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# Correspondence

## Huntoon Unfair to Ponzi

Although Mr. Charles Ponzi did indeed sell a fraudulent pyramid scheme to gullible investors, as Dr. Huntoon pointed out,<sup>1</sup> at least his scheme was voluntary, unlike the Social Security and Medicare programs, which require people pay taxes involuntarily.

As David G. Surdam, an adjunct associate professor of economics at the Graduate School of Business, University of Chicago noted:<sup>2</sup> “The Social Security program has been dubbed a ‘Ponzi scheme’.... The allegation is unfair to Mr. Ponzi. ...[F]raudulent as his scheme was, Ponzi had to persuade people to invest. The federal government doesn’t use persuasion. As the commercial says, ‘It’s the law’.”

**Robert J. Cihak, M.D.**

Kirkland, WA

<sup>1</sup> Huntoon LR. The Medicare crisis: a communications exercise. *J Am Phys Surg* 2003;8:4.

<sup>2</sup> Surdam DG. At least Ponzi didn’t threaten violence. *Ideas on Liberty* 2003;53(3):14-17.

**In Reply:** Actually, if imitation is the highest form of flattery, then Mr. Ponzi would no doubt be quite flattered to know that the very government who prosecuted him and deported him for his fraudulent financial scheme adopted it years later as the financing mechanism for government welfare programs that dwarf his original scam. And, despite comments to the contrary, the choice to adopt such a scheme was purely voluntary on the part of the majority whose elected officials passed Medicare into law. The majority who voted for it were Ponzi People in every sense of the term. The “unfairness” is due to the big feet of pure democracy trampling upon the Republic and the protection the latter was supposed to afford the minority. But even the minority, who are opposed to Ponzi schemes but are forced to support them involuntarily via taxation, make a voluntary choice to participate/comply rather than leave the country to escape such oppression and fraud. Moreover, the majority could decide to repeal the law via exerting pressure on their elected officials.

The problem, of course, is that people today are every bit as gullible and greedy as they were in the days of Ponzi – most still think that they can vote “something for nothing” for themselves.

**Lawrence R. Huntoon, M.D.**

Lake View, NY

## A Double Standard

In most western nations, governments impose some minimum level of professional standards. This is particularly so in medicine and surgery, where the doyens of the profession do not lightly tolerate frauds and charlatans. However, a curious anomaly arises in regard to induced abortions, most of which are performed for social, not medical reasons.

In no other area of surgery is information deliberately withheld from patients. Indeed for some surgical procedures such as hip replacements, prospective patients are required to watch a video of the operation and after-care, while a voice-over explains the possible outcomes and the risks, including infection. However, with induced abortion, information about what exactly is being removed from the patient’s body is withheld, or the description is misleading (“blob of tissue,” “clots,” “products of conception”).

In a report on the provision of abortion services in Australia, practitioners were advised that when using ultrasound to estimate gestational age, the screen should be turned away from the mother because viewing her fetus might cause her to change her mind. Such a recommendation would be intolerable in other areas of medicine.

All surgery carries some risk, and reputable surgeons discuss the procedure with patients and explore other options, as surgery is often a last resort. In contrast, whenever any legislation is proposed on giving pregnant women information about alternatives to abortion, or requiring them to view films of fetal development before termination, such legislation is vigorously opposed by abortion practitioners.

Why does the American College of Obstetricians and Gynecology tolerate such anti-information, anti-education tactics by a minority of its members? The American College of Surgeons would not tolerate a branch of the profession opposing a discussion of alternatives to tonsillectomy, and would probably investigate a surgeon who had a record of removing healthy appendices or tonsils in 99 percent of his cases.

Why is the removal of healthy fetuses from healthy wombs, without any exploration of alternatives to this surgery, tolerated by the medical profession?

**Babette Francis**

National & Overseas Co-ordinator  
Endeavour Forum Inc.  
Toorak, Vic., Australia

**Radiation Risks**

We appreciate Dr. Kauffman's discussion of radiation hormesis.<sup>1</sup> Although the debate is certainly ongoing, some evidence seems to support the theory.<sup>2</sup> We look forward to future clarifying research.

**Mark D. Hiatt, M.D., M.S., M.B.A.**

**Suresh K. Agarwal, Ph.D., F.A.C.R.**

Department of Radiology  
University of Virginia Health System  
Charlottesville, Virginia

<sup>1</sup> Kauffman JM. Diagnostic radiation: are the risks exaggerated? *J Am Phys Surg* 2003; 8(2): 54-5.

<sup>2</sup> Johansson L. Hormesis, an update of the present position. *Eur J Nucl Med Mol Imaging* 2003; 30(6): 921-33.

I read with interest Dr. Kauffman's article concerning radiation risk exaggeration.<sup>1</sup> While he made a compelling case for radiation hormesis, there are some problems with his thesis. First, using comparisons of background radiation differences in various geographical regions and relating them to cancer death statistics is poor science. There are far too many variables to explain the differences.

The main weakness in the paper is the basic assumption that all people have the same ability to repair radiation-induced DNA injuries. We know that there are many conditions associated with faulty DNA repair, including aging, genetic cancer risk, exposure to environmental toxins, and poor nutrition. In fact, recent studies have shown

that women at high risk for breast cancer frequently have impaired DNA repair mechanisms. This would make them especially susceptible to unrepaired damage by repeated mammograms. There are safe and effective alternatives.

