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On Hyperbaric Oxygenation

Dr. Richard Neubauer of Lauderdale-by-the-Sea, Fla., has explained to me that the time has come to make hyperbaric oxygenation [see pp. 117-120] more available and to obtain scientific approval and third-party reimbursement. Reviewing the literature that he has sent me, I find that this modality is unequivocally of potential value in acute anoxic states. Certainly, carbon monoxide and cyanide poisoning have been accepted indications for a number of years, but the value of hyperbaric oxygenation in other anoxic situations has been shown in animal studies. In acute ischemic stroke, treatment with hyperbaric oxygenation within the first four hours reduces morbidity and mortality significantly. Benefits have also been shown in traumatic brain injury. There is a scarcity of chambers to handle these situations and a serious lack of knowledge among professionals concerning indications and dosage.

Functional brain imaging after hyperbaric oxygenation clearly demonstrates varying degrees of recoverable brain function in many patients suffering the chronic sequelae of stroke, traumatic brain injury, or anoxic encephalopathy. Cost savings even from late utilization of hyperbaric oxygenation could be substantial.

I would like to comment on two issues from personal experience.

I had a stroke a number of years ago, and Dr. Neubauer made a chamber available to me. Although I may have recovered from the stroke spontaneously, I feel that the pressurized oxygen gave me every advantage. I have had this chamber for more than 6 years. I take six treatments per week at 1.35 atmospheres absolute (ATA) for one hour each and have had more than 3,000 exposures. I am 95 years old and work five days a week doing research, lecturing, and writing papers. Oxygen toxicity has never been a problem. I suggest investigation of the effectiveness of this procedure in permitting scientists or executives to maintain whatever mental acuity they have, using neuropsychologic and intelligence testing as well as functional brain imaging. I understand that Dr. Neubauer and Clark Kirk, Sr., began a project with this hypothesis in 1972. Psychological studies have shown a transient rise in the intelligence quotient (IQ), which seems to fall off after a period of time. I have not given it the opportunity to wear off. Whether I would be as mentally alert without this treatment I am not sure, but I would be hesitant to stop my daily sessions.

A totally unexplored area with which I have personal experience requires extensive investigation. This is the application of hyperbaric oxygenation in chronic obstructive pulmonary disease. My wife of many years suffered from this, and when the chamber was installed in my home, she was bedridden and severely emaciated. Her pulmonologist expected her to die within two months. Drs. Richard Neubauer and William Maxfield suggested supplemental oxygenation at very low pressures of 1.1-1.25 ATA for 20 minutes twice a day. This was indeed helpful. Mici became more alert, began to gain weight, and no longer needed constant supplemental oxygen, although she did use oxygen at night. The pressure was gradually increased to 1.35 ATA for 40 minutes twice a day. Mici gained 35 pounds and became bright, alert, and ambulatory. If the technician missed a single treatment, she would deteriorate. She had five wonderful unexpected years. One hopes that home chambers may become readily available.

I also wish to comment on the overwhelming evidence of the effectiveness of hyperbaric oxygenation in cerebral palsy and the brain-injured child. Reproducibility of results from around the world is compelling. Although double-blind cross-over controlled studies are the standard of the scientific community, effectiveness has been demonstrated by Dr. Neubauer and a number of others, using each patient as his own control, and documented by sequential functional brain imaging. Experience is such that a double-blind study may be immoral.

In the long-term history of hyperbaric oxygenation,[1] many of the problems have resulted from inappropriate pressures and treatment protocols. The proper dose in many conditions has not been fully ascertained and may vary as does insulin dose in a diabetic. I feel that the lower-pressure protocol and use of functional brain imaging will eventually make hyperbaric oxygenation a standard treatment.

Edward Teller, Ph.D. (1908-2003)
July 9, 2003

[1] Trimble VH. *The Uncertain Miracle*. Garden City, N.Y.: Doubleday; 1974.

An Issue for Medical Herdology: Smokeless Tobacco

Occasionally a physician must wonder whether conventional scientific wisdom can be debunked as quickly as junk science is elevated. As the *Journal* has been exploring such questions, the issue of smokeless tobacco may be of interest to readers.

