MODERN MEDICINE: AN ILLUSION

By K. C. Blair
GoodSamIAm.org
Good Samaritans International

A paper given before the
Society For Scientific Exploration,
25th Annual Meeting, Orem, UT
June 2006

Modern Medicine: An Illusion

SSE 2006 Paper

K. C. Blair

KC is a consumer and compassion scientist, studying the relationship of the objective and subjective to *overall health* and other behavior. He is the founder, sponsor and director of Good Samaritans International.
Email: KCBlair@GoodSamIAm.com, Visit: www.GoodSamIam.org

ABSTRACT

From my research of modern medicine and *overall health* I would like to report a new finding, an illusion, an injustice, a new theory and its potential mechanism. The **new finding** is that modern medicine is a dichotomy of 1) the subjective compassion and 2) the objective physical. The subjective compassion works to create *overall health*, while the objective physical, ex. drugs stripped of compassion as in clinical trials, seems not to work as we have been led to believe. The **illusion** is that drugs cure us, when it is really compassion healing us. The **injustice** is incorrectly giving the physical drugs credit for compassion's healing, which then limits our belief of compassion's power and its contribution to human potential. **The Compassion Theory:** C*ompassion is our tool to create resonance from dissonance, enhancing love and its correlates, like overall health.* The Compassion Theory has been derived from research of compassion's findings. The **mechanism:** 1) Creating compassion seems to result in new and incremental love and its direct correlates, like healing, health, happiness, creativity and longevity. The more compassion we create, the more love and enhanced positive correlates result. 2) Ignoring compassion seems to result in love's inverse correlates, like depression, pain and sickness, signaling the need to add more compassion. It seems the more we ignore compassion the more likely the negative correlates manifest as life-threatening disease and early death.

Definitions: Resonance is two or more entities in the universe in synchronization, creating the synergy of its correlates. Love is resonance from the living. Compassion is creating new and incremental love, its correlates and an awareness of it. Resonance to the scientist is love to the poet.

Keywords: health—medicine—placebo—compassion—subjective—nonlocal—illusion

COMPASSION'S *OVERALL HEALTH* EFFECT

The Great Soup Illusion

Back when most mothers were stay-at-home moms, a soup company executive wanted to make an advertising claim that "Soup is good food." He hoped it would increase all soup consumption – his company's soup the most. So, he asked two questions of his marketing researchers. 1) Do households serving more soup have healthier family members? 2) Do households serving predominantly healthier soup ingredients like homemade and vegetables explain more of the enhanced health than households serving predominantly less healthy ingredients, like commercial and chicken noodle? His researchers recruited female heads of households belonging to consumer diary panels with a history of purchase and usage data, who authorized access to their family members' medical records. The findings would be based on the relationships of the quantity and quality of soup servings to the quantity and quality of family member doctor visits.

Finding #1 made everyone happy. The more household soup servings, the healthier were the family members. Finding #2 surprised and puzzled everyone. Families eating predominantly healthier ingredients explained no more of the enhanced health than families eating predominantly less healthy ingredients. While the executive got the association he wanted and his campaign succeeded, his researchers were left with the puzzle of how soup could be good food, if consumers who ate predominantly healthier ingredients were not healthier.

I began to develop a hypothesis that the number of servings of moms' tender loving care (TLC) and not the physical ingredients was enhancing family members' *overall health*. And I began to see a potential illusion that the healing credit earned by moms' subjective TLC was unfairly being given to the objective ingredients (Appendix A1).

I call the Soup Illusion "The Great" because it opened my mind to the possibility of how other things might work, for example modern medicine. I decided it was time to begin my study of how the placebo, the placebo effect and the drugs' active ingredient effect relate to *overall health*.

What is the role of the subjective and objective in our *overall health?*

Note that I italicize *overall health* because medical researchers have determined its subjective measure predicts morbidity and mortality or health and longevity better than all of the other measures studied, which were objective. (See Appendix 1a) *Overall health* is the criterion measure I try to use in all my research, while it seems to be mostly ignored by allopathic medicine.

The Placebo's Compassion Effect

The placebo effect in patients, directly from physicians and indirectly through their medicines and procedures, has been known in medicine throughout much of its history. The placebo pill and placebo procedure were popularized by orthodox allopathic

medicine, when included in its randomized placebo-controlled, double-blind, "gold standard" clinical drug trials, starting around 1960.

Allopathic medicine, also called allopathy, is our conventional, orthodox medicine. Its premise seems to be that its physicians and their treatment by drugs and procedures can cure us, or at least reduce or eliminate our symptoms. It is made up of MDs, their staffs, nurses, clinics and hospitals; pharmaceutical companies, their executives, Ph.D. pharmacists, researchers and lab technicians, animal and human subjects; pills, procedures, medical devices and appliances, "gold standard" clinical testing, medical journals, peer-reviewed journal articles; neighborhood pharmacists, insurance and healthcare companies, their programs, the Food and Drug Administration (FDA), our elected government representatives, the consumers and voters.

Drug scientists develop, then test in clinical trials the "real drug" against a "fake drug," i.e. placebo pill, to make sure the real thing does significantly better than the fake thing. (The fake actually does quite well without the active ingredient of the real drug, but why?) More research has been conducted by orthodox allopathic medicine on the placebo effect than all drugs in the market combined.

The Latin translation of placebo is, "I shall please." So, **the placebo effect is really the compassion effect and more research has been conducted on the compassion effect than perhaps anything else**. From placebo research we have learned that new information can add to meaning, influencing our beliefs and expectations and they affect the (placebo) compassion effect, as we shall see.

