

the People's Doctor

A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

VOL. 10, NO. 9

BULK RATE
U.S. POSTAGE
PAID
PERMIT NO. 9323
CHICAGO, IL

P.O. Box 982

Evanston, Illinois 60204

IN THIS ISSUE:

Artificial Hearts and Organ Transplants



Dr. Robert Mendelsohn

As doctors and hospitals become increasingly enthusiastic about transplants, the public apparently has other ideas. According to a Gallup poll, only 45 percent of the population is now likely to donate organs (American Medical News, July 25, 1986). In 1968, the figure was 70 percent.

"Reasons given for not wanting to donate one's organs indicate distrust of the medical profession," admits the American Medical News. Twenty-three percent of those unwilling to donate organs express the fear that "they might do something to me before I am really dead," and "I'm afraid the doctors might hasten my death if they needed my organs."

Even the physicians aren't very keen on transplants. The National Task Force on Organ Transplantation complains that, while a majority of physicians understands the effectiveness of kidney transplants and approves the concept of post mortem organ donations, doctors too frequently do nothing about participating in the donation process. The reluctance of physicians to discuss organ donation with families leads the National Task Force to recommend that each hospital appoint a designated staff physician--not necessarily the acting physician--to approach potential donors.

Perhaps the doctors know something the National Task Force doesn't. Perhaps the doctors say one thing when polled, but they behave very differently when faced with real patients.

In any event, the number of people who are turning away from transplants between 1968 and 1985 represents a healthy reaction to the strange, if not ghoulish, scenarios being played out by organ-hungry researchers.

(The following was originally written in February, 1985 on the day after the world's third artificial heart was connected to Murray Haydon.)

Questioning artificial hearts

While we all wish Mr. Haydon a speedy recovery and good health, it is not too early to scrutinize his case in order to learn for the next time.

First, I find it very difficult to understand his doctors' reports. After the surgery, the Humana Hospital spokesman said, "He (Haydon) is not in danger" (Chicago Sun-Times, February 18, 1985). But then he said, "You can't say he's out of danger." Just what does the spokesman mean?

That same spokesman also said, "While you can't say he was looking forward to it..." But he followed that statement up with, "He was in a very positive frame of mind." In the future, I hope Humana finds a spokesman who does not speak out of both sides of his mouth at the same time.

Then there is Dr. Allan Lansing, Chairman of Humana, who states that he felt much more confident in this situation with Haydon than he had with William Schroeder, the second recipient of an artificial heart. Why should that be so surprising? After all, both Schroeder and Barney Clark (the first recipient) had had disease in other parts of their body. But before his operation, Haydon was stronger and healthier than the first two recip-

ients. If the transplant surgeons continue to select healthier and healthier patients, why shouldn't they expect better outcomes?

Haydon suffered from cardiomyopathy, a word which means a disturbance of the heart muscle. The word describes his condition, but gives not a clue as to cause. We are not told whether his heart muscle was damaged by a virus or bacteria or by alcohol or by doctor-prescribed drugs (for example, some anti-cancer drugs, etc.) or by X-ray therapy--all causes of cardiomyopathy. I hope that the press will begin to raise such important questions about causation.

Furthermore, we are told that Haydon's chief medical problem was his 25-pound weight loss during the month preceding his surgery. At the same time, we are told that he had recently received heavy doses of heart medications. Did the weight loss occur in spite of, or because of, those medications?

Just as with Clark and Schroeder, the doctors predicted that Haydon had only days or weeks to live without the artificial heart. Yet, while the average length of life following the diagnosis of cardiomyopathy is two years from the onset of symptoms, some patients survive for five years or even longer.

Since the doctors' guesses (and that's all they are) may be right or wrong, why not take the next dozen candidates who line up for this operation and let the doctors guess--right away--their life expectancy. Let's see how good their track record really is. This should not be very difficult to do, since the Humana people already have told us that they are evaluating many potential recipients.

