A Patient's Adventure With the Allopathic* Medical Profession

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A Patient's Adventure With the Allopathic Medical Profession
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*__allopathy__: the usual method of treating disease with remedies that produce effects differing from those produced by the disease itself; as opposed to __homeopathy__: a method of treating disease with small amounts of remedies that, in large amounts in healthy people, produce symptoms similar to those being treated.

Contents

1 Medical Background

Before launching into the following narrative, it might be well to mention that, prior to the incidents described below, I have practically no medical history whatsoever. I was born by caesarean section, and the doctor nicked me behind the ear when he cut my mother open to deliver me. I've never seen the scar myself, but my mother (bless her) could still see it while I was a little boy. So that was my introduction to allopathic medicine: injured by a doctor before I was even born. However, it wasn't all like that. My dance through life with the "medicine men" has been a mixed bag.

When I was four years old, I fell headlong into a fire, landing with my left forearm in the coals, and thrust my right hand into the same coals in a reflexive effort to hoist myself out of the blaze; and in the process sustained some pretty severe burns. My parents rushed me to St. Vincents Hospital in Santa Fe, New Mexico, where I met a Dr. Ellis (I still remember his name), who had had extensive experience with burn victims as a medic during the course of the Second World War, then in memory still green. Ignoring my screams of agony, he mercilessly and vigorously scrubbed away all the burned flesh on my left forearm with Vaseline. Dr. Ellis knew his business. I healed with only a small burn scar at the baseof my right thumb, which I bear to this day. Otherwise, there remained not a mark on me.

A few months later, I fell head-first out of the top berth of a three-dcecker bunk onto a very hard and unyielding concrete floor, and turned purple from my hairline to the base of my nose. (1948 was a rough year for me.) This occasioned another trip to St. Vincents Hospital, where X-rays disclosed that I had *not* suffered a concussion; and I healed without a scar, or other noticeable impairment. Other noticeable impairment. Other noticeable impairment. . . .

I have no recollection of further interactions with the medical profession until years later. My mother studied—again at St. Vincents Hospital—to became a Licensed Practical Nurse, when our family broke up; and she was for a time employed in the office of a gynecologist in Santa Fe, before she and I moved to the Pacific Northwest in 1960. And so I was in that way briefly exposed, tangentially, to the allopathic medical profession.

I (involuntarily) encountered a few military doctors in the context of my brief and undistinguished military career during the Vietnam War; and I consulted an allergy specialist in Sequim, Washington, during the '90s, when I was plagued with annual misery, beginning every March when the alders bloomed, and dusted every available surface with unimaginable heaps—mostly on automobile windshields, still water, and within my tortured sinuses—of yellow pollen. The doctor gave me a single shot of a corticosteroid that most amazingly caused my symptoms to vanish utterly for the rest of the season. I saw him for my annual shot during a few consecutive years, and my symptoms gradually waned, even-

tually vanished altogether, and have not bothered me since. I stopped smoking tobacco in 1969, marijuana the following year, and have never smoked anything again.

At the time of the events described here, I was 67 years old, lived in Taos, New Mexico, and have enjoyed exceptionally sound health throughout the intervening years; which brings you up to date on virtually my entire medical history, such as it was, prior to the events that follow. I believe the events described here would not have had such a favorable outcome, had not my regular health care provider, Lia Bello FNP, CCH, Santa Fe, New Mexico[1] put immediately into my hands a manuscript edition of the book by Daniel Cobb, Doctor of Oriental Medicine[2] that is now a freely available download in The Wellspring Library.[3]

2 Onset

Thursday afternoon, 23 Jun 2011, having made encouraging progress during the prior 3½ hours on a piece of writing I was working on, I noticed that the time was drawing near to my necessary departure for my paid employment; and being somewhat drowsy, I decided to take a catnap; which I attempted, and is not particularly unusual. However, this time I was unable to make myself comfortable; and shortly after I lay down, I felt my body come all over hot and sweaty, weak, and trembly, which was unlike any sensation I had ever felt before. I got to my feet, and I found my stance surprisingly wobbly and uncertain.

I decided to call my paying employers, and let them know I might be somewhat late for work; for feeling the way I did at the moment, I could hardly imagine pedaling my bicycle into work during the next half hour or so. Ruth, the co-owner of the enterprise, called me back promptly, and I told her I was feeling strangely, and uncertain I could make it to work on time. She suggested I dial 911, which at the moment I was reluctant to do, and replied that I would just like to rest for awhile, and see whether what I was feeling would clear up. She said she would call me in half an hour and check up on how I was feeling.

I lay back down, but the sensations I was having, including a chest pain, profuse sweating, trembling, and unsteadiness on my feet, did not ameliorate at all, and I called Ruth back about ten minutes later. She said she could be at my home almost immediately, and take me to the hospital. I conceded that she might come by and at least have a look at me, and on that basis tell me what she thought. I had caught a glimpse of myself in the bathroom mirror, and the image I saw did not look to me at all like that of a well man.

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[1] `homeopathicare.org/`

[2] `wellspringpublishinggroup.com/wl/dc01.html`

[3] Daniel Cobb, DOM, *Reversing Heart Disease The Easy Way*, The Wellspring Publishing Group, 2008, 2012. `wellspringpublishinggroup.com/wl/download.html`

3 Hospitalization

Ruth came quickly, and confirmed that I did not look well; and we also agreed that she should take me to Holy Cross Hospital in Taos; which we put into action, and I entered the ER Unit shortly thereafter, while Ruth assisted me by filling out the necessary admittance forms. The details of this procedure are hazy to me now, but included Ruth getting in touch with my daughter Jennifer; which brought Jen eventually to Holy Cross Hospital to take over assisting me. Ruth left at some point, having been of invaluable assistance to me, and I was checked into a hospital room, where further tests were administered.

Preliminary diagnosis was that I had elevated blood sugar levels, indicating possible onset Diabetes Mellitus Type 2, and had suffered a myocardial infarction. The elevated level of sugar in my blood, suggesting onset Diabetes, was later attributed to my body's stress reaction to my heart attack. It was eventually decided that Holy Cross was not equipped to deal effectively with my case, and the doctor recommended that I be taken by ambulance to the UNM University Hospital in Albuquerque, for a heart catheterization; to which I acquiesced, and an ambulance was summoned from Red River to take me there. We arrived at the UNM Hospital at about 06:30 Friday morning, 24 Jun 2011, where I was admitted to a room on the 7th Floor South. Further blood tests were run, and I was administered the recommended heart catheterization a few hours later.

The procedure, throughout which I was a conscious and interested observer, began with insertion of a plastic tube into my Right Coronary Artery via an entrance at my wrist. What was going on inside was made dynamically visible in real time by an X-ray-opaque die injected through the catheter; disclosing that the artery was blocked by a blood clot which obstructed blood flow to the lower right quadrant of my heart. The surgeon sucked the clot out, and inserted a stainless steel mesh stent into the artery, which reinforces the artery wall at the point of injury.

The operation was quickly performed, and I was returned to my room, where I found that the surgeon had done a good piece of work: for the mild pain I had felt in my chest from the onset of the episode at my own home, had now gone away, was no longer a source of discomfort to me, and has not returned since. In fact, as the day progressed, although fatigued by the adventures of the preceding several hours, I felt once again quite nearly "my old self."

The remainder of my stay at the UNM University Hospital was occupied by convalescence from that brief operation, and numerous blood tests, and other kinds of tests aimed at ascertaining the condition of my heart, blood, and the prognosis for my recovery.

One of these follow-on tests, which proved to be of particular importance to that prognosis, was a sonic scan of my heart, conducted Saturday morning, 6/25. I was not able to

have an ideal view, because the apparatus was wheeled beside my bed, allowing me only an oblique view of the screen. Nevertheless, what I was able to glimpse of it impressed me considerably: for it displayed an enlarged view in real time of my working heart in action; and it seemed to be working with might and main, constantly, tirelessly, marvelously, like a muscular fist the size of a small ham, opening and closing vigorously, with a strength and persistence that seemed impossible. When I reflected that it had been doing that without interruption, or a "pause for breath," so to speak, for more than the prior 67 years, from the time my nascent body was still *in utero*, just the thought of it took my breath away.