I would like to share a summary of my learning with you of how placebos and drugs work by developing a hypothetical pill.

1. **+10%.** First, we will start with starch, a slightly sensitizing ingredient, giving the pill its bulk and form. If people in a clinical trial are told there is a 100% chance their starch pill is a fake medicine, it still will help **+10%** (pre to post change) versus the no-pill group because we seem to allow the attention and care of others to help us heal. For our purposes here assume there is a +0% effect in the no-pill control group during the clinical trial. I had learned soup's compassion effect may heal and now I learned that the placebo pill's compassion effect does heal, so it looks even more likely that moms' TLC as compassionate intent contributes directly or gets transferred through soup to enhance more *overall health*.
2. **+30%.** If you tell another randomly equivalent group of people the chances are 50:50 the same starch pill could be the real thing or a fake, it would have a **+30%** effect. This shows how adding verbal information can expand meaning to more people and broaden beliefs, enhancing the compassion effect.
3. **+40%.** To another random group let us add more ingredients, slightly more sensitizing than starch, called "inactive ingredients." They will have a **+40%** effect because just the presence of more physical ingredients adds meaning to more people to expand beliefs, enhancing compassion's effect. (Appendix A3)
4. **+90%.** Now, before adding the final ingredient, let us say we are making our placebo pill to be presented to the patient as a "pain-reliever" or an

"antidepressant." Drug company executives, in off-the-record conversations, have told me that a placebo tested in these two very different contexts (representing them as a "pain-reliever" or as an "antidepressant") now has a **+90%** effect for each. ***This is a much greater effect than it used to be, and significantly higher than the average placebo effect of approximately 30-40%.***

How can one explain how the same placebo pill works better in one context versus another or is getting better at helping more patients over time? Some believe it is due to the variation in advertising and the increased advertising information in these product categories, which increase consumer awareness, expanding meaning to broaden beliefs and enhance the compassion effect – all before adding the active ingredient. Drug researchers now have been forced to test in different contexts like dental offices and foreign countries, where beliefs are limited, making it easier and cheaper for new drugs to beat the placebo. **This compassion effect and the relief from, "You are going to be fine," is what we *immediately* feel from compassionate doctors, their staffs, RNs, their treatment and the trauma care workers. It enhances our *overall health*, like from our moms' soup servings of tender loving care.**

5. Finally, we will add the most sensitizing ingredient, called "active" by industry insiders, which is toxic to many consumers who are harmed, maimed or die from it. It seems everything we were doing in developing our pill was compassion-related until the active-toxic ingredient was added. While the active-toxic ingredient might sensitize and hype the placebo compassion effect, especially when first taken in clinical trials and in the marketplace, to many it seems to act more like "recreational" drugs and alcohol – first a high, then stress, harm, maiming, followed by death. And when it is mixed with other active-toxic ingredients inside us, called "drug cocktails," they work even more negatively and faster, taking our most vulnerable first. **This active-toxic effect in the *longer term* is why the drug effect is more negative than positive. Adverse drug reactions (ADRs) seem to be the greatest of allopathy's negative contributors to our *overall health, as you shall see.***
6. **Compliance.** Remember how consuming more of mom's soup servings seemed to correlate with incremental *overall health*, regardless of the ingredients? Well, in medicine there is a similar concept called "compliance" or "adherence," which is about whether you take all of your pills as prescribed. Drug company executives have told me compliance is extremely important to them – because small increases in compliance have a large profit return. That aside, we have found compliance research that helps us better understand how more of the subjective compassion and objective pills relate to our *overall health*.

   Taking pills and consuming soup both are about the subjective compassion and objective physical ingredients, but the common denominator contributing to *overall health* seems to be the subjective and not the objective. And incremental compassion seems to relate to incremental *overall health*.

> See Appendix E for compliance research. You may find the snippets from placebo and drug compliance research interesting reading. "**Summary.** The more we comply with taking our mom's TLC soup, the placebo compassion and our caring doctors' non toxic drugs, the more we enhance our *overall health.* But the more we comply with the *active-toxic ingredients* in drugs, the more we depress our *overall health.*"

An Example of a Drug Illusion
Andrew Weil, "integrative medicine" author and MD seen on PBS, tells a story about his doctor friend, who ran into an old patient friend. She looked terrible. In response to his question of how she was, she said she had contracted every known disease, was taking a different pill for each and felt awful. Sometime later he saw her again and she radiated health and happiness. In answer to his question of how she recovered, she said she got so bad she decided to take her own life by going off her medications. Soon, she realized she was feeling healthier and then became aware the drugs she first thought were helping her began contributing more negatives than positives to her *overall health.* She said she swore off all meds for good and has never felt better.

An Example of a Procedure Illusion
Dean Ornish, MD researcher, has learned from his experiments with heart patients that more intimacy of any kind from relationships, helps to stop the progression of heart disease, helps to heal the heart and enhances *overall health.* He found more love works better and faster than changes in physical behavior, like heart surgery, diet and exercise. When we give credit to surgery, diet and exercise, it is more likely the incremental attention and care that is doing the healing. So, why not find a compassionate physician, who will read Dean Ornish's work, skip the surgery and its negative effects and help you heal with compassion, or at least try compassion first.