(When I originally wrote this in May, 1985, the media were carrying reports of artificial heart recipient William Schroeder's re-entry to Humana Hospital in serious condition from a brain hemorrhage.)

*Heart implants
aren't true
scientific
experiments*

As reported in newspapers and on television, the complications and deaths suffered by artificial heart recipients certainly give those patients on the waiting list for this procedure a glimpse into its risks. But how many of these are being revealed to the patients by the doctors?

Only months after the death of Barney Clark did we learn (Archives of General Psychiatry) that this first patient in whom Dr. William DeVries implanted the artificial heart expressed a wish to die after prolonged complications following surgery. What did his doctors do? They went to court and had him declared mentally incompetent. His wife signed all subsequent consent forms.

Before doing these heart operations, the doctors assure us that they have given patients the opportunity to learn all the risks, and they cite as proof the length of the consent form--17 pages, 25 pages, 50 pages, whatever. While some doctors may be impressed with the quantitative aspects of the consent form, I am sure you and I are much more interested in the quality of that form. Apparently, so are the National Institutes of Health which reviewed the consent form signed by the parents of Baby Fae, the child who had a baboon heart transplanted into her at Loma Linda University Medical Center.

As reported in the American Medical Association News (March 29, 1985), the NIH concluded that the Loma Linda surgeons did an adequate job of discussing the risks and benefits of the procedure done on Baby Fae "with three exceptions." The three "shortcomings" in those doctors' informed consent procedures were:

1) The expected benefits of the procedure appeared to have been overstated. (I'll go along with that.) NIH advised that the informed consent document should "more reasonably convey the expected benefits and risks, particularly the possibility of survival."

2) The procedure used by the Loma Linda team did not include the possibility of searching for a human heart for transplant.

3) The parents were not told whether their child would have been provided with medical care and compensation if she had been injured during the procedure.

Since surgeon Leonard Bailey, M.D., plans to attempt this baboon implant procedure again (although he does not predict when another such transplant may take place) isn't it about time that NIH began studying in advance the consent forms that will be prepared by Bailey, DeVries, and other transplant surgeons who might take part in these bizarre "experimental" assaults on the human heart?

The reason I place quotation marks around the word "experimental" is because these operations are not bona fide medical experiments. In a true medical experiment, half of the candidates for a certain treatment receive that treatment while the other half do not. The results in both groups are then compared so that scientific conclusions can be drawn. Right now, the Baileys and DeVrieses warn us that, if the implants and transplants are not carried out immediately, the patient will be dead in four days or four hours or four weeks or whatever. But why should we trust these prognoses, especially when they come from a surgeon with an ax (scalpel?) to grind? After all, the surgeon has a vested interest in operating. Furthermore, it is not a rare event for patients who have been given a deadly prognosis to live long enough to attend the funerals of the doctors who made that forecast.

Of course, the doctors believe so strongly in their transplants that they will claim that assigning some patients to the control group is unethical. However, that belief is based not on scientific evidence, but rather on their guesses, conjectures, opinions and other unscientific considerations. Conversely, they do not consider it unethical to give treatment which, having no scientific basis, may lead to profound suffering and premature death.

Perhaps if real honest-to-God scientists, rather than ambitious surgeons, take an active role in designing the protocols for this new form of treatment, these heart operations will become legitimate scientific experiments rather than instances of surgical adventurism.

A major voice in American medicine has joined with mine in criticizing heart transplants and artificial hearts, that of David H. Spodick, M.D., Professor of Medicine, University of Massachusetts Medical School and Director of the Cardiology Division of St. Vincent Hospital, Worcester, Massachusetts. Dr. Spodick wrote me after I questioned the ability of cardiac surgeons, including Humana Hospital's Dr. DeVries, to predict the life expectancy of their patients. In order to justify the implanting of artificial hearts or the use of heart transplants, those surgeons have been telling us that a particular patient may live only two more hours or two more days or two more weeks without such intervention.

