

THE MEDICAL TIME BOMB OF IMMUNIZATION AGAINST DISEASE

The greatest threat of childhood diseases lies in the dangerous and ineffectual efforts made to prevent them

by ROBERT S. MENDELSON, M.D.

I know, as I write about the dangers of mass immunisation, that it is a concept that you may find difficult to accept. Immunizations have been so artfully and aggressively marketed that most parents believe them to be the "miracle" that has eliminated many once-feared diseases. Consequently, for anyone to oppose them borders on the foolhardy. For a paediatrician to attack what has become the "bread and butter" of paediatric practice is equivalent to a priest's denying the infallibility of the pope.

Knowing that, I can only hope that you will keep an open mind while I present my case. Much of what you have been led to believe about immunizations simply isn't true. I not only have grave misgivings about them; if I were to follow my deep convictions in writing this chapter, I would urge you to reject all inoculations for your child. I won't do that, because parents in about half the states have lost the right to make that choice. Doctors, not politicians, have successfully lobbied for laws that force parents to immunize their children as a prerequisite for admission to school.

Even in those states, though, you may be able to persuade your paediatrician to eliminate the pertussis (whooping cough) component from the DPT vaccine. This immunization, which appears to be the most threatening of them all, is the subject of so much controversy that many doctors are becoming nervous about giving it, fearing malpractice suits. They should be nervous, because in a recent Chicago case a child damaged by a pertussis inoculation received a \$5.5 million settlement award. If your doctor is in that state of mind, exploit his fear, because your child's health is at stake.

Although I administered them my-self during my early years of practice, I have become a steadfast opponent of mass inoculation because of the myriad hazards they present. The subject is so vast and complex that it deserves a book of its own. Consequently, I must be content here with summarizing my objections to the fanatic zeal with which pediatricians blindly shoot foreign proteins into the body of your child without knowing what eventual damage they may cause.

Here is the core of my concern:

1. There is no convincing scientific evidence that mass inoculations can be credited with eliminating any childhood disease. While it is true that some once common childhood diseases have diminished or disappeared since inoculations were introduced, no one really knows why, although improved living conditions may be the reason. If immunizations were responsible for the diminishing or disappearance of these diseases in the United States, one must ask why they disappeared simultaneously in Europe, where mass immunizations did not take place.

2. It is commonly believed that the Salk vaccine was responsible for halting the polio epidemics that plagued American children in the 1940s and 1950s. If so, why did the epidemics also end in

Europe, where polio vaccine was not so extensively used? Of greater current relevance, why is the Sabin virus vaccine still being administered to children when Dr. Jonas Salk, who pioneered the first vaccine, points out that Sabin vaccine is now causing most of the polio cases that appear. Continuing to force this vaccine on children is irrational medical behaviour that simply confirms my contention that doctors consistently repeat their mistakes. With the polio vaccine we are witnessing a rerun of the medical reluctance to abandon the smallpox vaccination, which remained as the only source of smallpox-related deaths for three decades after the disease had disappeared.

Think of it! *For thirty years kids died from smallpox vaccinations even though no longer threatened by the disease.*

3. *There are significant risks associated with every immunization and numerous contraindications that may make it dangerous for the Shots to be given to your child.* Yet doctors administer them routinely, usually without warning parents of the hazards and without determining whether the immunization is contraindicated for the child. No child should be immunized without making that determination, yet small armies of children are routinely lined up in clinics to receive a shot in the arm with no questions asked by their parents!

4 *While the myriad short-term hazards of most immunizations are known (but rarely explained), no one knows the long term consequences of injecting foreign proteins into the body of your child.* Even more shocking is the fact that no one is making any structured effort to find out.

5. There is growing suspicion that immunization against relatively harm-less childhood diseases may be responsible for the dramatic increase in auto-immune diseases since mass inoculations were introduced. These are fearful diseases such as cancer, leukemia, rheumatoid arthritis, multiple sclerosis, Lou Gehrig's disease, lupus erythematosus, and the Guillain-Barre syndrome. An autoimmune disease can be explained simply as one in which the body's defense mechanisms cannot distinguish between foreign invaders and ordinary body tissues, with the consequence that the body begins to destroy itself. Have we traded mumps and measles for cancer and leukemia?

I have emphasized these concerns because it is probable that your paediatrician will not advise you about them. At the 1982 Forum of the American Academy of Pediatrics (AAP), a resolution was proposed that would have helped insure that parents would be informed about the risks and benefits of immunizations. The resolution urged that the "ALA? make available in clear, concise language information which a reasonable parent would want to know about the benefits and risks of routine immunizations, the risks of vaccine preventable diseases and the management of common adverse reactions to immunizations." Apparently the doctors assembled did not believe that "reasonable parents" were entitled to this kind of in-formation because *they rejected the resolution!*

The bitter controversy over immunizations that is now raging within the medical profession has not escaped the attention of the media. Increasing numbers of parents are rejecting immunizations for their children and facing the legal consequences of doing so. Parents whose children have been permanently damaged by vaccines are no longer accepting this as fate but are filing malpractice suits against the manufacturers and the doctors who administered the vaccine. Some manufacturers have actually stopped making vaccines, and the lists of contraindications to their use are being expanded by the remaining manufacturers, year by year. Meanwhile, because routine immunizations that bring patients back for repeated office calls, are the bread and butter of their specialty,

paediatricians continue to defend them to the death.

The question parents should be asking is: Whose death?

As a parent, only you *can* decide whether to reject immunizations or risk accepting them for your child. Let me urge you, though-before your child is immunized-to arm yourself with the facts about the potential risks and benefits and demand that your paediatrician defend the immunizations that he recommends. If you decide that you don't want to have your child immunized, but your state laws say you must, write to me, and I may be able to offer suggestions on how you can regain your freedom of choice.

MUMPS

Mumps is a relatively innocuous viral disease, usually experienced in childhood, which causes swelling of one or both salivary glands (parotids), located just below and in front of the ears. Typical symptoms are a temperature of 100-104 degrees, appetite loss, headache, and back pain. The gland swelling usually begins to diminish after two or three days and is gone by the sixth or seventh day. However, one gland may become affected first, and the second as much as 10-12 days later. The infection of either side confers life-time immunity.

Mumps does not require medical treatment. If your child contracts the disease, encourage him to stay in bed for two or three days, feed him a soft diet and a lot of fluids, and use ice packs to reduce the swelling. If his headache is severe, administer modest quantities of whiskey or acetaminophen. Give ten drops of whiskey to a small baby and up to one-half teaspoon to a larger one. The dose can be repeated in one hour and again in another hour, if needed.

Most children are immunized against mumps along with measles and rubella in the MMR shot that is administered at about fifteen months of age. Paediatricians defend this immunization with the argument that, although mumps is not a serious disease in children, if they do not gain immunity as children they may contract mumps as adults. In that event there is a possibility that adult males may contract orchitis, a condition in which the disease affects the testicles. In rare instances this can produce sterility.

If total sterility as a consequence of orchitis were a significant threat, and if the mumps immunizations assured adult males that they would not contract it, I would be among those doctors who urge immunization. I'm not, because their argument makes no sense. Orchitis rarely causes sterility, and when it does, because only one testicle is usually affected, the sperm production capacity of the unaffected testicle could repopulate the world! And that's not all. No one knows whether the mumps vaccination confers an immunity that lasts into the adult years. Consequently, there is an open question whether, when your child is immunized against mumps at fifteen months and escapes this disease in childhood, he may suffer more serious consequences when he contracts it as an adult.

You won't find paediatricians advertising them, but the side effects of the mumps vaccine can be severe. In some children it causes allergic reactions such as rash, itching, and bruising. It may also expose them to the effects of central nervous system involvement, including febrile seizures, unilateral nerve deafness, and encephalitis. These risks are minimal, true, but why should your child endure them at all to avoid an innocuous disease in childhood at the risk of contracting a more

serious one as an adult?

MEASLES

Measles, also called rubeola or 'English measles,' is a contagious viral disease that can be contracted by touching an object used by an infected person. At the onset the victim feels tired, has a slight fever and pain in the head and back. His eyes redden and he may be sensitive to light. The fever rises until about the third or fourth day, when it reaches 103-104 degrees. Sometimes small white spots can be seen inside the mouth, and a rash of small pink spots appears below the hair line and behind the ears. This rash spreads downward to cover the body in about 36 hours. The pink spots may run together but fade away in about three or four days. Measles is contagious for seven or eight days, beginning three or four days before the rash appears. Consequently, if one of your children contracts the disease, the others probably will have been exposed to it before you know the first child is sick.

No treatment is required for measles other than bed rest, fluids to combat possible dehydration from fever, and calamine lotion or cornstarch baths to relieve the itching. If the child suffers from photophobia, the blinds in his bedroom should be lowered to darken the room. However, contrary to the popular myth, there is no danger of permanent blindness from this disease.

A vaccine to prevent measles is another element of the MMR inoculation given in early childhood. Doctors maintain that the inoculation is necessary to prevent measles encephalitis, which they say occurs about once in 1,000 cases. After decades of experience with measles, I question this statistic, and so do many other paediatricians. The incidence of 1/1,000 may be accurate for children who live in conditions of poverty and malnutrition, but in the middle-and upper-income brackets, if one excludes simple sleepiness from the measles itself, the incidence of true encephalitis is probably more like 1/10,000 or 1/100,000.

After frightening you with the unlikely possibility of measles encephalitis, your doctor can rarely be counted on to tell you of the dangers associated with the vaccine he uses to prevent it. The measles vaccine is associated with encephalopathy and with a series of other complications such as SSPE (subacute sclerosing panencephalitis), which causes hardening of the brain and is invariably fatal.

Other neurologic and sometimes fatal conditions associated with the measles vaccine include ataxia (inability to coordinate muscle movements), mental retardation, aseptic meningitis, seizure disorders, and hemiparesis (paralysis affecting one side of the body). Secondary complications associated with the vaccine may be even more frightening. They include encephalitis, juvenile-onset diabetes, Reye's syndrome, and multiple sclerosis.

I would consider the risks associated with measles vaccination unacceptable even if there were convincing evidence that the vaccine works. There isn't. While there has been a decline in the incidence of the disease, it began long before the vaccine was introduced. In 1958 there were about 800,000 cases of measles in the United States, but by 1962-the year *before* a vaccine appeared-the number of cases had dropped by 300,000. During the next four years, while children were being vaccinated with an ineffective and now abandoned "killed virus" vaccine, the number of cases dropped another 300,000. In 1900 there were 13.3 measles deaths per 100,000 population. By 1955, before the first measles shot, the death rate had declined 97.7 percent to only 0.03 deaths per 100,000.