The operator mentioned that the wand with which she was probing my chest was like a flashlight, and as she moved it around the outside of my body, it "illuminated" my heart from different directions, bringing various details within view. She was also able to record and amplify the sound being made by my heart, and the opening, closing, and blood flow through its valves and chambers. These too sounded vigorous, tireless, and nothing short of miraculous, yet virtually silent and unseen under normal circumstances.

The doctors were particularly interested in viewing the resulting scan, and evaluating it as an important part of determining when I might safely leave the Hospital. Perhaps being a weekend, it was a couple of more days before the doctors were able to evaluate the scan; but they were pleased by what it showed them.

They had been keen to observe my functioning heart, in order to determine whether the interrupted blood flow through my Right Coronary Artery had been prolonged enough, or severe enough, to have caused any of the affected heart tissue to die, or to be seriously damaged. If so, this would be a source of unbalance in the overall performance of my heart, analogous, I ventured, to a crew member failing to pull his oar with the vigor of his mates. Exactly, the doctor affirmed.

In my case, I was told, this had not happened to any alarming extent. Yes, my heart had been taxed, but remained strong, and was making a very satisfactory recovery. I was released from the UNM Hospital around 16:00 6/27/11.

4 Aftermath

Back in the "real world," or at least, that part of the world with which I am more generally familiar (as opposed to the "medical world," which for me is almost totally uncharted territory), I found myself faced with a novel set of circumstances, "up close and personal," with which I had never before been confronted. Mainly, I now had in the midst of my heart arterial system a foreign object that was never present before: a stainless steel stent that will remain within me for as long as my body continues to function. The stent may well have

saved my life in the immediate moment; that, I presume, was the assessment of the doctors, and they ought to know. However, there are unavoidable risks involved with every event, and the risks that have emerged from this new set of circumstances are different from, or added to the risks, known and unknown, I have faced before.

One of the known risks associated with the presence of a stent is that the artery in which it was placed, and opened, may in time close again around the stent, and occasion a recurrence of the condition it was intended to heal. This eventuality would be even more threatening than the original condition, because of the complicating presence of the stent itself, which of course was not a factor in the original instance.

More generally, the stent is a foreign object in the midst of my circulatory system, and my body's natural response is to reject foreign objects in its midst, for instance by encapsulating it with tissue. The stent itself is coated with a slow-dissolving medicine, or drug, to inhibit this reaction during the healing process, and other drugs were prescribed to maintain conditions within me that discourage this adverse reaction, after the stent's own medicine has eventually been exhausted.

To this end, the doctors prescribed a regimen of medications, including blood thinners and anticoagulants intended to minimize the risk of blood clots forming at the location of the stent, obstructing blood flow in the artery, and causing a recurrence of the original condition. However, my analysis and intuition suggested to me that there are probably a number of "very good reasons" for blood to have the properties it has, including its propensity to clot quickly in response to injuries, such as the cuts and abrasions encountered in the course of daily living. Medications which interfere with or obstruct this useful property of blood may thus be the source of additional risks.

It emerges that there is a cascade of consequences in response to the artificial invasion of the human body, even though the invasion is prompted by efforts to prolong the life of the body thus invaded. The body reacts adversely to the invasion, requiring intervention with medicines to counter the adverse reaction, which may prompt in turn further adverse reactions. The intent behind the process is that the body should achieve a stability that gracefully accommodates the presence of the foreign object that sustains the body's life, yet is itself the initial cause of the cascade of events, counter-events, and reactions to them.

I thus became gradually aware of multiplying risks, that I have never before had occasion to consider. I was told, for instance, that

> according to JAMA [*Journal of the American Medical Association*], scripts [medical prescriptions] are the 4th leading cause of death, around 106,000 yearly, while all the street drugs combined kill around 10,000. Yearly 1.5 million experience adverse effects to the degree they require hospitalization. More

> than 700,000 people end up in emergency rooms with adverse reaction. Count me among those as I've been there several times because of that. This part is the one that hit home: each year scripts cause serious damage and PERMANENT DISABILITY to 2.2 million, and the majority of script related deaths/adverse reactions are never reported. They estimate maybe 1% to 4% are reported.[4]

Therefore, I felt that my anxiety over the need to receive daily doses of prescription drugs as a measure to sustain the stability of my post-operative condition were not without reasonable foundation; and that my desire to find natural, non-synthetic alternatives to as many of them as possible was not motivated by insubordination, and was not a reflexively negative reaction to competent medical advice. I do appreciate, honor, and am sincerely grateful for the life-saving treatment I received in the face of a potentially mortal emergency.

However, at the end of the day, I recognized that I, not any doctor, must face the responsibility of how I shall navigate for as long as my continuing life remains navigable. The possibility, and its consequences, of being mistaken, misinformed, and/or not entirely aware of "all the relevant facts," is an unavoidable factor for which I must budget in meeting this responsibility.

A specific issue that emerged into my awareness concerns *cholesterol*—a matter that had not previously been a part of my conscious attention—and the medication, *lipitor*, prescribed to control it.

I learned that

> Cholesterol is a waxy steroid of fat that is manufactured in the liver or intestines. It is used to produce hormones and cell membranes and is transported in the blood plasma of all mammals. It is an essential structural component of mammalian cell membranes. It is required to establish proper membrane permeability and fluidity. In addition cholesterol is an important component for the manufacture of bile acids, steroid hormones, and Vitamin D. Cholesterol is the principal sterol synthesized by animals; however, small quantities can be synthesized in eukaryotes such as plants and fungi. It is almost completely absent among prokaryotes including bacteria. Although cholesterol is important and necessary for mammals, high levels of cholesterol in the blood can damage

[4]Lia Bello FNP, CCH, Santa Fe, New Mexico, in an e-mail correspondence dated 06/29/2011 09:59. See also *DEATH BY MEDICINE*—December 2003 by Gary Null PhD, Carolyn Dean MD ND, Martin Feldman MD, Debora Rasio MD, Dorothy Smith PhD (`www.vacinfo.org/Null.pdf`)—which boosts the estimated figure of 106,000 iatrogenic, or medically induced deaths per year, and the 4th leading cause of death, to "the number one killer at 738,000 annual deaths."

> arteries and are potentially linked to diseases such as those associated with the cardiovascular system (heart disease).[5]

From *The Ultimate Solutions to Heart Disease, Stroke and Alzheimers, part 1*,[6] I learned about a Chinese government study that investigated "why they don't have the level of cardiovascular disease we have in the West; but if they come over here they catch up with us in 5 or 6 years."[7] The Chinese study disclosed the presence of a substance found in *red yeast rice*—which is itself a byproduct of the manufacture of rice wine, and occupies a prominent place in the typical Chinese diet—that has the effect of inhibiting the liver's production of cholesterol by about 60 mg a day.

The story is that on the basis of this finding, a number of pharmaceutical companies began synthesizing and manufacturing this cholesterol-inhibiting molecule, and marketing it under names like *baycol*, *lipitor*, *mevacor*, *zocor*, and others, also known generically as *statin* drugs. However, the statins are known to cause liver and muscle damage in some people; whereas there are no known side effects from ingesting red yeast rice.[8] And as an added bonus, red yeast rice could be had for about 22¢ a capsule, as opposed to $2 to $5 or more for a single statin dose.

That is not the end of the story, however. Red yeast rice had been widely available as a condiment, and could be had over the counter more or less anywhere. However, on the grounds that it contains a substance identical to a medical drug—even though that drug had been molecularly copied from its source model in red yeast rice—the FDA declared red yeast rice is also a drug, and placed it under FDA regulatory control, effectively removing it from the market[9]—and incidentally removing it from competition with products of the pharmaceutical industry.

This sequence of events raises some rather ugly questions about the U.S. health care system, some of which are addressed by Stephan A. Schwartz in an article titled *An Appraisal of The Illness Profit System*.[10]

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[5]Wikipedia article, *Cholesterol*. `en.wikipedia.org/wiki/Cholesterol`

[6]Dick Washburn.
`www.healthsalon.org/168/the-ultimate-solutions-to-heart-disease-stroke-and-alzheimers-part-1/`

[7]*Ibid*.