"Wait just a minute, here! How dangerous can seeking allopathic treatment be to our *overall health,* when everyone is doing it?" I'm glad you asked. Let us find out just how dangerous it is, when as a group we are exposed to allopathy.

"I do not know where we would be without all these medicines." Let's see what happens without them.

ALLOPATHIC MEDICINE'S *OVERALL HEALTH* EFFECT

Contrary to what many of us have been told, the Hippocratic Oath (Appendix 1b) does not state, "First, do no harm." Its actual translation from Greek is, **"**I will prescribe regimens for the good of my patients according to my ability and my judgment and ***never do harm to anyone*****." – *Hippocratic Oath***.

While I was writing this I was exposed to a Tylenol advertisement. Its company executives continue to advertise Tylenol as "the safest pain-reliever you can buy without a prescription." Yet, there was a recent study (*Watkins, JAMA, 05Jul06*) with a new

Tylenol finding, "If you take Tylenol for four days as directed you may be at risk of liver damage." Tissue damage from the safest pain-reliever, Tylenol, starts immediately. Think of all the drugs we take that are less safe, the cumulative damage they do to our organs and healing system and the life-threatening diseases, suffering and early deaths from them.

In searching for allopathic drugs' relationship to *overall health*, I found the overall effect to be more negative than positive. Several different independent research approaches supporting this statement follow.

1. **Fear Sells Allopathy.** The advertising research I conducted for pharmaceutical companies found drug advertising first depressed the consumers' *overall health* and created a need and search for relief. This was a complete surprise to me. Then I learned from an MD friend that some physicians do this directly to their patients, as well. I hate to say it but allopathy often reminds me of the old snake oil salesman's adage, "First ya make 'em sick, then ya sell the cure." But sadly, we found that after depressing health to sell more product, the depressed health did not return to the pre-advertising levels. (Appendix A4)
2. **A Scientist First Looks for an Overall Effect.** While looking for allopathy's positive overall effect, I discovered seven cases when orthodox allopathic medical practitioners went on strike, excluding emergency care, in four countries over a forty-year period. The strikes made it possible to determine what would happen to our *overall health* when consumers were not exposed to overall allopathy. The results were that the death rates *dropped* during the strikes in all seven cases (100%) with an average decrease in death rate of **32%.** After the strikes, the lower death rates returned to their higher pre-strike levels. So, *overall health* on average seems to be enhanced with no exposure to allopathic medicine and depressed from exposure to it. (Appendix B) (Appendix A5)
3. **Iatrogenic Deaths, Itemized.** Iatrogenic means due to mistakes caused by doctors, surgeons, medical products and services. Iatrogenic death is the unnecessary premature end of life caused by allopathic mistakes. Think of it another way: You expose yourself to allopathy for issue A and die from an unrelated issue B. Gary Null is a Ph.D. nutritionist and researcher who sometimes appears on television. He writes that U.S. iatrogenic deaths, i.e. deaths from the unintended consequences reported in government and hospital records, add to 784,000 per year. Or, 30% of all U.S. deaths are the result of the unintended consequences of allopathic medicine, *year after year*. [Iatrogenic deaths itemized: hospital adverse drug reactions (ADRs) 106,000 (14%), medical errors 98,000 (12%), bedsores 115,000 (15%), infection 88,000 (11%), malnutrition 108,800 (14%), outpatient ADRs 199,000 (26%), unnecessary procedures 37,136 (5%), surgery related 32,000 (4%), total for the year 783,936 (100%).] While there may be some overlap resulting in overstatement, research has been estimated that deaths from medical mistakes admitted and reported are less than one in five, resulting in a potentially greater understatement. Malpractice lawsuits, aimed at holding physicians responsible for their negative outcomes, likely result in many such mistakes to be covered up to avoid financial liability. (See projection from Appendix C) (Appendix A5)

4. **From More Exposure, More Deaths.** In Australia, a "robust regression analysis" determined that, other things being equal, ***the more allopathic doctors per 1,000 people, the more deaths there were***. The researchers were able to conclude more deaths resulted from more practitioners, rather than the reverse. (Appendix D)
5. **An International Analysis Agrees.** I found the World Health Organization ranks the U.S. 1st in healthcare spending and 15th in health quality. I have seen this kind of relationship in other fields of my research. Where spending is increased to create more exposure to something negative, i.e. harming more than helping, one should expect the *overall health* ranking of countries spending more on something negative to decrease versus other countries spending less on something negative.
6. **Medical Workers Live in Secrecy and Guilt.** My qualitative research, using one-on-one casual conversations within the different functions and levels of orthodox medicine over a thirty-year period, found that industry workers *know*. They were unanimous in admitting their industry and companies have secrets – that they are responsible for many deaths and more injuries. All seemed to feel bad; some showed shame. One middle management drug company analyst said it best, "It is too difficult for people in our industry to say the obvious, 'My work is killing some of the people it is supposed to be helping.'" (Appendix F)
7. **No Known Positive Effect on *Overall Health*.** While I am surrounded by anecdotal evidence from allopathic believers about being cured of a specific symptom, I have found no scientific research indicating the practice of allopathy contributes more positives than negatives to *overall health*. I started off thinking all the evidence would support allopathy but I found none. Then I tried to find weak evidence of any kind to show I was trying to be balanced, but found none. Now I have to add some anecdotal balance. People have started to approach me after hearing me talk to say they do not go to doctors because they think it is too risky, they rarely get sick and they do not talk about this because others make negative judgments about them.
8. **No Known Allopathic Medicine Theory.** Recently, I was reminded that in all the years allopathic medicine has been practiced there seems to be no theory explaining how allopathy contributes positively to our *overall health*. Perhaps medical researchers have tried to derive a theory from the data and failed, as I have. Perhaps I conducted this research, I am talking about and publishing my findings because I have no vested interest in allopathic medicine.