Even in the young, healthy person we know that mitochondrial DNA contains very few DNA repair enzymes, making the mitochondria very susceptible to radiation injury, even at lower dosages.

Mitochondrial decay is considered to be a major contributor to many degenerative diseases, including neurodegeneration. In fact, studies have shown that Alzheimer's disease patients are especially susceptible to neural radiation injury.

As for radiological exposures, we must appreciate that many patients are severely nutritionally depleted, making these individuals especially vulnerable to unrepaired radiation injury.

While I agree with the radiation hormesis hypothesis in terms of background radiation exposure for the average healthy individual, we should take into consideration these special conditions.

**Russell L. Blaylock, M.D.**

Ridgeland, MS

<sup>1</sup> Kauffman JM. Diagnostic radiation: are the risks exaggerated? *J Am Phys Surg* 2003;8:54-55.

**In Reply:** Except for one sentence, the letter is very reasonable and perceptive. Dr. Blaylock even agrees that alternatives to mammograms should be preferred. The sentence is: "The main weakness in the paper is the basic assumption that all people have the same ability to repair radiation-induced DNA injuries." The required brevity of my paper forced me to leave out all the qualifiers characteristic of good science. The conclusions I drew were average results. In my longer paper,<sup>1</sup> the greater susceptibility of children to radiation is mentioned. If that one sentence were left out—or if "basic" were changed to "implied"—I would not have any reason to respond.

**Joel M. Kauffman, Ph.D.**

Philadelphia, PA

<sup>1</sup> Kauffman JM. Radiation hormesis: demonstrated, deconstructed, denied, dismissed, and some implications for public policy. *J Scientific Exploration* 2003;17(3):in press.

**Not the Whole Story on ADHD**

In the recent article on attention deficit-hyperactivity disorder (ADHD),<sup>1</sup> the authors have presented an excellent review of the nutritional deficiency of the essential fatty acids in the typical American diet. This deficiency has an effect on many organ systems and chronic disease states in addition to affecting the central nervous system. Unfortunately, the etiology of ADD and ADHD is not so simple.

There are 85 peer-reviewed articles in the medical literature showing the relationship between food allergy and ADHD. The American diet now over-emphasizes dairy products and grains, to the exclusion of meats, fruits and vegetables, resulting in many nutritional deficiencies. This also results in greatly increasing food sensitivities to dairy products and grains. Although nutritional deficiencies aggravate any clinical condition, the primary cause of ADD and ADHD is food allergy.

The authors also fail to mention sleep apnea, which, in children, is secondary to hypertrophy of the tonsils and adenoids blocking the respiratory tract. There are now numerous articles showing that sleep deprivation and sleep apnea can greatly affect the health of the individual in general, as well as worsening ADD and ADHD.

**John H. Boyles, Jr., M.D.**

Centerville, Ohio

<sup>1</sup> Ottoboni F, Ottoboni A. Can attention deficit-hyperactivity disorder result from nutritional deficiency? *J Am Phys Surg* 2003;8:58-60.

**In Reply:** We agree that there is a strong association between food allergy and ADHD, and that current dietary nutritional deficiencies and imbalances result in sensitivities and food allergies. We also agree that the etiology of ADHD is not simple. It is for this reason that the title of our paper is a question rather than a statement of fact.

We suggest that both food sensitivities and ADHD may be concurrent symptoms with the same underlying cause, namely the American diet. The many articles in the medical literature showing an association between food allergy and ADHD are no doubt true. However, association does not prove that food allergy is the cause and that ADHD is the effect. An equally plausible interpretation of these data is

that food allergy and ADHD are symptoms of a common underlying cause, in this case, diet.

The biochemistry of the essential fatty acids suggests an answer to this dilemma. The national diet is overly rich in omega-6 fatty acids and badly deficient in omega-3 fatty acids, particularly eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA). This very high omega-6 to omega-3 dietary ratio stimulates an enzyme (delta-5 desaturase) in the essential fatty acid metabolic pathway and causes this enzyme to produce a surplus of omega-6 arachidonic acid that is metabolized to harmful eicosanoids. Among these harmful eicosanoids are the LT-4 leukotrienes that, when in surplus, cause a number of adverse effects including bronchoconstriction, respiratory distress, asthma, allergies, and hypersensitivity disorders. It is worth noting that today's American diet also includes a large surplus of sugar and starch. Sugar and starch, both high-glycemic carbohydrates, promote high blood insulin levels that, in turn, further stimulate the delta-5 desaturase enzyme and result in the production of even more of the harmful leukotrienes mentioned above<sup>1, pp.41,51</sup>

DHA has another important role in the etiology of ADHD: DHA is an essential building block for brain tissue. Without sufficient amounts of DHA in the diet, the brain cannot develop normally. Studies referenced in our paper show that when DHA is deficient in the diet of the birth mother and/or in infant formula, the child usually has a smaller than normal brain size, lower levels of DHA in blood and brain tissue, poorer mental function, and a higher risk of ADHD.