[8]Well, it turns out this may not be entirely true. I have learned from *Reversing Heart Disease The Easy Way* by Daniel Cobb DOM, The Wellspring Publishing Group, 2012, p. 13, that red yeast rice inhibits other liver functions as well; including the manufacture of Co-Enzyme Q 10, which is vital for the production of collagen, which is often required in large amounts for the repair and maintenance of bodily tissues.

[9]Wikipedia article *Red yeast rice*, Regulatory restrictions. `en.wikipedia.org/wiki/Red_yeast_rice`

[10]`www.explorejournal.com/article/S1550-8307%2810%2900291-0/fulltext`

"Is the health of the American people," Schwartz asks, "an essential part of our national security and prosperity? Is America better equipped to deal with the challenges of the 21st century when it has a healthy population more capable of working at its full potential? If the answer is yes, then the next question to ask is: why is our healthcare system so very bad—37th in the world according to the World Health Organization?"

Schwartz goes on to observe that

> measured in a dozen different ways, our healthcare system is not about health. What we have in the United States is an Illness Profit System. The illnesses and traumas of human beings are just the mechanism by which the money taps are opened. It is part of the human condition that everybody gets something that requires medical attention some time in their life, and the Illness Profit System is structured to exploit this. If you get well, it makes money on your treatment. If you don't get well, it makes even more money on your treatment. The system is profitable at either end but is weighted toward illness. It's more profitable. To hide its rapacity, the Illness Profit System relies on the humanitarian face presented by the health professionals who administer the treatments. It understands and exploits their calling to the service of healing, and our natural deference to the men and women who care for us, even as the system is constantly and cynically trying to corrupt them.[11]

These are large issues, and they stretch far beyond the small horizon of a single individual struggling to reach plausible, workable decisions about how to deal with the expanded complexity of unfamiliar medications, possible dietary adjustments, and a host of other concerns that had formerly not been matters of concern to me at all. And they form the larger context in which these personal struggles occur.

How does one reach confident decisions upon matters from which his very life may hang, when he finds reason to *doubt the benevolence* of the overarching health care/illness profit system upon which his life depends? This is not directed at the very able doctors, nurses, and other medical professionals I actually met during my hospitalization, and who convinced me without exception that I was in the hands of caring, competent, capable human beings who evidenced every effort to save my life, and care for me to the best of their very considerable ability. Yet those sweet, intelligent, capable individual humans are part of a larger apparatus, called the *health care system*, or the *illness profit system*, which seems to have a different agenda than the saving of lives, and the nurturing of sound health throughout the population.[12]

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[11]Schwartz, *loc. cit.*

[12]For extensive elaboration, beyond but not excluding the medical/pharmaceutical industries, see *Grunch of Giants* by R. Buckminster Fuller. `bfi.org/about-bucky/resources/books/grunch-giants`

It is this overarching system that funds the research, and influences the curricula at medical schools in which each new generation of doctors, nurses, and medical professionals are trained. It decides what research questions will be asked, addressed, and funded, and which will not. If it has a different agenda than the saving of lives, and the nurturing of sound health throughout the population, what is that agenda? And what is the reliability of the medical opinions delivered by the professionals it educates and trains?[13]

These are not flip, impertinent questions intended to stir disaffection among medical professionals, or between doctors and laity. They are troubling questions, that emerge spontaneously in the context in which enormous populations live, work, and strive for improved conditions in the contemporary world. They are prompted by a realization that, all our sophisticated medical and other technology notwithstanding—and it truly is impressive, spectacular, and in many ways well nigh miraculous—the difference between what we understand, of ourselves, and of the world and universe in which we live, and what we do not yet understand, is not much changed from what it has ever been. In relation to the vast ocean of mystery we have not yet plumbed, what we know and understand is slight; what we have yet to learn is great. I believe this applies in principle no less to the medical profession today, and probably into the foreseeable future, than to any other profession, or station in human society.

5 Prescriptions

The medical prescriptions assigned to me by doctors at The University of New Mexico Health Sciences Center, University Hospital, are compiled in a separate document;[14] including transcriptions of the common uses, directions, precautions, drug interactions, and adverse effects, delivered to me by the pharmacy at which I had the prescriptions filled. I have reproduced them, not because they provide gripping reading material (they do not), but because they constitute a significant part of the information available to me about the specifics of my intended post-operative care. As discussed below, all of them contain the following paragraph:

[13] This is not a rhetorical question. See the PLoS Medicine *Wyeth Ghostwriting Archive* for discussion and documentation of the practice of ghostwritten articles placed in peer review medical journals under the authorship of credentialed doctors, which were actually written anonymously as disguised advertisements promoting the benefits, and obscuring the hazards, of commercial products of the pharmaceutical industry. `plosmedicine.org/static/ghostwriting.action`

[14] "Undisclosed Lawyers Employed by the Pharmaceutical Industry," *Allopathic Prescriptions*, The Wellspring Publishing Group, 2012. `wellspringpublishinggroup.com/wl/allopathic-Rx.pdf`

> PATIENT-ORIENTED DISCLAIMER: The information in this monograph is not intended to cover all possible uses, directions, precautions, drug interactions, or adverse effects. This information is generalized and is not intended as specific medical advice. If you have questions about the medicines you are taking or would like more information, check with your doctor, pharmacist, or nurse.

6 Questions

First question: What am I supposed to make of all this?

The impression I have from the combined content of the *uses, directions, precautions, drug interactions, or adverse effects* supplied to me by my pharmacist is that none of it was ever intended for anybody actually to *read*; but rather to provide legal shelter for the principals of the pharmaceutical industry, in the not improbable event of one or more complications arising through use of their products of uncertain safety and reliability. As mentioned in § 4, including footnote 4: 738,000 people die every year from the fatal effects of prescribed medications, while street drugs account for only 10,000 fatalities. One-and-a-half million people are hospitalized every year, due to the hazards of prescribed medications; and more than two million suffer serious bodily harm, and *permanent disability*, due to the same cause. And this represents only one to four percent of the actual holocaust: the other ninety-six to ninety-nine percent remain unreported and entirely ignored. No wonder the lawyers employed by the pharmaceutical industry take such exquisite pains to specify every nuance of everything that can possibly go wrong for patients using their products; and then, just for good measure, conclude with the standard PATIENT-ORIENTED DISCLAIMER reproduced above, and included among the directions, precautions, drug interactions, and adverse effects, delivered with *every one* of my prescribed medications.

Frankly, this looks to me like a transparent evasion of responsibility. Then, in the event of potential or threatened litigation, they can always say, "We told you so; you were warned in advance, and bear full responsibility for all risks associated with your voluntary use of our products."

Well, in my case—as in countless others—it wasn't exactly voluntary, or what anyone could honestly call *informed consent*. A man entering a hospital emergency room off the street while in the throes of a heart attack is not in an advantageous negotiating position. The hospital personnel either save his life, however they can, or they don't. In my case, they did; and I cannot express my full appreciation for that astonishing fact.

Nevertheless, coming out the other end of the hospitalization process, I found myself not only still alive, but also loaded up with an entirely unanticipated cocktail of incomprehensi-

bly complex and hazardous med interactions which I was told I must continue taking daily, maybe for the rest of my life. This is a circumstance I was not willing to accept, without doing everything in my power to amend it—which I have fulfilled, as described below. In general, *any substance* its manufacturers explicitly warn pregnant or potentially pregnant women against taking, "since it may cause fetal harm,"[15] is not anything I am at all willing to ingest into my body. So yes, I do have some questions, offered in profound gratitude and appreciation—and also in iron determination not to be the pharmaceutical industry's cash cow, or involuntary lab rat, for the rest of my days.