All the research from the different approaches shows that exposure to allopathic medicine is more negative than positive to our *overall health*. The negative effect of the objective physical seems to be overpowering the positive effect of the subjective compassion from all the practicing and caring people in allopathy.

Reasonable Questions to Ask of Allopathy

Q1. How can pharmaceutical company executives, their MDs and supporting staffs responsible for helping us by developing and researching the physical drugs and procedures versus placebos in the same clinical trials, ignore the obvious of validating the safety and effectiveness of *overall allopathy* to *overall health*?

Q2. How can pharmaceutical company executives, MDs and marketers responsible for helping us, knowingly depress the health of consumers with advertising and how can physicians in one-on-one conversations with patients create fear, a need and search for relief, the stress of which does not go away. I have personally interviewed the workers, who know the problems they are creating but continue anyway. I honor the workers, who, when they *know*, leave the industry. *(*Appendix F*)*
Q3. How can people responsible for helping us, subtract, withhold and discredit information about the safest and most effective tool of doctors, pills and procedures ever tested – compassion?
Q4. How can people responsible for helping us, profit from selling drugs, procedures and related services they *know* kill and maim millions of their own customers, maybe even friends and loved ones, year after year?
Q5. *What is wrong with this picture?*

THE COMPASSION THEORY

A Review

I just reviewed some findings, conclusions and hypotheses, mostly mine, taking place in my real-world laboratory of the marketplace. They lead to a new theory of healing and health.

1. Creating compassion replaces dissonance with resonance for successful communications, helping information flow between and within us.
2. Refocusing consumer attention from love and contentment to symptoms, using advertising and personal conversations depresses *overall health*.
3. Creating compassion enhances love and its correlates – healing, health, longevity, immunity, happiness, optimism, creativity and productivity. This correlation may be what others call coherence, synchronicity, resonance, staying positive and creating reality.
4. Direct compassionate intent like distant prayer, well wishing and positive thoughts, enhances the correlates of love, like *overall health*.
5. Transferring compassionate intent through black boxes, sacred places, mass marketed products and advertising seems to enhance love and its correlates, like *overall health*.

The Compassion Theory

From my research I have derived a new theory, representing my point of view of how compassion influences *overall health*. **The Compassion Theory:** C*ompassion is our tool to create resonance from dissonance, enhancing love and its correlates, like overall health.*

The Mechanism Between Compassion and *Overall Health*

I developed The Compassion Theory mostly from my experimental research in the real-world laboratory. We generally start with two or more very large random groups of consumers spread around some geographical region of interest to our client. Compassion is offered to consumers along with other communications indirectly through mail

advertising to households or directly through compassionate intent to one or more groups (experimental) but not the other groups (control). Weeks later I measure usually with telephone interviews in all groups without the group members knowing the information sent and interviews conducted were related to each other and part of a marketing experiment. Everything is randomized and blind to everyone.

I define compassion as "new and incremental love" and measure the compassion effect with the amount of incremental love in the experimental over control groups. I also measure increments of the other dependent variables I call love's correlates, like unity, overall health, wholeness, immunity, happiness, optimism, creativity, and longevity. For clients, I measure love's correlates in which they are interested, like incremental purchasing and productivity. If by offering compassion, indirectly or directly, I enhance the correlates, including *overall health*, consumers likely will exhibit the correlated behaviors of more purchasing and productivity.

You and I can measure our *overall health* at any time, like my interviews did in the experiments, with the subjective and valid question, "Would you say your *overall health* is excellent, very good, good, fair or poor?" Medical researchers have demonstrated that this subjective question's answer about *overall health* predict health and longevity ***better*** than the other measures and questions tested which were objective. (Appendix 1g) The most important and predictive answer on the word scale is, "Excellent." Optimism researchers have found what we say creates what we become and changing what we say changes what we become (Appendix 1g). I always try to answer the popular greeting, "How are you?" with my intent of how I want to be: "Excellent." When I mistakenly say, "Fine," I know it is the wrong answer and a signal I am not focused enough on what I want to be, so I relax and create compassion to self-correct immediately. After a year of doing this I realized I had become what I intended to be: Excellent, and a more compassionate person. This is just one example of how a mind's compassionate intent works. What we observe and measure we often influence in the direction we want, believe and expect it to be. It turns out we know more about our overall health then anyone else, including physicians. And we can influence it better, if we choose.

Through experiments I have found the more we create compassion, the more we enhance feelings of well being from love's direct correlates, like resonance, unity, wholeness, healing, overall health, immunity, happiness, optimism, creativity, productivity and longevity. When we ignore ourselves and do not create enough compassion we are reminded to create more with feelings of love's inverse correlates, like dissonance, separation, depression, pain, illness, unhappiness, pessimism, lack of creativity and productivity. If we pay attention to the reminders and create more compassion to replenish our insufficiency of love, we will be less likely to develop serious diseases leading to death, sometimes without the reminders.