We would agree that sleep apnea is very often related to obesity and poor health. The American diet, because of its very high omega-6 to omega-3 ratio and its high levels of sugar and starch, is also likely to be a major underlying cause of obesity as well as heart disease, stroke, and type-2 diabetes.<sup>1</sup>

**Fred Ottoboni, M.P.H., Ph.D.**  
**Alice Ottoboni, Ph.D.**  
Sparks, NV

<sup>1</sup> Ottoboni, A, Ottoboni F. *The Modern Nutritional Diseases*. Sparks, Nev.: Vincente Books; 2002:41,51.

### **A Contrary View of Carl Drega**

Like many other readers, Dr. Faria has been seriously misled in his positive review

of the lead essay in Vin Suprynowicz's *The Ballad of Carl Drega*.<sup>1</sup>

I happen to live within 30 miles of the place where Carl Drega murdered four good and decent New Hampshire citizens. Our local newspaper was the lead newspaper reporting this event. I have had a long conversation with the reporter on the scene, Peter Riviere, who knew all of the victims well. I am also a Second Amendment champion and highly sensitive to government tyranny of the type exhibited at Waco and Ruby Ridge.

Carl Drega was a paranoid nut case. He attempted to build a structure out into the Connecticut River, which since 1791 has been the property of the state of New Hampshire, not private property. When the state stopped his construction, Drega, who had run afoul of conventional land use ordinances before moving to Colebrook, went nuts, sued everybody, defied everything, stockpiled weapons, and finally started killing people.

Trooper Lord, who approached Drega in the Colebrook parking lot, had made a special effort to befriend (and defuse) him. Drega killed him point blank through the door of his cruiser. Then he shot and killed Trooper Phillips. Then he gunned down part-time municipal judge Vickie Bunnell in the back. Then he shot weekly editor Dennis Joos in the back. Then he drove the patrol car to the home of a selectman to kill him, only to find he wasn't home. Then he went over to Vermont, winged a game warden, and was finally killed in a police shootout.

This murderous psychotic doesn't deserve to be deified. He refused to make relatively minor accommodations to the rules of civil society that virtually everybody else had no problem accepting. He went looking for a fight, infringed on property that wasn't his, and went psycho when the owner objected. His killing spree claimed the lives of four decent, respected local people—not the kind of government thugs who burned Waco and shot Vickie Weaver and Donald Scott. This is not a police state story. This is a story of a homicidal madman.

Americans need to have more "libertarian candles" to sensitize them to invasions of their rights and liberties. Suprynowicz deserves much credit for making this his cause. But his ill-informed selection of Carl

Drega as a libertarian poster boy will make that cause look silly, if not contemptible.

**John McClaughry**  
Kirby, Vermont

<sup>1</sup> Faria MA. Review of *The Ballad of Carl Drega: Essays on the Freedom Movement 1994 to 2001* by Vin Suprynowicz. *J Amer Phys Surg* 2003;8:64.

**In Reply:** From John McClaughry's letter, I infer that he has not read Vin Suprynowicz's superb book. What a pity! If one disagrees with the case of Carl Drega, how about those of Gary Watson, Donald Scott, David Aguilar, Carol Pappas, Ralph Garrison, and the others?

The book is much more than the story of Carl Drega, and those other unknown Americans. It is a poignant compilation of the strides and advances of omnipotent government at the expense of individual liberty. And yet, as I wrote in another, longer review of the book for *NewsMax.com* (March 11, 2003), Suprynowicz is not advocating an armed insurrection against the U.S. government, although he does insist we must get angry when we see injustices committed against our fellow citizens. His book is rather a call for vigilance and limited, constitutional government with the consent of the governed.

I surmised when I wrote those reviews that the book would "inflame the minds of those who worship omnipotent government," but, alas, it has seemingly done more than that. The heat has spread to inflame those within our own camp.

**Miguel A. Faria, Jr., M.D.**  
Macon, GA

Mr. McClaughry was mailed a free review copy of my book when it came out. He returned it, unread.

He still doesn't seem to have read my book. Are we also to purge our libraries of books about John Dillinger and Genghis Khan? Does a mere *title* now prove an author has "deified" his subject?

Can Mr. McClaughry provide a photo of the "structure" Carl Drega was "building ... on property that wasn't his"? The *Boston Globe* reported that he was attempting to repair flood damage to 80 feet of his own riverfront property, which collapsed after a 1981 flood, and had been issued permits. When the state threatened to trespass on his land and charge him for removing his repairs, he fought through the courts for

years. Who drove him “nuts”? Can Mr. McLaughry assure us the regulatory state will provoke no more such incidents? If not, shouldn't we analyze the cause?

Michelle Dumas of Somersworth, N.H.—an officer of the New Hampshire Libertarian Party—responded to these charges in a letter to the *Foster's Daily Democrat* last October, writing: “Any reader of Vin Suprynowicz's book clearly understands that the book does not—in absolutely any way—glorify the violent tragedy perpetrated by Carl Drega. As Mr. Suprynowicz clearly states himself, the book could easily have been titled ‘The Ballad of Donald Scott,’ in reference to the California businessman shot dead in his own home by agents raiding his ranch on a bogus drug allegation.... But the true message of the book ... is about looking behind these needless deaths at the root causes, so that we may find a way to prevent them in the future....”

