. These drugs change a person's psyche so they no longer live in the same reality as the rest of us.

Deviant behavior, thoughts of murder and suicide, among these users is well established. Yet, rather than confront the widespread use of these legal, yet highly destructive drugs, many in society—encouraged by feebleminded politicians—prefer to shift the blame onto the gun. But those under the influence of these drugs will find other means to act out the fantasy world their physician has helped them create. Consistently, year after year, according to the FBI, more people are killed by hammers and clubs than by rifles. In 2011, for example, there were 323 killed by a rifle and 496 killed by a hammers and clubs.[172] Neither the hammer nor the gun is the issue. The issue too many times is psychotropic drugs, legally prescribed by medical doctors. The most recent data I could find from the National Center of Health Statistics reveals that:

> Antidepressants were the third most common prescription drug taken by Americans of all ages in 2005–2008 and the most frequently used by persons aged 18–44 years. From 1988–1994 through 2005–2008, the rate of antidepressant use in the United States among all ages increased nearly 400%.[173]

Looking for any way possible to get these dangerous drugs into the population, the FDA has already approved some antidepressants to help smokers stop smoking. Even as I write, the FDA (which Big Pharma manipulates like a marionette) is considering Paxil to treat menopausal hot flashes. It has issued a favorable review despite the failure to meet initial targets during research. This is blatantly profit driven, for obviously their known, deadly side effects are of no concern; not when compared to the estimated $1.5 billion expanded market it will open.

Beyond the issue of the violence perpetrated by many psychotropic drug users, this issue demonstrates how the health care dilemma entails far more than mere easy access and adequate funds. We must look at what we are funding. This is the real issue. Unnecessary test and procedures, unwarranted hospitalizations, unnecessary and even harmful medications, unnecessary medical office visits, unnecessary medical devices, etc. This is where the money is going; and yet this is what the The Affordable Care Act desires more of for everyone.

Chapter Eleven
Ask The Right Questions, Get The Right Answers

What then is the answer to this national dilemma of misallocated resources and fraudulent practices? Speaking as one with a considerable degree of insider knowledge and experience in health care, I propose a realistic answer to this entangled quandary. No doubt other reforms could also be in order, but for any of them to make even the slightest difference, the proposal I am about to set forth (or another similar proposal that addresses these pertinent issues) is an absolute necessity. It is an obvious and practical solution that neither the medical community nor their hired political lobbyist wants to discuss; for it would greatly rock their world.

Quality of Health Care

To appreciate this plan will require a new way of thinking about our health care system; a change, if you will, in our espoused values as they pertain to health care. Or rather, and perhaps better stated, a change in our perception of health care. This being said, the questions that must shape our new set of values, or our new perception of health care, are the following:

How do we define quality health care?

How do we best achieve the judicious, efficient and effective utilization of our medical resources?

Is health care to be a business, a public service, or something in between?

As for the definition of quality health care, I contend the following. Quality health care includes all proven and potentially effective treatments and remedies that achieve health, maintain wellness and promote the freedom from or management of disease processes: from nutrition and fitness to medications, technologies and surgical interventions.

We best achieve the judicious, efficient and effective use of public resources by applying these resources toward quality health care services that cannot be provided without professional expertise. Health care is then viewed as both a business and a public service: low acuity care would operate as a free market enterprise with no federal funding, while high acuity care and hospitalization would be a free public service, subsidize by federal funds.

Public Service and For Profit Enterprise

For routine, low-level health care services, patients would be encouraged to take responsibility for their own health. The physician monopoly on health care would be abolished, so that patients could seek advice from any health care professional they desired: a nutritionist, a naturopath, a nurse, a therapist of various disciplines, a chiropractor, an exercise physiologist, a dentist, a physician, or they might simply choose to treat themselves. Having such options would open the market, create meaningful competition and thereby lower costs; and I assure you, these various professionals know more about their particular discipline than does the current physician. Even the inquisitive nonprofessional, with but a small amount of research, can know as much about their particular medical condition as does their physician.