Dr. Spodick, who is widely known within the medical profession as "the conscience of cardiology," wrote me: "Your discussion of the artificial heart and baboon heart is 'right on.' At a recent American Heart Association meeting, the group at Stanford, California, looked into treatment of 'end-stage' cardiomyopathy (the serious heart muscle condition of many of the candidates) patients with beta blocker (e.g., Inderal) therapy. This was done while they were waiting for a suitable heart donor for transplant. Naturally, all had been judged to be candidates for death without the transplant. On the beta-blocking therapy, the majority of patients improved."

The next sentence in Dr. Spodick's letter is a little technical-- "Some had a substantial increase in left ventricular ejection fraction, going in some cases to approximately normal." But his next sentence speaks

for itself--"These (patients) were taken off the transplant waiting list."

Dr. Spodick's technical language continues. "Furthermore, the peak exercise ejection fraction was higher in all the patients after the beta-blocker therapy as were other indices of function." But the next sentences are easy to understand: "At least the four who were taken off the transplant list were shown fortuitously not to need transplant in the presence of superior treatment! This is probably true of others judged by surgeons and cardiologists to be 'goners.'"

So the next time dare-devil surgeons threaten a cardiomyopathy patient with death unless he submits to their "treatment," let's tell the patient and his cowering family to get a second opinion from Dr. Spodick and his colleagues.

What can we learn from the William Schroeder case?

The longest living recipient (620 days) of a permanent artificial heart, Schroeder was the last survivor out of five patients who were given the Jarvik-VII. His surgeon, Dr. William DeVries, justified the implant, claiming that even though Schroeder suffered a series of strokes while on the pump, "His experience contributed significantly toward minimizing the risk of strokes for artificial heart recipients."

Well, let's look at the evidence. The first recipient, Barney Clark (who survived 112 days), also suffered from strokes that caused seizures and mental confusion. Clark also developed lung and kidney problems. The second recipient, Murray Haydon, didn't have kidney problems, but he was hospitalized for strokes and lung problems. Apparently, some of these problems were solved in time for the third recipient, Jack Burcham. He died of a different complication--hemorrhage. The fourth recipient, Leif Stenberg, died of a massive stroke.

It seems as though the resolution of one complication merely clears the stage for the appearance of a new--and equally life-threatening complication. Therefore, while we all should be thrilled at Dr. DeVries' announcement about progress in lessening the risk of strokes, we should insist that he not overlook the risk of hemorrhage, lung problems, kidney problems and damage to the other organs in the body which are affected by the artificial heart.

After William Schroeder's death, Dr. DeVries was quick to point out that the patient had spent time with his family at Christmas and birthday celebrations, time he would not have had if he hadn't decided to have the device implanted. How does Dr. DeVries know whether or not Schroeder might have lived longer without the implant than with it?

Furthermore, what is the reason for all the secrecy that surrounds government approval of these surgical adventures? The FDA gave its approval for DeVries to continue doing further implantations after "closed-door deliberations." Now doesn't it seem that every detail should be openly presented when such a crucial public decision is reached? Just consider the conflicts of interest of the major players in the artificial heart drama.

No one knows whether Schroeder or any of the other recipients gained or lost from the operation. But everyone knows that Dr. DeVries gained. The other surgeons gained. The hospitals gained. The FDA is supposed to protect patients from those special interests that have an ax to grind--or in this case--a scalpel to wield.

*Double transplant
raises questions*

Recently, an Arizona man received both a lung transplant and a heart transplant. As reported by Associated Press (November 30, 1985), there were some interesting aspects about this case, for which Dr. Jack

Copeland was the surgeon. (You may remember that this same Dr. Copeland was the object of controversy in 1985 over the use of an unauthorized artificial heart.)

