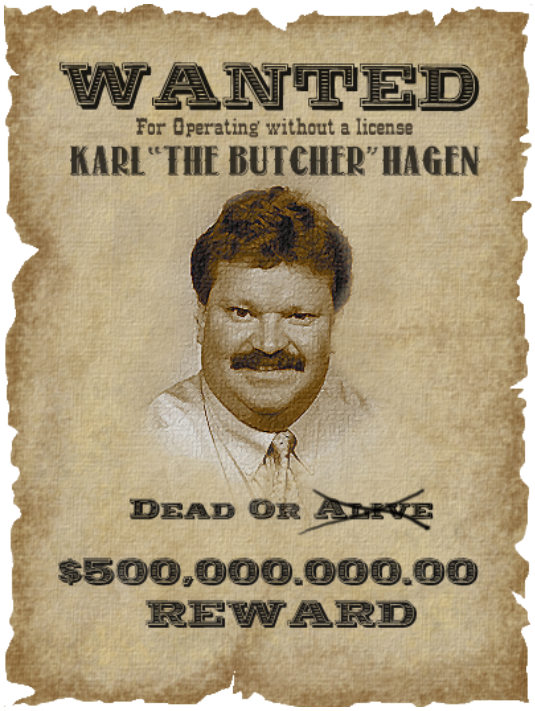
Is Your Surgeon Licensed? Are You Sure?



The mug seen in the poster is the surgeon that nearly cost me my life, Karl Hagen. This rant is not intended as simply a personal attack on a single surgeon, but I am using his story as an example of a very real problem that could affect you or your family. Until recently, I was not aware that a doctor or surgeon who has had their license revoked in one state can move their practice to another state and legally begin a new practice. The biggest mystery to me is why any state medical board would want to license a doctor that another state has deemed unfit to practice medicine. This is what the state of Florida granted to Karl Hagen – and this is not an isolated or rare case. I was shocked to discover that this is a quite common occurrence and it is not unique to Florida.

At first glance, this may not seem like as frightening of a prospect as it actually is, because any responsible person will do extensive research on their doctors and surgeons before submitting themselves for treatment. Prior offenses and reprimands on medical professionals are of public record and easily searchable through websites like HealthGrades.com. Most of us are not going to consider the fact that we may require emergency medical treatment at some point in our life and not be afforded the luxury of time necessary to research or seek recommendations for our doctors. Not all surgeries or treatments are scheduled.

I was admitted to South Lake Hospital for a simple blood transfusion and never thought that I may require surgery. I would have never went to a rural hospital for surgery. By the time I was taken in for surgery, I had been unconscious for more than 48 hours. Many patients are rushed into emergency rooms everyday needing immediate treatment. We all would hope that if we we're in need of emergency medical treatment or surgery, that the nearest hospital we were taken to would not have doctors on call that have had their licenses revoked in other states. After all, ER doctors and surgeons are the one doctor that the patient will not have the opportunity to conduct a background check on before ending up under their knives.

In an emergency situation, you could find your life in the hands of a doctor that was determined to be unqualified to practice medicine in another state, as was the case with Karl Hagen. To make matters worse, not only do hospitals hire these doctors, but they are not required to inform the patient, nor their family of the fact that an unlicensed doctor is about to begin invasive procedures on their loved ones. Karl Hagen's dismal record as a surgeon is of public record and can be verified here. In addition to several blunders, some of which cost the patients their life, he also had his license to practice medicine in California revoked on July 29, 2009. He operated on me on September 20, 2009, just two months later. At the time he was about to operate on me, my wife did a quick research of his credentials, but at that time all the information listed for Karl Hagen was reported as "pending". The record that exists now on-line, including the revocation of his license, did not appear until over a year later. South Lake Hospital certainly knew of his problems, because his case had been decided and the Florida State reprimand and California revocation of his license had all transpired months before he operated on me.

I am not sure whether Hagen ever practiced in California. His

online profiles always list both states, Florida and California as where he is licensed to practice. HealthGrades.com still lists him as being licensed in California and Florida here – even though he is no longer licensed in that state. His license in California was revoked in 2009, but as far as I can tell, it was based on reprimands he received while practicing in Florida. He has a long history of medical reprimands and did settle for $300,000.00 in a case which cost the patient their life. This seems a rather low amount of compensation for the loss of one's life, but seems common in the world of malpractice law. If a pharmaceutical company injures or kills a person, the financial damages can be staggering – usually in the millions, but as I have mentioned many times before, doctors are awarded special protection under the law that no other professional enjoys.

In the first account brought against Doctor (and I use that term loosely, because California no longer considers him a doctor) Karl Hagen in 2006, he failed to examine the x-ray for a woman who was scheduled to have a chest tube placed. The excuse given for this blunder reads like a gag from a bad sitcom. According to the public record, a doctor told the nurse to schedule the operation for a chest tube to be place. The nurse asked the doctor if it was to be placed on the left side and the doctor replied "right", indicating that it was to be placed on the right side. The nurse assumed the doctor was saying "right" in agreement with her and therefore prepped the left side for the surgery. The detailed legal account of this case can be found here and included a $5,000.00 fine – considerably less than the payment he received for the service, I'm sure.

Yes, it was an error in communication between the doctor and nurse – sort of an Abbott and Costello type deal – and might be a riot in a comedy routine, but is not very amusing when a patient's life is in jeopardy. Karl Hagen was reprimanded and

punished by the state of Florida because he failed to check the x-ray himself. But, even less excusable was the fact that the patient already had several chest tubes placed on the right side that had been ineffective.

So Karl Hagen is presented a patient who has several scars on her right side from prior chest tubes and still decides to place the new one on the left – you would think that the scars on the right side would have been a signal for him to examine the x-rays. The patient did eventually die, but I'm not sure whether his error contributed to her death or not. The punishment for this critical error was "education" – sort of like those courses you have to take after getting a traffic ticket. That'll teach him a lesson! Do you feel more comfortable letting this guy open you up now, knowing he took those courses? At this point, California still considered him licensed in their state and he continued to practice in Florida.

His worst sanction came from another deadly mistake and was very similar to the error he made on me. He operated on a man who suffered from diverticulitis, which is a bulging pocket in the colon that becomes impacted and infected. He was to resect that portion of the colon, which is the proper procedure for diverticulitis, and to then form a stoma for a colostomy – again, all typical treatment for this illness. Hagen obviously has a bad habit of not thoroughly checking the viability of the tissue when resecting bowels. He failed to send the material to pathology and instead discarded it. This caused a 17 hour delay in surgery when the necrotic tissue he left inside the patient caused a systemic infection which ultimately led to the death of the patient. The detailed legal account of this malpractice can be found here.

When I read that report, it was like deja vu and sent chills down my spine. Hagen had repeated this error while operating on me. We had to obtain all of the medical records to provide to the transplant surgeons in Miami in order to qualify for an

intestinal transplant. Going over Karl Hagen's surgical notes, he records that the section of jejunum, that he was forming into the stoma, appeared to be compromised and yet he used it and never sent a sample of the tissue to pathology to see if it was viable. To make matters worse, he even wrote in his surgical notes that the compromised tissue could result in a high morbidity and mortality (notes that he thought I would never see).

Over the next five days, the stoma continued to darken in a manner referred to by doctors as a "dusky" appearance. The Attending Doctors were concerned about this and continued to consult with Hagen, but he refused to take the time to examine it. He also insisted it was fine and would begin to turn pink as blood began circulating to it. On the contrary, it continued to darken each day and became less and less active. The doctors of South Lake Hospital played a dangerous waiting game and refused to send me for an MRI, because the hospital's only MRI machine was located in small building across the parking lot and it would be very difficult to transport me with all of the IV pumps I was attached to.

I was literally dying from the three feet of necrotic bowels left inside of me and these doctors did not want to make the extra effort to move me to the equipment necessary, because for some strange reason they had it housed in a building over fifty yards from the hospital. By the time they decided that my condition was becoming too critical to ignore any further (four days) they did transport me to the machine.

Luckily for me, the MRI revealed what appeared to be a partial occlusion of the mesenteric artery (the artery that supplies blood to the intestines). Why do I say lucky? Because this hospital was not equipped for vascular surgery, so the decision had to finally be made to transfer me to a better equipped hospital. Even at this point, Karl Hagen was still maintaining that the stoma was fine and continued to ignore the problem. Hagen was quite clear about his position to my

family. He personally felt that I would have such a horrible quality of life if I lost that last three feet of intestines that I may be better off dead. He had obviously decided to himself to spare me the suffering and just let me die if the stoma did not come back to life on its own. This is not his decision to make. All of the other attending doctors were in agreement with Hagen, because they didn't know that intestinal transplants were possible. I really believe they transported me to the other hospital so I would die there, rather than at their hospital.

I arrived at the trauma hospital in Orlando, where I was prepped for the vascular procedure. The vascular surgeon hoped that after the clot removal that the stoma would begin to brighten up, once the blood flow was improved. He removed the occlusion and watched me closely over the next couple of hours really expecting the stoma to come back to life. By this time the stoma was nearly black in color. They left me alone for a couple of hours and I was in the room alone. It was during that time when I began to have seizures. There is a bit of missing time during the seizure, because the last thing I remember was a large oxygen mask being pulled off of my face and the room was suddenly filled with doctors, including the vascular surgeon.

At this point the vascular surgeon immediately called Karl Hagen to have him come over and examine the stoma and consult them on what actions needed to be taken. Hagen felt no need to make the twenty-minute trip to Orlando. He determined over the phone that the seizures were unrelated to the black stoma and that they needed to just wait another day or so for the blood to get to the stoma and I would be fine. It is certain that Karl Hagen was going to play the waiting game until I died, had I remained at that hospital. You would think that after all the patients he had lost in the past by leaving necrotic tissue inside, he would not continue to make the same dumb-ass mistake – but he's obviously quite a dumb-ass and

doesn’t learn from his past mistakes.

My wife asked the vascular surgeon to take action and he said something about me being Hagen’s patient and it would be wrong protocol for him to intervene. He must have used the word, territory, because the last thing I can clearly remember was my wife loudly proclaiming to the vascular surgeon that; “He isn’t anyone’s territory, he’s my husband!”. Then she added; “Can you just sit here and watch him die?”. He contacted the trauma surgeon who was on-call and assisted him in the an emergency surgery, because I was in septic shock by that time.

Several weeks later I had to visit the trauma surgeon so he could examine the incision. He actually told us that they had considered just closing me up and keeping me sedated until I died in the next couple of hours. It was the vascular surgeon that convinced him to go on with the long hard operation. It took hours for them to irrigate and suction out all of the necrotic tissue that had turned to liquid and spread throughout my abdomen. The vascular surgeon told us that it was only because of my age that they committed to the effort.

Because of just how critical the situation became, I know that had I not been transferred to the Orlando hospital my fate would have been death, because Karl Hagen would never had made the effort. This was the only difference between me and the other patient who had died several months earlier under Hagen’s care. Karl Hagen is still practicing medicine somewhere and I have no idea how many people he will have to kill before he loses his license to operate for good?

It was the incident with that other gentleman that ultimately caused Hagen to lose his license to practice in California. The lawsuit, reprimand and revocation of his license had all transpired prior to my operation. In other words, South Lake Hospital allowed a surgeon who had lost his license to practice in California to continue to practice and perform serious operations in their hospital. I have stated his name

many times in this article so that it may be found on any searches being done by any patient who may be under his care or considering him for a surgery. I did not realize that this problem existed and I wonder how many people know this is possible. I have since done research on this subject and have found that it is quite a large problem in this country. If you were unaware of this problem (as I was) and believe it may only be a Florida problem, here are some articles on how common this occurs:

New York Times: SOME ERRANT DOCTORS GET NEW U.S. FUNDS BY CHANGING STATES

WPTV.com: DOCTORS LOSE LICENSE BUT STILL TREATING PATIENTS

FSBCT: A FAILURE TO PROTECT THE PUBLIC

It seemed that there were a multitude of cases of doctors who had lost their license to practice in the state of New York that move their practice to Connecticut and continued treating patients. I really cannot understand the logic used by any state medical board to grant a license to doctors who had their license revoked to practice medicine in another state. If you have that many deadly mistakes in your career, maybe it's time to seek a new one.

I cannot expect the federal government to forbid states to license doctors based on the decision of another state to revoke their license, but it would seem reasonable to demand that hospitals that allow a doctor to practice must have to make that information known to potential patients and be liable for any damage that doctor commits. If a pack of cigarettes have to have warning information as to the danger they possess, then similar information should have to be provided for a dangerous doctor. There are hundreds of patients rushed into emergency surgery everyday – many are unconscious and in critical condition. How is it their responsibility to research the doctor or surgeon on-call at

the hospital they are rushed to? Is it too much to ask that hospitals not permit doctors with so many discipline problems administer to emergency or trauma cases? Maybe they could be restricted to private practice or clinics where the patients are of sound mind and not in a rush for treatment.

At the point it was determined that I required surgery, my family wanted me transferred to a better equipped hospital in Orlando, but the doctors actually refused, even though they had a helicopter pad and are part of the Orlando Health system who pays to equip them with emergency transport equipment for just such occasions. Time was not the motivating factor, because their on-call surgeon, Karl Hagen, was not available and they told my family that he had 24 hours to respond to the emergency page. I would have actually gotten faster treatment had they shipped me to ORMC, where trauma surgeons are on-call 24-7. The refusal to transport me was solely based on greed and pride. Most doctors are far too arrogant to admit when a case is beyond their training and experience.