While this routine, day-to-day health care would be a pay-per-service enterprise, with no federal funding, the allocation of advanced medical services, such as surgery and hospitalization, would be deemed a public service, provided freely to all citizens by the federal government. But here are the caveats. Only truly ill patients in need of advanced medical care that could not be provided elsewhere, and whose conditions could be improved

upon discharge, would be hospitalized freely and cared for by highly trained physicians and surgeons.

As such, hospitals would be for the seriously and critically ill; they would not constitute the current "Club Med" atmosphere, which is largely a respite for folks with coughing spells, the flu, sore muscles, weakness, old age, terminal conditions and all other manner of non-serious, or conversely, untreatable, chronic conditions. Furthermore, hospitalization would only apply those conditions that could reasonably be expected to be improved upon discharge. Those with medical condition that cannot change with hospitalization, or with conditions that could easily be treated elsewhere, would not be hospitalized. This alone would be an unimaginable relief to the current system.

Again, as I mentioned earlier, one might expect these qualifications for hospitalization to be the current model; but I assure you they are not. The far majority of hospitalized patients in the current system could easily be treated elsewhere and many of them will not be any better upon discharge than they were upon admission.

It must be noted that by containing the overutilization and fraudulent services (which currently accounts for the majority of care provided) substantially less funds would be required; indeed it would require but a small fraction of the present cost. If Dr. Mendelsohn is correct with his claim that 90% of medicine is unwarranted, it could be as low as 10% of our current costs.[174]

Physicians and Surgeons

To take care of these high acuity patients in need of hospitalization, a well trained, genuine, academic doctorate of medicine would be instituted. Perhaps it could be called the Doctor of Medicine, Critical Care (MD, CC). Unlike the current inadequate requirements for medical licensure and certification in critical care, this advanced degree would require another four years of intense academic work beyond the present inept medical education. No one but the MD, CC could admit or write medical orders for hospitalized patients.

To contain overutilization and promote optimal care,

hospitals would pay these MD, CCs handsomely for their time; versus the current system that reimburses physicians by individually-billed, piecemeal services, which fosters fraud and overutilization. Proven, medically effective, protocols (for both hospitalization and treatment) would be established to replace the historic and often haphazard physician's "personal opinion" method of medical treatment. These protocols would be constructed by and subject to a centralized peer review panel consisting of experts from several disciplines within the medical community: physicians, surgeons, pharmacists, nurses and various types of therapists.

To implement this reform immediately, a coalition of prominent, highly regarded physicians and surgeons from major universities and hospitals would be grandfathered in as the first of the new breed of MD, CCs. They would structure the new, advanced medical education program for future MD, CCs.

Other than hospitalization, those seeking medical advice would do so for an out-of-pocket-fee, or via a privately paid insurer. There would be no federal money for these low acuity services. However, neither would there be government mandated regulations as to which provider one must seek advice. One could consult a private practice physician, a nurse practitioner, a nutritionists, a naturaopath, a physical therapist, etc.; one could even crack open a medical textbook and decide one's own course of action.

This substantially deregulated low acuity medical care would create a competitive market, rather than the current, legislatively mandated monopoly featuring the expensive pharmaceutical gatekeeper, who is too often inept at the task. Several studies have demonstrated the poor outcome of our current system in which regulations mandate that medical advice be provided by no one but the physician. That one is a licensed medical doctor is no guarantee that he/she will provide sound medical advice; indeed it does not even make it a likelihood.

Firing the Gatekeeper

The physician's role as the legislated pharmaceutical

gatekeeper would not exist any longer. Currently, although many patients already know what medication they need, still they must go through the legislated bureaucratic hoop of paying the gatekeeper for a prescription. Up to 70% of these gatekeepers prescribe what their clients (patients) request. Without the mandated gatekeeper's role, those patients who do not know what they need, if anything at all, can find out from any number of sources other than the government's gatekeeper. The pharmacist would be an excellent choice. This is who the physician calls when he/she needs information. How many times have I witnessed a pharmacist explain to a physician that the medication he/she has ordered conflicts with another drug the patient is on, is the wrong dose, or simply is the wrong drug for the disease?