Perhaps an author should feel complimented when his work comes to merit its own, dedicated gadfly. Among others who hastily condemned my book—unread—were former New Hampshire Governor Jeanne Shaheen and Vermont Libertarian Party Chairman Brendan Kinney.

The most succinct reply, I believe, came when Jim Davies of New Hampshire answered Mr. Kinney:

“Hi, neighbor....”

“When the Drega incident occurred, I wrote on it in my then-weekly newspaper column across the Connecticut River with a view very close to your own; though even then, I drew some fire for being too nearly sympathetic to what one reader called a simple murderer.

“Having read Vin's account of the story early in his book *The Ballad*, I've changed my mind. I think he has it about right. Obviously, as Libertarians we can't go around urging people to follow his example, and very likely, Drega was not a man who had systematically thought out his position as academically as we like to.

“But as I see it, he did not initiate force. He was patient with force initiators for years and years, but then eventually snapped.

“Might he have done better to kill aggressors other than those he did kill? Possibly. But that's the risk they run; they taunt and taunt and strut their thing and fling their tin-pot authority around, and then eventually someone in total, nothing-to-lose desperation strikes back....”

**Vin Suprynowicz**  
Las Vegas, NV

## **Response to Critics on the Adverse Effects of Thimerosal in Childhood Vaccines**

*[Editor's Note: Some vociferous criticisms have been made of the article concerning possible adverse effects of thimerosal published in our spring issue. To date, however, no one has been willing to send a signed letter for publication. Because the critique has been widely circulated by internet, as in reference 18 below, we offered the authors an opportunity to respond.]*

The United States is in the midst of a devastating epidemic of neurodevelopment disorders. Statistics from the U.S. Department of Education on autism in children aged 6 to 21 years served by the Individuals with Disabilities Education Act (IDEA) showed an increase from 11,956 cases in 1992-1993 to 97,329 in 2001-2002, an increase of 714 percent.<sup>1</sup> (Data for each state are found in Table 1 appended to the internet posting of this letter at [www.jpands.org](http://www.jpands.org).) Between 9 and 15 percent of all children aged 6 to 17 years were served under IDEA during the 1999-2000 school year.

In light of the threat of this epidemic to the very existence of our society, it is not surprising that our recent article,<sup>2</sup> in which we have shown an epidemiologic link between thimerosal and neurodevelopment disorders, has generated tremendous controversy. We would like to respond to some of the erroneous statements made about our work.

Some object to our use of the Vaccine Adverse Event Reporting System (VAERS) database to conduct an epidemiologic assessment. No database is perfect. Inherent limitations include incomplete reporting, misreporting, and under-reporting. We employ various methods to control for these limitations.

As an example, we have evaluated rotavirus vaccine and intussusception, a recognized complication of rotavirus immunization.<sup>3</sup> We determined that, prior to the introduction of rotavirus vaccine, not one case of intussusception had been reported following more than 50 million doses of Diphtheria-Tetanus-whole-cell-Pertussis (DTwCp) vaccines. We then evaluated cases of intussusception reported in 1999 following DTWcP and rotavirus vaccines, which were both administered at 2, 4, and 6 months of age in the U.S. We found that only 4 percent of cases of intussusception were misreported as being associated with DTWcP vaccines, rather than with concurrently administered rotavirus vaccine.

Additionally, we evaluated cerebellar ataxia reported following DTWcP vaccine in comparison to Diphtheria-Tetanus-acellular-Pertussis (DTaP) vaccine.<sup>4</sup> A previous report from Japan had shown that

cerebellar ataxia was reported with similar frequency following these vaccines. It was hypothesized that popular media reports of the risk of serious neurologic disorders following DTWcP vaccine might cause overreporting to VAERS. However, our results showed virtually the same frequency of reports of cerebellar ataxia following DTWcP and DTaP vaccines (0.29 per million vaccinations vs 0.30 per million vaccinations, respectively), essentially the same rate as was expected based upon the Japanese data, confirming the validity of VAERS reports.

Governmental agencies have previously conceded that the VAERS database may be used for “hypothesis proving.” By using a vaccine control group and the Biological Surveillance Summaries of the CDC, we and others have been able to undertake a statistical epidemiologic assessment of the VAERS, as was previously developed and published by Rosenthal et al.<sup>5</sup> from the National Immunization Program (NIP) of the CDC. Specifically, they reported that, “Rates of reported adverse events per 100,000 vaccinations were significantly lower [ $P < 0.001$ ] after administration of diphtheria and tetanus toxoids and acellular pertussis vaccine than diphtheria and tetanus toxoids and pertussis vaccine for the following outcomes: all reports, 2.2 vs 9.8; fever, 1.9 vs 7.5; seizures, 0.5 vs 1.7; and hospitalizations, 0.2 vs 0.9.” In addition, Sever et al.<sup>6</sup> from the Anthrax Vaccine Expert Committee (AVEC), have examined the VAERS database, “...to assess the causal relationship between vaccination and reported adverse events.... Six events qualified as serious adverse events, and all were judged to be certain consequences of vaccination.”