The patient, aged 32, had been waiting a year for these donor organs. At the time the organs became available, he was having dinner at a cousin's home in Phoenix. Since heart transplants are used on patients who are in end-stage cardiac disease, a year seems to me to be a little long for a patient to be classified as "terminal."

Dr. Copeland was pleased with the results of this transplant. (The organs had been taken from a woman who shot herself in the head). He characterized the woman's injury as being due to a "profound bullet wound to the head" which led to a "premature heart failure." (Strange language, indeed.) The doctor continued, "If we can get him through the first weeks and months, he should have a good shot."

By the way, Dr. Copeland had trouble finding the patient because the beeper the man had carried for several months apparently was not working. Here's hoping for better luck with the technology involved in the surgery and post-operative procedures!

*Kidney
transplants
and cancer*

The next time someone points with pride to kidney transplants as being one of the greatest breakthroughs of modern medicine, you might call his attention to evidence from the Department of Surgery at the University of Sydney (Australia) which shows that 44 percent of Australian kidney transplant patients develop cancer less than five years after their surgery.

A study of 400 transplant patients conducted by Dr. Graham Kelly and Professor Ross Sheil pointed the finger at azathioprine and other immunosuppressive drugs taken by transplant patients as the likely cause.

*Why trauma
centers?*

For many years, ambulances and paramedics took patients who had traumatic injuries to the nearest hospital emergency room, most of which were called trauma centers. But recently this system has changed drastically in my home town of Chicago. Nine city and suburban hospitals now have been officially designated as "trauma centers."

The Chicago Tribune (May 16, 1986) says this change has come about because these nine hospitals, which are all university or university-affiliated medical centers, can deal better with trauma victims because of better technology and personnel.

It is estimated that only five to 10 percent of the Chicago area people who are injured in automobile accidents or suffer from gunshot wounds will require this "highest" level of treatment. According to the Chicago Department of Health, the other 90 to 95 percent of injuries can be treated at regular hospital emergency rooms and need not go to the specially-designated trauma centers. Paramedics at the scene of an injury will determine who goes where. (Patients who suffer heart attacks and other medical emergencies that do not involve trauma will be taken to ordinary hospital emergency rooms.)

Perhaps all this changing around sounds perfectly legitimate to you. But to someone as suspicious of doctors as I am, certain questions arise:

1) Since the present system has been around for more than two decades, what has brought about this sudden change?

2) Why would the hundreds of community hospitals which were previously called trauma centers be suddenly willing to give up this designation (and considerable income) in deference to the Big Nine?

3) What has happened to stimulate the Big Nine into cornering the market on severely injured patients?

4) Why have the Big Nine left the heart attacks, strokes and other medical conditions to the community hospital emergency rooms?

5) Is this being done exclusively in the interests of the patients, or is there a hidden agenda somewhere?

I think the answer to all the above questions lies in the recent explosion of transplant teams in the emergency rooms of large research and teaching hospitals. Within the last year, several university medical centers in the Chicago area have proudly announced the recruitment of highly-trained and highly-paid teams of doctors and technicians who are dedicated to the harvesting and transplanting of hearts, livers, kidneys, corneas and other body parts.

We know, of course, that these teams are not interested in the deteriorated organs of folks suffering from heart attacks, arteriosclerosis, strokes and other diseases of the elderly. So those patients may as well be left to the nearest emergency rooms. Nor are the transplant teams interested in accident victims who are not seriously injured. Since they are likely to recover, they may as well be left to the local doctors.

But as far as transplant teams are concerned, the cream of the crop comes from such patients as the healthy young motorcyclist or sports car driver who is the victim of a severe accident. Or from the healthy young victims of severe gunshot wounds.

What may happen to such patients?