The argument that the physician's prescription is necessary to avoid misuse of any particular pharmaceutical is erroneous. As has been shown time and again, physicians provide misdiagnoses from 40% to 60% of the time; and they make incorrect prescriptions up to 71% of the time.[175,176] Well-informed patients, with genuine concern for their own health, often know more about their condition than does their physician and, thus, are far more likely to self-diagnose and self-medicate with greater accuracy. Forcing everyone to conform to the ritual of paying the pharmaceutical gatekeepers is an enormous waste of cash that largely does little more than feed the foxes. Barring extremely dangerous poisons and narcotics, pharmaceuticals would be deregulated so that all medications could be accessed over the counter . . . no gatekeeper required. If the opinion of a physician, a nurse practitioner, a nutritionist, etc., is desired, it can be paid for out of pocket; or through a private insurance agency. If dangerous poisons or narcotics are required, they would be prescribed by the MD, CCs, for the very nature of these drugs presumes a very sick individual.

Along with the deregulation of pharmaceuticals would be a severe punishment for anyone convicted of committing a crime while under the influence of a pharmaceutical. Later, I speak of this in more depth.

Just as the low acuity level of health care would be a vastly deregulated, open market, pay-per-service system, so too would be the manufacturing and sales of medical devices and pharmaceuticals. While the government would safeguard against fraudulent services and suppliers, the various redundant patents and marketing laws that keep pharmaceutical costs high would be abolished. The length of pharmaceutical patents would be shortened. Patent renewals would be abolished; and additional patents for minor variations and additional uses of an already patented drug, refused.

Because the allopathic medical monopoly would be disbanded, visits to any of the various medical or health care practitioners would be more affordable. Likewise, because most pharmaceuticals would be accessible to the public, these visits would also be optional. Thus, the savings realized from appropriate utilization and public access to affordable pharmaceuticals (without having to see the gatekeeper), would lower the current tax burden while permitting everyone to receive free catastrophic health care and hospitalization. Not only would these competitive markets in medical services, supplies and pharmaceutical greatly reduce the costs of routine health care so that it was affordable, the best of the competition would rise to the top.

Fallacious Objections

As for the deregulation of physicians and pharmaceuticals, I suspect there are two primary objections: the one medical, the other social. Although I have already addressed this to some degree, I will rehearse the arguments.

The medical concern would be; that for safety and health reasons a physician needs to diagnose and prescribe the proper medication. To this I respond: This is a fallacious argument; either, you have not read or, at the very least, not understood the previous pages. Although, ostensibly, this is a function of our physicians, with a 40% to 60% misdiagnosis and an even more pitiful failure to properly prescribe the accepted medication, they are not doing a very good job; indeed, often they do more harm

than good. It is time to let individuals be responsible for their own health. In the current system physicians not only fail miserably at this task, they (as an aggregate) actually promote the overuse and misuse of pharmaceuticals on a regular basis. They have proven to be miserable failures at the task of containment and regulation.

The primary practical purpose of the allopathic physician in the current system is to peddle drugs for the pharmaceutical industry, not to regulate their use; this concept of regulation is a facade. If the dispensing of these products were deregulated physicians would be forced to learn and practice health care, for they would have to prove their worth among the other health care advisors, rather than merely ride the shirttail of legislated regulations, which currently mandates their existence and protects their ignorance.

To reinforce the degree of physician failure, consider this recent study structured around "unannounced standardized patients presenting with common clinical problems". These pre-selected standardized patients made 400 visits "to more than 100 board-certified primary care internal medicine physicians" to ascertain the appropriateness of care provided. When considering the simple adherence to the guidelines of standardized best practice recommendations, accurate treatment was a mere 73%. This pitiful number fell to 22% when "contextual factors were introduced that required attention to avoid ineffectual or potentially harmful care"[177] I dare say the population at large without any training would likely be this capable, even more so when it is their own health involved.

A different article in JAMA aptly illustrated this point as well. In this study, "71% of newly licensed family practitioners prescribed potentially inappropriate medication to their elderly patients, . . ."[178] One cannot argue these are anomalies, isolated situations; for clinical accuracy has been tested many times over the last 100 years and it always has similar pitiful results. It is not without reason that Robert Mendelsohn, MD, said,

I don't advise anyone who has no symptoms to go to the

> doctor for a physical examination. For people with symptoms, it's not such a good idea, either. The entire diagnostic procedure—from the moment you enter the office to the moment you leave clutching a prescription or a referral appointment—is seldom a useful ritual. . . . you should approach the diagnostic procedure with suspicion rather than confidence. [179]

Unlike the public, physicians are acutely aware of their failure rate. That is why doctors need your trust.