Second question: I understand by the information I have received that heart attacks are caused by high levels of so-called "bad cholesterol" (LDL) in solution in the circulatory system, which comes out of solution and forms deposits of plaque within the coronary arteries that supply blood and nourishment to the heart. According to a brochure I received during my hospitalization,

> *Coronary Artery Disease (CAD)* is usually caused by *atherosclerosis*, and affects the *coronary arteries* that surround the heart. These coronary arteries supply blood with oxygen and other nutrients to the heart muscle to make it function properly. CAD occurs when the inner walls of the coronary arteries thicken due to a buildup of cholesterol, fatty deposits, calcium and other elements. This material is known as *plaque*. As plaque develops, the artery narrows. When the artery narrows (for example with physical exertion or mental stress), blood flow through the artery is reduced so less oxygen and other nutrients reach the heart muscle. This reduced blood flow may cause mild to severe chest pain or chest pressure. This pain or pressure can also spread to the arms or jaw, a condition known as *angina pectoris*. Complete obstruction (no blood flow) of a coronary artery can result in a heart attack *(myocardial infarction)*.[16]

Question: By what mechanism do high levels of cholesterol in the bloodstream accumulate as plaque deposits in the coronary arteries—*the most turbulent part of the circulatory system*—instead of the far less turbulent veins and capillaries far removed from the constantly vigorous heart? If CAD is *caused* by excessive levels of cholesterol in the blood, one would naturally expect these high levels to show up first as plaque deposits in the large veins, where blood flow is the most sluggish; instead of in the "rapids" around the heart,

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[15] *Ibid.*, e.g. pp. 2-3.

[16] *TAXUS® Express²™ Paclitaxel-Eluting Coronary Stent System; TAXUS® Liberté® Paclitaxel-Eluting Coronary Stent System: A Patient's Guide*, Boston Scientific Corporation, Natick, MA. `www.bostonscientific.com`

where the blood is perpetually in turbulent motion. Why is "hardening of the veins" never heard of, yet "hardening of the arteries" (an informal designation for atherosclerosis) is a common description of plaque accumulations in the coronary arteries? This question is discussed further in the following Section.

Third question: As noted above in § 4, cholesterol, both the "good" HDL variety, and the "bad" LDL, are essential for numerous cellular and bodily functions, and are normally manufactured in the liver and intestines of healthy individuals. *On what basis are natural products of healthy human metabolism labeled "bad," and justify artificial medical interventions to suppress?*

7 Answers

I have found through my research that there are answers to some of my questions—and that not all such answers have their sources within the conventional allopathic medical paradigm, and often reach strikingly different conclusions from those reached by allopathic medicine.

For example: as already mentioned, atherosclerosis is sometimes called "hardening of the arteries." Its cause, according to standard allopathic interpretation, is a buildup of plaque within the artery, as a result of too much cholesterol in solution in the blood. This is based upon the assumption that when cholesterol levels mount beyond a certain healthy level, cholesterol comes out of solution, and has a tendency to accumulate as plaque within the arteries. If so, then to reverse this condition, it would seem plausible that measures should be taken to bring cholesterol levels down, thereby reducing the tendency for plaque to accumulate.

However, there is credible dissent to these assumptions, and those who seek a deeper understanding of why plaque accumulates within coronary arteries in the first place. One such dissenting voice is given expression in by Dr. Daniel Cobb,[17] who points out, as already mentioned, that the coronary arteries are the *most turbulent* part of the entire circulatory system: for the reason that they are at the very location of the most forceful blood flow, energized by the heart muscle, which works without ceasing, with tireless, seemingly inexhaustible vigor. Cobb observes that the one place in the entire circulatory system *least likely*

[17]Daniel Cobb, DOM, *Reversing Heart Disease The Easy Way*, The Wellspring Publishing Group, 2008, 2012, § 1.4 Turbulence, p. 2; Fig. 4, Turbulence, p. 45. `wellspringpublishinggroup.com/wl/cobb.pdf`

See also Mike Ciell, R.Ph., *One Pharmacist's View of Coronary Heart Disease: Comparing the "Lipid Theory" With the "Unified Theory"*, 2008. `ourhealthcoop.com/pauling.htm`

for excess cholesterol coming out of solution to settle as plaque, is within the perpetually turbulent coronary arteries.

Yet it is within the coronary arteries that plaque deposits are most often found. They are never encountered within veins, where the blood flow is much more sluggish and sedate. No one has ever entered a hospital with a condition of "hardening of the veins." There must be a reason for this, and it seems that the allopathic paradigm has not made clear what that reason is.

It should come as no surprise that, short of the heart itself, the most vigorously active part of the circulatory system, the coronary arteries, should also be subject to the most intensive "wear and tear;" and conversely, that particular measures should have evolved within all animal and human circulatory systems for effectively repairing such "wear and tear," and maintaining the system at peak performance at all times. The primary molecular material for effecting this vital maintenance is *collagen*: "one of the most abundant proteins in the body," Cobb writes, "and it forms the basis for most of the strength of connective tissues such as skin, ligaments, and artery walls."[18]

So when damage or injury occurs within arteries—or anywhere in the body—collagen is the material of choice for repairing the damage. Naturally, there is a high demand for collagen, so it is necessary, and fortunate, that collagen is abundant. But what happens when, in spite of that usual abundance, demand for collagen exceeds the supply? This might happen in the event of severe injury, where a great deal of damaged tissue requires repair, and healing.

It can also happen when the necessary ingredients for manufacturing collagen are in short supply. One vital ingredient in the "recipe" for collagen is particularly prone to this contingency: *vitamin C*. This is so, because vitamin C is an unstable, "volatile" molecule: it doesn't hang around in the system very long, once it has been absorbed. And vitamin C must be absorbed from dietary sources, because unlike some mammals,[19] humans do not manufacture our own vitamin C. We have to eat it.

Fresh fruits and vegetables are good sources for vitamin C, but stale fruits and vegetables are not: the vitamin C has deteriorated, and is no longer present in them. Similarly, within the human body, vitamin C must be put to immediate use when it is available, and although it is abundant in many foods, it is often in short supply in contemporary human diets.

Thus, in people with diets deficient in vitamin C, the demand for collagen is also likely to be greater than the supply. Yet the circulatory system is so vital that when any part of

[18]Cobb, 2008, 2012, p. 6.

[19]Significantly, those mammals that do produce their own vitamin C are not subject to atherosclerosis (Ciell, 2008, pp. 3-4, `ourhealthcoop.com/pauling.htm`).

it sustains injury, *it must be repaired promptly*. But what if there is not enough collagen to effect the repair? This is where what Cobb calls "Plan B" comes into play.

Let's say that there has been some damage sustained at a certain location within a coronary artery wall. Left unrepaired, the damage in this vigorous, turbulent environment, can only worsen—leading eventually to *breakthrough bleeding*, or a hemorrhage of the artery. I don't need to tell you that this would be *really bad*, and most likely fatal. Due to vitamin C deficiency, there is not enough collagen immediately available to effect a proper repair—but there is a sticky, waxy substance in solution in the blood with just the right properties for at least placing a "band-aid" to protect the injury, until enough collagen can be deployed actually to repair the damage. That sticky, waxy substance is known as *cholesterol*—particularly LDL, or "bad" cholesterol—and when it adheres to an artery wall at the site of an injury, it is known as *plaque*.

This view of things stands the allopathic approach to heart disease on its head; and cholesterol and plaque, cast by allopathic medicine in the role of the body's perpetual enemies, emerge instead as loyal friends, and healing agents for injuries sustained in the vigorously challenging environment of the coronary arteries. And ironically, the allopathic medical approach emerges as the *real enemy* of this healing process, in large part by labeling (*libeling!*) LDL cholesterol as "bad," and introducing artificial substances into the body designed to obstruct its natural production.

The down side of the "Plan B" solution is that it is only temporary. The real solution is the repair of the injury with collagen; but that is often postponed indefinitely, due to a chronic shortage of collagen, due in turn to a chronic shortage of vitamin C.

This is an alarming situation—yet no alarms are sounded. Silent years may go by, during which coronary arterial damage accumulates, exhibiting no visible symptoms. Plaque deposits continue to accumulate, keeping pace with unhealed injuries by plugging leaks, and protecting arterial walls as much as possible from further damage, pending the chronically delayed *real* healing solution supplied by collagen . . . and arteries gradually narrow, leading to eventual heart attacks, and to hundreds of thousands of preventable, premature deaths.