The VAERS database provides a perspective regarding adverse events following vaccination that is available by no other means of analysis. More than 200,000 adverse event reports are recorded in the VAERS database following more than one billion doses of more than 30 different types of vaccines administered as part of the U.S. National Immunization Program. No data set will ever be able to provide this much information about the actual clinical effects of such a large number of immunizations of so many different types.

Most epidemiologic studies encounter this problem: “Several social and medical attributes are associated both with avoidance or delay of vaccination... Studies that fail to control adequately for such confounding factors are likely to underestimate the risks of adverse events attributable to vaccination.”<sup>7</sup> Analyses of the VAERS database using the CDC's methods of comparing one vaccine to another, instead of comparing vaccine recipients to a background population, circumvents this difficulty because equal avoidance or delay

of vaccination is likely for both vaccine populations under study.

Our calculation of the instantaneous exposure of U.S. infants to thimerosal from childhood vaccines in comparison to the Federal Safety Guidelines has also been criticized, citing the 2001 Institute of Medicine (IOM) report,<sup>8</sup> which found that the dose to infants from vaccine was only slightly in excess of the Guidelines. The IOM calculated exposure in the first six months (180 days) of life by dividing the dose received in the vaccines by 180. By this method, the infants were barely in excess of the Environmental Protection Agency (EPA) limit of 0.1 mcg of methylmercury/kg/day, but not in excess of the Food and Drug Administration (FDA) limit of 0.4 mcg/kg/day. (Since that report was published, the FDA has lowered its maximal permissible oral dose of methylmercury to concur with the EPA limit.)

Applying the IOM method to a newborn weighing 3 kg, hepatitis B vaccine containing 12.5 mcg of mercury gives a dose 39 times the daily permissible oral intake, and this cannot be hidden by dividing by the child's age (1 day).

We believe the IOM method of calculation to be absolutely erroneous and extremely misleading. By this method, if a 55-year-old man were given a lethal dose of ethylmercury today, the dose averaged over the number of days in his lifetime would not exceed EPA or FDA limits, but he would still be dead.

The FDA and EPA maximal permissible doses for the oral doses of methylmercury are daily instantaneous maximal doses, and the vaccines administered to children are instantaneous exposures to mercury. Thus, the appropriate calculation finds that infants were, when thimerosal was present in childhood vaccines, exposed to instantaneous levels of mercury that were many-fold (i.e. in some cases more than 100-fold) in excess of the Federal Safety Guidelines for the oral ingestion of methylmercury.

Some have objected to our applying the Federal Safety Guidelines for the oral ingestion of methylmercury to exposures from injected ethylmercury from thimerosal. The IOM itself uses this comparison. Moreover, injection results in much greater absorption of mercury than does oral ingestion.

Criticism of our estimates of mercury dosage appears to be based on a misunderstanding of the information available from VAERS. The VAERS database states which dose was associated with the adverse event; thus, we were able to determine the approximate amount of mercury that the child had been exposed to from previous immunizations. Because VAERS records the vaccine manufacturer, we could, by reviewing the Physician's Desk Reference (PDR) and the 2001 IOM Report, determine how much thimerosal was present in

each vaccine under study. Unfortunately, we were unable to provide the identities of the vaccine manufacturers or the number of doses distributed based upon the Biological Surveillance Summaries of the CDC, which are broken down by manufacturer. The CDC claims that this information is proprietary and required us to agree not to divulge it, as a condition of being given access to these summaries.

Some argue that the CDC's summaries do not accurately reflect the dosages administered to children, but others rely on that data. As Rosenthal et al.<sup>5</sup> state: "The annual numbers of pertussis-containing vaccine doses administered during the period from 1991 to 1993 were estimated from the Centers for Disease Control Biologics Surveillance. This surveillance system receives voluntary reports from all manufacturers of doses distributed and doses returned by providers, thereby permitting calculation of net doses distributed, an approximation of doses administered."

We have also been attacked for our analysis of the data from the Vaccine Safety Datalink (VSD) database because neither the original preliminary VSD study of thimerosal and neurodevelopment disorders nor any of the follow-up expanded studies identified a "signal" indicating any association between thimerosal and autism. This statement is incorrect regarding the VSD and neurodevelopment disorders.

A complete review of the relevant VSD studies was published in the 2001 IOM report.<sup>8</sup> In a study of 114,966 children in HMO-B, increasing ethylmercury dosage was associated with a statistically significantly increased adjusted risk of any neurodevelopment disorder, stammering, language delay, and speech delay. In a study that analyzed 15,309 children in HMO-A for only a limited number of types of neurodevelopment disorders, increasing dosage of ethylmercury was associated with a statistically significantly increased adjusted risk of stammering and emotional disturbances.

The IOM then considered information from the Phase II study that was conducted by the CDC group using the Phase I study design in an East Coast HMO (i.e. Harvard Pilgrim of Massachusetts). In this study it was only possible to analyze attention deficit disorder and speech delays. Based upon an examination of 17,500 children, there were no significant differences in risk of these two outcomes associated with receipt of thimerosal-containing vaccines.