Those numbers alone are dramatic evidence that measles was disappearing before the vaccine was introduced. If you fail to find them sufficiently convincing, consider this: in a 1978 survey of thirty states, more than half of the children who contracted measles had been adequately vaccinated. Moreover, according to the World Health Organization, the chances are about fifteen times greater that measles will be contracted by those vaccinated for them than by those who are not.

"Why," you may ask, "in the face of these facts, do doctors continue to give the shots?" The answer may lie in an episode that occurred in California fourteen years after the measles vaccine was introduced. Los Angeles suffered a severe measles epidemic during that year, and parents were urged to vaccinate all children six months of age and older-despite a Public Health Service warning that vaccinating children below the age of one year was useless and potentially harmful.

Although Los Angeles doctors responded by routinely shooting measles vaccine into very kid they could get their hands on, several local physicians familiar with the suspected problems of immunologic failure and "slow virus" dangers chose not to vaccinate their own infant children. Unlike their patients, who weren't told, they realized that "slow viruses" found in all live vaccines, and particularly in the measles vaccine, can hide in human tissue for years. They may emerge later in the form of encephalitis, multiple sclerosis, and as potential seeds for the development and growth of cancer.

One Los Angeles physician who refused to vaccinate his own seven-month-old baby said: "I'm worried about what happens when the vaccine virus may not only offer little protection against measles but may also stay around in the body, working in a way we don't know much about." His concern about the possibility of these consequences for his own child, however, did not cause him to stop vaccinating his infant patients. He rationalized this contradictory behaviour with the comment that "As a parent, I have the *luxury* of making a choice for my child. As a physician... legally and professionally I have to accept the recommendations of the profession, which is what we also had to do with the whole [Swine Flu](#) business."

Perhaps it is time that lay parents and their children are granted the same luxury that doctors and their children enjoy.

RUBELLA

Commonly known as "German measles," rubella is a non-threatening disease in children that does not require medical treatment.

The initial symptoms are fever and a slight cold, accompanied by a sore throat. You know it is something more when a rash appears on the face and scalp and spreads to the arms and body. The spots do not run together as they do with measles, and they usually fade away after two or three days. The victim should be encouraged to rest, and be given adequate fluids, but no other treatment is needed.

The threat posed by rubella is the possibility that it may cause damage to the fetus if a woman contracts the disease during the first trimester of her pregnancy. This fear is used to justify the immunization of all children, boys and girls, as part of the MMR inoculation. The merits of this vaccine are questionable for essentially the same reasons that apply to mumps inoculations. There is no need to protect children from this harmless disease, so the adverse reactions to the vaccine are

unacceptable in terms of benefit to the child. They can include arthritis, arthralgia (painful joints), and polyneuritis, which produces pain, numbness, or tingling in the peripheral nerves. While these symptoms are usually temporary, they may last for several months and may not occur until as long as two months after the vaccination. Because of that time lapse, parents may not identify the cause when these symptoms reappear in their vaccinated child.

The greater danger of rubella vaccination is the possibility that it may deny expectant mothers the protection of natural immunity from the disease. By preventing rubella in childhood, immunization may actually increase the threat that women will contract rubella during their childbearing years. My concern on this score is shared by many doctors. In Connecticut a group of doctors, led by two eminent epidemiologists, have actually succeeded in getting rubella stricken from the list of legally required immunizations.

Study after study has demonstrated that many women immunized against rubella as children lack evidence of immunity in blood tests given during their adolescent years. Other tests have shown a high vaccine failure rate in children given rubella, measles, and mumps shots, either separately or in combined form. Finally, the crucial question yet to be answered is whether vaccine-induced immunity is as effective and long lasting as immunity from the natural disease of rubella. A large proportion of children show no evidence of immunity in blood tests given only four or five years after rubella vaccination.

The significance of this is both obvious and frightening. Rubella is a non-threatening disease in childhood, and it confers natural immunity to those who contract it so they will not get it again as adults. Prior to the time that doctors began giving rubella vaccinations an estimated 85 percent of adults were naturally immune to the disease.

Today, because of immunization, the vast majority of women never acquire natural immunity. If their vaccine-induced immunity wears off, they may contract rubella while they are pregnant, with resulting damage to their unborn children.

Being a skeptical soul, I have always believed that the most reliable way to determine what people really believe is to observe what they do, not what they say. If the greatest threat of rubella is not to children, but to the fetus yet unborn, pregnant women should be protected against rubella by making certain that their obstetricians won't give them the disease. Yet, in a California survey reported in the *Journal of the American Medical Association*, more than 90 percent of the obstetrician-gynecologists refused to be vaccinated. If doctors themselves are afraid of the vaccine, why on earth should the law require that you and other parents allow them to administer it to your kids?

WHOOPING COUGH

Whooping cough (pertussis) is an extremely contagious bacterial disease that is usually transmitted through the air by an infected person.

The incubation period is seven to fourteen days. The initial symptoms are indistinguishable from those of a common cold: a runny nose, sneezing, listlessness and loss of appetite, some tearing in the eyes, and sometimes a mild fever.

As the disease progresses, the victim develops a severe cough at night. Later it appears during the

day as well. Within a week to ten days after the first symptoms appear the cough will become paroxysmal. The child may cough a dozen times with each breath, and his face may darken to a bluish or purple hue. Each coughing bout ends with a whopping intake of breath, which accounts for the popular name for the disease. Vomiting is often an additional symptom of the disease.

Whooping cough can strike within any age group, but more than half of all victims are below two years of age. It can be serious and even life-threatening, particularly in infants. Infected persons can transmit the disease to others for about a month after the appearance of the initial symptoms, so it is important that they be isolated, especially from other children.

If your child contracts whooping cough, there is no specific treatment that your doctor can provide, nor is there any you can apply at home, other than to encourage your child to rest and to provide comfort and consolation. Cough suppressants are sometimes used, but they rarely help very much and I don't recommend them. However, if an infant contracts the disease, you should consult a doctor because hospital care may be required. The primary threats to babies are exhaustion from coughing and pneumonia. Very young infants have even been known to suffer cracked ribs from the severe coughing bouts.

Immunisation against pertussis is given along with vaccines for diphtheria and tetanus in the DPT inoculation. Although the vaccine has been used for decades, it is one of the most controversial of immunizations. Doubts persist about its effectiveness, and many doctors share my concern that the potentially damaging side effects of the vaccine may outweigh the alleged benefits.

Dr. Gordon T. Stewart, head of the department of community medicine at the University of Glasgow, Scotland, is one of the most vigorous critics of the pertussis vaccine. He says he supported the inoculation before 1974 but then began to observe outbreaks of pertussis in children who had been vaccinated. "Now, in Glasgow," he says, "30 per-cent of our whooping cough cases are occurring in vaccinated patients. This leads me to believe that the vaccine is not all that protective."

As is the case with other infectious diseases, mortality had begun to decline before the vaccine became available. The vaccine was not introduced until about 1936, but mortality from the disease had already been declining steadily since 1900 or earlier. According to Stewart, "the decline in pertussis mortality was 80 percent before the vaccine was ever used." He shares my view that the key factor in controlling whooping cough is probably not the vaccine but improvement in the living conditions of potential victims.

The common side effects of the pertussis vaccine, acknowledged by *JAMA*, are fever, crying bouts, a shock-like state, and local skin effects such as swelling, redness, and pain. Less frequent but more serious side effects include convulsions and permanent brain damage resulting in mental retardation. The vaccine has also been linked to Sudden Infant Death Syndrome (SIDS). In 1978-79, during an expansion of the Tennessee childhood immunization program, eight cases of SIDS were reported immediately following routine DPT immunization.

Estimates of the number of those vaccinated with the pertussis vaccine who are protected from the disease range from 50 percent to 80 percent. According to *JAMA*, reported cases of whooping cough in the United States total an average of 1,000--3,000 per year and deaths five to twenty per year.

DIPHTHERIA

Although it was one of the most feared of childhood diseases in Grandma's day, diphtheria has now almost disappeared. Only 5 cases were reported in the United States in 1980. Most doctors insist that the decline is due to immunization with the DPT vaccine, but there is ample evidence that the incidence of diphtheria was already diminishing before a vaccine became available.

Diphtheria is a highly contagious bacterial disease that is spread by the coughing and sneezing of infected persons or by handling items that they have touched. The incubation period for the disease is two to five days, and the first symptoms are a sore throat, headache, nausea, coughing, and a fever of 100-104 degrees. As the disease progresses, dirty-white patches can be observed on the tonsils and in the throat. They cause swelling in the throat and larynx that makes swallowing difficult and, in severe cases, may obstruct breathing to the point that the victim chokes to death. The disease requires medical attention and can be treated with antibiotics such as penicillin or erythromycin.

Today your child has about as much chance of contracting diphtheria as she does of being bitten by a cobra. Yet millions of children are immunized against it with repeated injections at two, four, six, and eighteen months and then given a booster shot when they enter school. This despite evidence over more than a dozen years from rare outbreaks of the disease that children who have been immunized fare no better than those who have not. During a 1969 outbreak of diphtheria in Chicago the city board of health reported that four of the sixteen victims had been fully immunized against the disease and five others had received one or more doses of the vaccine. Two of the latter showed evidence of full immunity. A report on another outbreak in which three people died revealed that one of the fatal cases and fourteen of twenty-three carriers had been fully immunized.

Episodes such as these shatter the argument that immunization can be credited with eliminating diphtheria or any of the other once common childhood diseases. If immunization deserved the credit, how do its defenders explain this? Only about half the states have legal requirements for immunization against infectious diseases, and the percentage of children immunized varies from state to state. As a consequence, tens of thousands-perhaps millions-of children in areas where medical services are limited and paediatricians almost nonexistent were never immunized against infectious diseases and therefore should be vulnerable to them. Yet the incidence of infectious diseases does not correlate in any respect with whether a state has legally mandated mass immunization or not.

In view of the rarity of the disease, the effective antibiotic treatment now available, the questionable effectiveness of the vaccine, the multimillion dollar annual cost of administering it, and the ever-present potential for harmful, long-term effects from this or any other vaccine, I consider continued mass immunization against diphtheria indefensible. I grant that no significant harmful effects from the vaccine have been identified, but that doesn't mean they aren't there. In the half century that the vaccine has been used no research has ever been undertaken to determine what the long-term effects of the vaccine may be!