Most recently, we were told by an employee of South Lake Hospital, that Karl Hagen had been banned from practicing there further. Though I cannot verify her reason for his dismissal, the employee told us that it had something do with an alcohol abuse problem. Why in the hell would South Lake Hospital allow such a surgeon to work out of their hospital? When you allow a doctor, who a major state like California decided was unfit to practice medicine, did you really believe he would achieve great things for your hospital? So this hospital allowed this surgeon to perform such a risky surgery on me knowing his past malpractice record, the loss of his license to practice in California and that he had a drinking problem. The most frightening part of this is that even though he has been removed from South Lake Hospital, he is still license to practice medicine in the state of Florida – if he loses his license in Florida anytime soon, he may move to another state and be practicing in a hospital near you.

If you think he is a unique case, you'd be wrong. Do a little research and it won't take long to see that this is happening all over the U.S.. We wonder why the U.S. is ranked 37th in health care. There are very talented people who become doctors and then there are people who were just not intended to be doctors, but become one anyway. It's kind of like those wannabe singers that turn up for auditions for American Idol and holler like a wounded moose – it makes you wonder what ever made them believe they were going to be the next singing sensation. Maybe we need a Simon Cowell in the medical auditions. Someone with the stones to tell an untalented doctor to get out of the business.

Some medical apologist posting as 'Kathleen" left a comment over at Paleohacks.com in response to a link that someone had provided to my article "How Common Are Medical Errors". Her brilliant rebuttal was to point out that all of the mistakes made on me were simply because I was in Florida. How much do you want to bet she works in the medical profession? This is the exact "stick-your-head-in-the-sand" mentality that allows this type of thing to perpetuate. Medical errors are the 3rd highest killer in the United States and this ignoramus wants us to believe that all of them happen only in Florida.

So if all the statistics concerning medical errors from Florida were removed, then the U.S. would magically leap to number one on the world stage. Can someone really be so mentally blind? I gave the national statistics in that article, yet her wishful thinking says "Yeah, but it's much better where I live". No it's not! As a matter of fact, it could be much worse. I'm sure that Florida has a very high hospital mortality rate compared to most states because they have more seniors as its populace. After all, Florida is the place most people go to die. Getting rid of Florida or avoiding treatment in Florida is not going to fix the problem, as this medical shill suggested. It's just another excuse to look the other way and why nothing is being done to fix the

problem – because they refuse to see a problem.

Doctors losing their license in one state and moving to another to practice is actually becoming quite a common problem in the U.S. medical system and I believe that few people are aware of it. It would seem to me that a license to practice medicine is a privilege, not a right. Just because someone spent all the time and money in education to become a doctor should not mean that they are perpetually granted the right to practice, even after leaving a population of cadavers in their wake.

So many lives could be spared if some of these problems I have pointed out in this series were given more awareness. The three main topics I would like to see made common knowledge are:

- Colonoscopies injure and kill more people than they save. (as a matter of fact, your chance of being killed by a colonoscopy are 3 time greater than ever getting colon cancer)

- Medical errors are the 3rd largest killer of humans in the U.S. (you really have to question and research any and all treatments offered by doctors and are best to have a family member or close friend with you as a much as possible if you are hospitalized)

- Doctors who lose their license in a U.S. state should not be able to work in emergency rooms or in any other manner where patients do not have the opportunity to do a background check prior to treatment.

The last topic in my series called “Medical Mayhem”, will address a very lethal problem in the medical systems that there is no hope of changing, but I will rant about it anyway. It concerns “The Cynical Attitude Of Doctors Towards Patients”. This attitude is where many of the following problems stem from. Everything bad that happened to me was

the result of a cynical approach by a doctor – and almost every doctor and more than half of the nurses had this very same cynical attitude. I hope you will return to read it.

Why Are Intestinal Transplants Such A Secret?

I have been very saddened by a series of emails I have been receiving recently. Some of these messages have been left in the comments, but I felt that their stories deserve more attention. Many people are suffering and dying because of the lack of information concerning intestinal transplants. If you have never heard of intestinal transplants, don't be embarrassed, as most doctors are unaware of them. This is due to a lack of media attention on the procedure and the fact that most doctors feel no need to learn anything new after they graduate medical school – except what the pharmaceutical companies pay them to learn.

In a way, the comments and emails has had a positive side, because the information I have provided has found its way to some people in need. Unfortunately, it was far too late for one reader, Jan, whose courageous mother, Marlyn, lost her life in a battle with intestinal necrosis. The doctors were refusing to remove the necrotic bowel for some unknown reason – most likely due to the fact that they had no knowledge of the success of intestinal transplants. It is in her mother's memory that I am writing this most important post that I hope you will take to heart.

The doctors here in Orlando had made a similar decision in my case following the first resection of bowels. I was left with

three feet of jejunum, but the tissue was necrotic and killing me. The surgeons refused to operate again. Because they had no knowledge of intestinal transplants, they had decided that I could not live on less than three feet of small bowel and would be better off dead. They made that quite clear. Fortunately for me, I was transferred to another hospital for a vascular procedure and the surgeons there did remove the necrotic tissue, even in spite of the fact that they did not know of intestinal transplants either and also felt I would die without the three feet. My wife was able to plead enough to guilt the doctors into doing the surgery, but they were reluctant and told her I would have a miserable existence and die a slow agonizing death. They were wrong, but surgeons are making these decisions strictly based on the lack of publicity concerning the success of intestinal transplants.

Whenever I tell someone that I was the recipient of a full intestinal transplant, I rarely get what I call the "Shock And Awe Reply.". I had never heard of intestinal transplants and was very shocked to find out it was possible. So by way of the "False Consensus Effect", I thought that this would be the typical reaction to this news. Instead, I am usually extended what I call, "The Gesundheit Reaction". This is when the person reacts as though I had my tonsils taken out and say something like; "well I hope you feel better" or any other casual response as if someone sneezed. It is not the type reaction I might expect if I were to tell them I was a cancer survivor – even though there are many more cancer survivors than intestinal transplant survivors. Losing your intestines is considered a death sentence to more than 90% of the doctors in the U.S..

If I were to tell someone that there is a cure for cancer, the news would spread like wildfire, so why hasn't the information concerning intestinal transplants? It's quite frustrating, but I am beginning to see why. It seems that most people do not want to admit that they are unaware of a medical

treatment. Many people I have encountered since my transplant simply smile and nod as if they have known many people who have received intestinal transplants. It is only if I specifically ask them, “have you ever heard of an intestinal transplant?”, that they will admit that they haven’t. It’s either a lack of curiosity or too much pride that causes this complacency.

Most people have heard of transplants. Kidneys, livers, heart and lung transplants have been possible for many decades, so most people assume that intestinal transplants are as common and this is very far from the truth. Intestinal transplants are the rarest of organ transplants and its outcome was not very promising until recently. The intestines presented a very large problem when it came to transplants. The intestines are considered the largest lymphoid organ in the human body. Because the intestines are a “dirty organ”, filled with thousands of different strains bacterial and fungal colonies, the human immune system reacts more rapidly and aggressively when defending the intestines than any other organ. We had to develop this system or we couldn’t have survived as a species.

We eat a tremendous amount of bacteria and fungus everyday. Much of these microbes colonize in our intestines and many of them are beneficial to our digestion and help us to break down foods that would otherwise be indigestible. But any of these microbes can become lethal if they enter our bloodstream. For this reason, the largest part of our immune system is located in our gut. When bowels from a donor (with different DNA) are placed within the recipient, the immune system cannot tell the difference between the new bowel and the pathogens within, so it unleashes an attack on everything and ultimately destroys the new intestines. A slow, horrible death is soon to follow.

The first intestinal transplants were attempted in the 1960s, with a 0% survival rate. Even though there were great strides being made with kidneys, livers and even hearts and lungs over

the next decade, all intestinal transplants attempted resulted in severe organ rejection and the patients died in a short period of time. There really was no success in this type of transplant until the 1990s, when the transplant program at the University of Pittsburgh had some level of success by first transplanting some of the donor's bone marrow into the recipient. This made the recipient's immune system accept the foreign organ better. Some of the recipients survived for the first year or so, but overall survival rates were still dismal. There was less than a 25% chance that a recipient would survive the first year after the transplant, so these transplants were only reserved as a desperate effort. The patient had to literally be at the point that all of their access arteries were gone and they could no longer receive TPN and were waiting to die of dehydration before a transplant would be attempted.

It wasn't until a drug called "Campath" was introduced to the process that the survival rate began to doubled. No one really understands how Campath works to make the body accept the organ – it just does. I did not have to go through the painful process of a bone marrow transplant prior to the intestinal transplant. Because I was given an IV infusion of Campath, my body accepted the organ and I had no signs of rejection.

Dr. Andreas Tzakis (pictured on the left), the surgeon that performed my transplant, was working at the University of Pittsburgh at the time of the first successful intestinal transplants. He was the first doctor to use Campath. There is little doubt that I had the best surgeon that you could hope for working on me. Dr. Tzakis has performed more transplants than any surgeon in the world. He has performed over 2,000 liver transplants and has the highest record of success in intestinal and multivisceral transplants.

Dr. Tzakis was actually successful at first transplanting a baboon liver into a human.

There are so few hospitals that can perform intestinal transplants, that I was able to get an organ after only 6 days on the transplant list. Most people in need of a kidney can be on the list for years, because kidney transplants are so common and nearly every hospital can perform them. A kidney transplant is less than a week stay in the hospital at Jackson Memorial. But most intestinal and multivisceral recipients can spend up to 6 months in the hospital recovering or longer.

There is a huge difference in the severity of these transplants. A liver transplant can still carry great risks, but no other transplant is as rare or complicated as an intestinal or multivisceral transplant (which include intestines). Less than 3,000 intestinal transplants have ever been performed and since few people survived them in the first 20 years they were attempted, there are probably less than 1,500 survivors walking around today. So, the chance that you have met someone else who had an intestinal transplant is highly unlikely. I wish people would stop acting as if they were aware of them, when 90% of doctors don't know that they are possible and that includes specialists in GI medicine. Not one gastroenterologist that worked on me here in Orlando had heard of these transplants.

I believe that this is the explanation for the "The Gesundheit Reaction". Most people feel a transplant is a transplant, so it's not a big deal. If you were to ask most doctors, they would tell you that intestinal transplants are impossible and no one survives them. Many people are going to die this year based on that information from their doctor. When Jan first contacted me, her mother was still alive, but her bowels were necrotic and she was dying. The doctors were refusing to remove the dying bowels. I wrote back and told her that the doctors were not aware of transplants and had made the decision that she would be better off dead – just like they

did with me. I provided her with the contact information to the doctors in Miami that performed my transplant.

Jan wrote back the next day and told me she had relayed my story to the doctor and he replied something like, “yeah,it would be nice to believe in magic.”. Asshole! This is the arrogance of most doctors. Does he think I’m making this shit up? I am living proof that they are successful and it wouldn’t take him 15 minutes of research on the internet to confirm that this procedure is not only possible, but hundreds of people will be saved by intestinal transplants this year. Even more could be saved, if the news about them could spread.

I have tried to get media attention on this life-saving procedure, but these type of things are never sexy enough for the mainstream media unless a celebrity has been afflicted. Had a celebrity ever needed an intestinal transplant, it would suddenly become a national crisis and everyone would know about them from the countless reports following the celebrity’s recovery. So far, no celebrity has needed an intestinal transplant, so the fact they exist has remained a secret. Can we wait until a celebrity needs an intestinal transplant to make this procedure common knowledge? In her last email, Jan not only informed me of her mother’s unfortunate passing, but also told me of a 34-year-old man who also lost his life at the same hospital, because the doctors did not know of these transplants.

If you read of my story, please do not keep this information to yourself. If you believe that my story is common and that doctors know what to do when someone loses their intestines – you are mistaken. I implore you to spread the word to as many people as possible. Email others, tweet about it, blog about it, mention it on Facebook or anyway you can think of to let everyone know that this procedure exists – it could save thousands, if not tens of thousands of lives. According to the statistic that Jan left in the comments, over 145,000

people are dependent on TPN. Many of these people will die, because a human can not live on TPN indefinitely . If you read my post on "The Effects Of Sugar On Arteries" and "The Truth About Soy", you will understand how TPN will keep someone alive, but is also killing them at the same time. People requiring full-time TPN will usually die within two years.

These people will die never knowing that there was a realistic option to live out their natural life. Living on TPN is a very poor quality of life – I know because I lived that way for more than six months. Besides the knowledge that it would ultimately destroy my liver and arteries, I suffered two systemic infections that nearly killed me. TPN is high in sugar and feeds both bacteria and fungus. The human body will not defend a plastic catheter, so the lines colonize with pathogens quickly – pathogens that are then flushed through the heart with the TPN infusions. An intestinal transplant is the only realistic long-term option for someone suffering with Short Bowel Syndrome.

These deaths are not just limited to adults and elderly. When I was at Jackson Memorial Hospital, there was an entire floor dedicated to the pediatric intestinal and multivisceral transplants. There were more children receiving these transplants than adults. There are children who are born with a birth defect known as "Short Bowel Syndrome". Some are born without much of their GI tract and some are born with their intestines outside of their body, which die and have to be removed. I seen toddlers who were getting full multivisceral (multi-organ) transplants. I met one young woman who was 18 years old when I met her, but was born without intestines and received a multivisceral transplant at the age of 8. Without the transplant, she would have never lived to the age of eighteen and she is still going.