In the light of these inconsistent results, the IOM found that the studies were inconclusive with regard to causality. However, further examination shows that IOM was seriously misled by this presentation. A review of the U.S. Department of Education data concerning autism in children 6 to 21 years old shows that the overall prevalence of autism increased by

435 percent from 1992-1993 to 1999-2000. This report shows that California, where the VSD Phase I studies were conducted, had a 422 percent increase in autism during this period, while Massachusetts, where the Phase II study was conducted, had only a 10 percent increase in autism over the same period. A general review of the U.S. Department of Education data shows that every state in the United States, with the exception of Massachusetts, experienced a greater than 100 percent increase in autism, and many states experienced a many thousand percent increase in autism during this period. Thus, the CDC's method was able to show an effect where an effect was present, and returned a negative result in the state with the least increase in autism. Thus, we believe that these CDC studies strongly support a causal relationship between the increasing mercury from thimerosal-containing childhood vaccines and the increase in neurodevelopment disorders.

Our attempts to gain access to the VSD database began before the CDC's press release announcing that the VSD was opened to the public at the end of August 2002. Despite more than 10 months of communication, and our providing the CDC with a cashier's check for about \$3,200 out of our own pockets, we still have not been given access to the VSD database. Moreover, we have been told that outside investigators will have no access to data regarding thimerosal and neurodevelopment disorders until the CDC publishes an analysis of this material – much of which has been in its possession since 1999.

The 2001 U.S. Department of Education Report provides a completely independent source and method that strongly confirms previous epidemiologic assessments.

Some have cast aspersions on the editors and peer reviewers of the *Journal of American Physicians and Surgeons* for publishing our article. This is also a direct assault on major peer-reviewed journals that have previously published articles by us that used similar methods. Additional articles by us are in press.<sup>9,10</sup> Many other authors using a variety of study methods will soon publish papers that confirm and extend our work, such as a study by Baskin et al.<sup>11</sup> demonstrating that thimerosal in micromolar concentrations rapidly induces membrane and DNA damage, and initiates caspase-3 dependent apoptosis in human neurons and fibroblasts, and a study by Holmes et al.<sup>12</sup> on significantly different mercury levels in the first baby haircuts of autistic children in comparison to normal controls. The association of thimerosal in vaccines and other medical products with neurodevelopment and other disorders is very real and simply cannot be denied.

We have been criticized for failing to comment on a recent article by Nelson and Bauman,<sup>13</sup> which appeared after our article

was written. These authors do not acknowledge several recent epidemiologic studies that have shown an increase in the prevalence of autism from about 1 in 2,500 children in the mid-1980s to about 1 in 150 children by 2002.<sup>14-17</sup> Their arbitrary statement that ethylmercury is not like methylmercury in its effects is without basis, is contrary to published data, and even ignores the conclusion of the 2001 IOM Report regarding the biological plausibility of the relationship between ethylmercury from thimerosal in childhood vaccines and neurodevelopment disorders. Finally, their article is simply a commentary and was published before our epidemiologic data that support the hypothesized relationship.

We are stunned by this assertion in an official statement by the American Academy of Pediatrics (AAP)<sup>18</sup> concerning our article: "The authors claim falsely that children in the United States in 2003 may be exposed to higher levels of mercury from thimerosal contained in childhood immunizations than any time in the past, when in fact, all routinely recommended infant vaccines currently sold in the United States are free of thimerosal as preservative and have been for more than 2 years." Regrettably, our comments are true and can be verified by anyone. A simple review of the 2003 PDR indicates that thimerosal is present at 25 mcg per dose (i.e. in full strength) in multidose vials of DTaP vaccine manufactured by Aventis Pasteur, haemophilus influenza Type b (Hib) vaccine manufactured by Wyeth, Td vaccine (recommended for children > 7 years old) manufactured by Aventis Pasteur, and all influenza vaccines (influenza vaccine is now recommended for most children). Additionally, the PDR indicates that Merck makes a pediatric hepatitis B vaccine that contains 12.5 mcg per dose and adult hepatitis B vaccine that contains 25 mcg of mercury per dose. The package inserts of these vaccines also indicate that they still contain the original amounts of thimerosal. In addition, a sequential review of previous PDRs indicates that in 2002 and 2001 there were even more vaccines listed as containing thimerosal.

In a recent interview, Len Lavenda, a spokesman for Aventis Pasteur, stated: "In March 2001 we stopped all sales of that product [DtaP] in the preservative formulation...The PDR is outdated...The current package insert does not accurately reflect what is being marketed."<sup>19</sup>

If the assertions by the AAP and Lavenda are true, then vaccines are mislabeled. That is a criminal offense and a situation that cannot be tolerated in medicine. An independent analysis of vaccine content should determine the truth.

There has been much discussion about how we fund our studies. We have never

received one penny from anyone to conduct any studies but have funded all of our research out of our own limited resources. Dr. Geier has been paid as an expert witness and as a consultant in hearings before the Vaccine Compensation Act and in civil litigation involving adverse reactions. Similarly, David Geier has been a consultant in hearings before the Vaccine Compensation Act and in civil litigation involving adverse reactions to vaccines. However, as of the acceptance of our three papers on thimerosal and neurodevelopment disorders, we had never received any money from any cases alleging damage from thimerosal.

