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Government-Education Complex Hides Risk

Dr. Angela Lanfranchi exposes the evil and bias from the government-education complex (GEC) in stating that abortion (RR = 1.38) has "no effect" on breast cancer, while hormone replacement therapy (HRT) (RR = 1.26) has a "3+ association." Indeed, the "NIH and NCI violate their mission statements."[1]

The NIH/university collaborators in the Women's Health Initiative (WHI) also violate ethical guidelines for research in concealing or obscuring their risky hormone treatment of smokers.[2,3]

In the WHI, estrogen was administered to 8,506 women over age 50, including 880 smokers, despite the black-box warning that "cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. This risk increases with age and with heavy smoking—and is quite marked in women over 35 years of age."[4] Layde's mortality rates show 250% more cardiovascular deaths in smokers.[5] Yet the WHI was terminated at 5.2 years because of a 25% increased risk of myocardial infarction in recipients of HRT, even though the total death rate was *lower* at that point in women receiving HRT, including smokers. The WHI, however, misleads by graphing a 20% higher death rate 2 years beyond the data.

After reviewing various guidelines on the ethics of biomedical research in human subjects, such as the Nuremberg Code, Declaration of Helsinki, Belmont Report, and the International Ethical Guidelines for Biomedical Research Involving Human Subjects, members of the Department of Clinical Bioethics of the National Institutes of Health (NIH) proposed seven requirements for a systematic and coherent framework for evaluating the ethics of clinical research:[6] 1) enhancement of health or knowledge; 2) scientific validity (methodologic rigor); 3) fairness in selecting subjects for scientific reasons, not based on privilege or vulnerability; 4) favorable risk-benefit ratio; 5) approval and supervision by independent individuals; 6) informed consent; and 7) respect for subjects' privacy, well-being, and right to withdraw.

"Fulfilling all 7 requirements is necessary and sufficient to make clinical research ethical," the authors conclude.[6]

Why then do GEC doctors hide the risk of breast cancer associated with abortion? Why did GEC/WHI physicians give estrogen to smokers despite the black-box warning? Why did the study design of WHI include smokers? Does the GEC hide results, thus increasing abortions and reducing HRT, imposing increased risk of death, cancer, and painful fractures on millions of American women? How can we trust the GEC, which violates its own rules, to protect safety or quality?

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1 Lanfranchi A. The federal government and academic texts as barriers to informed consent. *J Am Phys Surg* 2008;13:12-15.
2 Writing Group for the Women's Health Initiative Investigators. Risks and benefits of estrogen plus progestin in healthy postmenopausal women. *JAMA* 2002;288:321-333.
3 FOIA Case: 05-FOI-00237-NHLBI-31708, Sep 15, 2005.
4 *Physicians' Desk Reference*, yearly editions 1990–2008.
5 Layde PM, Beral V, Kay CR. Further analyses of mortality in oral contraceptive users: Royal College of General Practitioners' Oral Contraceptive Study. *Lancet* 1981; 1(8219): 541-546.
6 Emanuel EJ, Wendler D, Gray C. What makes clinical research ethical? *JAMA* 2000; 283:2701-2711.

The Insulting Code of Conduct

The editorial on the physician "code of conduct"[1] was very helpful and timely. A Dayton-area hospital attempted to implement such a code through a threatening letter to medical staff from the outgoing chief of staff dated Dec 12, 2007. My copy arrived in the middle of the holidays, offering virtually no time to act before the Jan 10, 2008, deadline "in order to maintain medical staff membership." Not a word about the Code of Conduct was heard at the hospital's Christmas party, held Dec 10.

The stated objectives of this document are to prevent or eliminate conduct that "disrupts the operation of the hospital or impugns the care provided at the hospital,

negatively affects the ability of others to perform their jobs, creates a hostile work environment,…or adversely affects or impacts the community's confidence in the hospital…."

As designed, the code was to apply to the medical staff only, not to other hospital employees or to the administration.

A number of examples of disruptive conduct are offered, including "derogatory comments about the quality of care being provided by the Hospital, another Medical Staff member, or any other individual outside of appropriate Medical Staff and/or administrative channels"; "refusal to accept assignment or participate in committee, clinical service, or peer review affairs except on one's own terms…"; or "disrupting the orderly conduct of clinical service and other committees and staff meetings."

This document effectively would muzzle physicians' freedom of speech and give the hospital the unilateral authority to set all the rules, including those for peer review.

It also lists an economic example of "disruptive conduct": "lack of appropriate response to emergency or night call including, where appropriate, one office visit follow up without regard to insurance status." This would extend the hospital's authority to mandate what occurs in a physician's office!

Hospital bylaws traditionally include responsibility for emergency physician care to those who lack the ability to pay, and most physicians do not have any problem with that. But many "insurers" now refuse reasonable payment to physicians. Rather than help to improve this inequity, the hospital could use this code to force physicians to submit to it. It is indeed frightening to see the minuscule value the hospital places on the economic survival of its medical staff, while, simultaneously, the hospitals in my community routinely overcharge the self-insured population as much as 400% or 500% of what is charged to their managed-care payors!