I really don't get a tremendous amount of traffic at this site, so it is up to everyone to spread this vital information – information that could have saved Jan's mother's life or the

34-year-old man, had they found my site sooner. I have tried to contact a variety of talk shows, such as Ellen and Oprah, with absolutely no response. One letter rarely gets a response from these shows. If you have read my story and were amazed that someone could survive a full intestinal transplant (both small and large), please take the time to write a letter or email to some of these talk shows about it. Maybe if they were to receive a volume of letters they would feel this warrants some media attention. Feel free to send a link to my story (found here). I know of several other intestinal and multivisceral transplant survivors that would be willing to share their stories.

Even smaller internet venues seem to scoff at this story. I had contacted Jimmy Moore, who first agreed to interview me on his podcast over 6 months ago, but never followed up on his promise. I guess the 150th interview with someone who lost 20 pounds on a low carb diet is a more compelling account to Jimmy than someone who survived an intestinal transplant. He may be underestimating his listening audience – or maybe not. It's sad to believe that another Tom Naughton interview about "Fat Head" the movie, could be more vitally important than the news about someone left for dead being resurrected. News that could have easily saved a life, like Marlyn's, if we could get the information out there. Good luck Jimmy – hope you never need a transplant. I guess I'm not a big enough internet star to warrant his time. Funny how even a small amount of internet fame can go to someone's head real fast and to the point where they only want to suck up to other celebrities.

It's this starfucker mentality that keeps this type of information in the dark. Because I'm not famous, my story is irrelevant, because after all, only celebrities suffer, feel pain and need our help. Only a celebrity can be the arbiter of what the rest of us should be concerned about. Global warming myths and animal rights far out-trump the fact that people of little fame and wealth are dying unnecessarily.

None of the doctors, in two separate hospitals here in Orlando, had heard of intestinal transplants. As much as we'd like to believe that it is their responsibility to provide that information, they have chosen to ignore the call, so it is up to the rest of us.

It was my wife's tenacity and exhaustive research that led us to Jackson Memorial Hospital in Miami (one of a handful of hospitals in the world that have successfully performed this procedure). Most of the doctors here told me I was a fool for considering undergoing these transplants and that I had a small chance of survival. Actually, Jackson Memorial has over a 65% first year survival rate, so the odds were in my favor. I received my transplant over 2 years ago and am doing well – the doctors were giving me less than 2 years on the TPN, so I would have already been dead by now had I not have opted for the transplant. The fact that I suffered two deadly systemic infections during the time I was on TPN would certainly support the claim that I would have been dead by now. I was only approved for the transplant because I had nearly died twice from sepsis, due to the TPN line colonizing pathogens.

The longest living intestinal transplant patient is a woman who had her transplant over 20 years ago – and the medication and post operative treatments have been greatly improved since her operation, so my chances of living more than 20 years are better than hers. She is still alive and well. The young woman I met at Jackson in Miami, who was born without intestines, has now been alive for more than 11 years – that's 11 years more than she would have had without the transplant. She just graduated High School this year – amazing. Some other 8-year-old will not be so lucky and never see their graduation without your help. Any child living on TPN will die without a transplant – a senseless death strictly based on the doctors lack of knowledge about the success of the intestinal transplant programs at several hospitals across the United States. Here is a list of the hospitals that I know of

that have successful intestinal and multivisceral transplant programs.

University of Pittsburgh Pittsburgh Pennsylvania

Jackson Memorial Hospital Miami, Florida

Cleveland Clinic Cleveland, Ohio

Georgetown University Hospital Washington D.C.

UCLA Hospital Los Angeles, California

University of Nebraska Omaha, Nebraska

There may be others, but these programs have a high survival rate, especially The University of Pittsburgh, Jackson Memorial (in Miami) and the Cleveland Clinic. the University of Pittsburgh is where the first successful intestinal transplants occurred. Dr. Andreas Tzakis was one of the pioneers at the time and was working at the University of Pittsburgh. He has since established the intestinal and multivisceral transplant program at Jackson Memorial Hospital in Miami, so their program is equally as good as Pittsburgh.

It is easy to assume that the doctors know about this procedure and inform TPN patients of this option, but that is not the reality. Somehow, this life-saving procedure remains a secret to most doctors and hospitals. If you are reading this, you now know of a medical procedure that few doctors know are possible. It would seem irresponsible for doctors treating TPN patients, especially those who are failing to thrive, not to know about intestinal transplants, but for some reason, that's the reality. This is why I simply shake my head when people believe that their doctor is up on the latest research concerning any disease and why doctors continue to spout outdated advice concerning heart disease, diabetes or any other modern disease. Never trust that your doctor has all the answers. I know that many of you feel that's what you

pay the doctor for and just look to them for answers – that'll get you dead! You have to invest your own time in doing the research concerning your health. If my story, Jan's mother's story or the 34-year-old man's story is not enough to convince you not to place all your options at the discretion of your doctor, then you could well end up deceased long before your time.

The doctors were fine with letting me die on TPN, believing there was nothing more they could do. It was my wife's relentless research that discovered that the doctors were wrong or I wouldn't be writing this post. Not one of those doctors invested any time into doing the research. Even after my wife made the contacts in Miami, the doctors that were treating me attempted to talk us out of undergoing the transplant. While we were in Miami, the husband of the nurse manager told us of a dialysis clinic where the doctors hand out published pamphlets scaring patients away from getting kidney transplants, by exploiting all of the rare risks. Their motivation was strictly money. There is more money to be made by daily dialysis treatments, than curing the disease with a transplant. At over $200.00 a bag, TPN is also very profitable to the pharmaceutical companies, because a person with no intestines needs a bag everyday. While I was on TPN, the cost of medication, TPN and hydration infusions were costing over $500.00 per day! You can see why there is a motivation to keep those people on TPN.

Let's not wait until your favorite pop star, actor or politician needs a transplant to finally consider it interesting enough to tweet about it. You could help save countless lives by simply spreading my story. By all accounts, I shouldn't be alive. I am the closest thing to a walking miracle that you will find. Jan lost her mother due to complacency, please don't let the next person or child on TPN die because this subject is not sexy enough to pass on. The only way that the nightmare I lived through will have any

reason is if it can help someone else who is dying on TPN. Don't casually dismiss my story and think that this could never happen to you. You could be in an accident tomorrow and lose your intestines or you could be injured by a colonoscopy, like I was, and require an intestinal transplant to live. I am not selling anything at my site and I make no money from links sent out to my story – it's about saving lives. I would love to see more traffic come to my story, so I will know that the word is spreading and lives will be spared.

This deed will only cost you a few minutes of your Twitter time, but could certainly save a life or two. Trust me when I tell you that many doctors do not know about this procedure and are letting TPN patients die prematurely. Just take a minute and Tweet my story around. Better yet, take a minute to go to any talk show's website and shoot off an email with a link to my story. Making these transplants common knowledge will save lives of both adults and children.

Thanks,

Wolverine

How Common Are Medical Errors?

In my 30+ years as a contract artist I have provided services to a multitude of different industries which, more often than not, operate with an extremely high-efficiency. Errors are typically not tolerated for long, especially in the film, theme park and toy industries, where everything is on a rushed schedule. Other than government, I have never seen as many blunders committed daily as I experienced in hospitals. I'm not sure anyone outside of government or hospitals would stay in business long with such inefficiency. To illustrate what the iatrogenic rate would compare to when applied to other businesses, I refer to a paper published by Dr. Lucian L. Leape in his 1994 JAMA paper, "Error In Medicine". Leape calculated that the error rate in hospitals would translate to:

- Two unsafe plane landings at O'Hare airport per day
- 16,000 pieces of lost mail by the U.S. Postal Service per hour
- 32,000 bank checks deducted from the wrong accounts every hour

With industries of commerce, profits are at stake; in government and hospitals it's only human lives lost – the profits continue to roll in even in spite of rising failures.

It boggles my mind that our priorities can be so misplaced in this nation. Though I am an advocate of the capitalist model, I believe it has become quite perverted when commerce can be placed a much higher priority over the "life, liberty and the pursuit of happiness" promised in the earliest document signed by our nation's founders. The only reason that the medical industry continues to thrive within a flurry of errors and inefficiency when any other business would flounder, is because medical professional can collect fees irregardless of how miserably they fail. Few other businesses have that luxury.

America, being the only remaining superpower with leading technology, is only ranked 37th in health care on the world stage according to the last WHO ranking in 2000. In 2006, the United States was number 1 in health care spending per capita, but ranked 39th for infant mortality, 43rd for adult female mortality, 42nd for adult male mortality, and 36th for overall life expectancy, according to the New England Journal of Medicine.

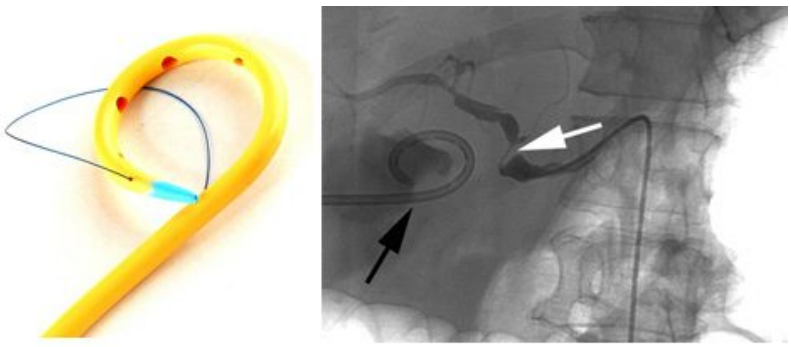
Anyone who has read my blog for any period of time knows about the royal blunder that started all of my problems – an injury from a colonoscopy and the inability of the doctors to diagnose the problem for the three days I was in critical condition. The excessive delay in treatment ultimately cost me all of my intestines and should have cost me my life. But the mistakes and negligence didn't stop there – far from it. In this article I will give some of the accounts of avoidable mistakes made by doctors and nurses that should have taken my life had my wife, sister or I not intervened. Prepare for a very long article. Rather than listing a lot of random statistics, I felt that personal stories may have more impact. Because of the high frequency of errors, I have listed a lot of them. Everything that follows happened in less than a 12-month period of time, between September 2009 to September 2010 (with the exception of the reversal which was January 2011).

I hope you find the stories interesting enough to read them all. These are only the life-threatening mistakes. I could write volumes if I listed all of the clerical and non-life threatening mistakes.

Medical Errors Made On Wolverine

- September 20, 2009 – It didn't take long after the first mistake before the second took place. The surgeon failed to get a pathology on the bowel tissue remaining and left a section of necrotic tissue inside of me (he even wrote in his surgical notes that the tissue appeared compromised, but used it to form a stoma anyway). Even in light of an obviously dying and inactive stoma, he continued to ignore all the signs of sepsis for 5 days. As a result, the necrosis spread to the existing jejunum and I succumb to septic shock and seizures. At this point, I still had enough small bowel to possibly live on and not require a transplant. But because he left some necrotic tissue behind, I was ultimately rushed in for surgery for a second time. All of the remaining small intestines had to be removed, giving me a very remote chance of survival. This became less inexcusable when I later discovered that this same surgeon had been reprimanded by the Florida Medical Board and had his license revoked in California less than a year earlier for doing the exact same thing – only in that case it did cost the patient their life. Until now, I didn't know that hospitals could hire surgeons who had their license to practice revoked in other states nor was the hospital required to inform the family of that fact. Certainly my family would not have let that surgeon work on me had they been given that information. I plan to cover this in great detail in a future post.
- On November 18. 2009, I was admitted to the hospital for a fever. Blood cultures revealed a gram negative blood

infection called; Enterobacter cloacae and CT imaging showed an abscess in the abdominal cavity. In these cases, use of the infusion port should always be suspended, because it is often found to be colonized quickly from a blood infection. (the human body does not defend a plastic catheter the way it would the arteries). The nurses continued to access the mediport for two days to infuse TPN and antibiotics, thereby flushing the infection straight into my heart where it was circulated throughout my system. The high sugar, vitamin and mineral content of TPN feeds pathogens and increases their rate of reproduction. The gram negative infection was later found to be colonized in the port catheter, and as a result of using the port, I was sent into septic shock with severe rigors, a temperature of 105.8º and a resting heart rate in excess of 198 bpm (I was at very high risk for cardiac arrest). I was rushed to surgery to remove the port and then sent to the ICU, where I was place on pressors to elevate my crashing blood pressure. This mistake could have possibly killed me. Septic shock is often lethal and I was lucky to survive.



Pigtail Catheter

- On November 29, 2009, while still in the ICU, a pigtail drain had been surgically implanted in my abdomen to release the infection from the abscess. The drain line was evidently annoying the night nurse, so she decided to place tape around the line and pin it to my gown while I was sleeping. She forgot to unpin the line or

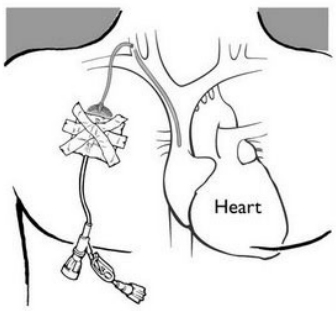
inform the day nurse who replaced her. The day nurse came in to change the gown and violently ripped it off of me and rushed out the door to get a new gown. The last thing I remember seeing was the pigtail end of the line flying through the air and knew I was in trouble. Besides being extremely painful, I was rushed back to interventional radiology to have the drain replaced before the wound closed with the infection inside. It took a tremendous amount of force to withdraw that pigtail from within my abdomen *(the pigtail is designed to prevent it from coming out and requires a surgical procedure to remove)*. A nurse once told me the story of a man who accidentally stepped on his line while standing up from being seated on the toilet. The catheter was ripped from his chest, tearing a hole in the superior vena cava and he bled out before they could get him to surgery. The force needed to pull out that pigtail would have been plenty enough to tear the port from my chest.