A friend recently asked me to review research studies that were to be presented at a health policy conference and determine whether the results were scientifically valid and medically sound. I did this as a volunteer and have no relationship with the scientists or institutions and no vested interest in the studies, their sponsors, or conference underwriters.

As one of the topics was smoking cessation, a presentation I was asked to review contained data on successful strategies for smokers to employ. I should further disclose that I'm a non-smoker, non-dipper, non-chewer who has always advised patients and anyone else who will listen not to use any form of tobacco products. I must confess here that the studies I reviewed were startling, to say the least.

The first study, from the Department of Pathology, School of Medicine, University of Alabama at Birmingham, and the Department of Medicine, University Hospital, Umea, Sweden, concerned the use of snus (Swedish moist snuff). The researchers found that: "Amongst men ever-tobacco use was stable in all survey years at about 65%, but the prevalence of smoking declined from 23% in 1986 to 14% in 1999, whilst snus use increased from 22% to 30%. In women the prevalence of smoking was more stable in the first three surveys (27%) but was 22% in 1999, when snus use was 6%. In all years men showed higher prevalence of ex-smoking than women. A dominant factor was a history of snus which was more prevalent at younger ages." They concluded that, "The recent transition from smoking to snus use amongst men, and incipiently amongst women, in northern Sweden is remarkable and relevant to the global discussion on strategies to reduce smoking."

I found the research data to be sound and the credentials of the researchers to be solid. Fair enough, I thought, they found that Swedish men were able to switch from cigarettes to snus. Now, I thought, the Swedish male population risks assorted cancers and diseases of the mouth as opposed to lung cancer, heart disease, and emphysema. I surmised that Swedish women, like many American women, still smoke cigarettes and aren't easily convinced that moist snuff is the ladylike path to harm reduction.

The next study[2] stated: "The most recent epidemiologic review of the cancer risks associated with smokeless tobacco use appeared in 1986, when 10 studies were available. This review describes 21 published studies, 20 of which are of the case-control type. We characterize each study according to the specific anatomic sites and according to the type of smokeless tobacco products for which it provides relative risks of cancer. The use of moist snuff and chewing tobacco imposes minimal risks for cancers of the oral cavity and other upper respiratory sites, with relative risks ranging from 0.6 to 1.7. The use of dry snuff imposes higher risks, ranging from 4 to 13, and the risks from smokeless tobacco, unspecified as to type, are intermediate, from 1.5 to 2.8. The strengths and limitations of the studies and implications for future research are discussed." The study goes on to compare, in relative terms, the risk levels of moist snuff and chewing tobacco vs. dry snuff. While no variety is essentially risk free, there is credible evidence that some risk levels were markedly lower.

Intrigued, I began reading more and compared what I found with data from *The Lancet*[3] and the World Health Organization Cancer Mortality Database regarding smoking-related deaths. In light of the dangers inherent to cigarette smoking, it is every physician's responsibility to urge patients to quit.

However, "nicotine delivery devices" are addictive, and nicotine replacement devices (patches, gum) don't work for everyone.

What should physicians do? Can they in good conscience (and in accordance with the Oath of Hippocrates) urge patients to substitute one bad habit with another, lesser bad habit? When the government gets involved, as it inevitably does, what will its health bureaucrats recommend in the way of appropriate practice, labeling, or regulatory oversight?

For those of us who have worked in public policy–I served as Public Health Commissioner in Texas and in the Department of Health and Human Services in the first Bush Administration–the conflict between policy, politics, and best practice is familiar, and often overtakes the issue itself. There are moral, ethical, and political implications in many health policy solutions and suggested treatments; just consider condom distribution, needle exchange, or methadone programs. The fact is that although the "solutions" sometimes seem as objectionable as the underlying problems, that does not mean we should ignore them and negate their validity.

I hope other physicians will help me work though this issue, as by posting comments in a thread on the AAPS forum (http://aaps.forums.commentary.net, or click "forums" at www.aapsonline.org).

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[1] Rodu B, Stegmayr B, Nasic S, Asplund K. Impact of smokeless tobacco use on smoking in northern Sweden. *J Intern Med* 2002; 252: 398-404.

[2] Rodu, Cole P. Smokeless tobacco use and cancer of the upper respiratory tract. *Oral Surg, Oral Med, Oral Pathol, Oral Radiol Endod* 2002;93:511-515.

