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Uncodeable Transaction Benefit: the Patient-Physician Relationship

Transaction costs of taxes and regulations disrupt the fair distribution of goods and services.[1]

The transaction benefits of the patient-doctor relationship, friendship and trust, may matter more to both patients and doctors than either the coded money measure of economists or the transaction costs of bureaucratic hurdles noted by Schlafly, as suggested by studies of worker priorities and HMO prescription filling.

A 1945 college text, *Practical Psychology* by Berrien, reported that the relationship with the boss was the first job priority for men, and the second for women. Relationships with coworkers were first with women and second with men. Distance, working hours, air conditioning, and wages were next, in that order. Thus, the transaction benefits of relationships and the transaction costs were more important than wages.

A decade ago, follow-up of prescriptions written by some Kaiser doctors seeing 40 patients a day revealed that only about 50 percent were filled, although there was no charge, and the pharmacy was just down the hall. Did the absence of a transaction benefit—time to explain the need for the medicine—outweigh the minimized transaction costs and zero added price?

My patients rarely fail to buy the medicine I prescribe and almost always smile gratefully when paying the $50 cash at the time for a 15-minute visit. I smile, too, as I put the patient first, before insurer or regulator. Try it. You'll like it.

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Andrew Schlafly's article on the Coase Theorem was both excellent and illuminating. The subject is closer to my field than his, so I feel I should have written an article, but I could not have done nearly as well. It's a masterpiece in my book. Obviously, lawyers can teach us actuaries a thing or two.

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[1] Schlafly A. The Coase Theorem: the greatest economic insight of the 20th century. *J Am Phys Surg* 2007;12:45-47.

More on the Adverse Effects of Abortion

I read with interest the recent article on forecasting breast cancer incidence by abortion and fertility rates.[1] The effects on preterm birth risks and cost of medical care are also important considerations.

If the U.S. could slash its current high preterm birth rate (PTB), medical costs could be reduced. Dr. Richard E. Behrman, representing the Institute of Medicine, identified prior first-trimester induced abortion (IA) as an "immutable medical risk factor associated with preterm birth."[2] The U.S. PTB rate was 12.5% in 2004,[2] 40% higher than the rate of 8.9% in 1980.

Poland's experience lends much credence to Behrman's abortion-preterm birth warning. Between 1989 and 1993, Poland's IA rate/100 births plummeted by 98%, owing to very restrictive Polish abortion laws.[3] If IA significantly elevates PTB risk, one would expect Poland's PTB rate to slump 5–10 years after the IA rate plunge. One of us (WRJ) located UN data that addresses this expectation: between 1995 and 1997, Poland's PTB rate dropped by 41.8%,[4] maternal mortality decreased 41.4%,[3] and infant mortality was down by 25.0%.[3] We know of no other such rapid decrease in PTB rate.

Improved diet and better medical care are alternate explanations for the "Polish preemie plunge." However, in a 1987 study of Polish women, those with prior IAs had 88% higher relative odds of PTB compared to women with zero prior IAs.[5] An October 2007 study listed 58 studies finding significantly higher PTB or LBW (low birth weight) risk for women with prior surgical IAs, and one such study involving chemical abortions.[6]

Although it is possible that the decline in Polish legal abortions is partly offset by illegal abortions, the evidence of controlled studies[5,6] provides very strong evidence that IA elevates the risk of PTB.

There are no peer-reviewed animal studies demonstrating that vacuum aspiration (VA) abortion procedures do not increase the PTB rate in later pregnancies. In fact, there are no published animal studies at all pertaining to the safety of VA. Thus, as of 2007, VA is an unproven experimental procedure.

We predict that cutting the high rate of IA in the U.S. would not only decrease future breast cancer incidence but also reduce PTBs.

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1 Carroll MA. The breast cancer epidemic: modeling and forecasts based on abortion and other risk factors. *J Am Phys Surg* 2007;12:72-78.

2 Behrman RE, Butler AS. *Preterm Birth: Causes, Consequences, and Prevention*. Washington, D.C.: National Academies Press; 2007. Available at: http://books.nap.edu/openbook.php?record_id=11622&page=625. Accessed Nov 6, 2007.

3 TransMONEE 2007 Database, UNICEF Innocenti Research Centre, Florence, Italy. Available at: www.unicef-irc.org/databases/transmonee/2007/Country_profiles.xls. Accessed Oct 30, 2007.

4 *Demographic Yearbook 1999: Natality Supplement*. New York, N.Y.: United Nations Department of Economic and Social Affairs; 2002. Available at: http://unstats.un.org/unsd/demographic/products/dyb/DYBNat/NatStatTab12.pdf. Accessed Nov 6, 2007.

5 Krasonski G, Gladysiak A, Krajewski J. Fate of subsequent pregnancies after induced abortion in primiparae. *Wiad Lek* 1987; 40:1593-1595.

6 Calhoun BC, Shadigian E, Rooney B. Cost consequences of induced abortion as an attributable risk for preterm birth and impact on informed consent. *J Reprod Med* 2007;52:929-937.

In his ecological study, Patrick Carroll showed that abortion is the "best predictor" of breast cancer, and that fertility is also a useful predictor.[1] He overcame the problem of learning women's abortion histories by using national data from eight European countries that are believed to have nearly complete abortion counts. His study is not affected by recall bias—a hypothetical problem that the National Cancer Institute[2] and others (inaccurately) claim is a limitation affecting retrospective studies.