There are different kinds of compassion, making it easy to create more of it. Our research has found our compassionate intent of the subjective – positive thoughts, well wishing and prayer – influence overall health from a distance and the subjective may be more effective than sending it indirectly through objective things. (Appendix 1c) But research

seems to show we can transfer our compassionate intent to heal through black boxes, sacred places, a pill's placebo compassion effect and mass-marketed products, like soups and the emotional advertising of love and unity from Gerber, Tide, Cheerios, Volvo and OnStar. Finally, visiting your sick friend is also important because it is so difficult to create the compassion we need when our health is depressed. Offering compassion and receiving gratitude in return enhances the *overall health* of the sick person and her visitor. This is how compassionate doctors, nurses and their staffs help us. Adding all of these things is like mom continuously serving different kinds of her TLC to her loved ones, directly and indirectly through soup and everything else she does for her children. Actual medical records and valid subjective measures show the more we focus on compassion, the healthier we are.

From soup and placebo research, plus experiments for my clients, I learned that our mind wills compassionate intent as a tool to enhance love and its correlates to help us get more of what we want, like *overall health*. This is just one way we use compassion, *as we create better realities*.

Be excellent.

APPENDIX 1

URLs to External Sources

1a. http://www.goodsamiam.com/validity.htm

1b. http://en.wikipedia.org/wiki/Hippocratic_Oath

1c. http://www.goodsamiam.com/distant_healing_research.htm

1d. http://www.goodsamiam.com/resources.htm

1e. http://www.cdc.gov/nchs/

1f.
http://www.cdc.gov/nchs/products/pubs/pubd/hestats/prelimdeaths04/preliminarydeaths0
4.htm

1g. http://www.goodsamiam.com/resources.htm (See Seligman)

APPENDIX A

Proprietary Research. Almost all of our research projects have been for client organizations to which the data belong, making that research proprietary. But it has been peer-reviewed by people in our client organizations, usually in different functions and at several different levels. While we cannot expose the project data, we can synthesize across the studies, summarize our learning and make our cumulative know-how available to others, as all suppliers do to their prospective clients. When our source is proprietary we will show it as (Proprietary)

Sources
A1. My personal friend and I did projects for the soup company. He owned a data processing company, while I owned a full-service marketing development and consumer research company. He was the D.P. supplier on the "Soup Servings" project and was my D.P. supplier as well. He kept me up to date on the conversations inside the soup company about this issue, which we discussed and analyzed together for my purposes. (Proprietary)

A2. Whenever I started my consumer experiments with two or more random groups, sent compassionate information indirectly through direct mail advertising or directly through prayer to the experimental group but not the control group, and then many weeks later measured both groups with subjective questions in a telephone survey, I not only determined there was incremental love in the experimental group versus the control group but there were increments of love's correlates, as well. (Proprietary) (Appendix 1d, authors: Benson, Dossey, Feste, Grayson, Groopman, Hammond, Harrington, Hay, Koenig, Levin, McGarey, Myss, Pearl, Rossman, Seligman, Shafarman, Shapiro, Shealy, Siegal, Weil)

A3. Historical research and more recently drug client executives and researchers have told me that the placebo effect is on average 30%-40% or more, as it has been growing. They agreed with the relationship of the 30% for starch alone and 40% for inactive ingredients. (Proprietary)

Joel M. Kauffman, Ph.D. medical researcher, in his book, ***Malignant Medical Myths***, writes about Allen Roses, M.D. and Worldwide VP of genetics at GlaxoSmithKline. Dr. Roses said that fewer than half of the patients who were prescribed some of the most expensive drugs actually derived any benefit from them. "The vast majority of drugs--more than 90 per cent--only work in 30 or 50 per cent of the people," Dr. Roses said. "I wouldn't say that most drugs don't work. I would say that most drugs work in 30 to 50 per cent of people. Drugs out there on the market work, but they don't work in everybody." Dr. Roses cited some response rates but from what I could tell he has not subtracted the placebo effect, which now likely averages around 30 to 50 percent.

A4. I have conducted advertising research experiments for pharmaceutical clients and was surprised to find that the advertising was depressing the consumers' *overall health*. It seemed to happen because advertising refocused attention from love and contentment

to symptoms and fear. Before I saw the findings I anticipated the advertising effect would be to help consumers, the drugs would contribute to *overall health* and because of that I was contributing to a win-win. We started with random groups of people selected from some geography in which our clients were interested. We usually direct mailed advertisements with coupons, samples and sometimes a cover letter to the experimental groups but sent nothing to random control groups. The envelopes usually had the client or brand name on the outside. Weeks later we telephone interview at random from all groups and asked subjective questions about *overall health* and other correlates of love, as well as objective questions about the purchasing of the brands. We do not ask about the advertising and it is very unlikely the respondents related the interviews to the mailing. After tabulating the data we determined the incidences of the dependent variables in each group, subtracted the control incidences from the experimental ones and determined the probability the differences were due to random error. (Proprietary)

In addition to advertisers, we learned from our doctor friends that they have peers, who know better but still create fear in patients, resulting in more treatment and fees. We continue to learn from patients that their doctors go on "fishing expeditions" with their high-tech measuring equipment until they find medical problems. They say something like, "The probability is 90% it (this shadow) is not serious but you never know until you test it in a lab and that requires surgery. And since we are already in there we might as well remove (something) to eliminate that as a possibility. That will save you from another operation that is just as serious." The patients then develop fear and stress, which they cannot live with and end up choosing an invasive procedure, which is on average worse than having none. (Proprietary) I hate the thought: "First ya make 'em sick, then ya sell the cure." The old snake oil salesman's adage lives in modern medicine.