CHICKEN POX

This is my favourite childhood disease, first because it is relatively innocuous and second because it

is one of the few for which no pharmaceutical manufacturer has yet marketed a vaccine. That second reason may be short-lived, though, because as this is written there are reports that a chicken pox vaccine soon may appear.

Chicken pox is a communicable viral infection that is very common in children. The first signs of the disease are usually a slight fever, headache, backache, and loss of appetite.

After a day or two, small red spots appear, and within a few hours they enlarge and become blisters. Ultimately a scab forms that peels off, usually within a week or two. This process is accompanied by severe itching, and the child should be encouraged not to scratch the sores. Calamine lotion may be applied, or cornstarch baths given, to relieve the itching.

It is not necessary to seek medical treatment for chicken pox. The patient should be encouraged to rest and to drink a lot of fluids to prevent dehydration from the fever.

The incubation period for chicken pox is from two to three weeks, and the disease is contagious for about two weeks, beginning two days after the rash appears. The child should be isolated during this period to avoid spreading the disease to others.

TUBERCULOSIS

Parents should have the right to assume, and most do assume, that the tests their doctor gives their child will produce an accurate result.

The tuberculin skin test is but one example of a medical test procedure in which that is definitely not the case. Even the American Academy of Pediatrics, which rarely has anything negative to say about procedures that its members routinely employ, has issued a policy statement that is critical of this test. According to that statement,

Several recent studies have cast doubt on the sensitivity of some screening tests for tuberculosis. Indeed a panel assembled by the Bureau of Biologics has recommended to manufacturers that each lot be tested in fifty known positive patients to assure that preparations that are marketed are potent enough to identify everyone with active tuberculosis. However, since many of these studies have not been conducted in a randomized, double-blind fashion and/or have included many simultaneously administered skin tests (thus the possibility of suppression of reactions), interpretation of the tests is difficult.

That statement concludes, "Screening tests for tuberculosis are not perfect, and physicians must be aware of the possibility that some false negative as well as positive reactions may be obtained."

In short, your child may have tuberculosis even though there is a negative reading on his tuberculin test. Or he may not have it but display a positive skin test that says he does. With many doctors, this can lead to some devastating consequences. Almost certainly, if this happens to your child, he will be exposed to needless hazardous radiation from one or more x-rays of his chest. The doctor may then place him on dangerous drugs such as isoniazid for months or years "to prevent the development of tuberculosis." Even the AMA has recognized that doctors have indiscriminately over prescribed isoniazid. That's shameful, because of the drug's long list of side effects on the nervous system, gastrointestinal system, blood, bone marrow, skin, and endocrine glands. Also not to be overlooked is the danger that your child may become a pariah in your neighborhood because

of the lingering fear of this infectious disease.

I am convinced that the potential consequences of a positive tuberculin skin test are more dangerous than the threat of the disease. I believe parents should reject the test unless they have specific knowledge that their child has been in contact with someone who has the disease.

SUDDEN INFANT DEATH SYNDROME (SIDS)

The dreadful possibility that they may awaken some morning to find their baby dead in his crib is a fear that lurks in the mind of many parents. Medical science has yet to pinpoint the cause of SIDS, but the most popular explanation among researchers appears to be that the central nervous system is affected so that the involuntary act of breathing is suppressed.

That is a logical explanation, but it leaves unanswered the question: What caused the malfunction in the central nervous system? My suspicion, which is shared by others in my profession, is that the nearly 10,000 SIDS deaths that occur in the United States each year are related to one or more of the vaccines that are routinely given children. The pertussis vaccine is the most likely villain, but it could also be one or more of the others.

Dr. William Torch, of the University of Nevada School of Medicine at Reno, has issued a report suggesting that the DPT shot may be responsible for SIDS cases. He found that two-thirds of 103 children who died of SIDS had been immunized with DPT vaccine in the three weeks before their deaths, many dying within a day after getting the shot. He asserts that this was not mere coincidence, concluding that a "causal relationship is suggested" in at least some cases of DIPT vaccine and crib death. Also on record are the Tennessee deaths, referred to earlier. In that case the manufacturers of the vaccine, following intervention by the U.S. surgeon general, recalled all unused doses of this batch of vaccine.

Expectant mothers who are concerned about SIDS should bear in mind the importance of breastfeeding to avoid this and other serious ailments. There is evidence that breastfed babies are less susceptible to allergies, respiratory disease, gastroenteritis, hypocalcaemia, obesity, multiple sclerosis, and SIDS. One study of the scientific literature about SIDS concluded that "Breast-feeding can be seen as a common block to the myriad pathways to SIDS."

POLIOMYELITIS

No one who lived through the 1940s and saw photos of children in iron lungs, saw a 'President of the United States confined to his wheel-chair by this dread disease, and was forbidden to use public beaches for fear of catching polio can forget the fear that prevailed at the time. Polio is virtually nonexistent today, but much of that fear persists, and there is a popular belief that immunization can be credited with eliminating the disease. That's not surprising, considering the high-powered campaign that promoted the vaccine, but the fact is that no credible scientific evidence exists that the vaccine caused polio to disappear. As noted earlier, it also disappeared in other parts of the world where the vaccine was not so extensively used.

What is important to parents of this generation is the evidence that points to mass inoculation against polio as the cause of most remaining cases of the disease. In September 1977 Jonas Salk, the developer of the killed polio virus vaccine, testified along with other scientists to that effect. He said that most of the handful of polio cases which had occurred in the US since the 1970s probably were

the by-product of the live polio vaccine that is in standard use in the United States.

Meanwhile, there is an ongoing debate among the immunologists regarding the relative risks of killed virus vs. live virus vaccine. Supporters of the killed virus vaccine maintain that it is the presence of live virus organisms in the other product that is responsible for the polio cases that occasionally appear. Supporters of the live virus type argue that the killed virus vaccine offers inadequate protections and actually increases the susceptibility of those vaccinated.

This offers me a rare opportunity to be comfortably neutral. I believe that both factions are right and that use of either of the vaccines will increase, not diminish, the possibility that your child will contract the disease.

In short, it appears that the most effective way to protect your child from polio is to make sure that he doesn't get the vaccine!

East West Journal November 1984. (Also a chapter in *How To Raise a Healthy Child In Spite of Your Doctor*)

The Devil's Priests

By Robert S. Mendelsohn, M.D.

Chapter 7: [1991] Confessions of a Medical Heretic Doc

I always laugh when someone from the American Medical Association or some other doctors' organization claims that doctors have no special powers over people. After I finish laughing, I always ask how many people can tell you to take off your clothes and you'll do it.

Because doctors are really the priests of the Church of Modern Medicine, most people don't deny them their extra influence over our lives. After all, most doctors are honest, dedicated, intelligent, committed, healthy, educated, and capable, aren't they? The doctor is the rock upon which Modern Medicine's Church is built, isn't he?

Not by a long shot. Doctors are only human — in the worst ways. You can't assume your doctor is any of the nice things listed above, because doctors turn out to be dishonest, corrupt, unethical, sick, poorly educated, and downright stupid more often than the rest of society.

My favorite example of how doctors can be less intelligent than the situation calls for is a matter of public record. As part of the hearings before the Senate Health Subcommittee, Senator Edward Kennedy recalled a skiing injury to his shoulder, suffered when he was a young man. His father called in four specialists to examine the boy and recommend treatment. Three recommended surgery. The advice of the fourth doctor, who did not recommend surgery, was followed, however. He had just as many degrees as the others. The injury healed. Senator Kennedy's colleagues then proceeded to question Dr. Lawrence Weed, Professor of Medicine at the University of Vermont and originator of a highly popular patient record system for hospitals. Dr. Weed's reply was that the "senator's shoulder probably would have healed as satisfactorily if the operation hadn't been performed."

When doctors are formally tested, the results are less than encouraging. In a recent test involving the prescribing of antibiotics *half* of the doctors who voluntarily took the test scored sixty-eight percent or lower. We've already seen in the previous chapters how dangerous it is to have a doctor work on you. All of that danger doesn't necessarily derive from the inherent risks of the treatment itself. Doctors simply botch some of those procedures. When *I* meet a doctor, I generally figure I'm meeting a person who is narrow minded, prejudiced, and fairly incapable of reasoning and deliberation. Few of the doctors I meet prove my prediction wrong.

Doctors can't be counted on to be entirely ethical, either. The dean of Harvard Medical School, Dr. Robert H. Ebert, and the dean of the Yale Medical School, Dr. Lewis Thomas, acted as paid consultants to the Squibb Corporation at the same time they were trying to persuade the Food and Drug Administration to lift the ban on Mysterlin, one of Squibb's biggest moneymakers. Dr. Ebert that he "gave the best advice I could. These were honest opinions." But he also declined to specify the amount of the "modest retainer" Squibb Vice-President Norman R. Ritter admitted paying him and Dr. Thomas. Dr. Ebert later became a paid director of the drug company and admitted to owning stock valued at \$15,000.

In 1972, Dr. Samuel S. Epstein, then of Case-Western Reserve University, one of the world's authorities on chemical causes of cancer and birth defects, told the Senate Select Committee on Nutrition and Human Needs that "the National Academy of Sciences is riddled with conflict of interest." He reported that panels that decide on crucial issues such as safety of food additives frequently are dominated by friends or direct associates of the interests that are supposed to be regulated. "In this country you can buy the data you require to support your case," he said.

Fraud in scientific research is commonplace enough to keep it off the front pages. The Food and Drug Administration has uncovered such niceties as overdosing and underdosing of patients, fabrication of records, and drug dumping when they investigate experimental drug trials. Of course, in these instances, doctors working for drug companies have as their goal producing results that will convince the FDA to approve the drug. Sometimes, with competition for grant money getting more and more fierce, doctors simply want to produce results that will keep the funding lines open. Since all the "good ol' boy" researchers are in the same boat, there seems to be a great tolerance for sloppy experiments, unconfirmable results, and carelessness in interpreting results.

Dr. Ernest Borek, a University of Colorado microbiologist, said that "increasing amounts of faked data or, less flagrantly, data with *body English* put on them, make their way into scientific journals." Nobel Prize winner Salvadore E. Luria, a biologist at the Massachusetts Institute of Technology, said "I know of at least two cases in which highly respected scientists had to retract findings reported from their laboratories, because they discovered that these findings had been manufactured by one of their collaborators."