Lindefors-Harris et al. is the only study whose authors claimed to find direct evidence of recall bias.[3] That team, however, withdrew their claim in 1998[4] after Brind et al.[5] and Daling et al.[6] noted the implausibility of their findings. Others have tested for recall bias, and no researchers now claim to have found direct evidence of it.[6-8] The prospective study, Howe et al., reported a statistically significant odds ratio of 1.9 (95% CI, 1.2-3.0) among women who had abortions.[12] Critics, nevertheless, persist in claiming recall bias is a problem plaguing retrospective research.[9-11]

A noteworthy feature of Carroll's paper is his explanation for the reverse gradient showing that more upper-class women develop breast cancers than do lower-class women (unlike with other cancers). Carroll suggested nulliparous abortions as the reason for this disparity.

Carroll correctly labeled nulliparous abortions as "highly carcinogenic." His view is consistent with Russo and Russo's research[13-17] revealing that the worst time for women to be exposed to abortion, combined oral contraceptives,[18-20] or another carcinogen takes place between the onset of menstruation and first full-term pregnancy. During the "susceptibility window," nearly all of the breast lobules consist of cancer-susceptible Type 1 and 2 lobules, where 95% of all breast cancers originate.

In a normal pregnancy but not in most miscarriages, elevated estradiol levels stimulate the proliferation of Type 1 and 2 lobules. Estrogen is a mitogen and a genotoxin.[21-23] An abortion in the first or second trimester leaves the mother with an increased number of Type 1 and 2 lobules. During the last months of a full-term pregnancy, pheromones produced by the fetus—human chorionic gonadotropin and human placental lactogen—help mature most lobules into fully cancer-resistant Type 4 lobules. At the end of full-term pregnancy, 85% of the lobules are cancer-resistant Type 4 lobules.

Abortion is an accepted risk factor for premature birth, particularly among teenagers.[24-26] Premature birth before 32 weeks gestation increases breast cancer risk.[27-30] The hormonal changes to the breasts are identical in the case of premature birth and abortion.

Carroll's research is consistent with the conclusions reported in earlier analyses of the epidemiological research[31,32] showing that abortion is a risk factor for breast cancer. Significantly, since the publication of his analysis in 2005, no one has challenged Joel Brind's conclusions that, "Recent prospective studies, widely touted as refuting the abortion-breast cancer link, are found to embody many serious methodologic flaws sufficient to invalidate their findings."[32]

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1 Carroll P. The breast cancer epidemic: modeling and forecasts based on abortion and other risk factors. *J Am Phys Surg* 2007;12:72-78.

2 National Cancer Institute. Fact Sheet: Abortion, Miscarriage and Breast Cancer Risk. Available at: www.cancer.gov/cancertopics/factsheet/Risk/abortion-miscarriage. Accessed Nov 6, 2007.

3 Lindefors-Harris BM, Eklund G, et al., Response bias in a case-control study: analysis utilizing comparative data concerning legal abortions from two independent Swedish studies. *Am J Epidemiol* 1991;134:1003-1008.

4 Meirik O, Adami H-O, Eklund G. Letter. Relation between induced abortion and breast cancer. *J Epidemiol Community Health* 1998;52:209.

5 Brind J, Chinchilli V, Severs W, Summy-Long J. Letter. Reply to: Relation between induced abortion and breast cancer. *J Epidemiol Community Health* 1998;52:209-211.

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Global Warming

The article by Robinson et al.[1] is the best yet in debunking the mass propaganda about global warming being caused by humans. Each of the article's many graphs is a jaw-dropper. Of particular interest were statistics that you won't find in the establishment press or classrooms, such as the negligible amount of human-generated C02 relative to total C02. The amount is almost as negligible as the number of countervailing facts on global warming known by the average indoctrinated American.

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[1] Robinson AB, Robinson NE, Soon W. Environmental effects of increased atmospheric carbon dioxide. J Am Phys Surg 2007;12:79-90.

Errata

In Joel Kauffman's review of *Vaccine: The Controversial Story of Medicine's Greatest Lifesaver*, by Arthur Allen, *J Am Phys Surg* 2007;12:58-59, the prevalence rate for autism in 2000 was incorrectly stated as "about 72 per 1,000," owing to an error in placing the decimal point. According to data published by the Centers for Disease Control and Prevention (CDC) for the year 2000, the prevalence of autism spectrum disorders (ASD) ranged from 4.5 to 9.9 per 1,000 with an average prevalence of 6.7 per 1,000 children (from six data collection sites). ASD prevalence ranged from 6.6 to 14.6 per 1,000 boys and 2 to 4.2 per 1,000 girls. Source: "Prevalence of the Autism Spectrum Disorders in Multiple Areas of the United States, Surveillance Years 2000 and 2002." Available at: www.cdc.gov/ncbddd/dd/addmprevalenc.htm. Accessed Oct 26, 2007.

A statement in the Introduction to "Mathematical Modeling of AIDS Progression: Limitations, Expectations, and Future Directions" by Rebecca Culshaw, *J Am Phys Surg* 2006;11:101-105, should read: "A recent paper published on the correlation between viral load and CD4+ decline in unmedicated HIV-positive individuals found that very little (typically 4–6%) of the observed variation in CD4+ decline could be accounted for by plasma viral load levels." The original read "46%"