Although claiming that corrective steps are "collegial," the hospital warned that "a single incident of inappropriate conduct… may be so unacceptable that immediate disciplinary action is required." This could include summary suspension of privileges. The document clearly states that "*practitioner's counsel shall not attend any of the meetings described in this policy*." Once accused of "disruptive conduct," physicians could be stripped of any defense whatsoever!

The observation that medical executive committees often rubber-stamp the administration's initiatives is correct. That is exactly how this document came to be presented to our medical staff: a mandate coming through the MEC to sign immediately or lose privileges. Sadly, some physicians did indeed sign away their rights, and some didn't even bother to read it.

Thankfully, the Montgomery County Medical Society intervened, and the document is now being completely reworked in order to apply to everybody in the hospital, even the administration. I am hopeful that elements of fair play will be introduced, allowing the accused to defend themselves.

Although the outgoing Chief of Staff vigorously defended this document as though it were his own work, others believe they see the fingerprints of certain physician-unfriendly law firms.

Physicians need to de-authorize their MECs to act on behalf of the medical staff with regard to any changes to medical staff bylaws or to policies and regulations that affect all physicians in the hospital. The medical staff bylaws should also specifically provide that all members of the medical staff are entitled to legal representation at their own expense in any matter that could have a potential adverse effect on the physician's hospital privileges.

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[1] Huntoon LR. The insulting physician "code of conduct." *J Am Phys Surg* 2008;13:2-4.

We All Have HIV

In support of the claims in books recently reviewed in the *Journal*,[1,2] a unique insight provided by an older laboratory finding by Roberto A. Giraldo, M.D.,[2] recently came to our attention. This helps to explain the disconnect between a positive result of a test for human immunodeficiency (HIV) and the actual acquired immune deficiency syndrome (AIDS).

Giraldo noted that most serologic tests that check for antibodies against pathogens use neat serum undiluted. Some exceptions are for antibodies to measles, varicella, and mumps viruses, which use a dilution of 1:16; cytomegalovirus, which uses a dilution of 1:20; and Epstein-Barr virus, which uses a dilution of 1:10. Giraldo was surprised to learn that the screening test for HIV, the enzyme-linked immunosorbent assay (ELISA), uses a 1:400 dilution. The confirmatory Western Blot test uses a 1:50 dilution.

With a test kit from Abbott Laboratories that is commonly used worldwide, Giraldo himself re-tested about 100 serum samples that were reportedly negative for HIV at 1:400, and found that every single one tested positive when not diluted. The absorbance was lower than that of serum that had tested positive at 1:400, indicating a lower level of antibodies, which might give a negative Western Blot (the latter was not tested). One of the explanations suggested by Giraldo is that everyone is carrying the virus at some level.[3] This would support the position of Dr. Peter Duesberg that HIV is a ubiquitous passenger virus.[4]

About 0.47% of Americans aged 18–49 were HIV positive in surveys from 1999–2006, and this is unchanged from surveys in 1988–1994.[5] Clearly there is no epidemic of HIV infection or AIDS.

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[1] Kauffman JM. Review of: *The Origin, Persistence, and Failings of the HIV/AIDS Theory,* by Henry H. Bauer. *J Am Phys Surg* 2007;12:121-122.
[2] Kauffman JM. Review of: *Science Sold Out: Does HIV Really Cause AIDS?* by Rebecca Culshaw. *J Am Phys Surg* 2007;12:122.
[3] Giraldo RA. Everybody reacts positive on the ELISA test for HIV. *Continuum* (London), 1998/1999;5(5, midwinter):8-10. Available at: www.virusmyth.net/aids/data/rgelisa.htm. Accessed May 7, 2008.
[4] Duesberg P, Koehnlein C, Rasnick D. The chemical bases of the various AIDS epidemics: recreational drugs, anti-viral chemotherapy and malnutrition. *J Biosci* 2003;28:383-412.
[5] CDC National Center for Health Statistics. New report provides information on HIV prevalence in the U.S. household population. News Release, Jan 29, 2008. Available at: http://cdc.gov/nchs/pressroom/08newsreleases/hiv.htm. Accessed May 7, 2008.

CO_2 and Climate Change

Congratulations for publishing what was for me the clearest and best-researched article I've ever read on the issue of climate change.[1] This great research paper should be required reading for all college freshmen. Your article nailed the key points that atmospheric temperatures are regulated by the sun and the fact that any legitimate discussion of the Earth's weather or climate changes must include a variety of data point changes that are observed over very long periods of time. When a cool-headed analysis like yours is undertaken, it's almost shocking to see how different the scientific conclusions are as compared to today's popular headlines, which are increasingly filled with politics and panic on this subject.

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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.