Another now classic example of fraud occurred in the Sloane-Kettering Institute where investigator Dr. William Summerlin admitted *painting* mice to make them look as though successful skin grafts had been done. A predecessor to Dr. Summerlin in the field of painting animals was Paul Kammerer, the Austrian geneticist, who early in the twentieth century painted the foot of a toad in order to prove the Lamarckian theory of transmission of acquired traits. When he was later exposed in Arthur Koessler's book, *The Case of the Midwife Toad*, Kammerer shot himself.

Dr. Richard W. Roberts, director of the National Bureau of Standards, said that "half or more of the numerical data published by scientists in their journal articles is unusable because there is no evidence that the researcher accurately measured what he thought he was measuring or no evidence that possible sources of error eliminated or accounted for." Since it is almost impossible for the average reader of scientific journals to determine which half of the article is usable and which is not, you have to wonder whether the medical journals serve as avenues of communication or confusion.

One method of judging the validity of a scientific article is to examine the footnote for the source of funding. Drug companies' records regarding integrity of research are not sparkling enough to warrant much trust. Doctors have been shown not to be above fudging and even fabricating research results when the stakes were high enough. Dr. Leroy Wolins, a psychologist at Iowa State University, had a student write to thirty-seven authors of scientific reports asking for the raw data on which they based their conclusions. Of the thirty-two who replied, twenty-one said their data either been lost or accidentally destroyed. Dr. Wolins analyzed seven sets of data that did come in and found errors in three significant enough to invalidate what had been passed off as scientific fact.

Of course, research fraud is nothing new. Cyril Burt, the late British psychologist who became famous for his claims most human intelligence is determined by heredity, was exposed as a fraud by Leon Kamin, a Princeton psychologist. It seems that the “coworkers” responsible for Burt’s research findings could not be found to have actually existed! There is even evidence that Gregor Mendel, father of the gene theory of heredity, may have doctored the results of his pea-breeding experiments to make them conform more perfectly to his theory. Mendel’s conclusions *were* correct, but a statistical analysis of his published data shows that the odds were 10,000 to one against their having been obtained through experiments such as Mendel performed.

Doctors’ unethical behavior is not limited to the medical business. A doctor whose name is practically synonymous with development of a major surgical procedure was convicted of five counts of income tax evasion for omitting more than \$250,000 from returns for 1964 through 1968. A few years ago the chairman of the Board of the American Medical Association was indicted, convicted, and sentenced to eighteen months in jail after pleading guilty to participating in a conspiracy to misuse \$1.8 million in bank funds. According to the FBI, he and his codefendants had conspired to “obtain unsound indirect loans for their own interest. . .paying bank funds on checks which had insufficient funds to back them. . .and defrauding the government. . .”

Keep in mind that these shenanigans are going on at the highest levels of the medical profession. If this kind of dishonesty, fraud, and thievery is going on among the bishops and cardinals of Modern Medicine at Yale and Harvard and the National Academy of Sciences and the AMA, imagine what is going on among the parish priests at the other medical schools and medical societies!

Perhaps the most telling characteristic of the profession that is supposed to deliver *health* care is that doctors, as a group, appear to be sicker than the rest of society. Conservative counts peg the number of psychiatrically disturbed physicians in the U.S. at 17,000 or one in twenty, the number of alcoholics at more than 30,000, and the number of narcotics addicts at 3,500 or one percent. A thirty-year study comparing doctors with professionals of similar socio-economic and intellectual status found that by the end of the study nearly half the doctors were divorced or unhappily married, more than a third used drugs such as amphetamines, barbiturates, or other narcotics, and a third had suffered emotional problems severe enough to require at least ten trips to a psychiatrist. The control group of non-doctors didn’t fare nearly as badly.

Doctors are from thirty to one hundred times more likely than lay people to abuse narcotics, depending on the particular drug. At a semiannual meeting of the American Medical Association in 1972, surveys cited showed that nearly two percent of the doctors practicing in Oregon and Arizona had been disciplined by state licensing authorities for drug abuse. An even larger percentage got into trouble for excessive drinking. Even the AMA admits that one and one-half percent of the doctors in the United States abuse drugs. Various reform and rehabilitation measures over the years have not changed these percentages. Keep in mind that these figures represent only the identified cases. In Illinois, for example, Dr. James West, chairman of the Illinois Medical Society’s Panel for the Impaired Physician, reported that four percent rather than two percent of Illinois doctors are narcotics addicts. He further estimated that eleven-and-one-half percent were alcoholics - one in nine.

Suicide accounts for more deaths among doctors than car and plane crashes, drownings, and homicides *combined*. Doctors’ suicide rate is twice the average for all white Americans. Every year,

about 100 doctors commit suicide, a number equal to the graduating class of the average medical school. Furthermore, the suicide rate among female physicians is neatly four times higher than that for other women over age twenty-five.

Apologists for the medical profession cite several reasons for doctors' high rate of sickness. The drugs are easily available to them; they must work long hours under severe stress; their background and psychological makeup predisposes them to stretch their powers to the limits; and their patients and the community make excessive demands on them. Of course, whether or not you accept these reasons, they don't explain away the fact that doctors *are* a very sick group of people.

Nonetheless, I prefer to look for more reasons. Fraud and corruption in the research process comes as no surprise to anyone who witnesses the lengths to which drug and formula companies go to doctors to their way of thinking. Free dinners, cocktails, conventions, and subsidized research fellowships still are only superficial explanations. When you examine the psychological and moral climate of Modern Medicine, you begin to get closer to understanding why doctors are so unhealthy.

Medical politics, for example, is a cutthroat power game of the most primitive sort. I much prefer *political* politics, because there you have the art of the *possible*, which means you have to compromise. Medical politics is the art of sheer power. There is no compromise: you go right for the jugular vein before your own is torn out. There's no room for compromise because churches *never* compromise on canon law. Instead of a relatively open process in which people with different interests get together to try to get the most out of the situation that they can, in medical politics there is a rigid authoritarian power structure which can be moved only through winner-take-all power plays. Historically, doctors who have dared to change things significantly have been ostracized and have had to sacrifice their careers in order to hold to their ideas. Few doctors are willing to do either.

Another reason why doctors are less prone to compromise is because doctors tend to restrict their friendships to other doctors. Close friendships between doctors and non-doctors are nowhere near as frequent as among other professions. Consequently, doctors rarely have to defend their opinions among people who don't share their background and who might offer a different point of view. Doctors can develop their philosophy in relative privacy, foray at intervals into the public scene to promote these ideas, and then rapidly retreat to the security of other doctors who support the views of the in-group. This luxury is not available to others in influential positions in public life.

Of course, doctors do see their patients. But they don't see them as people. The doctor-patient relationship is more like that between the master and the slave, since the doctor depends on the complete submission of the patient. In this kind of climate, ideas can hardly be interchanged with any hope of the doctor's being affected. Professional detachment boils down to the doctor rendering the entire relationship devoid of human influences or values. Doctors rarely rub elbows with non-doctors in any other posture but the professional.

Furthermore, since the doctor's ambitions project him into the upper classes, that's where his sympathies lie. Doctors identify with the upper class and beyond, even. They view themselves as the true elite class in society. The doctor's lifestyle and professional behavior encourage autocratic thinking, so his conservative politics and economics are predictable. Most doctors are white, male,

and rich—hardly in a position to relate effectively with the poor, the non-white, and females. Even doctors who come from these groups rarely return to serve and “be with” them. They, too, become white, male, and rich for all practical purposes and treat their fellows with all the paternalistic contempt other doctors do.

When asked where doctors learn these bad habits, I used to reply that doctors learned them in medical school. Now I realize they learn them much earlier than that. By the time they get to pre-medical training, they’ve picked up the cheating, the competition, the vying for position — all the tricks they know they need if they want to get into medical school. After all, our university system is modeled after the medical schools, and our high schools are modeled after our universities.

The admissions tests and policies of medical schools virtually guarantee that the students who get in will make poor doctors. The quantitative tests, the Medical College Admission Test, and the reliance on grade point averages funnel through a certain type of personality who is unable and unwilling to communicate with people. Those who are chosen are the ones most subject to the authoritarian influences of the priests of Modern Medicine. They have the compulsion to succeed, but not the will or the integrity to rebel. The hierarchy in control wants students who will go through school passively and ask only those questions the professors can answer comfortably. That usually means they want only one question at a time. One of the things I advise my students to do in order to survive medical school is to ask one question but never ask two.

Medical school does its best to turn smart students stupid, honest students corrupt, and healthy students sick. It isn’t very hard to turn a smart student into a stupid one. First of all, the admissions people make sure the professors will get weak-willed, authority-abiding students to work on. Then they give them a curriculum that is absolutely meaningless as far as healing or health are concerned. The best medical educators themselves say that the half-life of medical education is four years. In four years half of what a medical student has learned is wrong. Within four years of that, half again is wrong, and so on. The only problem is that the students aren’t told which half is wrong! They’re forced to learn it all. Supervision can be very close. There is no school in the country where the student-teacher ratio is as low as it is in medical school. During the last couple of years of medical school, you frequently find classes of only two or three students to one doctor. That doctor has tremendous influence over those students, through both his proximity and his life-and-death power over their careers.

Medical students are further softened up by being maliciously fatigued. The way to weaken a person’s will in order to mold him to suit your purposes is to make him work hard, especially at night, and never give him a chance to recover. *You* teach the rat to race. The result is a person too weak to resist the most debilitating instrument medical school uses on its students: fear.

If I had to characterize doctors, I would say their major psychological attribute is fear. They have a drive to achieve security-plus that’s never satisfied because of all the fear that’s drummed into them in medical school: fear of failure, fear of missing a diagnosis, fear of malpractice, fear of remarks by their peers, fear that they’ll have to find honest work. There was a movie some time ago that opened with a marathon dance contest. After a certain length of time all the contestants were eliminated except one. Everybody had to fail except the winner. That’s what medical school has become. Since everybody can’t win, everybody suffers from a loss of self-esteem. Everybody comes out of medical school feeling bad.

Doctors are given *one* reward for swallowing the fear pill so willingly and for sacrificing the healing instincts and human emotions that might help their practice: *arrogance*. To hide their fear, they're taught to adopt the authoritarian attitude and demeanor of their professors. With all this pushing at one end and pulling at the other, it's no wonder that doctors are the major sources of illness in our society. The process that begins with cheating on a biology exam by moving the microscope slide so that the next student views the wrong specimen, that continues with dropping sugar into a urine sample to change the results for those who follow, with hiring others to write papers and take exams, and with "dry labbing" experiments by fabricating results, *ends* with falsifying research reports in order to get a drug approved. What begins with fear and fatigue over exams and grades ends with a drug or alcohol problem. And what begins with arrogance towards others ends up as a doctor prescribing deadly procedures with little regard for the life and health of the patient.