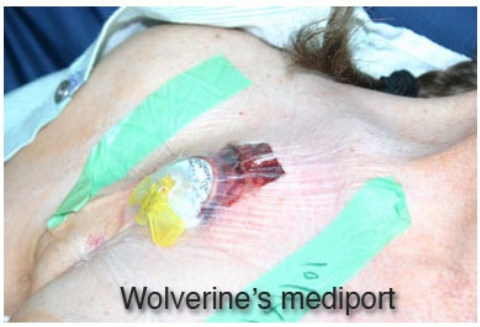
- By December 3, 2009, after two weeks of very aggressive antibiotic treatments to kill the bacteremia, my sister requested that the infectious disease doctors administer a prophylactic treatment of antifungal agents. She predicted that I was at high risk for a fungal infection because so many of the probiotics *(many of our good bacteria protect us from fungal overgrowth)* had been destroyed by the antibiotics. The doctors argued and refused the treatment. One of the doctors actually said that I was not at risk for a fungal infection because; “men do not get yeast infections – only women do”. This is just one of many experiences where I learned that doctors are not necessarily very smart just because they’re educated. I was released from the hospital and was not home for more than two days before my fever would skyrocket again. We opted to make the longer trip into Orlando to admit me to a

better hospital, because we refused to ever go back to a hospital (South Lake Hospital) where doctors don't know that candida can breed in places other than vaginas.

- On December 7 2009, I was admitted to the other hospital. We explained to the ID doctors what had happened and why we believed it was a fungal infections. As usual, the doctors rolled their eyes and ignored what we said *(typical cynical nature of doctors to believe whatever the patient says is always wrong)*. Of course all cultures for bacteria came back negative *(duh, little surprise given the two weeks of massive antibiotics I had just had)*. It took us three days to finally convince them to run fungal cultures and of course, they came back positive for a systemic candida infection. Systemic candida infections are the single most killer of TPN patients, because the fungus thrives on the high sugar content of the TPN and these ID doctors just wasted five days *(it takes several days for the cultures to grow and fungal cultures take longer than bacterial)* because they refused to listen to us. It was hardly rocket-science, as fungal growth had already become apparent around the follicles of my facial hair. At this point, we didn't feel like we were in any more competent hands than at South Lake. Whenever the doctors suspended the use of the port, my condition would improve. As soon as they began using it again, my fever would spike to over 105º F. It was pretty obvious to even a novice that the port was infected, but the doctors refused to remove it because they claimed the port continued to test negative for candida. After several weeks of this, my wife asked how they could have possibly tested the port because there was a clot in the line and the nurses were unable to draw blood from it? Instead they were drawing blood from each arm and telling me that was equivalent to a port draw. It turns out the nurses were reporting the

right arm draw as a port specimen and sending it to the lab. They continued to perpetuate this lie for more than six weeks, while I continued to suffer the deadliest sepsis known to TPN patients. Upon my wife's insistence, the doctors questioned the nurses and learned what they had done. A heparin lock was performed on the line to clear the clot and a successful draw was achieved. The cultures came back positive for a massive candida colonization. This bone-headed chicanery from these lazy nurses could have easily cost me my life. The nurses simply did not want to take the time to perform the heparin lock and defrauded the paperwork. Of course, no disciplinary action was taken on the nurses involved. As a result, I spent over six weeks with a sepsis and was sent home with the infected port a couple of times, only to return a day or two later with a high fever. In Jackson Memorial in Miami, the doctors have a policy to immediately remove any and every port or PICC line if a patient is presented septic and will not wait for a pathology and culture, which can take days. I believe this is a much better policy that all hospitals should be forced to adopt.





- During the same stay in that hospital, around December 12, 2009, a night nurse once entered the room late one evening to hang the TPN. She was very hurried because she had showed up late for work and was behind schedule. She quickly primed the line and attached it to the lead from my port, then realized that she had forgotten to place the in-line filter between the pump and my port.

We were a bit confused, because she had an extremely thick asian accent and kept calling it a “pilter”, so we had no idea what she was talking about. She finally grabbed a filter, which comes out of the package with about 2 feet of line. She placed the line between the pump and my port catheter. She began to reach for the start button on the pump. My wife yelled to her and grabbed her hand. In her haste, she had not primed the new line and would have pumped the entire line full of air directly into my heart had my wife not stopped her. Remember, I had a port catheter that delivered the infusions straight into my heart as shown in the image above. An air embolism in the heart is a quick ticket to the grave (think of the Bends). Had she started the pump, I would certainly be dead. I seriously doubt my death certificate would have reported the error had my wife not been there. My death certificate would have probably read: “cardiac arrest due to sepsis”. This is an example of how quickly you can die from an accident from a sloppy nurse and just how awesome my wife is. The anal retentiveness of my wife can be trying at times, but while I was in the hospital it saved my life on many occasions.

- December 24, 2009 – The doctors had ordered an ethanol lock to be performed on my port line, because doctors were still refusing to remove the port. In this procedure, ethanol is injected into the line and it is capped and locked for several hours to sterilize it. It is later drawn back out and is not intended to ever be infused into the patient. The line had been fitted with a red cap and then taped over and labeled; “do not use”. A nurse entered to administer medication. Rather than detach the other lead from the TPN to inject the medication (it was a two lead port), he removed the tape and the red cap and attached the syringe to the line. My younger sister asked him what in the hell he was

doing? This line had been capped because it was infected. A red capped line should have never been used. Had this been a heparin lock, he would have pushed the high dose of heparin into my heart. Any nurse should know that a red cap means not to use.

- After my transplant, on March 23, 2010, all of my future hospital stays would be restricted to Jackson Memorial Hospital in Miami. I was released from the hospital on May 7, 2010, after my transplant, but was not allowed to leave Miami. I was sent to a place called the Transplant House across the street from the hospital. On May 12 2010, I came down with a fever (I had been infected from an ileoscopy two days before). I was rushed into the ER by ambulance with a serious sepsis and was literally beginning to flatline. I was hurried to the SICU where my blood pressure had reached 35/28 and I was in shock. While being intubated, my right lung was perforated and collapsed, making a critical situation even more severe. Lung punctures during intubation is very common and not actually a mistake or error, but a known risk of the procedure. I am not listing this as an avoidable error but only to preface the next point on the list which was quite avoidable.

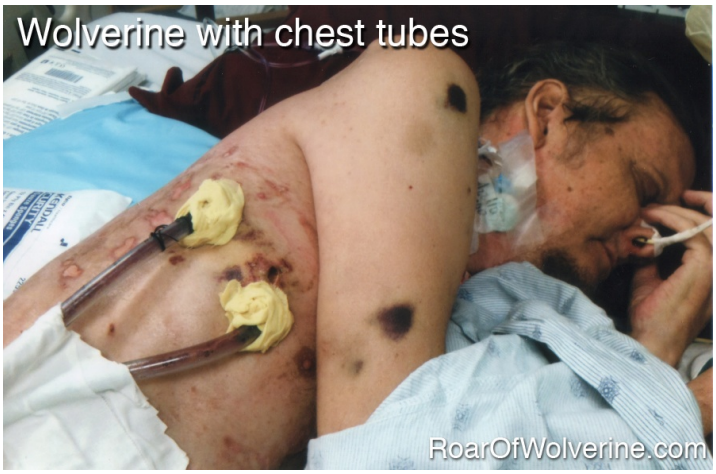
- The error came in the following days. I was placed into a drug induced coma between May 13, to May 27, 2010. I continued to come out of the coma fighting for air. My wife insisted that I was not able to breathe, but the nurses confidently claimed that I was just fighting the respirator. To appease my wife, they took x-rays of the lung and claimed that the lung appeared completely inflated and all was fine. I continued to come out of the coma and attempt to get out of bed fighting for air. My wife continued to insist that a CT be performed because the water on the chest tube canister was no longer showing bubbles, but the doctors thought it would

be too much trouble to transport all of the gear and life support I was hooked to down to radiology. Her persistence paid off and the doctors finally ordered the CT imaging on May 23rd, one day before I was scheduled to get a tracheotomy. (If a patient is unable to come off a respirator within a couple of weeks, they are required to have a tracheotomy placed). The CT revealed that the pneumothorax was behind the lung and the lung was being crushed from the back to the front. In a two-dimensional x-ray the lung appeared full, but in the 3 dimensional images from the CT it was as flat as a pancake. The three ineffective chest tubes that had been placed were removed and a proper one was finally placed. The lung inflated and I was able to have the respirator removed. A pneumothorax is a life threatening condition and yet I had to survive one for more than five days because of this mistake (It's a wonder I'm still alive).

- While I was in the coma, between May 13 to May 27, my wife was at my side the entire time. At one point, my monitor began to alarm because I had stopped breathing (I had the collapsed lung at the time). My wife looked around for the ICU nurse and he was nowhere to be found. ICU nurses are not to leave critical patients unattended for any reason. She had not seen the nurse for over an hour and was frantically calling for help, but none came. She finally had to run from the SICU (where I was) and over to the ICU and grab a nurse, who then came over, bagged and resuscitated me. (at that point I was clinically dead for a few moments). The original ICU nurse did not return for more than another half hour. My wife had seen my SICU nurse over in the ICU standing around chatting with some other nurses while I was dying. She removed that nurse from my service forever. Had my wife not been there, I would surely have become permanently dead. To my knowledge,

no disciplinary action was given to this nurse, who I'm sure is still working in the SICU. I wonder how many patients he will have to kill before someone advises him to seek a new career?

- On July 2, 2010, I underwent a lung resection to fix the pneumothorax, I was in ICU recovering the day after the surgery. Some ICU doctor walked in (I had never seen him before) and told me he would be back in a few minutes to lance the abscess on my back. I wasn't aware of any abscess and refused to allow him to touch me until I had spoken to the surgeon. He was very insistent, so I asked him to leave the room. Later, when the surgeon stopped by, I asked her about the abscess, which she claimed was a hematoma at the point of the surgical incision (surgery was done through a scope, similar to laparoscopic). She also added that had he lanced it, the infection would have made a straight path to the lung she had just operated on. The only entertainment came when this diminutive woman (5'4″) took this six-foot doctor out in the hall and gave him a verbal spanking he will never forget. Most people would have probably permitted him to go on with the procedure, and I might have many months earlier. By this time I had become quite suspicious because of all the errors I had encountered. This was all post transplant, so I was on immunosuppressant medication and an infection in that lung could have been lethal. To this day I don't know who that bozo was, just some ICU doctor that wanted to do an unauthorized procedure on a post operative patient. This goes on a lot in ICU. The ICU doctors have little regard for the surgeons and other doctors, so never allow them to administer non-emergency procedures on you without first consulting your doctor or surgeon.



- On July 14, 2010, I had been released with a chest tube still implanted. They cannot release you with a chest tube still attached to the rather large container it drains into. So they replaced the container with a device called a Heimlich Valve on the end of the tube, which allowed the release of fluid, but would not allow anything to back up into the tube. *A funny side note: The hospital typically used a surgical glove taped on the outlet, but I found a standard party balloon fitted with a rubber band worked better and was easier to change (the Thoracic surgeon thought it was ingenious and now recommends it to all chest tube patients). Whenever I would begin to cough, the balloon would blow up. My sister had bought a bag of balloons with smiley faces on them. I began having a coughing fit in the waiting area at clinic and this bright yellow smiling face balloon inflated so big we were afraid it was about to pop – which would have slung all of the infected fluid and pus on everyone in the waiting area – it was sort of frightening and funny at the same time.* But on to the point of the deadly error. On August 31 2010, my wife noticed that the valve seemed to be hanging very low when I exited the shower. It was normally at my mid-thigh level and now it was below my knees. My wife immediately rushed me to the ER and it was late in the evening and my surgeon was not available. Two of her assistants were on duty and came down to the ER to look

at the tube. One of them grabbed hold of the tube and braced himself against my body. He was obviously preparing to push the tube back in. My wife and I both simultaneously asked if they had lost their minds! Pushing that tube, which had now been exposed to every germ in that ER where I had been waiting for the last hour, back up into my pleural cavity would be suicide, especially in an immunosuppressed patient. They continued to insist it was safe and the right thing to do, but we stood our ground and not only refused, but asked them to leave the room (you can do that by the way, I don't think most people know that). The next morning, the thoracic surgeon came in and removed the tube and told us we were right in stopping them from pushing it back in. She agreed that pushing that filthy tube back inside of me most likely would have caused an infection, which in my case could well be deadly. No new tube was placed. To every doctors surprise, I didn't go into respiratory distress, because obviously the hole in the lung had healed prematurely (my Wolverine powers at work).