This picture of things is more complex than the simple allopathic model involving a supersaturated solution of cholesterol in the bloodstream; and the expectation that "the answer" lies in control of cholesterol levels. However, what is the *credibility* of this "vitamin C theory?"

As a matter of fact, "the vitamin C theory" has a rather distinguished pedigree. Cobb notes that the theory is not his own, and was highly favored by Dr. Linus Pauling (1901-1994), the only recipient of two unshared Nobel Prizes, and bearer of 48 honorary Doctorate

degrees.[20] On the contrary, a provocative question worthy of pondering is: *Why have the allopathic medical fraternity not followed up on Pauling's extensive research into reversing atherosclerosis by simple dietary means*, instead of persisting in medicinal interventions designed to short-circuit healthy bodily functions? Could it have anything at all to do with the fact that medicinal interventions are incalculably *more profitable* to the medical fraternity, than are dietary solutions?

Dr. Cobb also cites the work of Wayne Martin, Cobb's "favorite medical writer," who notes that, although today there are about 500,000 deaths in America from the kind of heart attack known as myocardial infarction (MI), "this is a new disease that has come about in [the 20th] century. Prior to 1925, there was almost no knowledge of this disease."[21]

In those days, MI was called *coronary thrombosis*, and was very rare. Martin cites a number of studies conducted over the years, in England and America, corroborating a ratio of MI fatalities per unit of population, "of one in 1900, to 10 in 1910, to 80 in 1980."[22]

Martin notes, however, that during the 1960s, two populations were studied "who were as free from MI deaths as was the English population in 1900. One such population was the black population in Uganda and the other was the North Indians living near Udiapur." He adds that "This suggests that we could again be as free from MI deaths as was the population of England in 1900."[23]

Prior to 1955, blood clots were believed by most of the medical profession to be the primary cause of coronary thrombosis, and patients were maintained on low doses of warfarin, an inhibitor of fibrin formation in blood clots. Warfarin in large doses was used successfully as a rat poison, causing rats to die of internal bleeding; but it didn't seem to be very effective

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[20] `en.wikipedia.org/wiki/Linus_Pauling`

[21] Wayne Martin, *Reducing Deaths from Heart Attacks and Cancer.* `www.second-opinions.co.uk/martin_chd.html`

[22] *Ibid.* Sources cited by Martin:

- A.G. Gibbon, Ischemic necrosis of the heart. *Lancet*, 1925, i, pp. 1270-9.
- Rodney Finlayson, Ischaemic Heart Disease, aortic aneurysms and atherosclerosis in the city of London 1868-1982. *Medical History Supplement* 5, 1995, pp. 151-69.
- Alastair Mackinnon, The origin of the modern epidemic of coronary heart disease in England, *Journal of the Royal College of General Practitioners*, April 1987, pp. 174-6.

[23] *Ibid.* Sources cited by Martin:

- Wilber Thomas et al., Incidence of myocardial infarction with venous and pulmonary thrombosis and embolism. *The American Heart Journal*, Jan. 1960, pp. 41-47.
- S.L. Malhotra, *The American Journal of Clinical Nutrition*, Vol. 20, May 1997, pp. 462-74.

in low doses against a second heart attack. By 1955, these disappointing results motivated doctors to seek elsewhere. Cholesterol was seized upon as the cause, and the name of the disease was changed to myocardial infarction.

This gave birth to the so-called *Prudent Diet*, which specified that the amount of polyunsaturated vegetable fatty acids in the diet should be twice the amount of saturated animal fat. Martin cites numerous studies made to prove the effectiveness of the Prudent Diet.

> The first study [Martin writes] was the Joliffe Anti-Coronary Club in New York City. Joliffe was a doctor working for the city. He was a diabetic and a vascular wreck. He was in a wheelchair and had gone blind in one eye. He looked to the Prudent Diet for his salvation.
>
> The control group in this trial was men of wealth on Wall Street who could afford good food. They had a diet that included lots of eggs, butter, cheese, and beef. The Prudent Diet group was mostly teaching staff at city universities. A drug firm made a special margarine rich in polyunsaturated fats to be part of the Prudent Diet. The Prudent Diet was very strict in having almost no butterfat and very little red meat.
>
> The trial ran for four years and was hailed as a great success for the Prudent Diet, as total serum cholesterol was reduced by 25 percentage points. One had to read the fine print, however, to discover that eight men on the Prudent Diet died of MI, whereas none of the controls eating eggs, butter, and beef died of a heart attack. Then Dr. Joliffe died, it was said of complications of his diabetic condition. He may have had a heart attack.[24]

Martin goes on to cite numerous other trials to confirm the Prudent Diet—with contrary or mixed results. He notes that by 1968, practically all of America was living on a diet that was very close to the Prudent Diet, and the results for those eating the Prudent Diet then under trial were not distinguishable from the results for the control group under the diet shared by most Americans at the time. Both groups experienced the same rates of fatal and non-fatal heart attacks.

Martin then cites "an 8-year trial of the Prudent Diet at a VA hospital in California, in which cancer deaths increased among the patients on the Prudent Diet by 15%. Not long after that, there was an editorial in the British Medical Journal asking if polyunsaturated fats were causing cancer, with a strong suggestion that they were."[25]

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[24] *Ibid.*; *JAMA*, Nov. 7, 1966, pp. 129-35 (Martin's citation).

[25] *Ibid.* Sources cited by Martin:

- American Heart Association Monograph No. 25, 1969. This entire monograph was devoted to this trial.

[Footnote continued on following page.]

Meanwhile, as already mentioned, the North Indians, in 1970 the world's largest consumers of butterfat as ghee, and also the world's largest consumers of onions and garlic, had continued to enjoy an MI mortality rate similar to the British in 1900—which is to say, practically nil.

> At this time [Martin writes], there was a strict vegetarian population in the South of India who lived on the Prudent Diet more closely than anyone in the USA. They had a high fat diet in which all the fat was polyunsaturated vegetable oil or margarine made from it. They were having 15 times the MI deaths as compared to the butterfat-eating North Indians.
>
> By 1988, things had changed in the North of India. Low-cost liquid polyunsaturated vegetable oil had priced ghee out of the market. Also, doctors were teaching the Prudent Diet. By then the death rate from MI in North India had increased to match that in the USA.[26]

In sum, although the low-cholesterol Prudent Diet is still favored by the allopathic medical community, and the pharmaceutical industry, there is a significant body of evidence available which demonstrates that the Prudent Diet is not very "prudent" at all, for anyone wishing to minimize the risks of fatal or non-fatal MI episodes; and it appears that the level of serum cholesterol in the blood has little or no relevance to the incidence of MI fatalities.

8 A Collision of Paradigms

For me, the discussion so far adds up to a collision of paradigms, in which the allopathic paradigm emerges seriously compromised by the encounter. Yet it is this paradigm that is "authoritatively" proposed to inform me in the conduct of my healing process, in the wake of my very own personal MI episode. I remain unconvinced. Rather, it looks to me as though the allopathic paradigm is busy wrestling—among other irrelevancies—with the challenge of suppressing cholesterol levels in a body that naturally *manufactures* it, and puts it to a variety of very positive uses; while the *real* causes of MI specifically, and many other ills generally—simple and widespread dietary deficiencies among industrialized humans—remain unrecognized, unaddressed, and untreated.

- *British Medical Journal* Editorial, August 11, 1973.

[26] *Ibid.* Sources cited by Martin:

- S.L. Malhotra, *American Journal of Clinical Nutrition*, Vol. 20, May 1967, pp. 462-74.
- Bihari Raheja, Ghee, cholesterol and heart disease. *Lancet*, Nov. 14, 1987, p. 114.

There have existed a wide spectrum of opinions about the causes, control, and cures for myocardial infarction, and related diseases; and these opinions have experienced many significant changes during the past century. A hundred years ago, these diseases were unknown; yet today medical opinion about them is dominated by the allopathic paradigm, in spite of abundant and richly various bases for contrary opinions, and alternative lines of research.