I have the need to keep saying that I am not talking about physicians and their staffs, nurses and others, who understand, value and use the tools of compassion and compassionate intent, and the trauma care workers, who need no bedside manners but say, "You are going to be okay. You are going to live." I honor them.

A5. National Center for Health Statistics. (Appendix 1f)
From these data KCB made the following projections for 2006 U.S. Population: 300,000,000; Death rate @ .86%: 2.58 million deaths (Other)

APPENDIX B

Quantitative Research Approach #1: Overall Effect of Exposure to Medical Intervention

When Doctors Strike, Death Rates Drop, Returning to Pre-Levels After the Strike

Doctor Strikes	Pre-strike Deaths per month	During Strike Deaths per month	Change #	Change %
1. Israel (2000) [note 1]				
a. Netanya no-strike contract clause (Like control group)	87	87	0	0%
Kehilet Yerushalayim Burial Society May 2000 strike vs comparison				
b. vs May 1999	153	93		
c. vs May 1998	133			
d. vs May 1997	139			
(Average b to d)	(142)			
e. April 2000 vs "Past Aprils" (avg.)	(150)	130		
Sum	(292)	223	-69	-24%
f. Tel Aviv pre/during (anecdotal recall) (count above Sum and f one time only to avoid overlap)			Decrease	Decrease
2. Israel 1983 Strike (anecdotal recall) [note 1]			Decrease	Decrease
3. Israel 1950s Strike (anecdotal recall) [note 2]			Decrease	Decrease
4. Canada 1960s Strike (anecdotal recall) [note 2]			Decrease	Decrease
5. Bogotá, Columbia [note 3]				-35%
6. Israel 1973 [note 3]				-50%
7. Los Angeles 1976 Work Slowdown [note 3]				-18%
Average percentage decrease where data were available (4 of 7 studies)				**-32%**

Note 1: BMJ (*British Medical Journal*) 2000; 320; 1561 (10June) *"Doctors' strike in Israel may be good for health"*-Judy Siegel-Itzkowick, Jerusalem
http://bmj.bmjjournals.com/cgi/content/full/320/7249/1561

Note 2: **See Rapid Responses at end of above BMJ article for recall of more strikes**
http://bmj.bmjjournals.com/cgi/content/full/320/7249/1561

Note 3: Mendelsohn, Robert S, MD
http://www.vaccination.inoz.com/doctordeathrate.html

Summary. There have been seven (7) medical worker strikes found in four (4) countries over a forty-year (40) period. Where reported, strikes included all but emergency personnel. **Seven of the seven (100%) strikes resulted in declining area death rates** during the strikes. Where reported, death rates returned to pre-strike levels after the strikes. In four of the seven (4/7) strikes, numerical percentage declines of death rates were reported; the average was **–32%**. It is interesting that the only place a no-strike area was found in 1a we see the same monthly deaths expected pre (87) and during (87). And

when we have only a work slowdown in 7 we get about one-half the monthly death rate change, as the strike, -18% versus -32%.

APPENDIX C

Quantitative Research Approach #2: The Itemized Effects of Exposure to Medical Intervention

"Death by Medicine," Null, Gary, Ph.D.
http://www.wnho.net/deathbymedicine.htm
Definition. *iatrogenic: induced inadvertently by a physician or surgeon or by medical treatment or diagnostic procedures.-Merriam-Webster. Example, iatrogenic death: you expose yourself to medical intervention for reason A and die from an unrelated reason B attributable to an allopathic medicine mistake.* – KCB

ABSTRACT

A definitive review and close reading of medical peer-review journals and government health statistics shows that American medicine frequently causes more harm than good. …. The total number of iatrogenic deaths per year shown in the following table is 783,936. It is evident that the American medical system is the leading cause of death and injury in the United States. The 2001 heart disease annual death rate is 699,697; the annual cancer death rate, 553,251.[5]

ANNUAL PHYSICAL AND ECONOMIC COST OF MEDICAL INTERVENTION Condition	Deaths	Cost	Author
Hospital Adverse Drug Reactions (ADR)	106,000	$12 billion	Lazarou[1] Suh[49]
Medical error	98,000	$2 billion	IOM[6]
Bedsores	115,000	$55 billion	Xakellis[7] Barczak[8]
Infection	88,000	$5 billion	Weinstein[9] MMWR[10]
Malnutrition	108,800	-----------	Nurses Coalition[11]
Outpatient ADR	199,000	$77 billion	Starfield[12] Weingart[112]
Unnecessary Procedures	37,136	$122 billion	HCUP[3, 13]
Surgery-Related	32,000	$9 billion	AHRQ[85]
TOTAL	**783,936**	**$282 billion**	

Summary. Gary Null has found that our **exposure to medical intervention costs over 784,000 iatrogenic deaths** per year. I have found this number represents **30%** of our total expected 2.58 million deaths each year. (Appendix A5) These numbers are conservative because medical workers are inclined to not report iatrogenic deaths.

APPENDIX D

Quantitative Research Approach #3: The Quantitative Effect of More and Less Exposure to Medical Intervention

"Will More Doctors Increase Or Decrease Death Rates? An econometric analysis of Australian mortality statistics" *Richardson and Peacock, Center for Health Program Evaluation, Working Paper 137, April, 2003*
http://www.buseco.monash.edu.au/centres/che/pubs/wp137.pdf

"Conclusions
Systemic evidence is surprisingly consistent. It implies an association between mortality and an increase in the doctor supply, which is not easily attributed to reverse causation or to a spurious correlation with some other attribute of the population. The cross-sectional evidence seems to be stable. The present results are largely consistent with those obtained from data 20 years ago. Ideally, further research is required using panel data. However until this is completed and the evidence presented here is contradicted, *then the hypothesis that iatrogenic effects may more than off-set the direct beneficial effects of additional, and largely unregulated, medical services must be contemplated seriously*."