- The final deadly mistake I am going to list concerning myself happened a year later on January 14, 1011, when I went to have the ostomy reversal. Every intestinal transplant patient is required to have an ileostomy for the first year following the transplant. They leave the colon and ileum separated, so the colon is not in use for the first year. The only reason they do this is so they can scope inside the ileum for signs of organ rejection. It was now time for my bowels to be reconnected, which meant I would no longer have an ostomy bag and would be normal once again (take a dump like everyone else). Shortly after the anesthetics wore off from the surgery, I began to experience a tremendous pain deep within the incision. By now, I had enough surgeries to know the level of pain to be expected and

this was far beyond the typical pain post surgery. I was given a shot of dilaudid, but it wouldn't touch the pain. I buzzed for the nurse and she went looking for a doctor. Instead of listening to me, the surgical assistant she found began to lecture me about pain-killers – even though I had not requested more pain-killer, but was inquiring why I still had so much pain even after the pain shot (typically dilaudid, which is about 8 times more powerful than morphine, can knock out any pain – and if it doesn't, you have a serious problem). Rather than investigate, he continued to lecture me and my wife and accused me of having a low-threshold of pain. His attitude was extremely cynical, which really angered me because it was that exact same attitude that the doctors gave me which cost me my intestines in the first place. They also never investigated to find the source of my pain (which was from ischemic and dying bowels) but allowed me to suffer for three days while telling me I had a low threshold of pain. Had I not been incapacitated by the intense pain, he would have been incapacitated because I would have leaped out of the bed and beat the living shit out of him. Instead, I yelled to the nurse to remove him from my room and never allow him back in (you can do this – I did) and get me a competent doctor. I guess the racket I was raising drew the attention of the Fellow who had assisted in the surgery and he entered the room. Rather than leap to the theory I was simply a wimp, he suspected there actually may be a problem and instructed the nurse to bring him a surgical kit and reopened the incision. We were all shocked when he withdrew a 4 x 4 piece of gauze which had been sewed into me. The gauze was extremely infected and he immediately irrigated the wound. By this time, a large bulge was noticeable on my side. It looked like I was pregnant over on the right side of the wound. Cellulitis had set in and I had to spend an extra week in the hospital on antibiotics to

clear all the infection. Being an immunosuppressed patient, any infection has the potential to kill me. How I survived these type mistakes is beyond me. Unfortunately, many of the friends we made there were not so fortunate and died from similar mistakes.

- I would like to list a medical error that happened to a young woman we met, who had lost nearly her entire digestive tract to Crohn's Disease. Onset of the disease began when she was only 9 years old. When we met her, she was 26 and had undergone over thirty surgeries, which ultimately left her with no intestines. She required a six organ multivisceral transplant and was so small, that her donor had to be a 6-year-old child who had passed away. From so many years of living with Crohn's and all of the resulting fistulas, she required very high doses of methadone to control her pain. A doctor once told us that the doses of methadone she received would kill a normal person, but she had built up a resistance to the drug. After her transplant, a night nurse came into her room to hang her medications. Her intestines were not yet working well enough to absorb the prograf (the anti-rejection medication all transplant recipients require) orally, so it was being infused intravenously. Prograf is a highly toxic drug to the organs, especially the kidneys. If we don't take enough, we will die from organ rejection and if we take too much we will die from toxicity. Her nurse screwed up and hooked her prograf and methadone to the wrong pumps. She set the methadone to infuse at 10 ml and the prograf to infuse at 100 ml and then left the room. The young woman awoke initially because she was not getting enough pain medication and buzzed for the nurse for her pain. Of course the nurse immediately began lecturing her on the dangers of pain-killers and accusing her of being an addict and all the other cynical crap we must deal with when we're in pain in a

hospital. Had the nurse investigated before launching onto her soapbox sermon and fumbling for her DEA badge, she may well have noticed her error sooner. An error that could have cost this girl her life and has certainly damaged her kidneys beyond repair. As a result, she spent the next three days with profuse vomiting and dehydration.

High Risk Decisions Derived From Power-Plays

There are some deaths due to power struggles between doctors. There are times when a doctor will simply flex their professional muscle and usurp the consensus of other doctors, just to exercise their power to do so. Medicine is not a democracy in a hospital. There are certain legendary doctors who can override the diagnosis or treatment options decided by even a team of doctors. It seemed at times, that some of them did it just to prove they could. The reason it felt this way was because they would not consider or examine any of the evidence or concerns given by the other experts, who were more involved in the case, but simply fly in and make a decision and force it to be carried out, even at the protest of the other doctors. You, as the patient are the only one who have the power to override the super-doctor. Chances are, if several other doctors disagree with superdoc's decision, you may want to reconsider his suggestion and opt for the treatment decided upon by the doctors more familiar with your case. Here are a couple of examples.

- This same young lady who had the Crohn's Disease once received several doses of thymoglobulin, rather than campath for an organ rejection issue. The thymoglobulin started a series of seizures, ultimately ending in a grand mal seizure which cause her to become blind in her right eye (thymoglobulin is notorious for creating seizures). It also created a lesion on one side of her brain. She sustained a lot of organ and brain damage from this decision, not to mention the blindness in her

right eye. The reason I list this is because the decision stemmed from a power struggle between two competing surgeons. Surgeon B knew that the standard treatment for such rejection by surgeon A would be campath. He took advantage of it being a weekend when surgeon A was not on-call and decided to try an older, less aggressive approach by ordering the thymoglobulin. I too had been caught as a pawn in their chess game when surgeon A's order for tobermycin usurped the requests from the ID doctors and thoracic surgeon, but more importantly – it overruled the competing surgeon B's suggestion.

- There was a gentleman who had many complications from a liver transplant because he also suffered from severe diabetes. Because of his diabetes, his stomach had shut down and was no longer working. He was also fighting a systemic infection from an obstruction in one of his bile ducts, where a stent had been improperly placed. All of the doctors agreed that the safest course of action would be to feed him with TPN infusions until the infection could be cleared. Their decision was overruled by the chief transplant surgeon who insisted that a stomach tube to be placed. The other doctors protested because all of his visceral organs (pancreas, spleen, liver, etc.) were inflamed, making the high risk procedure many times more dangerous. The spleen was infected and as a result, his blood platelets were below 30 (normal range 150-400), making him a high risk for bleeding. The chief surgeon convinced his wife to sign for the procedure and his liver was perforated. He began to spontaneously bleed internally and continued to decline for several weeks before the decision had to be made to remove him from life support.
- He was one of two of our friends that died from infections acquired from perforations. They both died

very slow, painful deaths, which took many months and the slow shut down of organs. Both ultimately had to be removed from life-support before perishing. There was a lot of debate and power-plays instigating the final decisions to perform the high risk procedures. Many of the same type of mistakes I encountered had happened to them, according to their families – the only difference was they didn't survive them, whereas somehow I did. But I never lose sight of the fact that I could have just as well suffered the same fate and taken much more damage to my other organs.

- I did suffer damage to my kidneys as well as my hearing as a result of a completely unnecessary treatment of a very dangerous antibiotic called Tobramycin (both nephrotoxic and ototoxic) started on September 10 2010. After my lung resection, Pseudomonas was found in the fluid draining from the chest tube. The thoracic surgeon and every doctor from infectious disease refused the use of this medication. They said that the infection was isolated to the pleural cavity and was little threat of going systemic and the drain was adequate. Because of the destructive nature of this highly toxic antibiotic, it is better reserved as a "last resort" medication, rather than a prophylactic. They didn't want the pseudomonas to become resistant to the tobramycin, so it could still be of benefit if the bug ever did go systemic. But the chief transplant surgeon (a rock star of the surgical world) who personally performed my transplant and is treated like a god in that hospital (for good reason, he has performed more transplants than any surgeon in the world and was one of the pioneers of intestinal transplants), overrode the other doctor's opinion and in a panic, ordered the medication to be administered for eight weeks as a prophylactic. I finally refused the treatment after the first week, on September 14th,

because my entire face and throat went numb and the ringing in my ears was so bad that I couldn't sleep. The medication was stopped and I healed just fine, so the usage was completely unnecessary and had I have gone the entire eight weeks, I'd be completely deaf and would have suffered total renal failure.

- I had taken over 55% hearing damage in both ears and the ringing was driving me insane (this was really upsetting because I am a musician). My wife did some research and found a doctor who had a treatment for damage sustained by tobramycin, which had been successful if applied soon after the event. The problem was that the equipment necessary for the procedure could not be transferred to the hospital, so I couldn't undergo the treatment until I was released from the hospital and everyday I didn't get treatment, the deafness became more permanent. I was finally release a week later and was able to get the treatment which was miraculous to say the least. Unfortunately, the procedure required three steroid shots directly into each eardrum (6 in all). He would only do one ear at a time, because of the risk of causing me to go completely deaf and the severe vertigo following the procedure. It took six appointments to get all of the treatments, but my hearing is near normal again and the ringing is very minimal. After getting just one of those painful shots in the eardrum makes it very difficult to line up to get five more. That was a dreaded three weeks. We did meet a woman who had gone completely deaf as a result of this medication.

- The damage I sustained to my kidneys is irreversible, which puts me at a huge disadvantage because the prograf I have to take is known to damage kidneys over time. Because of the doctor's knee-jerk use the tobramycin prematurely (and against the advice from all other doctors), I could eventually need a kidney transplant at

> some time in the future. Had I continued the eight weeks he prescribed, I would have already been in need of a new kidney and probably be on dialysis at this time. *Kidney transplants are a much easier and less risky operation, but many people die waiting to get a kidney. Because kidney transplants are so common and so many hospitals perform them, the supply is much lower than the demand and you can be on the waiting list for years. Only six hospitals in the world are capable of performing intestinal transplants, so I was able to get an organ after only six days of being on the list.*

It seems that a lot of the errors and delay in treatment today stems from an excessive amount of cynicism that many doctors and nurses have regarding patients and pain medications. I will cover this in further detail in my post; "The Cynical Attitude Of Doctors". There also seems to be a lot of mistakes that stem from cynicism that doctors have towards each other and the competition that arises as a result.

We can see that medical errors are quite common and not as rare as most people would believe. Aside from the notes on the young lady and the other unfortunate gentleman, these are all errors that happened on just me. I could write an article ten times longer if I wanted to included all the errors that happened to others that we met – some died as a result. Medical errors are in fact the third highest killer of people in the United States and that is only based on the mistakes that are reported. I do not believe that any of the mistake that I listed here were ever reported, because no one forced them to be. If we could include all of the mistakes that go unreported, medical errors could well rival, if not surpass, pharmaceuticals as the number one killer of human beings in the U.S.. If you tally them all together (drugs and errors), hospitals are without a doubt the biggest killer in America. [source] It kills more people than AIDs, breast cancer, and automobile accidents.[source] Each year in the U.S. there

are:

- 12,000 deaths due to unnecessary surgeries
- 27,000 deaths due to medical errors (that's only what's reported, I'm sure it's much higher)
- 80,000 deaths due to hospital borne infections (many of these are due to sheer sloppiness by the staff)
- 106,000 deaths due to negative effects from drugs

The source for this is found here.

Another note on the 80,000 deaths due to infections. It was all too common that my wife or I caught nurses attempting to access my port line without first cleaning it. Port leads dangle from the patient and make contact with the bed sheets, patient's body (often time in their armpits) and all of the transplant patients had ostomies that could leak intestinal contents (crap, stool or whatever you want to call it) onto the bed where the leads were lying. Hospital protocol, set forth by infectious disease experts, demands that the lead be scrubbed with chlorhexidine wipes for a minimum of thirty seconds – because it is not just the chemical that destroys organisms, but also the heat generated by the friction of aggressive scrubbing. There were some occasions that nurses would attempt to access without cleaning the lead at all and when they did clean them, it was just a single quick wipe – not the 30 second scrub required to sterilize it. If you are a patient, don't feel like you are being a pest by pointing this out and demanding that it be done properly. Infection is the 2nd largest killer in hospitals. These rules are always posted around the hospital by law, so that the patients can understand and recognize when a nurse or tech fails to follow them.

A few times we asked a nurse why they were about to access a lead without cleaning it? There were a couple of the nurses who tried to fly the excuse that they didn't have any of the chlorhexidine wipes on them at the time – offered as if that

was acceptable. My wife always kept a supply of them in the room so she would give those nurses (who thought my life wasn't worth their effort to walk back to the nurses station to get the supplies) no excuse for killing me in their haste. Hospital borne pathogens are some of the deadliest on earth, because they have been exposed to so many disinfectants and antibiotics that they have become resistant to nearly everything. Hospitals inadvertently breed superbugs.

I will admit that nurses work long hours (usually a 12 hour shift) and most hospitals are under-staffed with nurses, but these are humans lives we're talking about and hospitals make plenty of money to hire more nurses. There have been multitudes of studies that have proven that an employee's efficiency at their job begins to decline after an eight-hour shift [one study]. Other businesses that operate around the clock break shift rotations down to 3 eight hours shifts for this reason, but hospitals use two 12 hour rotations. Again, I will reiterate that those industries of commerce have profits at stake, whereas hospitals have only lives that can be lost to the mistakes of a tired and frustrated employee.