An individual like myself, caught up unexpectedly in a personal and immediate MI episode, finds himself in the peculiar position of having to deal with life-threatening circumstances, little or not at all understood. It feels something like walking gingerly through a minefield, aware that an error of judgment, or a misstep, may be fatal; yet having little reliable basis for any judgment at all.

Perhaps the most simple "solution" to this dilemma might be to trust the authoritative advice of the medical/pharmaceutical institutions, and follow "doctor's orders" to the letter. If this is the most *simple* solution, yet the 738,000 medically caused deaths in America every year, making such events the number one killer,[27] urges that the most *simple* solution may not be the most *prudent* solution.

On the basis of my admittedly sketchy understanding, I established the personal goal of returning, as quickly as possible, and as completely as possible, to my prior status of minimal—ultimately zero—reliance upon synthetic drugs of any kind. Naturally such a goal involves risks; but then risks are involved in any course, and in having no course at all. And in the end, all such risks are absorbed in the single certainty that whatever any of us does, or fails to do, we are here only temporarily, and provisionally, and are sooner or later destined to return to the mystery from whence we came.

Meanwhile, I have become increasingly skeptical of many aspects of the allopathic paradigm intrinsic to the so-called "health care"—otherwise known as the *illness profit system*—currently in place in America; and I view with growing alarm the cascading incidence of mounting and compounding risks associated with that system. It appears to me that the allopathic paradigm is prone, under the stresses of emergency, to sometimes ham-fisted intervention into the exquisitely balanced tapestry of the bodily mechanisms of living humans; and is quite ungraceful at handling the aftermath of such emergency procedures. The emergency procedures do save lives—they saved mine—for awhile. Yet for how long, and at what cost?

[27] Null, *et al.*, December, 2003, pp. 2-5. `www.vacinfo.org/Null.pdf`

9 Costs

During the five days I spent in hospital, June 23-27, 2011, I dropped from the status of paying my own way, owing nothing to anybody on Earth, with no obligations I could not at a moment's notice meet on demand; to being the owner of approximately $41,000 in medical debt. I then arranged a follow-up appointment with a local cardiologist, with whom I spent not more than 30 minutes—which even at that was interrupted, and the doctor was called away for a few minutes in the midst of our consultation. At the conclusion of our not particularly informative meeting, I was given a bill for $235, which I paid on the spot. However, I deem I have more productive uses for $235 than to exchange it a second time for any additional "advice" from that gold-plated cardiologist.

In less than a week's time, I seemed to have fallen into a surrealistic world in which the small sums with which I had so easily met my modest expenses, suddenly had no value whatsoever anymore. I could easily relate to Schwartz's article, *An Appraisal of The Illness Profit System*, discussed above in § 4, in which the calling to the "healing arts" has evidently been hijacked by a band of robbers and murderers, for whom *profit* is the only human value worth pursuing. It is a sad day when those who answer the call to become physicians for the healing of their fellow humans' injuries, have their names, and their profession, tarnished by such . . . I would say *obscenity* is not too strong a word.

10 Betting One's Life

Meanwhile, I have been faced by circumstances that pressed upon me the necessity of dealing with conflicting advice from contradictory, and almost certainly less than complete sources of information; and having to make decisions with potentially life-threatening consequences—at least to myself, if to no one else. For me, this has not been a trivial matter.

It is not a particularly unusual circumstance either. Every day, practically everybody bets his life that he is "right" about "how things are" in the world he enters when he gets out of bed in the morning. If he drives in the city, for example, he bets his life that oncoming traffic will keep to its side of the road, and that cross-traffic will stop and wait, while the light is green for him. Most of the time, these bets turn out as expected, and we hardly even give them a thought. But sometimes they don't, and somebody suffers property damage, or is injured, or killed.

On the basis of my research, I have reached the provisional "conclusion" that the allopathic paradigm is not a reliable guide to health and long life; that some if not all of the synthetic drugs prescribed for my alleged well being are more likely to harm me, in the

long run, than to heal me; and that there are alternative therapies with greater probability of prolonging my life and sound health.

This "conclusion" is provisional, because I am aware that I do not have, and cannot have, "all the relevant facts" in the matter; and that as we all do, I too must make my operational decisions on the basis of fractional information that may potentially lead me into a fatal error. It can't be helped; it's the best we can do. Sorry, if everything doesn't always turn out as expected, or hoped.

My quest to return to the condition I enjoyed prior to my MI episode, specifically the condition of not taking drugs or synthetic medicines of any kind, is informed by my belief that my "body-mind-spirit" is an intricately integrated, dynamic whole system, and that artificial tampering with any part of it potentially sets in motion a cascade of consequences that may ultimately affect every part of it. This MI episode has brought to my attention numerous facets of the dynamic functioning of the whole system of which I had not previously been aware, nor had given conscious attention: such as the importance of vitamin C, and other nutrients, to the system's optimal performance.

I attribute the MI episode itself to prolonged neglect, borne of ignorance of many of the vital conditions within the whole system that must be maintained in order that it may continue functioning in proper dynamic balance. I do not believe that the medicines that were prescribed in response to the episode are likely to contribute to the restoration of this dynamic balance, and on the contrary that their prolonged use is likely to disrupt that balance even further, with possibly fatal consequences eventually.

As I learn more about these matters, I act—acknowledging that what I learn is always partial, and although perpetually accumulating, is irreparably incomplete, and may consequently lead me into error. Having learned that, although a possible indicator, the presence of cholesterol in the blood probably does not have a *causal* relationship with MI, and consequently does not need to be artificially suppressed, I ceased taking the statin drug lipitor, as of 14 Aug 2011, when my supply was exhausted, and I did not renew the prescription. This may have the collateral effect of removing the statin's inhibition on my liver's production of Co-Q10,[28] which is vital to the production of collagen, for the healing of possibly longstanding injuries to my coronary arteries.

Eliminating lipitor from my medicine portfolio had the salutary effect of liberating the $90 I would otherwise have paid for 16 more doses, for other purposes, such as the purchase of supplemental Co-Q10, ascorbic acid (vitamin C), lysene, arginine, and vitamin E, all believed to be contributors to my eventual *healing*, as opposed to my eventual self-destruction. Not too scabby, I'd say—with the automatic caveat that I could be "wrong," or not entirely "right."

[28]Cobb, 2008, 2012, p. 13.

I have seen another local physician—not a cardiologist this time—who on review of my case, recovery, and general health, corroborated my decision to cease taking lipitor: on the ground, he said, that the statins are greatly over-prescribed, and not required in my case; and advised me to cease taking lisinopril as well. However, he strongly recommended that I continue taking my small doses of metoprolol, which he said is a very mild medicine with many benefits, including stabilization of any tendency toward high blood pressure. (It has the added virtue of being quite inexpensive, and not a financial burden.) These developments gave me the sense of making cautious headway toward replacing my prescribed drug regimen with products that, although of human manufacture or extraction, are nevertheless naturally native to the dynamic system of my "body-mind-spirit."

Accordingly, I gradually and gingerly added supplemental products to my daily medicinal routine, intended to support the healing-in-depth of the not entirely understood conditions that precipitated my MI episode. I felt I had in a sense "crossed the Rubicon," when I replaced my daily dose of aspirin with 500 mg of L-arginine, thereby running explicitly counter both to medical advice, and to the advice on the L-arginine jar label, which states: "Do not use if you have had a myocardial infarction or have established coronary artery disease."

The source of this cautionary message seems to have been a clinical trial whose objective was "To determine whether the addition of L-arginine to standard postinfarction therapy reduces vascular stiffness and improves ejection fraction over 6-month follow-up in patients following acute ST-segment elevation myocardial infarction."