> Don't believe for a minute that they don't play it for all it's worth. Because what's at stake is the whole ball game, the whole ninety percent or more of Modern Medicine that we don't need, that, as a matter of fact, is out to kill us. Modern Medicine can't survive without your faith, because Modern Medicine is neither an art nor a science. It's a religion."[180]

Claiming physicians can be harmful is more than mere hyperbole. Harm does exist. This harm is recognized by many physicians and discussed in professional publications. The National Roundtable on Health care Quality made this dismal observation.

> Serious and widespread quality problems exist throughout American medicine. . . . Very large numbers of Americans are harmed as a direct result. Quality of care is the problem, not managed care. Current efforts to improve will not succeed unless we undertake a major, systematic effort to overhaul how we deliver health care services, educate and train clinicians, and assess and improve quality.[181]
>
> . . . . . .
>
> The burden of harm conveyed by the collective impact of all of our health care quality problems is staggering. It requires the urgent attention of all the stakeholders: the health care professions, health care policymakers, consumer advocates, and purchasers of care. . . . Meeting this challenge demands a readiness to think in radically new ways about how to

> deliver health care services and how to assess and improve their quality. Our present efforts resemble a team of engineers trying to break the sound barrier by tinkering with a Model T Ford. We need a new vehicle or, perhaps, many new vehicles. The only unacceptable alternative is not to change.[182]

It is imperative that the nation regains control of its health. Medical knowledge abounds, readily accessible to everyone. It behooves the public to make use of this information. The 40% to 60% incorrect diagnoses rate is unacceptable;[183] not to mention the preponderance of incorrect treatments and conflicting drug prescriptions even when the diagnosis happens to be correct.

I highly doubt any of us would frequent an auto mechanic with a 50% accuracy rate in identifying a vehicle's problem. I guarantee no physician would, yet they seem perfectly content to practice in a field in which such pitiful troubleshooting accuracy is the norm. And we seem perfectly content to let them.

The crux of modern medicine is diagnosis. Treatment hinges upon diagnosis. The objective of allopathy is to make a differential diagnosis and then to provide treatment. This then begs the question: If physicians' diagnoses are incorrect about half of the time, then of what use are they? Considering the toxic nature of most of their synthetic pharmaceutical therapies (even when used according to design much less when prescribed incorrectly), are they not doing more harm than good? For if they diagnose incorrectly, they prescribe incorrectly; and if they prescribe incorrectly, their poisonous medications can do much harm. At the very least, they will not affect a cure and the patient will continue to suffer needlessly, while paying a handsome price for it. Add to this the separate (albeit related) issue of the likelihood that even if the physician's diagnosis is correct, the odds of him/her prescribing the correct treatment regimen is as pitifully unlikely as was the correct diagnoses.

Clearly the present system is broken. Patients who rely upon their allopathic physician to correctly diagnose or even to correctly treat them are playing with odds that are only slightly better than

gambling in Las Vegas. They would truly be better served if they had more options; that is, if they were allowed to choose their own preferred primary care advisor; be it a physician, a nurse practitioner, a nutritionist, a naturopath, a chiropractor, an herbalist, a homeopath, a pharmacist, or even themselves.

As for the social concerns of deregulating pharmaceuticals: that it would create a society of drug abusers. I flat out reject this argument. The increased alcohol abuse during the period of prohibition demonstrates the fallacy of this reasoning. Many drugs are currently legal and many more are easily attainable; yet there is no evidence of self induced abuse by the majority of the population. Contrarily, and unfortunately (as is the case with antidepressant drugs), there is ample evidence of physician induced drug abuse among much of the population. No doubt this would decline if we removed the medical order.

The truth is, if people want to use drugs they are going to do so whether they are legal or not. Indeed legalizing them would take away the criminal element. Those who commit violent crimes, or even motor vehicle violations, under the influence of a pharmaceutical or alcohol would be severely punished.