You can see why it is so important to have a loved one by your side. The patient is sedated (heavily drugged), confused and in pain most of the time and it is impossible for them to be attentive to everything going on around them. Nurses enter the rooms at all hours of the night and access PICC and port lines while the patient is sleeping. My wife slept in a chair in my rooms for nearly 14 months. There were other transplant patients who had family members stay in their rooms (mothers, wives, husbands) and there were some whose families left them entirely in the hands of the hospital staff so they could continue on with their careers. All of the ones who were left on their own also died. The ones who had family members all survived (except one) and those family members had similar stories of near fatal mistakes made on their loved ones that they had averted by being there. Those family members also

declined many unnecessary and risky procedures that were offered by doctors. A heavily sedated patient may sign a paper authorizing a procedure that they otherwise wouldn't sign in a less stressful or sedated state. If you have no surrogate and are incapacitated (coma, sedated, etc.) then it only takes two doctors to agree that a procedure is necessary to legally perform the procedure. Don't believe that crap that your loved ones are in capable hands when left alone in a hospital – they're not. Yes, these professionals are competent in their training, but too often become complacent and sloppy at the end of a long shift.

Why does this one occupation seem more prone to errors than all others? It is because they have a greater protection under the law and are held less accountable for their actions than any other individual citizen of this nation. If anyone else had the legal impunity that medical practitioners have, they too would dissolve into the giant mess that modern medicine has become.

I have covered this very subject in a recent post entitled "Malpractice Law: Reserved For Only The Frivolous" where I hope to illustrate how the laws are constructed to make it nearly impossible to bring an action against a doctor or hospital and just how low the limits on damages are set as a deterrent to anyone who would seek to bring an action against anyone in the medical profession. I am not an advocate of increasing the amount of lawsuits against medical professionals, but reducing them properly. The way the laws are presently designed perpetuates the smaller, less significant malpractice cases and deters the catastrophic cases from being sought. It is exactly the opposite of what it should be and in fact promotes more frivolous lawsuits, which I will explain in further detail in the upcoming post.

Another reason for the quantity of mistakes is because doctors get paid even if they fail at their diagnosis or treatment. If a plumber puts in a toilet and that toilet doesn't work, I

have every right not to pay him. The doctors that failed to diagnose the problem and cost me my intestines still got paid. I cannot think of one other occupation, other than government, that can still expect to be paid when they fail so miserably at their job. In my occupation, I risked forfeiting payment if I didn't complete the job by a particular date, much less totally failing at the task.

A third reason for the elevating errors in medicine is something I have only recently learned of. Doctors who have their license revoked in one state can have a license to practice granted to them by another state. I do not see why a state medical board cannot be held accountable for the mistakes committed by a doctor that they allow to practice, who had lost their license in another state? This is a bad filtration system for sifting out the untalented doctors who should probably seek another career. I cover this in much greater detail in my post entitled "Is You Surgeon Licensed? Are You Sure?".

It is not my goal to simply trash the medical profession, but an attempt to improve it. There were many very competent surgeons, doctors and nurses who worked very hard to save my life and without their dedication, I would be deceased. It just appeared that there were a disproportionate population of incompetent, lazy and sloppy practitioners who made the job of the competent medical professionals that much harder. It was bad doctors that screwed me up in the first place and it took stupendously talented and dedicated doctors to put me back together. If these errors could be minimized, there is no reason that the U.S. is not the leader in health care. If these practitioners were held more accountable for their mistakes, we would see a reduction in needless deaths and injuries.

I hope you will return to read more of these posts, or better yet, subscribe to be notified of new posts. I had to endure and survive a lot to bring you this information that few are

willing to expose. I hope that you will take it in the manner in which it is presented – with your health and safety in mind. It is my hope that through this truth in information people will be better prepared and aware of the dangers that lurk within the U.S. medical system, so you can better protect yourself if you become in need of medical treatment. If you do not become your own advocate and understand your rights as a patient, your chances of survival decrease dramatically. Stay healthy, please.

The Effectiveness Of Colonoscopies On Cancer And IBD

In part one of this series, I illustrated just how common that injuries and death are from colonoscopies, which is far greater than the doctors and the media have led you to believe. Yet, those in the medical industry and media often like to claim that colonoscopies have saved thousands of lives, so the benefits outweigh the risks. Is this anymore accurate than their claim that injuries are rare?

The two most common uses of this procedure is for cancer screening and diagnosis of Inflammatory Bowel Diseases. I will cover each separately starting with:

The Efficiency Of Colonoscopies for Cancer Screening

How effective is this procedure for early detection of cancer and is polyp removal (polypectomies) successful at arresting

cancer?

1. According to the American Cancer Society, up until 2009 "…there are no prospective randomized controlled trials of screening colonoscopy for the reduction in incidence of or mortality from colorectal cancer."

Here we see that few studies have been done to back the ridiculous claims of thousands of lives being saved. Let's look at a few that I could find.

1. The Minnesota Colon Cancer Study, which ran for 18 years and included 46,000 patients between the ages of 50 to 80, demonstrated only a 0.6% reduction in the incidence of colorectal cancer. This is a statistically insignificant amount. (*If you've heard greater risk reductions than 0.6%, you are not being lied to, but are receiving the relative risk as opposed to the absolute risk. This is a notorious "slight of hand" used by researchers and pharmaceutical companies to make their findings appear more relevant. An absolute difference is a subtraction; a relative difference is a ratio. The difference of a 0.2% to 0.1% drop would translate to a 50% reduction in relative terms, but in reality is quite insignificant. For more on relative vs. absolute statistics read here. Once you understand that difference, you will realize just how ineffective many drugs and treatments actually are compared to what you have been led to believe.)*

Here is the overall observation:

1. Despite tens of millions of colonoscopies performed between the years 2000 and 2007, the annual incidence of colorectal cancer in the United States INCREASED by about 30,000 more cases.

Any other product, outside of the medical industry, would be abandoned and forgotten with such a dismal rate of proven success. Yet, to hear Katie and others in the media tout this

procedure as the greatest life-saver since the polio vaccine, makes my blood boil – especially being a victim in its profitable wake.

Certainly the removal of polyps have saved many from developing colorectal cancer? Look at all of the millions of polyps that have been sliced out of colons since the advent of colonoscopies. The claim is quite impressive, but how has it actually played out on the world's stage?

From an article in the New York Times, dated 2006; "The patients in all the studies had at least one adenoma detected on colonoscopy but did not have cancer. They developed cancer in the next few years, however, at the same rate as would be expected in the general population without screening."

Another research study published in 2006 concluded that the screened patients in all of the studies developed colorectal cancer "at the same rate as would be expected in the general population without screening" in the next few years, even though all found polyps had been removed.

If polypectomies were as effective as advertised, and given the fact that about half of americans past age fifty get screened, we would have expected to see the incidence and mortality of colon cancer dive to a 45-50% reduction in mortality. Instead, we have seen a 22% increase. This increase could well be associated with the removal of the polyps themselves. Removing a polyp releases cancer cells into the bloodstream, spreading the cancer at an accelerated rate to other organs.

The result of the Telemark Polyp Study 1 highly supports that theory. Although there was a 2% reduction in colorectal cancers in the screening group that had polyps removed, they had a 157% higher mortality from other causes than the control group. The "all cause" death rate was significantly higher in the group that was screened. So, you may die prematurely, but

at least you will die knowing that you have no polyps in your colon while being embalmed. If being a polyp free corpse is all that's important to you then, by all means, get the colonoscopy.

Most people will live their entire life with colon polyps and never develop colorectal cancer. An estimated 95% of all polyps are benign. They will never become cancers, so removing them and claiming victory over cancer is as fraudulent as cutting every mole off of everyone and boasting that you saved them from melanoma. Removing a benign polyp creates and open wound within the dirtiest organ of the human body. You might as well slice open your finger and stick it into a septic tank or gas station toilet.

The large polyps most commonly removed via colonoscopy are rarely a cancer threat. By far, the largest portion of colon cancers start from flat lesions, which are usually never found or removed with colonoscopies, even though they are considered five times as cancerous as large polyps [source].

The National Cancer Institute's report suggests it is closer to ten times higher: *"In a study in which endoscopists used high-resolution white-light endoscopes, flat or nonpolypoid lesions were found to account for only 11% of all superficial colon lesions, but they were about 9.8 times as likely to contain cancer (in situ neoplasia or invasive cancer) compared with polypoid lesions."*

If colonoscopies are so ineffective at discovering cancer in early stages, why would this procedure be recommended as a proven prophylactic and diagnostic tool for cancer? It can only be driven by the extreme income potential, not only to the doctors, but to the manufacturers of this device that costs in excess of $28,000.00. This should be reason enough to hear a public outrage, but add in the fact that people are being killed or left disabled (as I am) and the outcry should be deafening and I believe it would be, if the american people

were given the truth.

The erroneous claims of the success of polypectomies is as much of an illusion as a psychic surgery. Doctors use this parlor trick to remove polyps commonly found in middle-aged to elderly patients and happily grabbed another $2,000.00 dollars and move to the next ~~sucker~~ patient. It all looks so impressive when they can show the patient high-resolution images of the polyps they discovered and removed from inside of them and claim that they saved them from cancer. When in reality, that polyp was little more threat to your life than that mole on their butt.

Even though I believe that Katie Couric has convinced herself that she is saving thousands of lives, her national endorsement of this service has most likely been responsible for the death of more people than she could possibly have saved. Katie responded in a knee-jerk reaction to her husband's untimely passing with the promotion of this money-making scandal of the medical supply companies. I feel that Katie owes it to her viewers to broadcast stories like mine, showing the potentially deadly and life crushing effects of this service she endorses to healthy people and the rare transplant I received, which would, in fact, have been the only thing that could have saved her husband. I will not hold my breath waiting for her call.

There is a rare group of individuals who suffer from a congenital defect known as Gardener's Syndrome. These people know who they are, because the cancer runs in their family. For them, screening at the age of 50 would be far too late, because they often develop colon cancer in their 30s. The benefits of colonoscopies does outweigh the risks in their case. But, if you are over 45 and have not developed colorectal cancer yet, you are not one of these people and the risks associated with a colonoscopy far outweigh any potential gain.

Katie's husband was only 42 when he succumb to colon cancer, leading me to believe he may have suffered from this rare gene mutation (average age of colon cancer is 71, so his case is rare). A simple polyp removal would not have saved his life. Only a full multi-visceral transplant could have. I know this because the woman assigned as my mentor had Gardener's Syndrome and required a six organ transplant at the age of 33 to rescue her. Katie's endorsement of colonoscopies is misplaced and she should instead be endorsing intestinal and multi-visceral transplants. But how would that profit GE and her investments in their products? Starting colon screening at the age of 50 would have been little consolation to her late husband, given the fact that he died at the age of 42. Unfortunately, this leads me to believe that Katie is only endorsing what is profitable to her, not what would have truly saved her husband's life. She is not on a crusade to save lives, but to boost her career.

The Use Of Colonoscopies For Inflammatory Bowel Disease

Besides its use for cancer screening, colonoscopies are also used by Gatroenterologist's to diagnose Ulcerative Colitis, Crohn's disease and other Inflammatory Bowels Diseases (IBD). This is a deadly combination. The risks of perforation are much greater in these patients. To use a device, which exerts so much pneumatic pressure within a human organ on patients who have weakened areas (ulcers and fistulas) and inflammation is irresponsible to say the least. This procedure should be completely forbidden for use on patients with severe IBD, yet doctors are using it as the tool of choice.

A sigmoidoscopy would be far less invasive and just as effective at diagnosing IBD diseases (by cellular biopsies). Sigmoidoscopy does not require the use of general anesthetics and has less than half the incidence of perforation [source].

A case study reported by the Journal Of the National Cancer Institute stated:

> *Overall, we found a perforation incidence of nearly two per 1000 colonoscopies, slightly more than twice the perforation incidence from sigmoidoscopy.*

But, a sigmoidoscopy charges out at a fraction of the cost of a colonoscopy and takes about the same amount of time to perform. So doctors naturally opt for the colonoscopy. I was never offered the option of, nor given the information about the safety differences between the two or I would most likely still have my native small bowels. I have no idea how many Crohn's or UC patients have been killed or damaged by these machines as I was, but I would reason to believe that the number is staggering – and of course, unreported.

I would like to give you an idea of the air pressure that can be exerted by this device. After my transplant, the technician operating the ileoscope was a Fellow, who was inexperienced at it. I began to complain of the tremendous pressure, but he ignored my discomfort and continued to pump away. Suddenly, everything in my stomach ejected from my mouth. I didn't have nausea, nor did I wretch. The air pressure was so great that it literally pushed upward through over 20 feet of bowels and blew open 2 one-way sphincters. I was terrified of these machines after this and would only allow Attending Surgeons to perform any future ileoscopes.

Perforations are difficult to diagnose and often go undetected for several days. Every hour counts after a perforation, because the leakage of colonic bacteria begin to spread infection and necrosis throughout the visceral organs. It can be difficult to diagnose and locate all perforations which has led to the levels of damage and death I have seen in several patients because of delay in treatment. It is the x-ray and/or CT screening for the presence of "free air" in the abdomen that is the golden standard used to diagnose perforations. "Free air" will not always be present nor easy to detect. The level of confidence that doctors instilled in

this diagnostic technique is what led them to dismiss the possibility of perforation and thereby ignore my failing vitals over the next four days.

Conclusion

Because of the savior status that this deadly procedure has received in recent years and the fact that celebrities like Katie Couric have made it a media darling, it is impossible to get anyone in the media to report anything that may suggest that there is a danger with this procedure. Even though it has never been proven to be effective at diagnosing cancer, nor have we seen any decline in colorectal cancer since its implementation, these whores in the media continue to insist that it has saved thousands of lives. Where are the studies to support their claims?