> **Design and Setting** "Single-center, randomized, double-blind, placebo-controlled trial with enrollment from February 2002 to June 2004."
>
> **Patients** "A total of 153 patients following a first ST-segment elevation myocardial infarction were enrolled; 77 patients were 60 years or older."
>
> **Intervention** "Patients were randomly assigned to receive L-arginine (goal dose of 3 g 3 times a day) or matching placebo for 6 months."
>
> **Results** "There was no significant change from baseline to 6 months in the vascular stiffness measurements or left ventricular ejection fraction in either of the 2 groups, including those 60 years or older and the entire study group. However, 6 participants (8.6%) in the L-arginine group died during the 6-month study period vs none in the placebo group (P=.01). Because of the safety concerns, the data and safety monitoring committee closed enrollment."
>
> **Conclusions** "L-Arginine, when added to standard postinfarction therapies, does not improve vascular stiffness measurements or ejection fraction and may

> be associated with higher postinfarction mortality. L-Arginine should not be recommended following acute myocardial infarction."[29]

The implication seems to be that if 8.6% of the L-arginine group died during the trial, as opposed to none in the placebo group, then the conclusion that L-arginine is not a good idea for MI patients seems to have a fairly solid basis. However, the patients in the trial were taking 3000 mg three times a day, whereas I started out taking 500 mg once a day. That's only 0.056 the dose that may have killed those six patients. So I had to evaluate the possibility that maybe 500 mg a day is not enough to kill me; or on the other hand, maybe it's not enough to compensate the blood thinning effect of the omitted aspirin. Talk about walking through a minefield—sheesh!

I had unilaterally dropped my daily aspirin dose on a prior occasion, mainly on the basis of the article, *Should you Replace your Daily Aspirin with Arginine?* by Owen R. Fonorow.[30] However, I was told at a follow-up appointment at UNM Hospital in Albuquerque that I must not discontinue my daily aspirin, because it has a synergistic effect with the blood thinner plavix, and is essential for keeping the stent open, and not clogging up; and that I could substitute a "baby aspirin" for the adult dose. So, I "crossed the Rubicon" with the decision Fri 26 Aug 2011, to go ahead and replace the aspirin anyway, and accept the consequences of using L-arginine instead. At latest report, the ticker is still ticking.[31] This decision is discussed further in § 12 Parting Shot.

This has been a gradual learning process on the basis of a combination of "experiments on myself," with careful consideration at every step, observation of the subtle consequences of my experiments, and as much knowledgeable advice as I can glean from any available (plausible) source. The allopathic medical profession is one potential source of plausible advice—but it's a mixed bag, with a mixed track record, involving the deaths of 738,000 patients every year, and caution is advised (by me, for me; your mileage may vary).

My experiments are informed chiefly by Cobb, 2008, 2012, discussed above in § 7 Answers, p. 12, ff.; and the supplement protocol he recommends, which he calls "the vitamin C theory"—although the complete protocol includes a number of components besides large doses of vitamin C.

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[29]Steven P. Schulman, MD, *et al.*, "L-Arginine Therapy in Acute Myocardial Infarction", *JAMA*, January 4, 2006—Vol 295, No. 1. `jama.ama-assn.org/content/295/1/58.short`

[30]`www.vitamincfoundation.org/arginine.htm`

[31]But of course, this did not give me the confidence of standing on "safe ground," because my original MI episode itself occurred when I had just been congratulating myself that I felt at the very pinnacle of my entire life's health and vitality. These things take place in the unilluminated corridors of one's circulatory system, without any visible symptoms—until they maybe kill you.

11 The Vitamin C Protocol

I have discussed the Vitamin C theory in § 7; but I have not yet given particulars of the protocol developed for actually putting the theory into practice. These I have absorbed piecemeal through my "experiments on myself," gradually adding one or two components of the protocol at a time, and evaluating my body's response to them; whilst gradually eliminating my prescribed medications in parallel, with similar evaluation. This I have done cautiously, in the manner of a blind man venturing into unfamiliar territory, tapping ahead of himself with a white cane.

The nucleus of the Vitamin C Protocol is of course vitamin C—meaning L-ascorbic acid, and nothing but L-ascorbic acid. Like many organic substances, ascorbic acid exists in two alternative forms: L- and D-ascorbic acid. L stands for *levo-*, or left-handed; D stands for *dextro-*, or right-handed. Hence, L- and D- forms can be thought of as mirror images of each other; or in more complicated terms, as polarizing light with opposing polarities. Our bodies use only the L- forms of many organic molecules, including ascorbic acid, and others I have mentioned, or will mention presently. If we imbibe the D- form, it is Discarded, requiring additional bodily effort with no payoff. So kids, if you do this at home, be sure to purchase only the L- variety. Avoid mixtures of L- and D- varieties, as the D- forms are just Dead weight, as far as their nutritional value is concerned.[32]

As described in § 7, vitamin C is vital to the production of collagen, which is essential for repairing injuries to connective tissue, such as the interior of artery walls. It is these injuries, according to the vitamin C theory, that attract deposits of cholesterol as plaque, when due to vitamin C deficiency, supplies of collagen are short. Now with large supplementary doses of vitamin C, the long-awaited collagen can be produced by the body, and the long-suffering arterial injuries can finally be properly repaired. This obviates the need for the accumulated plaque partially obstructing arterial blood flow. It can go away—but if it goes away in one or more large chunks, it's sure to cause trouble somewhere else in the circulatory system. What to do?

In 1993 Linus Pauling and Mathias Rath MD were awarded a US patent for a solution they used during bypass surgery to dissolve plaque deposits near the surgical site.[33] The solution was a combination of two amino acids, L-lysene, and L-proline. Both are components of collagen, and both dissolve plaque into many small pieces, so they may leave the healed artery harmlessly, rather than in hazardous large chunks, likely to lodge somewhere else in the circulatory system.

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[32]However, as noted below in the discussion of vitamin E, sometimes the D- form is Desirable, and the L-form is Left standing.

[33]Cobb, 2008, 2012, p. 11.

> Most animals produce vitamin C endogenously (within their bodies) and never demonstrate signs of cardiovascular disease. Humans, alternatively, must rely on dietary ascorbate to maintain health, and when insufficient supplies of ascorbate are present, humans suffer from a variety of chronic diseases, including coronary heart disease.
>
> Pauling's and Rath's research provides evidence that cholesterol plaques are actually the body's back-up mechanism for repairing damaged blood vessels, and that if you provide the body with enough free-circulating vitamin C, along with L-lysine and L-proline, the body's primary mechanism for making vascular repairs can be employed and cholesterol numbers can ultimately fix themselves.[34]

So vitamin C, in combination with L-lysene, and L-proline, form the core of the Pauling Vitamin C Protocol for the *reversal*, not the *control*, of atherosclerosis. That is, they combine in the production of adequate collagen to at once repair arterial injuries, and harmlessly remove the plaque that had temporarily prevented coronary hemorrhage, and accumulated potentially to obstruct arterial blood flow.

Meanwhile, omitting a few minute details, I finally fulfilled my objective of bringing to an end my dependency upon prescription drugs, of which plavix and metoprolol were the last to go. I took my final dose of the blood thinner plavix 13 Oct 2011, emptying the 90-dose bottle graciously supplied to me *gratis* by the Bristol-Myers Squibb corporation; and I subsequently made no effort to acquire a refill.

I had been cautioned about ending use of the "beta-blocker" metoprolol, which inhibits the "fight/flight" reflexive response to stressful circumstances, and tends to even out adverse fluctuations in blood pressure. Ending the drug suddenly, I was told, has the reverse effect of intensifying such reactions, with potentially adverse consequences to one recovering from an MI event. Accordingly, I "tapered off" on the metoprolol, taking ½ of a 25-mg tablet once a day, instead of twice a day, for three days prior to ceasing my metoprolol doses altogether, as of 15 Ocober 2011. I noticed later, however, that the procedure for withdrawal from metoprolol, quoted in *Allopathic Prescriptions*, § 1.4 metoprolol tart, p. 9, recommends that "Your doctor should slowly lower your dose over several weeks if you need to stop taking it, even if you only take it for high blood pressure." Oh well . . . I stopped taking metoprolol in October, 2011, tapering off for only three days; yet I experienced no adverse "withdrawal symptoms," and am still filled with gratitude for remaining alive and well. Maybe my habitual equanimity, and disinclination toward "fight/flight" reflexive responses to stress had something to do with it.