So then, I contend that we have been asking the wrong questions; making the wrong assumptions, and seeking wrong solutions. For what we currently understand to be quality health care is little more than a perceived need created by a self-perpetuating industry whose judgment is seriously clouded by a blatant conflict of interest. It is the classic tale of the fox guarding the hen house. But in this real-life story the fox has convinced himself and his prey that his ravage is for their own good.

The current system relies upon overutilized and misallocated resources to keep itself afloat. In the process it is bankrupting the nation and, by default, displacing funds that could be used to treat those who are truly ill. The magnitude of dollars wasted on overutilization and misallocation is such that if it were replace by clearly define judicious allocation of said resources, the nation's overall health care costs would be but a small fraction of the current dollars spent on Medicare alone. With judicious

application, every person in the country could have free access to advanced health care services.

The aforementioned reforms would improve the health care industry on all fronts. Standardized protocols, implemented by physicians truly trained for the task, would provide maximize benefit to hospitalized and critically ill patients, contain cost by preventing overutilization and outright fraud, and decrease frivolous as well as legitimate litigation. Allowing the public to take charge of their own health care, by letting them choose their preferred health care professional, and providing affordable medications without the bureaucratic approval of a pharmaceutical gatekeeper would lower costs significantly.

Most people are not stupid; and the argument that physicians must supervise the prescription of medications is old and worn out. As evidenced by traditional and current medical practices, which are incorrect virtually as often as they are correct, physician-control is clearly not an efficient or effective model. In all, the implementation of such reforms would dramatically change both the economics and the quality of health care for the better.

If I Were King

Because the health care dilemma affects various aspects of society, other facets and institutions of our culture might also need reform. To achieve these reforms I have imagined a world in which I am king. In this dream world I solve society's most pressing issues.

My proposed solutions to these various issues are brief and to the point. In Cliff Notes form if you will. While you might not agree with all the tenets of my kingdom, please keep in mind that health care reform is really the issue of concern; so do not throw the baby out with the bathwater. Certainly, I will never be king, nor do I really want to be; and just as certainly, Congress will never adopt my imperial suggestions. Perhaps, however, some in Congress might be enlightened. Perhaps some will consider the true maladies of our current culture. Perhaps some will consider just how sick our health care system actually is; which, as stated in the introduction, is like an irreparable myopathic heart hopelessly

destroyed by disease. No amount of money can cure this sick system. More personnel cannot cure it. Better-trained clinicians cannot cure it. It needs replacement. It must be cut away and a new system put in its place.

My Kingdom

I can think of seven edicts I would implement if I were king. One of them addresses health care directly; a couple others address issues that affect health care.

Edict One

First, I would purchase a fertile, temperate island and stock it with all manner of essential supplies to begin a new colony. I would call it, The Isle of Ban. The Coast Guard would diligently circle its perimeter to restrict all unauthorized persons from either coming or going. Federal prisons and state penitentiaries would be closed. Except for the non-violent and heinous criminals (both male and female), all 2 ½ million-plus inmates currently incarcerated at a cost of nearly $1 trillion a year would be transferred to the island. All future criminals who commit heinous and violent crimes, which cannot be judicially and financially rectified by restitution, would also be sent to the island.

Beyond the trillion dollars per year financial relief and the modest relief it would bring to the health care system, it would greatly impact crime. Not only would the recidivism rate of violent criminals be eliminated, those considering a life of crime would give it a second thought before assuming this occupation, for unmitigated, lifelong banishment to the unknown gives sufficient cause for pause.

There would be no authority or governmental intervention on the island. Neither would anyone, once banished to the island, be permitted to leave. Other than dropping off new residents, for a period of forty-nine years there would be no contact to or from the island—no telephones, no mail, no internet. The residents would be left to fend and govern for themselves.

After forty-nine years we would visit the island to assess its communal and governmental structure. If deemed civil, we would restore communication, let them rename their island, establish

another Isle of Ban elsewhere and, after another seven years probation (if they prove themselves civil), readmit the reformed islanders to the Union with all rights and privileges reinstated.

Edict Two

The second edict concerns the poor who, as Jesus observed, are always with us. There would be no federal money for the poor; however, each state would be required to set aside sufficient farmland for homesteads. The acreage would vary from one geographical area to another, depending upon the fertility of the land. Homeless families and jobless persons who could not sufficiently provide for themselves would be granted homesteads with a modest house and enough supplies, grains and livestock to sustain them for three years, while they got their spread up and running.