The words “cancer” and “terrorist” scare Americans more than any others in the English language. What are your chances of developing colorectal cancer? Even a person in a high-risk group is 12 times more likely to die from heart disease; 10 times from any other cancer, 6 times from a medical error, 3 times from stroke, and twice as likely to die from an accident. Yet, Americans are so motivated by the word “cancer”, that they are willing to submit themselves to this ambulatory surgical procedure, even when they feel perfectly healthy. Would you submit yourself to any other invasive surgical exploration as simply a screening technique for a disease you most likely don’t have?

Of the seven intestinal and multivisceral transplant recipients I met, only two had lost their organs to a disease. Nurses told me that better than 80% of the organ recipients were the result of bariatric surgeries, liposuction and colonoscopies (in that order). I met two women who lost their organs to faulty gastric by-pass surgeries and two were the result of colonoscopies. Disease is not your worst enemy, medical procedures are. And every one of these are elective

procedures undertaken by otherwise healthy people who were assured of their safety. Healthy people whose lives have now been destroyed and shortened by medical practitioners hawking unnecessary procedures for monetary gain.

I will continue to fight the battle of awareness until a much safer and more effective diagnostic tool for cancer, Crohn's and Ulcerative Colitis is invented. Because everyone seems happy with the status quo, nothing will be done to improve this diagnostic technique or better yet, come up with a far less invasive one, unless the dangers and the ineffectiveness of its use as a cancer screening device are made common knowledge.

Modern medicine needs to start looking in new, less invasive, directions – not to simply dump more money into promoting their existing products that do not work effectively – and even worse, are making people sicker or outright killing them. If half as much money went into research as is spent on the advertising and celebrity endorsement for the promotion of this outdated, crude and invasive torture device, we would have cured the damned disease by now. Curing a disease is never as profitable as treating one.

They have been quite efficient at sweeping my story under the carpet and my tiny place in cyberspace will never get this information the attention that it needs to save lives. I will continue to do whatever I can. If I can save just one person from having to live through the nightmares that I have, it will be worth the effort. But people, you to need to wake up and demand more truth about these modern "snake oil" practices.

If you wish to learn more about the dangers of this procedure, please read part 1; "The Dangers Of Colonoscopies" and the "Wolverine Story".

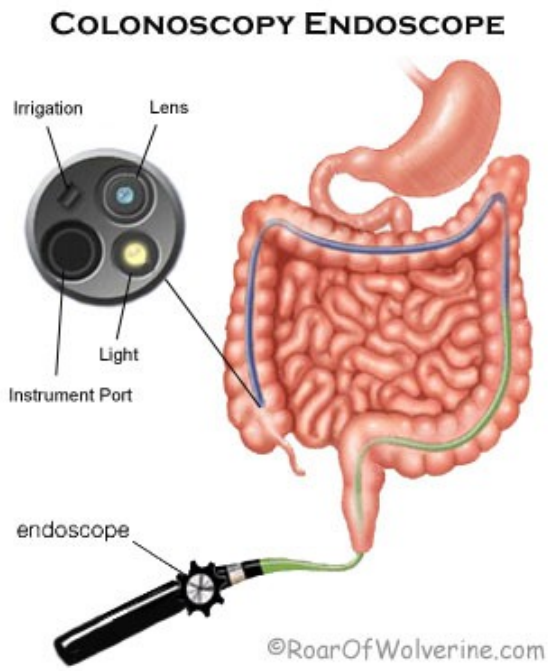
There is also a lot of good information and videos at

Konstantin Monastyrsky's website; here

I still have many more articles in this series upcoming, so please check back or subscribe to receive email notifications of when new articles are posted.

I am not a doctor nor attempting to give medical advice. I believe that every american has the right to the truth concerning the real, absolute risks and benefits in modern medicine – something you will not get from the mainstream media. Always remember that their broadcasts or publications are paid for by the manufacturers of these medical devices and pharmaceuticals. The entities in the media will not bite the hand that feeds. I am selling no products and am a victim of this profitable industry and will always give an unbiased opinion of my research and experiences, so you can have better information with which to make decision concerning your health. Stay healthy, please.

The Dangers Of Colonoscopies



The overuse of the procedure known as colonoscopies as a prophylactic for colon cancer, has not only become quite a fad in recent decades, but also a multimillion dollar industry. Every year, over 14 million perfectly healthy individuals age 50 and up, submit themselves to this invasive procedure in the hope of receiving protection from colorectal cancer. Do the benefits of this screening outweigh the risks involved?

Sometimes in this world, a treatment may be as dangerous as the disease itself. I serve as a living testament to the severity of the damages possible with this procedure. The many injuries that can be caused by colonoscopies, the anesthetics and preparation required for this procedure, is what I would like to cover in part 1 of this series. (In part 2 we will look at the known effectiveness of colonoscopies as a weapon against cancer)

I would like to preface this by saying that colorectal cancer is a very real, frightening and deadly disease, and I am in no way making light of that fact. But, a colonoscopy injury can be as lethal and cause as much fear and suffering as colorectal cancer itself. (For those who have not read my story, I lost all of my intestines due to a colonoscopy accident – NOT just my colon, but all of my small intestines too – a life-threatening condition known as short bowel syndrome. I lived for six months without intestines and being fed and hydrated with the use of TPN, but my life was ultimately save with a very rare intestinal transplant.).

So the question here is, which one carries the greatest risk of actually happening to you in your lifetime? Especially between the age of fifty to sixty?

Reported in this study from 2006; "The perforation rate reported from colonoscopies was 1 in 1000 procedures, and 'serious complications' occurred in 5 in 1000". According The Annals Of Internal Medicine's report on colonoscopies, an estimated 70,000 (0.5%) will be injured or killed by a complication related to this procedure. This figure is 22% higher than the annual deaths from colorectal cancer itself – the very disease the device was designed to prevent.

The average age for developing colorectal cancer is 71 [source]. The medical industry recommends screening starting at the age of 50 and as low as 45 for African-Americans. So, for the first couple of decades, you are risking your life with a dangerous, invasive procedure to diagnose a disease that is far less of a risk at that age than the odds of being injured by the screening device. I could stop right there, because that should be enough to make a critical thinker forget about this barbaric diagnostic tool, at least until the age of 65. But, there is more – a whole lot more to consider, which leads me to believe we should search to discover a safer and more effective tool.

Many of the related injuries associated with colonoscopies go unreported or are never diagnosed. Death from colon cancer will very rarely not be reported as the cause of death, so those are accurate predictions. But, we have no idea just how high the actual number for colonoscopy injuries and death may actually be [more]. I am living proof of that. The reason for the necrosis of my bowels was unreported because all priorities focused on saving my life, not what caused the decline. Nowhere on my medical record is the reason for what caused my organs to die reported, so I doubt that I am part of those statistics, even though I am a victim of a colonoscopy.

Typically, a patient left untreated for as long as I was will die. Had I died, the death report would say complications from necrosis of the bowels and mention nothing of the colonoscopy. Perforations and other injuries from

colonoscopies can be extremely difficult to diagnose and are often of little concern when the patient is dying. We also have to consider that doctors and hospitals will rarely report an injury from a colonoscopy unless forced to. It is up to the patient to successfully prove that the procedure caused their injury or resulting infection in a civil trial before it will be reported and logged. The fact that few, if any, of these cases will see the light of day is covered in my post "Malpractice Law: reserved Only For The Frivolous".

Even though statistics say that 70,000 people will be injured or killed by this procedure this year, the actual number is far greater. But even if you go by only those that have been forced to be reported, the number of injuries are still significantly higher than the incidence of colorectal cancer.

One of the more dangerous outcomes of a colonoscopy is the one I was a victim of – a perforation. Everyone considering this diagnostic procedure is required to sign a paper stating that they understand all of the injuries possible with this invasion of their organs with a mechanical device and the air pressure exerted in order to inflate the colon. The list of the horrific complications, including death, should be enough to give anyone pause. But, patients are immediately calmed when their doctors explains that these things are rare. The favorite tool of compliance in the doctor's arsenal is the phrase "I'm not worried about it". They're not the ones about to have a metal tube shoved four feet up their pooper and they also understand that by signing that paper, you have waived all rights to legal compensation if injured. Any wonder why they're not worried? As long as your insurance checks out, they won't break a sweat.

Other than perforations, there are other dangers, including a list of possible reactions to the anesthesia (propofol) that is typically used during a colonoscopy. Though rare, they can range from deep vein thrombosis, pulmonary embolism to pneumonia. Probably the largest risk with propofol is the

fact that it suppresses your respiration. If given too much, the patient can stop breathing. This is why you should make sure that you have this procedure performed in a facility that is equipped to handle such a situation, in case you stop breathing. No other cancer screening test requires a patient to be rendered unconscious to perform. Because you will be unconscious, you will not be witness to the procedure, so the patient has no idea how well the procedure was performed or how much time the doctor took to examine thoroughly. The insurance companies pay the same price whether the doctor takes 20 minutes or 2 minutes – the faster they can do them, the more procedures they can get paid for per day. Most accidents happen because of fast and sloppy procedures.

There can also be complications associated with the colon prep required for the procedure. This prep can include a 2 liter enema of synthetic laxatives administered about an hour before the procedure. This is called the Mechanical Bowel Preparation (MBP) and is completely unnecessary, yet many doctors still use this in spite of the fact that it has been proven to create a high risk of thrombosis. This cocktail of chemicals can cause everything from deadly electrolyte imbalances (which can lead to congestive heart failure), to possible thrombosis in the mesenteric artery, to kidney damage. It is believed that I developed a partial occlusion in the mesenteric artery (which feeds blood to all of the bowels) following the prep. I began to complain of intense abdominal pain directly after the MBP, yet the doctor decided to do the procedure anyway.

If this diagnostic procedure still sounds safe to you, we will also throw in the newest discovery that has come to light in recent years. It is impossible to sterilize an endoscope! This high-tech device cannot be boiled or steamed because high temperatures can destroy the sensitive electronics and optics. There are many tiny nooks and crannies in and around the tip of the scope, which are difficult to clean, even by

hand. More importantly, is the channel which runs the length of the scope inside. It is this port that the doctors insert the tools into. This channel is less than a millimeter in diameter and tunnels over four feet through the endoscope. Without boiling or steaming, I can not see how this channel could be sterilized (I will cover this in more detail in an upcoming post).

Recent biopsies of these scopes have revealed microscopic incrustation of fecal matter, tissue, blood, and mucus imbedded from previous patients. At present, medical personnel bathe the scopes in a disinfectant solution. They're not scrubbed. Not disassembled. Not heated. They're rinsed in an ineffective bath of Glutaraldehyde, which if not rinsed off thoroughly, has been cited as a cause of toxic Colitis. Properly cleaning an endoscope can take a lot of time and must be done by hand. Given the fact that colonoscopies have become a volume business, gastroenterologists have been known to cram in as many as 30 to 40 procedures per day. With such a cattle-call styled business, just how much time is really spent cleaning the scope?

It is very possible, and clinically proven, that you can be infected by HPV (Human Papilloma Virus); HIV; Mycobacterium tuberculosis, Helicobacter pylori,; Hepatitis B and C; Salmonella; Pseudomonas and Aeruginosa; Flu Viruses and other common bacteria such as, E. Coli O157:H7 and Creutzfeldt-Jakob Disease. And the pathogens you may be infected with are typically going to be a hospital borne variety, which means they are strains that have been exposed to, and become immune to most antibiotics. Leading microbiologists have advocated using sterile, disposable parts for endoscopes as well as the use of a condom-like sheathes for each new patient. But, the manufacturers and health-care providers have resisted these solutions because of added costs. Isn't that nice? These safety precautions are mandated in England, but not used here

in the U.S.. The FDA even recognizes this problem here, but acts as if their present recommendations are effective – they have been proven not to be.

Following my transplant, I was required to undergo an ileoscopy, including biopsies, weekly to check for signs of rejection. Patients are not anesthetized for this procedure because the scope is inserted into a stoma, rather than the anus, so it is painless. I was allowed to watch the procedure on a television monitor. They would fish a tool (similar to an alligator clip) through the instrument port of the scope (refer to image at the top of page), to tear off a piece of villi for a biopsy. Each time I could see a tiny injury which would begin to bleed. An open, bleeding wound near the tip of a scope which has been in many other colons and is unable to be sterilized – sounds like a real good medical practice. Each time you undergo a colonoscopy they may clip out a piece of your intestine for biopsy or snip off a polyp. There will be an open wound and mixing of your blood with whatever may be lingering on the end of that scope which has been in hundreds of other colons and is unable to be sterilized.

Because there is a small amount of internal bleeding after a procedure, this can be very dangerous to anyone on blood thinners or anti-coagulants, because the doctors do not hang around long enough to be sure that the injury heals. An open bleeding wound within a dirty colon is not the safest thing and certainly a risk for infection, but there have been patient bleed out days or even week later from a wound that did not stop bleeding – especially in elderly patients or diabetics who do not heal quickly.

A few days after one of the ileoscopy, I came down with a systemic gram negative rod infection called pseudomonas, a very deadly pathogen to immunosuppressed patients. The particular strain that I had contracted was identified as being multi-drug resistant, meaning it was certainly a

hospital borne variety. It nearly ended my life as I succumbed to septic shock and by the time the ambulance arrived at the ER, my blood pressure had dropped to 35 over 28 and I was unable to breathe on my own, so the doctors were giving me a very small chance of surviving the night. I needed to be placed on a respirator, so I was knocked out and kept in a coma for two weeks by use of propofol, the same drug used for most colonoscopies, so don't let anyone tell you that the drug used for the colonoscopy is just a mild sedative – it can place you into a coma and keep you there.