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[34]From the Executive Summary, *One Pharmacist's View of Coronary Heart Disease: Comparing the "Lipid Theory" With the "Unified Theory"* by Mike Ciell, R.Ph. `ourhealthcoop.com/pauling.htm`

In any case, having removed all "meds" from the picture—thereby having removed myself as a candidate for being among the 738,000 medical fatalities in America this year, (and again the next, and the next. . .)—I gradually "settled comfortably into" the following version of the Vitamin C Protocol recommended by Dr. Cobb:

11.1 Morning Protocol

- one level scoop Cardio-C, containing 2500 mg L-ascorbic acid, 2500 mg L-lysene, 500 mg L-proline;
- 1000 mg L-arginine;
- 500 mg rutin
- two 660-mg gelcaps vitamin E;
- 100 mg CoQ10;
- one 126.25-mg tab vitamin B complex;
- one tab zinc monomethionine complex, containing 30 mg zinc monomethionine, and 3 mg copper sebacate;
- 433 mg magnesium malate
- two 1200-mg gelcaps omega 3-6-9 fatty acids.

11.2 Evening Protocol

- one level scoop Cardio-C, containing 2500 mg L-ascorbic acid, 2500 mg L-lysene, 500 mg L-proline;
- 1000 mg ascorbic acid w/ rose hips & bioflavonoids;
- 500 mg rutin;
- 1000 mg L-arginine;
- two 660-mg gelcaps vitamin E;
- 100mg CoQ10;

- two 1200-mg gelcaps omega 3-6-9 fatty acids.

Note that vitamin E is a somewhat "peculiar" component of these protocols, because there are eight (count them) different molecules that go under the label, "vitamin E;" and Cobb cautions that all eight of them are needed: four *tocopherols*, and four *tocotrienols*. Complicating matters further, some of these "vitamin E" molecules "shoulder aside" absorption of others, if they are not present in optimal proportions. And complicating matters even further than that, doses of these molecules are often measured in International Units (IU), instead of grams (g) and milligrams (mg).

It gets worse. An IU, established by the World Health Organization, has no standard mass equivalence, and is specific to different substances. One IU of vitamin E is the biological equivalent of about 0.667 mg d-alpha-tocopherol (⅔ mg exactly), or of 1 mg of dl-alpha-tocopherol acetate.[35] Cobb mentions that "dl-alpha tocopherol, which is the synthetic form of only one of the eight vitamin E molecules . . . is plastic garbage and is not a naturally-occurring molecule."[36]

Anyway, I managed to locate a vitamin E product that includes all four tocopherols, and all four tocotrienols, in what I hope to be optimal proportions. Each gelcap contains:

- D-alpha tocopherol: 41 mg (60 IU);
- D-gamma tocopherol (from mixed tocopherol complex providing D-alpha, D-beta, D-gamma, and D-delta): 250 mg;
- mixed tocotrienols (D-alpha, D-beta, D-gamma, and D-delta) (from Tocomin® palm fruit distilate): 39 mg.

Note that all of the "vitamin Es" are of the *dextro-* variety, instead of the *levo-*, as discussed above at the beginning of § 11. So evidently, not all of molecular biology is limited exclusively to the L- forms. Complicateder and complicateder . . . I suppose the "dl-alpha tocopherol" Cobb describes as "plastic garbage" would be a *dextro/levo-* synthetic form? I'll leave sorting that out as an exercise for the interested reader.

The above listed protocol includes most, but not all of the entire list Cobb recommends, which he summarizes at Cobb, 2008, 2012, § 3.18, pp. 22-23.

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[35] `en.wikipedia.org/wiki/International_unit`

[36] Cobb, 2008, 2012, p. 11.

11.3 Maintenance

Eventually, I reached a point where I felt it appropriate to scale back my supplement protocol from the "Full Monty" intended to *reverse* the condition that led to my MI event, to one intended more for *maintenance* of ongoing sound health, which I feel I have regained. Dr. Cobb has recommendations for such a protocol, and Sat 24 Dec 2011, I commenced easing into my applied version of his recommendation, which shapes up as follows:

11.3.1 Morning Protocol

- one level scoop Cardio-C, containing 2500mg L-ascorbic acid, 2500mg L-lysene, 500mg L-proline;
- 500 mg L-arginine;
- 500 mg rutin;
- one 330-mg gelcap vitamin E;
- 100 mg CoQ10;
- one 126.25-mg tab B complex;
- one tab zinc monomethionine complex, containing 30 mg zinc monomethionine, and 3 mg copper sebacate;
- 433 mg magnesium malate;
- one 1200-mg gelcap omega 3-6-9 fatty acids.

11.3.2 Evening Protocol

- 500 mg L-arginine;
- one 330-mg gelcap vitamin E;
- 500 mg rutin;
- one 1200-mg gelcap omega 3-6-9 fatty acids.

As I learn more, and gain further experience in this ongoing "experiment on myself," I may modify the applied protocols further, and accordingly update this discussion.

12 Parting Shot

The weight of the experiences and perceptions described in *all of the above* raises in my mind some uncertainties about particulars of the Schulman, *et al.* clinical trial, "L-Arginine Therapy in Acute Myocardial Infarction" described above in § 10 Betting One's Life.

The trial was allegedly a test of the therapeutic effectiveness of L-arginine, couched in *extremely narrow terms*, it seemed to me. It was not intended to determine if L-arginine has any therapeutic value at all for MI patients, and if so, what that value might be. Instead, the question asked by the trial was to determine if elevated doses (9000 mg daily) are able to produce a specifically predefined effect in MI patients; found that it does not produce the specified effect; and noted further that 8.6% of the L-arginine group died during the trial, as opposed to none in the placebo group. This was taken to justify the conclusion that L-arginine in effect "failed the test," and "may be associated with higher postinfarction mortality;" and consequently "should not be recommended following acute myocardial infarction." End of story.

Well, just a durn minute there! The recommended dose on my jar of 500 mg caps of L-arginine is "2 capsules 1 to 3 times daily as needed." That's a maximum recommended dose of 3000 mg a day. The Schulman clinical trial was based upon a target dose *three times* that recommendation. Could that have had anything to do with the deaths of "8.6% of the L-arginine group?" On what basis was the L-arginine dose for the trial set at 9000 mg daily, instead of 3000?

These are questions, not answers, and I do not have the background necessary to argue with the findings of the trial; which mentions that "the majority of patients were treated with standard postinfarct therapies." I interpret that to mean that during the trial, in addition to L-arginine or a placebo, the trial patients were administered an assortment of prescription drugs similar to those that were prescribed for me—in addition, I imagine, to any medications they may have been taking prior to their MI events.

So there are significant differences between the patients in the clinical trial and my particular case:

1. I was not taking medications of any kind prior to my MI event;
2. Following my MI event, I made every effort to end my post-MI medications, in which I succeeded;
3. I made L-arginine part of my supplement protocol; but at a maximum dose of 2000 mg daily, never approached the dose level administered during the trial;

4. I have pursued a strategy whose goal is *reversal*, not *control*, of my atherosclerotic malaise;

5. The supplement protocol I adopted is based upon the solid medical research and practice of Dr. Linus Pauling, and associates, and numerous others, and is not in the shade of complex, unpredictable, and hazardous drug interactions requiring the complicated cautionary notices reproduced in *Allopathic Prescriptions*[37]—which give little comfort to the patients who take them, but are likely to get their manufacturers legally off the hook, in the event friends and family of any of the 738,000 medical fatalities each year want to try conclusions with them.

The "experiment on myself" continues—which is to say, I'm not dead yet—and as prior to the event, I am feeling healthier and more fit than I have ever felt in my life. I cannot honestly attribute that sense of well being to the allopathic medical profession—although I cannot deny either, that they saved my life in a mortal emergency; for which I feel undying and inexpressible gratitude.

However, my experience and research have only confirmed my longstanding conviction that my best chance at a long and healthy life lies in setting a course that gives the "medicine men" as wide a berth as possible. This is not intended as "advice" to anyone. It expresses only opinions and provisional "conclusions" which I apply voluntarily to myself, with the conscious awareness that they are unavoidably based upon partial information, and subject to unknown errors of interpretation.

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[37] `wellspringpublishinggroup.com/wl/allopathic-Rx.pdf`