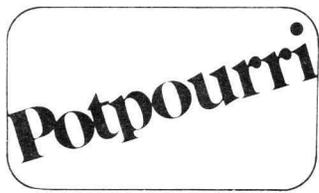
Let us imagine a transplant team sitting around at each of these nine hospitals, waiting from something to do. We know that not many people have signed away their organs on their drivers' licenses, but now laws have been passed which force hospital personnel to ask for organ donations from the family of every patient who is declared dead. And since patients now can be declared dead on the basis of a flat electroencephalogram (EEG), even when their hearts are beating and their lungs functioning, all that is needed is a steady supply of patients to hook up to the EEG machine. But where would that supply of patients come from if ambulances were to continue the present policy of taking accident victims to community hospital emergency rooms that have no transplant teams?

Therefore, a decision had to be made that critically injured patients had to come within the exclusive domain of hospitals that had transplant teams. The public would never perceive this hidden agenda and would instead applaud the effectiveness of the new plan, as witnessed by the rise in harvested organs and transplants. Soon, the nine designated trauma centers would be able to take credit for saving the lives and health of organ transplant recipients, as well as the lives of accident victims. The transplant recipients would have their lives saved by those accident victims who died in spite of the "best medical care the doctors could provide."

And who would ever check up to see whether patients might be pronounced dead a little too early? Who would question whether overzealous transplant attempts might kill more than they might cure? Certainly, community hospitals wouldn't object to the diverting of their patients and their income for this noblest of all reasons. And if they were to object, it would appear as though they were putting money ahead of patient care.

I can just hear my critics screaming words like "cynicism" and "paranoia" to account for the above scenario. Perhaps they're right. Perhaps they're not.

Meanwhile, since my theory carries the ring of plausibility, I recommend that every reader taken to a "trauma center" which is situated in a large research hospital--and his family--look around for hidden agendas that may conflict with the treatment necessary to save the patient's life.



Update on ultrasound

Dr. Ted Li of Harvard Medical School has joined the growing number of physicians who are attacking diagnostic ultrasound. Dr. Li delivered his message to the 1985 national meeting of the American Federation for Clinical Research. His research showed that the diagnostic value of obstetrical ultrasound as a routine screening procedure is "marginal," its therapeutic utility is "slight," and its cost is disproportionately high.

Dr. Li's research investigation showed that, based on the records of 3,100 women, there were 18 false-positive fetal anomalies. In other words, the ultrasound reading "found" the following abnormalities which really weren't there: three cases of intrauterine birth retardation, four cases of polyhydramnios (too much fluid surrounding the infant), one case of oligohydramnios (too little fluid surrounding the infant), four cases of abnormally increased fetal size, and six cases of placenta previa (abnormal location of the placenta). Think of all those mothers and fathers who worried unnecessarily about these abnormalities (which existed only on the ultrasound tape) during the pregnancy, at delivery and even afterwards.

The ultrasound examination also made mistakes in the other direction. Thus, six babies were born small for gestational age, even though their ultrasound readings were normal. Two cases of renal agenesis (failure of the kidney to develop) were missed, as was one case of an infant with an absent hand and wrist.

For your information, "minor" anomalies included four cases of hypospadias (abnormal location of the urethral opening in males), three cases of clubfoot and one case of undescended testes. Dr. Li stated, "Ultrasound failed completely to pick up minor anomalies. Its success rate was absolutely zero."

Perhaps before your doctor subjects you to this potentially damaging technology, he will tell you about these errors in diagnosis.

Malpractice research contradicts doctors' claims

If you are confused about the medical malpractice "crisis," I suggest you read the most comprehensive, understandable and clear treatment of the subject that I have seen.

In an April, 1986, eight-page series entitled "Medicine on Trial: The Malpractice Crisis" in the Orlando Sentinel, reporters Rosemary Goudreau and Alex Beasley presented the results of their nine-months-long in-depth research. Their surprising conclusions were that, despite statements to the contrary from the doctor/insurance company coalition, most lawsuits involving medical malpractice are won by patients. The reporters concluded that "frivolous" lawsuits are rare. In contrast to doctors' claims that patients are unnecessarily running to lawyers, the Orlando Sentinel article concludes that only one in 10 hospital accidents resulted in malpractice claims. Most patients suffered in silence.