Summary. The Australian researchers found that more doctors per 1,000 population lead to more overall deaths, as it seems iatrogenic deaths outnumber the lives saved by orthodox treatment; less doctors lead to fewer overall deaths.

The emphasis is mine. – KCB

APPENDIX E

COMPLIANCE & OVERALL HEALTH

Compliance def., the act of submitting; usually surrendering power to another

"Summary. The more we comply with taking our mom's TLC soup, the drug researchers' compassion placebo, our caring doctors' non toxic drugs and other *compassion-delivery* symbols, the more we enhance our *overall health*. But the more we comply with the *active-toxic ingredients* in drugs, the more we depress our *overall health*."

Consider these studies.

1. Irvine, et al, Psychosomatic Medicine 61:566-575 (1999), *Poor Adherence to Placebo or Amiodarone Therapy Predicts Mortality: Results From the CAMIAT Study*. "Similar to previous studies (4, 5), adherence to placebo therapy was associated with a significantly better survival rate in post-acute MI patients followed up for 2 year." "Conclusion. Poor adherence to placebo therapy is associated with a twofold greater risk of mortality, although the reason remains unknown."

2. Papakostas and Daras, Epilepsia, 42(12):1614-1625, 2001. *Placebos, Placebo Effect, and the Response to the Healing Situation: The Evolution of a Concept.* "Compliance (Adherence). Large-scale trials of drugs for heart disease have shown that patients who adhere to treatment, even when that treatment is a placebo, have better outcomes than do poorly complying patients(182)."

3. Barrett, et al. Perspectives in Biology and Medicine Spring, 2006. *Placebo, Meaning & Health.* "To explain these results, we suggest that the meaning of 'taking your pills' incorporates both active (taking care of one's self) and passive (being taken care of) elements of the shared biomedical belief system. People who take part in biomedical research often share values with the biomedical 'taking-your-pills-is-good-for-you' belief system, and tend to carry positive associations, both conscious and unconscious, between treatment adherence and good health."

4. Simpson, et al. bmj 2006; 333:15 (1 July) *A meta-analysis of the association between adherence to drug therapy and mortality* "Discussion. … For participants with good adherence to placebo or *beneficial* drug therapy, the risk of mortality was about half that of participants with poor adherence. Conversely, the risk of mortality was more than double for participants with good adherence to proved *harmful* drug therapy compared with participants with poor adherence.

   "The association between adherence to harmful therapy and mortality is important in the light of recent issues of patient safety and post-marketing drug surveillance. Our observation suggests that stratification by adherence group may facilitate

earlier identification of harm therapies if the rate of adverse events is higher in participants with good adherence…."

5. Chewning, bmj 2006;333:pp18-19 (1 July) **"***Commentary. The healthy adherer and the placebo effect*" "Healing lies not in the treatment but rather in patients' emotional and cognitive processes of 'feeling cared for' and 'caring for oneself,'" Chewning writes. "The meanings people attach to the 'pill' and 'behavior of the healer' are the key to the mind-body connection leading to health outcomes."

   "Taking pills as prescribed," Chewning says, "simply shows that patients are caring for themselves -- and that they believe their doctors are caring for them, too."

APPENDIX F

Qualitative Research: Casual Conversations With Medical Industry Workers

Background. First, let me give some information about this document's author. For thirty-five years, until recently, I lived and worked in the geographical center of the U. S. drug industry. As CEO of a marketing services firm, I visited, talked, dined with, entertained, sold to, developed information, did research for, and partied with people who work in modern medicine.

The casual conversations at that time with modern medicine industry employees would be called personal interviews now, as it is known as a subset of Q*ualitative Research.* But I asked my questions as an empathetic and caring person with no intent or interest at that time of ever writing about their voluntary information.

The most important aspects of this form of qualitative research of modern medicine follow.

- **Internal Consistency.** Based on their voluntary information, all of these people were in agreement with each other with regard to "drug safety." I never had a conversation with any employee or former employee of the industry whose information did not agree.
- **External Consistency.** The *qualitative* information is totally consistent with the three independent *Quantitative Research Approaches* in Appendix B, C, D and E above.

Here are some representative excerpts and summary descriptions of our conversations. I offer them to give the reader a feel for what the industry employees think and say about modern medicine and their role in it.

Drug Company Executives

When I said, privately, to these individuals, "There seem to be a lot of secrets in your company," or "… in your industry," they reluctantly admitted it. I have had executives tell me they know their drugs, "… are hurting many people, or worse." Some volunteered things like, "You will never know the extent of it."

In other words, the drug company executives with whom I talked knew how dangerous their drugs were.

But when one executive said to me, "What can you do to help us with our drug brands?" I said, "I can help you add information to your brands' communications that will help consumers get better, faster. But then they may not need to use your brands as much." She said, "That would not go over well around here." End of conversation.

Drug Company Non-Executives

The drug company production workers and non-executive office workers with whom I talked also knew their drugs were dangerous. Like the executives, I have heard several of

the non-execs admit they know their drugs are hurting people, or worse.