Assertions that we are anti-vaccine is belied by a review of our publications. We have opposed the current position of the World Health Organization (WHO) that poliomyelitis vaccination can be stopped within the foreseeable future.<sup>20</sup> We have also argued for a need to reintroduce a newly formulated vaccine to combat the alarming 30-fold increased incidence of Lyme disease in the United States from 1982 to 1996.<sup>21</sup>

As Fine and Chen have stated, "No intervention is entirely without risk..."<sup>7</sup> We as physicians and scientists have an obligation to conduct open and frank discussions about the safety and efficacy of vaccines. We believe that there is no doubt that continued immunizations are critical to our safety and welfare, but we need a concerted effort to improve the safety and efficacy of existing vaccines. Those who apparently have been injured by a vaccination should report their adverse reaction to the VAERS database and are entitled to rapid, non-litigious, and generous justice before the National Vaccine Injury Compensation Program (NVICP).

Personal assaults on us and on the journals in which we publish, along with denying the existence of the tragic massive autism epidemic, will neither cure the problem, nor will it restore confidence in our much needed vaccine program. Rather, we must admit our past mistakes openly and honestly, and then work to improve current and future vaccines. The first step in this process is the immediate removal of thimerosal from all vaccines, which we predict will result in the end of the autism epidemic.

**Mark R. Geier, M.D., Ph.D.**  
**David Geier**  
Silver Spring, MD

## REFERENCES

- 1 Department of Education (US). Available at: [www.ideadata.org](http://www.ideadata.org). Accessed June 16, 2003.
- 2 Geier MR, Geier DA. Thimerosal in childhood vaccines, neurodevelopment disorders, and heart disease in the United States. *J Am Phys Surg* 2003;8(1):6-11.

<sup>3</sup> Geier DA, Geier MR. Gastrointestinal reactions and rotavirus vaccination based upon analysis of the Vaccine Adverse Events Reporting System (VAERS) database for 1999. A model for the calculation of the incidence rates and statistical significance of adverse events following immunization. *Hepatogastroenterology* (in press).

<sup>4</sup> Geier DA, Geier MR. Serious neurological conditions following pertussis immunization: An analysis of endotoxin levels, the Vaccine Adverse Events Reporting System (VAERS) database and literature review. *Pediatr Rehabil* 2002;5:177-182.

<sup>5</sup> Rosenthal S, Chen R, Hadler S. The safety of acellular pertussis vaccine vs whole-cell pertussis vaccine: A post marketing assessment. *Arch Pediatr Adolesc Med* 1996;150:457-460.

<sup>6</sup> Sever JL, Brenner AI, Gale AD, et al. Safety of anthrax vaccine: A review by the Anthrax Vaccine Expert Committee (AVEC) of adverse events reported to the Vaccine Adverse Event Reporting System (VAERS). *Pharmacoevidemiol Drg Saf* 2002;11:189-202.

<sup>7</sup> Fine PEM, Chen RT. Confounding in studies of adverse reactions to vaccines. *Am J Epidemiol* 1992;136:121-135.

<sup>8</sup> Institute of Medicine (US). *Immunization Safety Review: Thimerosal-Containing Vaccines and Neurodevelopmental Disorders*. Washington, D.C.: National Academy Press; 2001.

<sup>9</sup> Geier DA, Geier MR. Neurodevelopmental disorders after thimerosal-containing vaccines: A brief communication. *Exp Biol Med* 2003;228:660-664.

<sup>10</sup> Geier DA, Geier MR. An assessment of the impact of thimerosal on childhood neurodevelopmental disorders. *Pediatr Rehabil* (in press).

<sup>11</sup> Baskin DS, Ngo H, Didenko VV. Thimerosal induces DNA breaks, caspase-3 activation, membrane damage, and cell death in cultured human neurons and fibroblasts. *Toxicol Sci* 2003; (in press).

<sup>12</sup> Holmes AS, Blaxill MF, Haley BE. Reduced levels of mercury in first baby haircuts of autistic children. *Int J Toxicol* 2003;111(4): (in press).

<sup>13</sup> Nelson KB, Bauman ML. Thimerosal and autism? *Pediatrics* 2003;111:674-679.

<sup>14</sup> Burd L, Fisher W, Kerbeshian J. A prevalence study of pervasive developmental disorders in North Dakota. *J Am Acad Child Adolesc Psychiatry* 1987;26:700-703.

<sup>15</sup> Ritvo ER, Freeman BJ, Pingree C, et al. The UCLA-University of Utah epidemiologic survey of autism: Prevalence. *Am J Psychiatry* 1989;146:194-199.

<sup>16</sup> Yeargin-Allsopp M, Rice C, Karapurkar T, et al. Prevalence of autism in a US metropolitan area. *JAMA* 2003;289:49-55.

<sup>17</sup> Bertrand J, Mars, Boyle C, et al. Prevalence of autism in a United States population: The Brick Township, New Jersey, investigation. *Pediatrics* 2001;108:1155-1161.

<sup>18</sup> American Academy of Pediatrics. Study fails to show a connection between thimerosal and autism. Available at: <http://www.aap.org/prof/thimaut-may03.htm>. Accessed May 27, 2003.

<sup>19</sup> O'Meara KP. Vaccines may fuel autism epidemic. *Insight on the News* 2003;19(4):24-27.