My advice to medical students is always to get out as soon as possible and as easily as possible. The first two years of medical school are survivable because the students are relatively anonymous. The student should try his or her best to remain so, since if the professors don't know him they can't get to him. The last two years are more personal, but the student has more time off to recover from the assaults. If a student simply does enough work to pass and doesn't get all wrapped up in the roller derby mentality, he or she can make it to the finish line relatively unscathed. Then, as soon as the student is eligible for a state license, I advise him to quit. Forget residency and specialty training because there the professionals have the student day and night, and he can really be brainwashed. That's when the real making of the Devil's priests occurs.

Doctors are only human. But so are the rest of us, and sometimes we need the services of all-too-human doctors. Because the doctor-priest acts as a mediator or a conduit between the individual and the powerful forces the individual feels he cannot face alone, a *faulty* conduit can result in some very powerful energy flowing into the wrong places. For example, when doctors are compared with other people in evaluating retarded and other handicapped persons, those who always give the most dismal predictions and the lowest evaluations are the doctors. Nurses are next lowest, followed by psychologists. The group that always gives the most optimistic evaluation is the parents. When I'm faced with a doctor who tells me a child can't do certain things and parents who tell me that the child can do them, I always listen to the parents. I really don't care which group is right or wrong. It's the attitude that counts. Whatever attitude is reinforced and encouraged will prove true. I know doctors are prejudiced against cripples and retarded people because of their education — which teaches that anyone who is handicapped is a failure and is better off dead — so I can protect my patients myself against the doctors' self-fulfilling prophecies of doom.

Yet doctors continue to get away with their attitude and their self-serving practices. Even though doctors derive a great deal of their economic status and power from insurance companies, the doctors are in control. So much in control, in fact, that insurance companies generally act against their own interests when the choice is that or weaken the power of doctors. Blue Cross and Blue Shield and other insurers logically should be searching for methods of *decreasing* unnecessary utilization of medical services. Occasionally, we see half-hearted attempts in this direction, such as the flurry of rules requiring second opinions before elective surgery, or the every-so-often policy of discontinuing reimbursement for procedures long fallen into oblivion. These efforts are more

window dressing than anything else. They are introduced with considerable fanfare, rapidly generate a groundswell of controversy, and then quietly slip away. Regardless of how well-intentioned they are, they still address themselves only to the peripheral aspects of medical care and not to the areas where real money is to be saved. If insurance companies really wanted to cut costs, they would promote reimbursement for a wide range of simpler, more effective, cheaper procedures — such as home birth. And they would allow reimbursement for measures that restore and maintain health without drugs or surgery — such as diet therapy and exercise.

One of the most fascinating statistics I've ever run across is one that was reported by the Medical Economics Company, the publishers of the *Physician's Desk Reference*. Among other questions, they asked a representative sampling of more than 1,700 people, "If you learned that your doctor had lost a malpractice suit, would it alter your opinion of him?" What amazes me is that *seventy-seven percent* of the people said NO!

Now I don't really know if that means that people *expect* their doctors to commit malpractice or if they *don't care* whether he does or not!

I do know that the insurance companies are bamboozled by the doctors into spending more money than they have to. I also know that only about seventy doctors lose their licenses every year — despite all the obvious corruption, sickness, and dangerous malpractice. Here we come to one of the truly wondrous mysteries of Modern Medicine. Despite (or because of?) all that fear and competition among medical students, doctors are extremely reluctant to report incompetent work or behavior on the part of their colleagues. If a hospital, for example, discovers malpractice by one of its doctors, the most that will happen is the doctor will be asked to resign. He won't be reported to state medical authorities. When he seeks employment elsewhere, the hospital will most likely give him a shining recommendation.

When the famous Marcus twin-brother team of gynaecologists were found dead of narcotics withdrawal during the summer of 1975, the news that the doctors were addicts came as a surprise to everyone but their colleagues. When the brothers' "problems" were noticed the year before by the hospital staff, the twins were asked to take a leave of absence to seek medical care. When they returned to New York Hospital-Cornell Medical Center, they were watched for signs that they had improved. They had not. Were they then whisked off the staff and kept out of touch with patients before anyone was seriously harmed? Were they reported to state licensing authorities? No. They were told *in May* that as of *July 1*, they would not be allowed to work in the hospital. They were found to have died within days after they lost the privilege to admit patients to the hospital.

Another favorite example of doctors allowing their colleagues to commit mayhem on unsuspecting patients occurred in New Mexico. A surgeon tied off the wrong duct in a gall bladder operation and the patient died. Although the error was discovered at autopsy, the doctor was not disciplined. Apparently, he wasn't taught the right way to do the operation, because a few months later he performed it again, wrong — and another patient died. Again, no punishment and no surgery lesson. Only after the doctor performed the operation a third time and killed another person was there an investigation resulting in the loss of his license.

If I had to answer the question of why doctors are so reluctant to report negligence in the practice of their colleagues yet so cutthroat when it comes to medical politics and medical school competition,

I go back to the basic emotions engendered in medical school: fear and arrogance. The resentment doctors are taught to feel for each other as students is transferred to the patients when the doctor finally gets into his own practice. Other doctors are no longer the enemy as long as they don't threaten to rock the status quo through politics or research which doesn't follow the party line. Furthermore, the old fear of failure never goes away, and since the patient is the primary threat to security — by presenting a problem which must be solved, much like a medical school test — any mistake by a single doctor threatens the security of *all* doctors by chalking one up for the other side. Arrogance on the part of any professional group is always directed at the outsiders that the group fears most — never at the members of the same profession.

Obviously, doctors get away with more arrogance than any other professional group. If Modern Medicine weren't a religion, and if doctors weren't the priests of that religion, they wouldn't get away with anywhere near so much. Doctors get away with substantially more than priests of other religions, because of the peculiarly corrupt nature of Modern Medicine.

All religions promote and relieve guilt. To the extent that a religion is able to encourage useful behavior by promoting guilt and relieving it, that religion is "good." A religion which promotes too much guilt and relieves too little, or which encourages the wrong kind of behavior—behavior which will not result in the improvement of the welfare of the faithful — is a "bad" religion. An example of how a religion promotes and relieves guilt is the almost universal proscription against adultery. Obviously, if religions didn't try to make people feel that adultery was "wrong" and encourage them to feel guilty about it, more and more people would do it and necessary social structures would weaken. People wouldn't know who their parents were, property could not be orderly transferred from generation to generation, and venereal disease could threaten the existence of an especially energetic culture.

Doctors are so powerful precisely because they have, as priests of the Church of Modern Medicine, *removed* all the old guilts. Modern Medicine invalidates the old guilts which, strangely enough, held people to their old religions. Nothing is a "sin" anymore, because there is a physical consequence, the doctor has the power to fix you up. If you get pregnant, the doctor can perform an abortion. If you get venereal disease, the doctor can give you penicillin. If you are gluttonous and damage your heart, the doctor can give you a coronary bypass. If you suffer from emotional problems, the doctor has Valium, Librium, and other narcotics to help you get by without caring, or feeling. If those don't work, there are plenty of psychiatrists.

There is one "sin" that Modern Medicine *will* make you feel guilty about: *not going to the doctor*. That's OK, because the doctor is the priest who takes away every other guilt. How much harm can there be in guilt that drives you to the doctor every time you feel sick?

The doctor-priest gets away with a lot because he can claim to be up against the very Forces of Evil. When a priest is in a touchy situation and the probability for success is dismal, he escapes blame by saying that he's up against the Devil. The doctor-priest does the same thing. When the prognosis is not good, he retreats into his mortality and admits that he's only a man up against the Devil. Then, if he wins, he's a hero. If he loses, he's a defeated hero — but still a hero. Never is he seen in his true light—as the *agent* of the Devil.

The doctor never loses, though he plays both sides against the middle and takes bigger risks than

necessary. That's because he has succeeded in identifying his rituals as sacred and potent regardless of their real efficacy. He uses his holiest implements to raise the ante and make the game more ominous than it really needs to be. If a mother comes into the hospital with her baby in the breech position and the fetal monitor says the baby is in distress, the doctor loses time in declaring it a life-and-death situation — which, indeed, becomes once he starts to perform a Caesarean-section delivery. Biologically, the doctor knows the C-section is dangerous. But game is no longer being played by biological rules. It's a religious game, a ceremony, and the priest calls the shots. If mother and child survive, the priest is a hero. If they die, well . . . it was a life-and-death situation anyway.

The doctor never loses: only the patients lose. The adage that a doctor buries his mistakes still applies. We used to refer mistakenly to doctors as airplane pilots. If the plane goes down, the pilot goes down with it. But the doctor *never* goes down with the patient.

Doctors also escape blame by claiming that their failures are caused by their successes. If you point out, for example, that a disproportionate number of premature babies seem to be turning up blind in premie nurseries, the doctor will say that it's the price you have to pay. "Gee, we managed to save these little 1- and 2-pound babies. Of course they all end up blind and deformed. They'd be dead if we didn't save them." Doctors use the same excuse with the problem of diabetic blindness. The reason we have so much diabetic blindness, they say, is because we have succeeded in keeping so many diabetics alive longer. Doctors will use this "we managed to keep them alive longer" excuse for *every* disease they have trouble treating successfully — which includes all the major causes of non-accidental death. They absolutely ignore the biological facts that creep in and point the finger at Modern Medicine's mismanagement of both health and disease. Doctors even manage to get away with blaming *their own* disease on their successes. When you point to the large numbers of dishonest, unhappy, and just plain sick doctors, the excuse usually runs something like this: "The reason for the psychological disability is our tendency to be compulsive, perfectionistic, easily given to a sense of guilt if our clinical efforts fail." A president of the American Medical Association offered that one.

Doctors protect themselves further through the sacred language of the priest. A religion must have a sacred language to separate the discourse of the priesthood from the lowly banter of the masses. After all, the priests are on speaking terms with the powers that seep the universe on course. We can't have just *anyone* listening in. Sacred language of doctors is no different from jargon developed by any elitist group. Its main function is to keep outsiders ignorant. If you could understand everything your doctor was saying to you and to other doctors, his power over you would be diminished. So when you get sick because of the generally filthy conditions in the hospital, he'll call your infection *nosocomial*. That way, you'll not only not get angry at the hospital, but you'll feel privileged to have such a distinguished sounding disease. And too *scared* to get mad.