For those of you who have been injured at the hands of doctors, hospitals and drug companies, this important series, whose articles bear such headings as "Doctors' errors can have deadly consequences, paralyzing results;" "One in 16 doctors gets hit by claim;" "Moms, babies at highest risk when medicine goes bad;" "All those tests protect doctors but can put patient in danger," and "No RX in sight for some bad doctors" should give you plenty of encouragement in your pursuit of justice.

(Reprints are available from the Orlando Sentinel, P.O. Box 2833, Orlando, Florida 32802.)

The People's Doctor Newsletter
P.O. Box 982
Evanston, Illinois 60204

Published monthly. Subscription rate: \$24.00 annually.
Robert S. Mendelsohn, MD, Editor
Vera Chatz, Managing Editor

© The People's Doctor Newsletter, Inc.

Another View

by Marian Tompson



After he was involved in an automobile accident, Maurice had a headache that wouldn't quit. For two months, he sought help from medical doctors only to be told that he either would get better in time or he would just have to learn to live with it. Desperate for some relief from the constant pain, Maurice finally decided to follow a friend's suggestion and see a chiropractor. As the time, he didn't have a very high opinion of chiropractic, but since his friend's wife had been helped by one, he decided to give it a try.

Not only did the chiropractor eliminate Maurice's headache, he also untwisted his body. The experience sent Maurice, who had already completed four years of college, back to school. This time, his goal was to become a chiropractor so that he could help others with his newfound knowledge.

So I guess it was inevitable that Maurice would write to me after he read my column on drugless headache remedies (Vol. 10, No. 4). Now speaking from professional as well as personal experience, Maurice took issue with my statement that "According to experts, most headaches are caused by tension." He expressed disappointment that no mention was made of the headache relief offered by chiropractors.

Maurice pointed out that too many headaches are passed off as being the result of eye strain, emotional stress, or tension. He referred me to the work of Max Murray Braaf, M.D., Director of the Polyclinic Headache Clinic in New York. According to Dr. Braaf, 90 percent of the headaches he has treated were caused by mechanical derangement of the cervical spine, irritating cervical nerve roots and/or the vertebral artery.

"These are types of problems that chiropractors see and treat with excellent results on a regular basis," Maurice wrote. In a study of 6,000 patients with headaches which recurred for two to 25 years (J. Trauma 15, 1975), Dr. Braaf reports that cervical spine trauma was the most important factor and should be suspected in every nonspecific case.

H. K. Brooke, writing on cervical headaches in the Canadian Family Physician (1972), also makes the point that while there is a great deal written about headaches from other causes, there is little in the literature about head pain which arises from the cervical spine and associated structures, although at least 70 percent of the headaches which he sees arise from this cause.

The Australian-New Zealand Journal of Medicine (1978) published a study in which 85 volunteers who suffered from migraine headaches were randomly allocated to three treatment groups. One group received cervical manipulation performed by a medical practitioner or physiotherapist, another group received cervical manipulation performed by a chiropractor, and the control group received mobilization performed by a medical practitioner or physiotherapist. Migraine symptoms were significantly reduced in the entire group. While no difference in outcome was reported by those who received cervical manipulation and those who received control treatment, the chiropractic patients did report a greater reduction in pain associated with their attacks.

Even basketball player Kareem Abdul Jabbar, who has had a long history of migraine problems, finds chiropractic treatment helpful. In a May 1984 Associated Press article, Jabbar told of waking up with a headache after sleeping on an airplane with his neck in a crooked position. Jabbar had been getting adjusted regularly by a chiropractor, and he hadn't had a migraine in nine months. "When I got this one, I knew what to do," he said. A neck adjustment was involved. Once his trainer put his neck back in line, Jabbar felt just fine.

My thanks to Maurice Cyr and the many other chiropractors who have written to provide this columnist with yet another view on headache relief.