It is quite obvious now that I contracted that pathogen from the scope I had just received two days before (I failed so quickly because I was so immunosupressed from the transplant). Seven months prior to that, I had been the victim of a perforation as the result of a routine colonoscopy, which ultimately cost me all of my intestines and nearly my life. That is two near death injuries on just one patient within seven months from two endoscopes.

I met six other transplant patients in the last two years. Three out of those six people, adding myself (making seven), had suffered a perforation from scopes and a fourth one had suffered a perforation in a similar invasive procedure. Two of those patients died as a result of their injuries and I nearly died on two different endoscope accidents. The third transplant recipient needed an emergency resection of her newly transplanted bowels because of a perforation from a scope. The baby of our transplant family, a young woman only 28 years old, is fighting a Klebsiella sepsis at this time, which was most likely transmitted via a recent scope. "Injuries and perforations from colonoscopies are rare" my ass!

Because of what happened to me and the manner in which the doctor lied to me about the rarity of these injuries is what has motivated me to study and investigate the subject for the last two years. I have discovered that perforations are not

as rare as the doctors would like us to believe. But at a charge of $1,500.00 to $2,000.00 per procedure and the fact that some gastroenterologist can rush in as many as 30 -40 procedures a day, it is not hard to see a motivation to suppress the truth about the dangers and your risk of being perforated or infected by this medical fad.

From an a 2006 article in The New York Times;

> *… if our group is representative of an average group, you will see people (doctors) who take 2 or 3 minutes and people (doctors) who take 20 minutes to examine a colon. Insurers pay doctors the same no matter how much time they spend." It is often about quantity, not quality and your risk of being injured increases the faster the practitioner attempts to finish your procedure, not to mention the efficiency of the cancer screening falls dramatically when hurried."*

I hope that one day this killer will end up on the junk pile of quack medical devices from the Victorian Age, and I hope I can have a hand in placing it there. This will not be easy. The medical industry now has celebrities, such as Katie Couric, actively using their fame to promote this procedure as a life-saving miracle, rather than the barbaric medieval medical device it really is. They used the fact that Katie lost her husband to colon cancer and swooped in on this grieving widow and convinced her this "snake oil" medical device could have prevented it. I am sure that the fact that NBC is also owned by General Electric, a manufacturer of endoscopes, had little to do with sponsoring her televised colonoscopy and using her celebrity pitching skills to bring this killer to the forefront of common medical practices.

You may be thinking that I must have lost my mind, because after all, this procedure has effectively saved thousands of lives, or at least that's what you've been led to believe by the medical industry and their advocates in the media. But is

there any more truth to this than the lie that injuries are rare?

Please read part 2 on this subject entitled; "The Effectiveness Of Colonoscopies On Cancer And IBD" and the introduction to this series entitled; "The Dangers In Modern Medicine".

The Dangers in Modern Medicine

I had originally planned to simply write a rant on the many common, avoidable and dangerous mistakes I have been witness to and experienced in modern hospitals. Unfortunately, the errors are so numerous that I have decided to create a new category entitled "Medical Mayhem", where I will write a series of posts broken down into several chapters.

I am presently writing a manuscript for a book about my ordeal, so some of these posts will be sort of a sneak-peek at some of what my book will entail. Trust me when I tell you that the page on this blog which covers my story is not but a fraction of what I endured and experienced over the last two years due to a sequel of medical errors. The purpose of these articles and my book will be a bit of an exposé on life in a hospital from a patient's perspective. Unlike the ridiculously over-glorified, god-like images portrayed on

television, I will paint the image of a true extended stay in a hospital in the U.S.. House, ER, Grey's Anatomy or any other pretentious heap of dung that's excreted from the minds of Hollywood writers are far from an actual depiction of doctors, nurses and hospitals and have only served to elevate these practitioners to the level of a deity that no human could live up to.

Medicine has become a multibillion dollar industry and never lose sight of the fact that IT IS AN INDUSTRY. It is no different from any other fortune 500 establishment or publicly traded entity that places the fiscal bottom line above all else, including the lives and safety of its consumers. The exact same misinformation, media manipulation, falsification of data and suppression of known dangers are implemented. Those in the medical industries are not a more ethical brand of creature just because they chose to go into medicine or pharmaceuticals for a profession. The same congressional lobbying, controlling the media by flexing their advertising muscle and even the same revolving door government appointments are in play – and perhaps implemented better than anyone in the tobacco, alcohol, insurance or oil industries (here I'm referring to the medical supply and pharmaceutical corporations and hospital financiers, not the doctors).

Thanks in part to the media, the medical industry conducts services under a misguided public's incessant belief that they operate on a higher level of ethics (here I include doctors). Maybe it's because of all the years they have been portrayed on television as saints in white coats, who are always right, and never lose a patient due to incompetence or negligence. The image of doctors fretting late into the nights and weekends, like a detective on a tough crime case, is sheer and utter bullshit. Doctors rarely spend more than 5 minutes with a patient and whatever diagnosis first pops into their head is the one they stay with irregardless of evidence to the contrary, or at least up until the point the patient crashes.

(It’s rather convenient the first diagnosis is usually whatever the “fad” disease at the time is; think “Fibromyalgia”).

I am not out to overly criticize nor paint those in the medical profession of possessing any lower values than any other human, but to illustrate that they are not divinely given any higher set of ethics, intelligence nor devotion to their patients (customers) than any other business professional. They are mortal beings, capable of the same human error, temperament, loss of concentration in their work and annoyance with their customers as any other merchant. More importantly, they are just as subjective to the effects of advertising and misinformation from large corporations, including pharmaceutical companies, medical equipment manufacturers and food processing companies as is the general public. It is the fact that they are held less accountable for their conduct that leads to a higher rate of incompetence than other occupations.

Doctors are simply the liaison between the medical corporation and the patient. They’re the “kind face” or trusted salesman for the corporate giants and the legal license from which to distribute whatever drug or diagnostic device they’re marketing today (hence, why commercials always say “ask your doctor if…”). Sort of a highly educated “stooge”, who get all of their knowledge and information based on the research conducted by the very people whose products they distribute, and rarely from any unbiased or independent studies.

Ethically speaking, there is certainly a difference between those who practice medicine, from those who sell it. The ones who practice medicine are typically snowed, bullied and manipulated by the ones who sell it (you know, the creators of the “disease-of-the-month”). Practitioners may have more than just money as their motivator as opposed to their corporate partners, but their profession seems to lead them to a great degree of cynicism and imperiousness. This is understandable,

given their omnipotent portrayal in the media. But, when you mix the greed of the money-makers with the arrogance of the practitioner, you simply get an inferior product or service – which in this case means suffering and death. Sort of like when you mix the greed of the record company with the arrogance of the performing artist, you get pop music (total crap). The U.S. spends more on health care than any other nation, yet we're ranked 37th in the last WHO ranking in 2000.

It is culturally implanted in americans to have some level of distrust towards their government, corporations and salespeople, but these same skeptical people will give a theist's faith to their doctors. Too bad the doctors do not reciprocate even a fraction of that trust back to their patients. Typically, practitioners consider any query as a challenge of their knowledge or competence as a doctor and quickly ignore or dismiss any questions or observations made by family members. Family members have a much higher degree of perception when their loved one is not "acting right" or in pain and any good doctor should listen (I will cover this more in "The Cynical Attitude Of Doctors"). About 50% of the nurses are much better at listening to family than doctors. My wife and I both practice the same level of caution and skepticism towards doctors than we would any politician, salesperson, corporate advertiser or anyone else vying for our business. Unfortunately, two patients we befriended were much more trusting and are no longer with us.

The biggest surprise to me is that Doctors enjoy a greater protection under the law than any other profession and are held to a lesser degree of responsibility – which seems rather ass-backwards given the fact they deal in human lives. No matter what you've been led to believe, it is virtually impossible to seek financial compensation for damages inflicted on you by a doctor. Even if successful (which is rare), there are federal caps set on medical torts far lower

than on any other type business or product liability. I cover this topic in great detail in my post in this series entitled; "Malpractice Law: Reserved Only For The Frivolous"

There was a character on the television series "Scrubs", named Neena Broderick, who was a ravenous malpractice attorney, hell-bent on suing the doctors for every little mistake. Once again, more Hollywood bullshit misguiding the general public about the doctor's responsibilities if mistreating a patient. If people knew the truth, they might be more careful when following their doctor's advice. After all, you alone will bear the full brunt of any errors made by your doctor, both physically and financially. I am talking here about doctors and not pharmaceutical and medical supply companies. These medical corporations are held to the law under product safety – not to be confused with malpractice. Nurses and other hospital employees are covered under the hospital's policy, but doctors are virtually untouchable, because they are not considered a hospital employee. With no system of checks and balances in place, any industry could easily decline into a money-making racket, and the medical industry is no exception.

I am in no way attempting to persuade people to avoid medical attention when necessary. Modern technological advances have the potential to save more lives and improve the public health like never before in history. I use the term "potential" because like any technology, it is only as good as the technician and their level of commitment. The real truth that the television medical dramas and pharmaceutical commercials will never reveal is that the number one killer in the United States is death due to pharmaceutical drugs – more people than are killed in traffic accidents. Nor will you discover that the third highest killer in the U.S. is due to medical errors. [source] [second source]

Given the fact that neither my accident, nor the ones that killed my friends was reported as the medical blunders they

were, would imply that there are thousands more swept under the carpet – possibly making medical errors, in reality, the number one killer. Modern medicine does save lives, but all totaled, it is certainly the number one killer of humans beings in the United States, by far. If we were able to add in the unreported and undiscovered errors, I am sure that it takes many more lives than it saves. Sorry to be the bearer of that news.

This is not to scare you from seeking medical attention when warranted, but a stern warning that you must be your own advocate , do your own research (all hospitals I resided in had wi-fi internet connection in every room) and to not be afraid to question doctors and nurses. You are allowed to refuse any medication, treatment or procedure you believe to be in error or too much of a risk. I have heard and read blogs where people claim "my doctor is making me take…". A doctor cannot make you do anything. Read your Patient's Bill Of Rights. A doctor must explain to you all the alternative treatments if asked. In other words, turn off the damned television in your hospital room and do some homework!

I spent over 14 months in hospitals and was nearly the victim of many common and avoidable errors. I was lucky that my loving wife took a leave of absence from her job and was at my side the entire time, diligently reading on her laptop. Thanks to her watchful eye and constant research, she helped avert several lethal mistakes nearly inflicted on me by hospital personnel. I spent several weeks either in a coma, heavily sedated or intubated, so it was important that I had her as an advocate when I was unable to respond or make decisions. Even when sedated or on a respirator (you cannot talk when intubated), she could always tell the doctors what I was feeling or needed with impeccable accuracy. No amount of training can teach that, it must come from someone close to the patient to read those expressions. Try to have a family member with you if you are incapacitated or unconscious.

I understand that my life was saved by an amazing transplant and those extremely skilled doctors worked diligently to give me back some quality of life. Though true, it cannot overshadow the reality that had I not been injured by a group of doctors and left to die as a result of their cynicism, I would have never needed that risky procedure. Nor can it change the fact that the same doctors who gave me back life with a transplant, nearly took that life on several occasions in the months that followed. How I survived some of the errors is still a mystery to the doctors, so it would be an overstatement to credit them with the survival. But these mistakes did prolong my stay in the hospitals by five months, exposing me for a longer time to hospital borne pathogens and medical errors.

While in the hospitals, I had nothing but plenty of time on my hands to research. Though much of the puzzle is incomplete concerning where the line exists between innocent mistakes to huge cover-ups, I have arrived at a much clearer image of how the medical money-making machine and the laws that protect it coexists. There is obviously an avoidance by the media and the legal system to bring to light the real dangers that exist in modern medicine and how it is, in fact, our number one killer. I am left to conclude this is due to the enormous amount of money that it generates for our economy and the idea that people "want to believe" in a group of highly intelligent people who can save us from all of our ills. Probably based in the same brain mechanism that makes people want to believe in aliens, gods, fortune tellers and psychics – and the healing powers of doctors is just as much a myth.

Mostly, I believe it's just considered too politically incorrect and audacious to speak out against the medical system, which is why attorneys never want to point the finger of blame at doctors. Doctors have obtained an almost divine aura of goodness around them and anyone who expresses a negative thought is treated as an infidel. I, on the other

hand, have never been considered politically correct and have little to lose at this point – so, I will begin my series with the procedure that ignited the nightmare that would become my life.

"The Dangers Of Colonoscopies"

"The Effectiveness Of Colonoscopies On Cancer And IBD"

"How Common Are Medical Errors?"

"Malpractice Law: Reserved For Only The Frivolous"

"The Cynical Attitude Of Doctors"

"Is Your Surgeon Licensed? Are You Sure?"

Please leave comments. I get a lot of readers, but few of them leave comments. Let me know if you like what I offer or if you think I'm full of shit. Really, I'd like to know how I am being received.

I apologize for the extra step it takes to leave a comment, which I'm sure deters some from leaving a note. I was getting hundreds of spam comments from robot softwares, so I had to set up protection rather than shut off comments all together. I'm sorry for the inconvenience.