Some said, when they learned how dangerous their company's drugs were, they stopped taking them or stopped taking all drugs.

One said, **"It is too difficult for people in our industry to say the obvious, 'My work is killing some of the people it is supposed to be helping.'"**

Pharmacists
The pharmacists with whom I talked said the manufacturers' drugs are dangerous, maiming, even killing us. Several more experienced druggists confided in me that they do not take drugs, or at least not for long, because they have seen so many people coming back to their stores with livers and other organs destroyed from taking too many drugs, as recommended. They volunteered they knew customers whose deaths were more likely to be from the drugs they took than from the problems the drugs were supposed to be helping.

Physicians
The doctors with whom I talked knew how dangerous the industry's drugs and invasive procedures were. I learned this directly from MDs who recommend drugs and invasive procedures and then indirectly through their MD friends who do not, themselves, dispense drugs or procedures. The non-dispensers sometimes gave more information as they made negative judgments of their dispensing friends' activities.

I also learned of the dangers from nurses and office workers in clinics.

There are some physicians who are trying to talk their patients out of using drugs or into using fewer drugs. And there are those, when learning how dangerous their drugs and procedures were, left or changed their practice to avoid doing harm. There are the complementary, alternative and integrative practitioners like Norm Sheely, Andrew Weil, Deepak Chopra, Stuart Freedenfeld and other creators of the first holistic clinics, who have seen the light. But, sometimes it was their nurses and office workers who saw the light first, or kept it on. Also, there are those physicians trained outside of allopathic medicine who help us learn how to heal without invasive procedures and drugs.

A growing number of physicians and staff are helping to lead us out of the dilemma of orthodox allopathic medicine. They are working on better models of healing and health.

Government People
Citizens want to trust their government, including the Food & Drug Administration. Yet pharmaceutical company executives have told me FDA executives know how dangerous industry procedures and drugs are.

The FDA misrepresents the dangerous as safe by putting our government's seal of approval on them. Yes, clinical testing is supposed to release the good things and hold back the bad things from the market. But the actual in-market, real-world data are the

most accurate data in Appendix B, C and D and that is the data showing drugs, clinical drug testing and peer-review to be dangerous.

Pharmaceutical companies seem to successfully pay for protection through contributions to both major political parties. Our representatives accept the money and cannot help but develop a vested interest in the pharmaceutical industry, far greater than do the people they represent. While our political representatives may be naïve, they seem to be trying to protect the drug companies from lawsuits by the consumers being injured.

Advertisers

Drug secrets kept from consumers often start with drug advertising. We have found from our advertising and promotion experiments conducted for our former pharmaceutical company clients that drug advertising first does harm. Intrusive and unsolicited drug advertising depresses people's health, merely by switching consumer attention from the positives of the daily feelings of love and contentment, which heal, to the negative symptoms of depression, pain, sickness and disease – the source of which is fear.

All uninvited negative headlines, sound bites, and content depress consumer health, stimulating a need for relief and a search for it. The consumer's new need and search for relief often result in the consumers buying the drugs in the ads, which created the problem in the first place. But the depressed health and the need for relief stimulated by the ads do not seem to go away when the consumers purchase and use the advertised brand.

One of the fathers of TV advertising research used to tell his clients that the old snake oil salesman's adage is alive and well: "First ya make em sick; then ya sell the cure." Are modern drugs just a sophisticated extension of the old snake oil – but more dangerous?

The newly depressed health, its resulting need and search for relief continued long after exposure to the ad and purchase of the products. We also found that the older and sicker the members of the advertisings' audience, the sicker they became and the more drugs they bought that were associated with the ads.

The drug company executives for whom we conducted the advertising experiments told me to take these findings, negatively associating their drugs with *overall health*, out of our presentations and reports they had seen. I refused, thinking the higher-ups would want to see they had problems.

Pharmaceutical companies stopped calling me as they learned of the results and that I would not suppress my findings. I stopped calling on pharmaceutical companies when I learned their secret and could not make a change for the better.

Safety, Guilt & Secrets

All of the people with whom I initiated conversations in their drug companies seemed more willing to talk about their dangerous products, internally known as "drug safety," if I approached the issue through the "company secrets" of which they seemed to feel

burdened.

When I provoked these executives with my statement about their company having a lot of secrets, they seemed shocked, got up and closed their doors, lowered their voices to the serious or secretive levels, shook their heads negatively and often looked down to avoid eye contact.

They seemed afraid, stressed, and in pain as they described the internal meetings they had attended in which fellow executives talked of their concerns for drug safety and what could be done about it. One executive said to me, "'Drug safety.' Get it? They are afraid to say 'consumer safety' or 'dangerous drugs' because they are afraid of where that might go."

In our conversations, none denied the deaths and permanent injuries nor did anyone defend their products or companies from causing those negatives. These people have real secrets and in my opinion heavy guilt. Some non-executive employees said they feel guilty but quitting their jobs would not help the situation and they said besides they need the money.

I believe all of the above people with whom I talked got into the industry to help people or at least liked that idea when they were hired. Then, like the cooperating frog put into cold water over the fire, the industry workers started to learn gradually what was really going on. A few left the industry, while most decided to stay, accept and honor the secret to protect themselves and each other. It is difficult to change when you have a vested interest in your work, company, family and paycheck.

Summary

It is sad that the industry's own research findings lead to the conclusion that modern medicine is so dangerous, everyone in the industry seems to know it, yet, the industry continues in its ways.