Doctors use their semantic privileges to make you feel stupid and convince you that they are genuinely privy to powers that you'd better not mess with. As long as their rituals are mysterious, as long as they don't have to justify them biologically, they can get away with anything. They're not even subject to the laws of logic. Doctors will, for example, justify coronary bypasses by saying that everyone who has one feels better. But if you ask to be treated for cancer with laetrile because everyone you know who has been treated with it feels better, your doctor will tell you that it hasn't been scientifically proved effective.

Semantic isolation also serves to disenfranchise the individual from the healing process. Since the patient has no hope of *knowing* what's going on, let alone assisting, why allow him or her any part in the process at all? The patient gets in the way of the ritual, so get the patient out of the way. That's one reason why doctors aren't interested in helping patients maintain their health. To do that, they'd have to *inform* them rather than *work on* them. Doctors aren't going to share information, because that means sharing power.

To back them up, doctors have an enormous tonnage of technological gadgets which proliferates alarmingly. First of all, the patient must stand in awe of the array of machinery the doctor assembles to attack his problem. How could any single person — other than the doctor, who has the power — hope to control such forces? Also, the electronic wizardry adds weight to the doctor's claim that he "did everything he could." If it's just a doctor standing there with a black bag, "all that he could" doesn't mean very much. But if the doctor throws the switches on \$4 million worth of machinery that fills three rooms, that means he did "all that he could" and then some!

Typical of any developed religion, the ceremonial objects in which the most power is concentrated reside in the Temple. The higher the status of the temple, the more machinery within the walls. When you get to the cathedrals and the little "Vaticans" of Modern Medicine, you are up against priests who have the weight of *infallibility* behind them. They can do no wrong, so they are the most dangerous.

The reforms that have been introduced in an effort to solve some of the problems I've talked about in this chapter don't impress me as doing very much good. Rehabilitation programs, for example, don't really attack the roots of the sicknesses doctors seem to fall prey to. That may be a result of their shying away from exposing the problem as a disease of the core of Modern Medicine. Of course, doctors are not trained to attack the core of *any* problem, merely to suppress the symptoms.

Attempts to keep doctors' knowledge up-to-date also do little good, since what doctors *don't* need is more of the same kind of information they received in medical school. That's precisely what they get in most continuing medical education programs. They're taught by the same people who taught them in medical school. Who's responsible for keeping them properly informed?

As I've already said, you have to protect yourself. To do that, you need to remember the two major attributes of doctors: fear and arrogance. What you have to do is learn how to work on his fears without challenging his arrogance until you have the winning hand. Since doctors are scared of you and what you can do to them, you shouldn't hesitate to use that fear. Doctors are scared of lawyers, not because lawyers are so powerful but because lawyers can ally themselves with you, whom the doctor *really* fears. If a doctor does you dirty, sue him. It is in courts and juries that you're most likely to find common sense. Find a good lawyer who knows a lot about medicine and who is not afraid to put a doctor through the ringer. If there's one thing a doctor doesn't like it's to be in court on the wrong end of a lawyer — because that's one place where the patient has allies that can effectively challenge the doctor's priestly immunity. The increase in malpractice suits is encouraging, since it means more and more people are being radicalized to the point where they challenge the doctor's power to determine the rules.

If your doctor gives you trouble but not enough to take him to court, you need to be careful about how much you challenge him —not because of what he can or cannot do to you, but because *how*

far you go will determine your effectiveness. If a doctor threatens you and becomes angry, you should stand up to him. Don't back down. Threaten him back. When a person really threatens a doctor, the doctor almost always backs down if the person shows that he means it. Doctors back down all the time because they figure, "What do I need this one cook for?"

It's important, though, not to threaten a doctor unless you are prepared to carry through. In other words, don't reveal your rebellion until you have to, until you have the emotional commitment and the physical capability to carry on a successful campaign. Don't get into an argument with a doctor with the hope of changing his mind on anything. Never say to the doctor who's treating you for cancer with traditional chemotherapy, "Doc, what do you think about laetrile?" You won't get anywhere, and you won't get any laetrile, either. Don't say to the doctor who recommends a security bottle for your baby, "But I'm breastfeeding and I don't want to do that." Don't bring your doctor columns from the newspaper expecting him to change his mind or try something new. Don't challenge him until you're ready with an alternative action. Do your own homework.

What does a Catholic do when he decides that his priests are no good? Sometimes he directly challenges them, but very seldom. He just leaves the Church. And that's my answer. Leave the Church of Modern Medicine. I see a lot of people doing that today. I see a lot of people going to chiropractors, for example, who wouldn't have been caught dead in a chiropractor's office a few years ago.

I see more and more people patronizing the heretics of Modern Medicine.

Ritual Mutilations

by Robert S. Mendelsohn, M.D.

Chapter 3: Confessions of a Medical Heretic by Dr Robert Mendelsohn, ISBN 0809277263

I believe that my generation of doctors will be remembered for two things: the miracles that turned to mayhem, such as penicillin and cortisone, and for the millions of mutilations which are ceremoniously carried out every year in operating rooms.

Conservative estimates—such as that made by a congressional subcommittee—say that about 2.4 million operations performed every year are unnecessary, and that these operations cost \$4 billion and 12,000 lives, or five percent of the quarter million deaths following or during surgery each year. The independent Health Research Group says the number of unnecessary operations is more than 3 million. And various studies have put the number of useless operations between eleven and thirty percent. My feeling is that somewhere around ninety percent of surgery is a waste of time, energy, money, and life.

Appendectomies

One study, for example, closely reviewed people who were recommended for surgery. Not only did they find that most of them needed no surgery, but fully *half of them needed no medical treatment at all!* The formation of committees to review tissue removed in operations has resulted in some telling statistics. In one case, 262 appendectomies were performed the year *before* a tissue committee began overseeing surgery. During the first year of the committee's review, the number dropped to 178. Within a few years, the number dropped to 62. The percentage of normal appendices removed fell fifty-five percent. In another hospital, the number of appendectomies was slashed by two-thirds after a tissue committee went to work.

These committees and study teams are composed of doctors who are still working within the belief system of Modern Medicine. There are dozens of common operations they would no doubt see as useful most of the time, such as cancer surgery, coronary bypass surgery, and hysterectomies. Yet as far as I'm concerned, ninety percent of the most common operations, including these, are at best of little value and at worst quite harmful.

Tonsillectomies

The victims of a lot of needless surgery are children. Tonsillectomy is one of the most common surgical procedures in the United States. Half of all pediatric surgery is for the removal of tonsils. About a million are done every year. Yet the operation has never been demonstrated to do very much good.

Back around the same time I got into trouble for cutting urological workups on children at an outpatient clinic, I got into trouble again for not discussing the size of tonsils. There are very rare cases—less than one in 1,000—where someone may need a tonsillectomy. I'm not talking about when the child snores or breathes noisily. But when it really impedes the child's breathing, if he or

she is really choking, the tonsils may have to come out. You don't have to ask a child or a parent about it. It's obvious! So I cut out that question on the examination. Of course, the number of tonsillectomies went way down. As you might expect, I soon got a call from the chairman of the ear, nose, and throat department: I was threatening his teaching program.

Tonsillectomies have been performed for more than 2,000 years, and their usefulness in most cases never has been proved. Doctors still can't agree on when the operation should or shouldn't be performed. The best reason doctors and parents can give for the attack on the tonsils is, as if they were some mountain range that had to be conquered, "because they're there."

Parents are lulled into believing that the operation "can't do any harm." Though physical complications are rare, they're not altogether non-existent. Mortality ranges in different surveys from one in 3,000 to one in 10,000. Emotional complications abound. Getting to eat all the ice cream you want doesn't make up for the justified fear a child experiences that his parents and the doctor are ganging up on him. A lot of children show marked changes for the worse in their behavior after the operation. They're more depressed, pessimistic, afraid, and generally awkward in the family. Who can blame them? They can sense, and unfortunately be seriously affected by, a patently absurd—though dangerous—situation.

Hysterectomy

Women also seem to be the victims of a lot of unnecessary surgery. Another operation steadily climbing towards the million-a-year mark is the hysterectomy. The National Center for Health Statistics estimated that 690,000 women had their uteruses removed in 1973, which results in a rate of 647.7 per 100,000 females. Besides the fact that this is a higher rate than for any other operation, if the rate continued, it would mean that *half* of all women would lose their uterus by age 65! That's if the rate holds steady. Actually, it's *growing*. In 1975, 808,000 hysterectomies were performed.

Very few of them were necessary. In six New York hospitals, forty-three percent of the hysterectomies reviewed were found to be unjustified. Women with abnormal bleeding from the uterus and abnormally heavy menstrual blood flow were given hysterectomies even though other treatments—or no treatment at all—would have most likely worked just as well.

Childbirth

In their lusting after the status and power of surgeons, obstetricians are rapidly turning the natural process of childbirth into a surgical procedure. Layer upon layer of "treatment" buries the experience under the mantle of sickness, as each layer requires another layer to compensate for its adverse effects. Strangely enough, you can always count on doctors to take credit for the *compensations*, but not for the medical disasters that make the compensations necessary in the first place!

Forceps

The first major intrusion into childbirth was the introduction of forceps. Two sinister sixteenth-century barber-surgeons, the Chamberlen brothers, always carried a huge wooden box into the delivery room. They sent everyone else out of the room and blindfolded the mother in labor before opening the box. It wasn't until the nineteenth century that the contents of the box became widely known: obstetrical forceps. Using forceps to extract the baby whether or not the birth proceeds

normally was the first step towards turning labor and delivery into surgery.

The next step came as scientists became interested in the birthing process. Doctors began to compete with midwives, and as they won, the process came to be supervised by the male doctor rather than the female midwife. It wasn't long before childbirth moved from the home into the hospital, where all the trappings and stage settings for treating it as a disease could be easily arranged. Of course, when the male doctors took over childbirth, it *did* become a disease. The doctors did something the midwives never did: they went right from the autopsy labs where they were handling corpses to the maternity wards to attend births. Maternal and infant death rates skyrocketed far beyond where they had been when midwives delivered babies. One courageous doctor, Ignaz Philipp Semmelweis, pointed out the deadly connection and was hounded out of medicine and into an insane asylum for suggesting that doctors were the agents of disease. Once Semmelweis' suggestion that doctors wash their hands before attending a birth was adopted, maternal and infant mortality rates dropped—an event for which the profession predictably took credit.

Once it became possible to drug the mother into a state of helpless oblivion, the obstetrician could become even more powerful. Since the mother couldn't assist in the delivery while unconscious, the forceps' place in the delivery room was assured.