<sup>20</sup> Geier MR, Geier DA. The state of polio vaccination in the world today: The case for continuing routine vaccination. *Toxicology Mechanisms and Methods* 2002;12:221-228.

<sup>21</sup> Geier DA, Geier MR. Lyme vaccination safety. *Journal of Spirochetal and Tick-borne Diseases* 2002;9:16-22.

## Opting Out of Medicare: a Very Rational Decision

The decision to opt out of Medicare is straightforward and easy, once you analyze the risks, costs, and benefits of taking part in this federal government entitlement program.

As with any such program, someone must pay for it. *There's no such thing as a free lunch*, the axiom popular in 1960s economics circles and quoted by Milton Friedman in 1976 at his Nobel Prize acceptance speech, is a reality.

The Medicare program has been likened to a Ponzi scheme. Current Medicare recipients take much more out of the system than they ever put into it. Taxpayers, doctors, and hospitals now share the enormous cost, but when this becomes impossible to bear, Medicare as we know it will no longer exist.

There are a number of reasons to opt out before the program's ultimate demise.

After moving our billing service in-house and no longer using an outside source, it became quickly apparent that in my practice Medicare claims were a huge problem. Not only was it difficult to get paid; many procedures were disallowed as being not "medically necessary," although clearly beneficial to patients.

In making such determinations, the government is essentially practicing medicine without a license. The decision-maker is certainly not a physician board-certified in pain medicine—and frequently is a clerk with minimal education. To be sure, there is a *physician* associated with the Medicare carrier, but this doctor has no training in my field of expertise. It is improper and unethical for a doctor without special expertise to override the decisions of a specialist. We have board certification and specialists for a reason – their knowledge is very specific and not common to all physicians.

Our analysis showed that while Medicare patients accounted for about 40 percent of our practice, the amount of corresponding revenue was 10 percent.

The overhead to treat Medicare patients was much higher than to treat non-Medicare patients. They typically have more medical problems, more difficulty understanding instructions, and require

more handholding from the office and the nursing staff than the average patient. My office nurse often had to perform social work in addition to her nursing duties. The number of Medicare patients necessitated an additional full-time nurse, physician, medical biller and receptionist, and a part-time nurse-anesthetist and radiological technician. The math quickly shows that this is a money-losing proposition.

Although physicians are trained to be healers and are not given courses in the economics of running a practice, we do live in the real world where we must pay liability insurance premiums (which have increased substantially this year), rent, salaries, and payroll taxes, and incur the cost of medications, equipment, office supplies, telephones, computers, and other essential practice items. In my practice it was not economically feasible to practice excellent medicine and also continue to treat the Medicare population.

Physicians' overhead continues to increase annually. Medicare reimbursement decreases annually. Overhead is unduly high in part because of onerous and oppressive government regulation. The more-than-132,000 pages of Medicare regulations require almost every office to have a compliance program and other wasteful and costly measures. Attorney and consulting fees range in the thousands to several tens of thousands of dollars. An entire industry specializes in these services!

Most doctors are bombarded by mailings, telephone calls, and e-mails urging them to attend costly seminars and hire consultants in order to comply with HIPAA, Medicare rules, and CPT coding. However, the doctor, not the consultants, is personally liable for any repercussions from implementing these consultants' advice. In addition, threat of a Medicare audit with stiff penalties and possible accusations—and conviction—of fraud and abuse weighed heavily in my decision to opt out.

An increasing number of incidents occur in which doctors are unjustly prosecuted and even incarcerated for errors in coding. It is virtually impossible for any human being to be fully compliant with all the rules. The Office of the Inspector General (OIG) did an interesting study in 2001. An OIG Chicago office representative presented the data at the AAPS annual

meeting in Cincinnati that September. The conclusion was that about 60 percent of the time Medicare representatives, advising doctors and staff on frequently asked coding questions, gave erroneous advice. Medicare itself does not know all the correct answers to coding issues, and yet physicians are held to this impossible standard!

One of the very few reasons *not* to opt out is the possible loss of referrals from other physicians. This factor was carefully evaluated, and it was decided that the practice was healthy enough to withstand a loss of all referrals from all physicians. Many physicians have determined that the best patient is the self-referred patient. With the popularity of internet access, many patients do their own research online and independently decide which specialist to consult.

After seriously considering the risks and benefits, I decided to opt out of the Medicare program in September 1998. My only regret is that I did not opt out earlier.

I have greatly reduced my overhead and aggravations. Practicing medicine is now unfettered. The focus is now on patient care and not on Medicare's ridiculously ambiguous rules. Most importantly, I do not have to think about the constant threat of unjust accusations of billing fraud and abuse.

I encourage all physicians in the Medicare system to consider opting out, thus restoring some respect to our noble profession. The Medicare program treats physicians maliciously, as proven by witch hunts and a seriously flawed reimbursement system.

Medicare even calls us "providers" rather than physicians or doctors. If we want to remain physicians in the tradition of Hippocrates, our choice is clear.

**Mary Jo Curran, M.D.**

**Mary Jo Curran, M.D.** is an anesthesiologist who now practices pain medicine. She is a Director of AAPS. E-mail: [mj@bepainfree.com](mailto:mj@bepainfree.com).