It would be theirs to improve and modify as desired, and to occupy as long as they wanted; but they could not sell it nor pass it down as an inheritance. If and when their circumstances improved and they chose to leave, the property would return to the state. Such individuals could not claim another homestead for a period of seven years.

Edict Three

My third edict is health care reform. The current health care system is largely populated with ill-prepared physicians who grossly overutilize resources and routinely engage in unnecessary procedures.

In the new system physicians and surgeons would go to school for another four years of academic education to truly learn what they are doing. They would be given the title Doctor of Medicine, Critical Care (MD, CC). The government would pay them a handsome salary for their sacrificial service to the community. It would be a competitive position to which only the best could attain. These MD, CC would work in and direct government hospitals.

Hospitalization would be free to all citizens. However, only truly ill patients in need of advanced medical procedures and care that could not be provided elsewhere, and those with conditions

that reasonably could be expected to be improved upon discharge, would be hospitalized and cared for by these well-trained, well-paid Medical Doctor's of Critical Care. Those with medical conditions that will not improve by hospitalization, or with conditions that could easily be treated elsewhere, would not be hospitalized.

Barring extremely dangerous poisons and narcotics, pharmaceuticals would be deregulated so that all medications could be accessed over the counter, no gatekeeper required. Pharmaceuticals would be made affordable, safer and more efficient by abolishing certain patent laws and restructuring the FDA to look after the welfare of the population rather than Big Pharma. Its current fill-my-pocket-and-I'll-give-you-what-you-want way of doing business would cease immediately.

The legalization and decreased costs of pharmaceuticals would effectively end the illegal drug trade and the crimes associated with it. If anyone is convicted of even one violent or heinous crime under the influence of drugs or alcohol, the aforementioned Isle of Ban awaits them.

Nutrition and preventive care would be taught and encouraged; so that people should become responsible for themselves. Those who desire professional attention for their common maladies could seek advice from anyone they desired: a nutritionist, a nurse practitioner, a naturopath, a chiropractor, a physical therapist, a medical doctor. But it would be an out-of-pocket, fee-for-service transaction. There would be no federal money for these visits; states could do as they please. Independent insurance companies or co-ops could be formed by those who want an alternative to out-of-pocket payments. However, with the deregulation and the absence of the expensive pharmaceutical gatekeeper the cost of health care services would drop considerably. The market for health care advisors would be very competitive as well and therefore affordable; and, as in all free markets, largely, only the best would survive.

Edict Four

The fourth edict would implement the following crucial

amendments. State autonomy would be reestablished with the federal government being drastically downsized: the ATF, the Commission of Fine Arts, all social welfare departments and many others would be abolished. Others would be cutback significantly: the IRS, the EPA, the Department of Health and Human Recourses, and others. The Department of Education would be cut to the bone. A challenge exam, for full credit, would be provided for all high school, college and post graduate courses. The government would provide no funds, whatsoever, for education. The Department of Education's only responsibility would be to maintain and regulate these credits whether earned by classroom attendance or by challenge exam.

As such, the federal government would largely be limited to the following: providing a military, protecting our borders, establishing treaties, sending ambassadors to foreign lands, enforcing federal criminal law, assuring interstate commerce, travel and communication, the provision of hospitalization and advanced health care, and the oversight of various regulatory issues. Elected officials would serve a six-year term with a three-term limit. A limited pension would be reserved for those elected officials who served a minimum of two full six year terms. Those who served three full terms would receive full pension.

Edict Five

My fifth edict would abolish federal income tax. The drastically downsized federal government (as set forth in the previous edict) would need far less funds to operate. Income streams would come from tariffs and a nominal consumer tax.

Edict Six

My sixth edict would require all citizens to enroll in mandatory history lessons to learn where we came from and how we got in this mess. Voter registration would require proof of citizenship and answering five random questions with 100% accuracy from the US Naturalization Citizenship Test.

Edict Seven

My seventh and final edict (because I really do not want to be

the king, but merely want the country to function effectively) would be to abolish my kingdom and return the country to the form of government established by our fine constitution.

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