Episiotomy

Sedated, feet in stirrups, shaven, attached to an intravenous fluid bag and a battery of monitors, the woman in labor is set up so well for surgery, an operation had to be *invented* so the scene wouldn't go to waste. Enter the episiotomy. So routine is this surgical slicing of the perineum to widen the opening of the vagina that few women and even fewer doctors think twice about it. Doctors claim that the surgical incision is straighter and simpler to repair than the tear that is likely to occur when the baby's head and shoulders are born. They fail to acknowledge that if the woman is not drugged silly, and if she's properly coached by someone who knows what's going on, and if she's prepared, then she will know how and when to push and not push to *ease* the baby out. When the birth is a conscious, deliberate experience, the perineal tear can usually be avoided. After all, the vagina was *made* to stretch and allow a baby to pass through. Even if tearing does occur, there's no evidence that the surgical incision heals better than a tear. Quite the contrary, my experience demonstrates that tears heal *better*, and with *less* discomfort, than episiotomies. There is some feeling that the episiotomy may lead to a later lessening of sexual pleasure.

Caesarean

Obstetricians were not long satisfied by the minor surgery of the episiotomy. They had to have something more awesome and dangerous. After all, the delivery room setting only adds to the feeling that something terribly abnormal must be happening here. And such an abnormal process surely demands medical intervention. The more extreme the better. And since the delivery room is really an operating room disguised by the simple addition of an incubator, what really should be going on here is a full blown operation. Hence the obstetrical sacrifice graduates beyond the simple mutilation of the episiotomy to the most sinister development of modern obstetrics, the epidemic of Caesarean deliveries.

Fetal monitoring

Fetal monitoring—listening to the fetal heart either through the mother's abdomen or, most recently, through electrodes screwed into the infant's scalp during labor—is the diagnostic sowing procedure that is reaping the harvest of Caesarean section deliveries. Whether or not the fetus is really in trouble, if the monitor says something is wrong, there's a rush to slice the mother open and remove the baby. Then the obstetrician can bask in all the limelight that comes with performing a miracle. After all, he's snatched a life from the jaws of certain death or disablement. Studies of comparable deliveries show that Caesarean deliveries occur three to four times more often in births attended by electronic fetal monitoring than in those monitored with a stethoscope. That's not so hard to understand.

If the mother doesn't *want* the operation, all the obstetrician has to do is point to the distressed blips on the monitor screen. That's *reality*, what appears on the cathode ray tube, not what the woman feels and wants.

A woman has plenty of other reasons not to want her delivery electronically monitored. In order to attach the electrodes to the fetus' scalp, the bag of waters must be artificially broken. This results in an instant depression of the fetal heart rate. In one study, children whose birth was electronically monitored were sixty-five percent more likely to suffer behavioral or developmental problems later in life.

Of course, what the woman feels and wants is secondary to what the obstetrician says must be. And that includes scheduling the delivery according to the doctor's convenience. In many hospitals the induced, "nine-to-five" delivery has become the rule. Working only from his calculations of when the baby is due—which can be off by as much as six weeks!—the doctor induces labor when he feels like it, not when the baby is naturally ready to pass through the birth canal. A labor induced by the doctor can end up a Caesarean delivery because a baby that's not ready to be born will naturally show more distress on fetal monitors, distress at being summoned prematurely.

Fetal lung disease, failure of normal growth and development, and other mental and physical disabilities associated with premature birth are dangers of induced delivery. As many as four percent of the babies admitted to newborn-intensive care nurseries come in after medically induced deliveries. Mothers, too, are more likely to end up in the intensive care ward after an induced delivery. Postoperative complications occur in half of all women who deliver by Caesarean section. And the maternal death rate is 26 *times* higher than in women who deliver vaginally. I propose that we drop the term fetal monitoring and start calling it *fatal* monitoring!

Full-term, regular size babies delivered by Caesarean section are also in danger of a serious lung condition known as hyaline membrane disease or respiratory distress syndrome. This poorly understood, sometimes fatal, and usually unresponsive to treatment condition was once found almost exclusively in premature infants. If a baby delivers normally, the compressing action of the uterus squeezes the chest and lungs as the baby emerges. The fluids and secretions that accumulate in the lungs are then propelled through the bronchial tubes and expelled through the mouth. This does not take place in Caesarean babies.

One study concluded that the incidence of this disease could be reduced at least fifteen percent if obstetricians were more careful about Caesarean deliveries. The same report stated that at least 6,000 of the estimated 40,000 cases of hyaline membrane disease could be prevented if doctors

didn't induce delivery until the fetus was mature enough to leave the womb.

Yet the rates of induced deliveries and Caesarean sections are going up, not down. I can remember when if a hospital's incidence of Caesarean deliveries went above four or five percent, there was a full scale investigation. The present level is around twenty-five percent. There are no investigations at all. And in some hospitals the rate is pushing fifty percent.

We tend to get the idea that medicine is always progressing and that surgical procedures are developed, proved useful, and incorporated into everyday practice—at least until they are supplanted by the next "miracle." But that's not the way it happens at all. Surgery goes through three phases, but none of them has the least to do with progress. The first phase a new surgical procedure goes through is enthusiastic acceptance. Of course, the natural order of things says that a new development should be treated with skepticism before enthusiasm. But that's not the way things work in Modern Medicine. Once an operation is proved *possible*, its enthusiastic acceptance is guaranteed. Only after an operation has been around for some time and the real usefulness and *abusefulness* have had plenty of chances to emerge from the fog of early enthusiasm, does skepticism begin to seep in from around the edges.

Coronary bypass surgery

Coronary bypass surgery enjoyed unbounded acceptance for the first five or six years. Everyone acted like the operation, in which a blood vessel clogged by fat deposits is surgically "bypassed," was the answer to the catastrophic rate of death by heart attack in the United States. But the lily hasn't been able to stand up to the gilding process. Though tens of thousands of men and women still line up for this operation every year, more and more people are getting skeptical. Apparently, the operation doesn't work as well as surgeons would like to think. A seven-year study by the Veterans Administration of more than 1,000 people found that except for high-risk patients with rare left-main artery disease, the coronary bypass provided no benefit. Mortality rates for surgery patients were not significantly different from those medically treated. In fact, among the low-risk patients, the mortality rates after four years were slightly *higher* among those receiving the operation. Other studies have shown that people who have coronary bypass surgery still show abnormalities on exercise EKG tests and that they have no less risk of suffering a heart attack than those who are treated nonsurgically. Though the operation seems to provide relief from angina pain, some doctors believe this may be either a placebo effect or the result of surgical destruction of nerve pathways. Furthermore, the bypass itself can become clogged and leave the patient right back where he or she started before the operation.

The most effective treatment for heart disease appears to be a radical change in diet from the typical high fat to one in which fat makes up ten percent or less of total calories, combined with a progressive exercise regimen. This treatment has demonstrated evidence of *healing* as well as relief from symptoms.

All of which will eventually push the coronary bypass into the third phase: abandonment.

But operations die hard, especially enormously profitable ones like the bypass. Although it's fairly obvious that replacing a two or three-inch section of a clogged large vessel isn't going to do anything for the 99.9 percent of clogged arteries that are *left*, the bypass operation still packs 'em in. Fortunes, careers, and lives still depend on it.

Perhaps what it will take to put the bypass under for good is the kind of courage it took one surgeon to pound the last nail into the coffin of "poudrage," a heart operation that was popular a few decades ago. In this operation, they would open up the chest and simply sprinkle talcum powder on the outside of the heart. Presumably, this would irritate the linings and the vessels so they would develop new blood vessels and increase circulation. Poudrage was all the rage until a surgeon took a series of patients for the operation, opened all their chests, but sprinkled the powder on only half of them. The results were exactly the same. They all felt the same after surgery!

Once a surgical procedure is abandoned by all rational pretense, it isn't necessarily abandoned by Modern Medicine. If you take the major categories of surgery, most reached this point years ago. Their real usefulness is hard to find, but they overflow with *sacramental* benefits. As rituals of the Church, they never die. Although tonsillectomies should have been for all *practical* purposes abandoned for 2,000 years, they're still quite popular as a medical ceremony. Ophthalmologists scare the hell out of parents by telling them their child will develop blindness in one eye if his or her mild crossed eye syndrome isn't surgically corrected. If that were true, we would have millions of people walking around blind in one eye, since that's how many cases never reach the ophthalmologists.

And though the bloom is off the rose as far as the coronary bypass is concerned, doctors in Modern Medicine's sacrament mill are developing the same basic—and useless—technique for use on *other* forms of cardiovascular disease!

Modern cancer surgery

Modern cancer surgery someday will be regarded with the same kind of horror that we now regard the use of leeches in George Washington's time. It was shown to be irrational thirty-five years ago when Warren Cole at the University of Illinois showed that if you examine the peripheral blood after you open the skin, you find that as a result of surgery the tumor cells have already spread. Doctors answered that by saying of course the tumor spreads, but the rest of the body can take care of it. That's a silly answer. If the person's body could "take care of it," the person wouldn't have cancer in the first place! Some say that cancer surgery is threatened because of all the new techniques for fighting cancer. It's the other way around: the new techniques are capturing people's imagination and hope because cancer surgery is proving a disappointment. Your surgeon, nonetheless, will be the last to admit this.

People ask me why there's so much unnecessary surgery, and I tell them there are more reasons why there *should* be than there are that there *shouldn't* be. The only reason why there shouldn't be so much unnecessary surgery is that it causes suffering and loss of life, health, and expenses that do not have to be. That consideration alone has never had much effect on the workings of the Church of Modern Medicine. On the other hand, the reasons why there should be unnecessary surgery are legion, and quite compelling within the ethical framework of the Church.

The simplest reason is that surgery can be put to many uses besides the stated purpose of correcting or removing a disease process. Surgery is a great teaching tool as well as a fertile experimental field—although the only thing that's ever "learned" or "discovered" is how to perform the surgery. When I was Senior Pediatric Consultant to the Department of Mental Health in Illinois, I cut out a certain kind of operation that was being performed on mongoloid children with heart defects. The stated

purpose of the operation was to improve oxygen supply to the brain. The real purpose, of course, was to improve the state's residency programs in cardiovascular surgery, because nothing beneficial happened to the brains of mongoloid children—and the surgeons knew that. The whole idea was absurd. And deadly, since the operation had a fairly high mortality rate. Naturally, the university people were very upset when I cut out the operation. They couldn't figure out a better use for the mongoloid children, and, besides, it was important to train people.

Greed plays a role in causing unnecessary surgery, although I don't think the economic motive alone is enough to explain it. There's no doubt that if you eliminated all unnecessary surgery, most surgeons would go out of business. They'd have to look for honest work, because the surgeon gets paid when he performs surgery on you, not when you're treated some other way. In prepaid group practices where surgeons are paid a steady salary not tied to how many operations they perform, hysterectomies and tonsillectomies occur only about one-third as often as in fee-for-service situations.

If we had about one-tenth as many surgeons as we have now, there would be very little unnecessary surgery. Even the American College of Surgeons has said we need only 50,000 to 60,000 board certified surgeons, plus about 10,000 interns and residents, to provide amply for the country's surgical needs for the next half century. According to their projections—which we would expect to be considerate of the financial plight of surgeons if their suggestions were taken seriously—almost *half* of the 100,000 or so surgeons we actually *do* have right now are superfluous. Those 50,000 or so extra unsheathed scalpels do a lot of damage.

Ignorance plays a part in a lot of unnecessary surgery, too. I don't mean ignorance on the part of the patients. If, for example, you eliminated all gynecological surgery that resulted from improper, outdated, and outright stupid obstetrical-gynecological *practice*, there wouldn't be much gynecological surgery left. Doctors know full well, for instance, that women who experience menstrual irregularities are more prone to develop vaginal or cervical cancer if they take oral contraceptives. In fact, the risk for some of these women, depending on what caused their menstrual irregularities, is more than ten times the already increased risk! Yet few doctors bother to find out who these women are before they put them on the Pill. I know of one woman who was taking the Pill for years—unadvised of the danger she was in. She had severe bleeding during her first period, an incident that marked her as someone who should *not* take the Pill. Even when her checkup revealed—via a Pap smear—that something irregular was going on, her gynecologist told her not to worry since she could always get a hysterectomy. Apparently, his motives were a mixture of greed and ignorance, because the next doctor she went to told her that if she didn't have a relatively minor surgical procedure right away, she would definitely need a hysterectomy within a few years. But even *that* minor operation could have been avoided had her doctor informed her of the danger she was in the moment she started taking the Pill.

Greed and ignorance aren't the most important reasons why there is so much unnecessary surgery, however. It's basically a problem of belief: doctors believe in surgery. There's a certain fascination in "going under the knife," and doctors take every advantage of it to get people there. After all, surgery is an element of Progress, and Progress separates us from those who came before us and from those we are *surpassing*. In America, what *can* be done *will* be done. Whether something *should* be done is beside the point. As long as we can build the tools and do it, it must be the right

thing to do. So not only do we have coronary bypasses, tonsillectomies, and radical mastectomies—but transsexual surgery as well.

Circumcision

The first surgery was religious, and ninety percent of the surgery performed today is also religious. The Jewish ritual circumcision, or *bris*, has a place in Jewish law and culture. The *bris* is performed on the eighth day of life by a trained mohel who uses the same technique that has withstood more than 4,000 years of use. Ten men stand by to make sure he does it right, too. Modern Medicine's routine circumcision, however, takes place on the first or second day of life, when blood loss can be especially dangerous. It's performed by a surgeon, or an intern, or a medical student using the "latest" technique. Where the *bris* ceremony includes pouring some wine in the infant's mouth, no anesthetic at all is used in Modern Medicine's ritual.

Routine circumcision of all males makes no sense outside of a religious framework. A circumcision is an operation, and its dangers are not inconsiderable. It's not altogether rare for a surgeon to get smart and use cautery instead of a knife—and to slip and burn off most of the penis.

In some primitive religions submitting to ritual mutilation elevates the victim to a higher consciousness. Through either the intense pain of the mutilation or the effects of drugs—or both—the victim hallucinates communion with the deities. Sometimes this "privilege" is reserved for the priesthood or for certain communicants of special status. In Christianity, only Jesus and the martyrs were graced with mutilation—except for a dubious mystic every now and then who miraculously bears the "stigmata," or the wounds of Christ.

In the Church of Modern Medicine, *no one* is excluded from the sacrifice. Until the invention of anesthesia, victims gritted their teeth and saw their gods with the clarity agony brings—until they passed out. Now the victim is "put under" in a form of mock death, so the surgeon not only has the opportunity to heal him, but bring him back from the dead as well. Of course, even that opportunity has been superceded by the refinement of local anesthesia. Now the victim can stay awake and observe the surgeon fiddling with his mortality. After the operation, of course, even children enjoy showing off their scars. If they're the children of doctors, chances are better that they'll have scars to show off, because doctors' families tend to have more surgery than anybody else. Which demonstrates that doctors believe in the sacrament's power at least as faithfully as they expect everybody else to.

One of the true tests of a fanatic is whether or not he takes his own medicine—or believes his own press releases. The fact that doctors do get in line for the sacrifice only strengthens its grounding in ceremony.

The most sinister aspect of Modern Medicine's belief in surgery is the presumption that lies behind that belief, that the priest can overcome anything because he can operate on you. *You don't have to take care of yourself, we can fix you if you go wrong.* All you have to do is believe enough to show up for the sacrament, which in this case is a ritual mutilation. Modern Medicine has succeeded in usurping the power of traditional religions so all of us, including the priests, rabbis, ministers, and monks, see ourselves as ultimately repairable *to and by* the power that resides in the tabernacle of the operating room.

To protect yourself from your doctor's belief in surgery and avoid the knife's sacramental use on your own flesh, your first step is to educate yourself. Once again, make it your business to learn more about your case than your doctor does. Books, journals, and magazines available at the public library should provide you with enough information.

You should be especially wary if your doctor recommends one of the common operations, such as tonsillectomy, hysterectomy, umbilical hernia repair, etc. Remember that the doctor doesn't view surgery as a potentially harmful invasion of your body, but as a beneficent ceremony that can't help but bestow some good. Even a trusted family doctor cannot be trusted to prescribe surgery *only* when it's really necessary.

You should start asking questions the moment the doctor mentions surgery. What is this operation supposed to accomplish? How does it do it? What will happen if I don't have surgery? Are there any alternatives to surgery? What are the chances the operation will not succeed in what it's supposed to do? After you've obtained your doctor's answers, you should check out everything he says on your own. Chances are good that you will find conflicting information if you dig deep enough. That's the idea.

Get a second opinion. Don't go to a doctor in the same group practice, or even to one on the same hospital staff. You may have to go out of town to reach a really independent doctor. You should ask the second doctor the very same questions that you asked the first. If you get two widely different opinions, you should first go back to the original doctor and confront him with the information. That still may not resolve the differences to your satisfaction. In that case, ask your general practitioner to hold an old fashioned consultation at which all the doctors are present with you.

This may sound like a lot of trouble to go to. But you should keep in mind that the ultimate goal is to keep you in one piece unless absolutely necessary. Don't be afraid to get a third or even a fourth opinion. Considering the enormous quantity of unnecessary surgery, the chances are quite good that what your doctor's recommending is also unnecessary. You should always keep this in mind, especially when the doctor tries to make you feel like surgery is the only answer to your problem. Not only might it not be the only answer, but it might be no answer at all. You might not even have a problem!

Don't hesitate to confront your doctor with whatever information, opinions, and feelings you gather from your "homework." You're bound to learn something from his reaction. Don't be afraid to rely on the opinions of friends, neighbors, family members, and people whom you believe have wisdom.

If you decide that surgery isn't the answer, do whatever you have to do to detach yourself from the situation. Don't be afraid of offending the doctor. Although it's best to simply declare the fact that you don't want the operation and you're not going to have it, you may feel better playing the "I'll think about it" game. Once your doctor has tried to persuade you to have surgery, he may not be able to retreat from that position and continue as your doctor. After all, if he has told you that surgery is the only avenue, he can't very well treat you some other way can he? One way or the other, if your decision to stay in one piece means you lose a doctor, you're better off.

If, on the other hand, you decide to have the operation, you still shouldn't lie back and let the ceremony proceed quite yet. Contrary to what most doctors would have you believe, it does make a lot of difference *who* performs the surgery. Why shouldn't it? It makes a difference who paints your

house or fixes your car doesn't it? Isn't it reasonable that talent should also make a difference in who removes your gall bladder?

People often ask me how to go about picking a surgeon if they "must" have surgery. I always say that if you really "must" have surgery, you're most likely in no position to make a choice because the only "must have" situation I recognize is the emergency. And in an emergency you don't have a choice. If you're in an accident and you need surgery, you take any surgeon you can get. In any situation short of an emergency, you've got plenty of time not only to decide whether or not you need the surgery but also who should perform the operation.

Again, you start to pick a surgeon by asking questions. You should talk to several surgeons and ask each and every one: How many times have you done this operation? What's your batting average? How many of the operations have been successful? How many haven't? What's your rate of complications? What is the death rate from this operation? How many of your patients have died during or shortly after this operation? Can you refer me to some of your patients who've had this operation? Would they be willing to talk to me?

My favorite question to ask a surgeon is, "If *you* were out of town when the operation was performed, who would you recommend for the operation?" A variation of that is, "If you needed the operation, doctor, who would you go to?"

You should also be asking the surgeons *what kind* of surgery is necessary. You might be able to get away with less radical surgery than originally recommended. And don't neglect to ask each surgeon, once again, if the operation is necessary. This may sound like a waste of time once you've already decided to have the operation. But you may come across new information, or a doctor who does have an alternative treatment. In any case, if you are exposed to new information, hit the books again and check it out.

If the surgical procedure is extremely complex, it might be a good idea to call whatever surgeon has a reputation for the operation. If he is in another city and you don't want to travel—or he doesn't want to take on another case—ask him to refer you to someone closer or someone who will take you on. You should also ask friends and family members to help out in finding the right surgeon. I also have a healthy respect for the ability of the average clergyman to pick out a good doctor. No matter who refers you, or what the reputation of the surgeon, you should never let down your guard and let things go by that you don't understand to your satisfaction.

And that goes double *after* the operation. If the operation doesn't work out as planned, or if you suffer side effects that don't seem called for, waste no time in having them checked out. As with the side effects of a drug, the discomfort may be temporary and harmless. Or it may be deadly. When you approach a different doctor with post-operative problems, you should challenge him with the following questions: Can you give me an honest opinion with regard to the other doctor's performance on this operation? Would you give me an honest opinion even though it were to result in a malpractice suit against the other doctor? Or against your hospital?

Depending on how he answers these questions, you can decide whether or not to trust him. In this and any other medical situation, your reluctance to give away your trust is your first defense. Make every doctor earn it, especially if he wants to mutilate you.