[3] Peto R, Lopez AD, Boreham J, Thun M, Heath C Jr. Mortality from tobacco in developed countries: indirect estimation from national vital statistics [comment]. *Lancet* 1992;339:1268-1278.

Mercury and Neurodevelopment Disorders

Having followed the work of Stajich, Pichichero, Holmes, and many others, I was skeptical that mercury was the main culprit in the epidemic of neuro-development disorders plaguing our children. I still believe that in the case of vaccines there is a cumulative toxicity from other agents including aluminum. However, the recent study by Bradstreet et al.[1] goes a long way toward showing that mercury is indeed one suspect, if not the most culpable one. There are many questions still to be addressed such as the numerous anecdotal reports of autism occurring after measles-mumps-rubella vaccine, which is thimerosal free. Your publication is helping to close the gaps in our knowledge.

Alan R. Yurko
Century, FL

[1] Bradstreet J, Geier DA, Kartzinel JJ, Adams JB, Geier MR. A case-control study of mercury burden in children with autistic spectrum disorders. *J Am Phys Surg* 2003;8:76-79.

Sham Peer Review

In his recent article on sham peer review, Dr. Waite has perfectly described a consistent and destructive syndrome.[1] The presentation of a sham peer review is so regular that I am tempted to propose the eponym "Waite's Syndrome."

Dr. Waite is correct that until now, courts have largely ignored the statutory requirements of the Health Care Quality Improvement Act of 1986 (HCQIA), interpreting the phrase "[a] professional review body's failure to meet" such conditions "shall not, in itself, constitute failure to meet the standards of subsection a(3) of this section"[2] as a loophole providing immunity for participants in a peer review proceeding, no matter how malicious, shabby, or inappropriate the action is.

A recent decision by the Superior Court of Massachusetts, *Harvey G. Clermont v. Fallon Clinic, Inc.*,[3] documented a thoughtful and detailed analysis as to whether the peer review process met the criteria stated in HCQIA. The Court concluded that the peer review body had not fulfilled any of the minimal criteria demanded for a fair hearing. Further, the Court concluded that the "failure to meet" exemption did not apply. This decision is obligatory reading

for all those supporting physicians who are the victims of a sham peer review. Perhaps the reviewed physician may now hope for a modicum of due process.

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[1] Waite VS. Sham peer review: Napoleonic law in medicine. *J Am Phys Surg* 2003;8:83-86.
[2] 42 U.S.C. §11112(a)1-4.
[3] *Harvey G. Clermont, M.D., v. Fallon Clinic, Inc*. (2003 WL 21321190 (Mass.Super.)) Also cite CIV.A.2001-1512 B.

In my observation, sham peer review,[1] also known as bad-faith peer review,[2-4] flourishes more luxuriantly now than ever.

In Saint Petersburg, Fla., in a hospital named for the city, a 74-year-old lifelong smoker died after my attempt to resuscitate her from the second cardiac arrest of her 1987 admission. Necropsy revealed 90 percent occlusion of the left main coronary artery, 100 percent occlusion of the left anterior descending, and congenital atresia of the right coronary circulation, yet the hospital instigated a witch hunt against me.[5] Survival to discharge after resuscitation from one cardiopulmonary arrest, stable for decades, is roughly 15 percent[6] and lower to absent for a subsequent arrest.

I prevailed, and the hospital reversed and annulled the summary suspension of my privileges. Counsel warned me that I would be ambushed if I stayed at the hospital. On his advice, I resigned my restored privileges forthwith.

After a sham investigation of the same case, in which the hospital provided all "evidence," the state leveled different sham allegations against me, and I prevailed again after almost two-and-a-half years of agony.

For all the good the enormous defense expense and "due process" did me, I might as well have saved the attorneys' fees and allowed the peer-review juggernaut to roll over me. When I apply for a job, the decision maker, whether administrator or physician, presumes that hospitals are always correct and always win at least moral victories and that physicians always hire crooked lawyers, so I must not *really* have won. In another typical scenario, especially in the current, superciliously risk-averse climate, the decision maker is not the employer but an inaccessible insurance underwriter, who declines to insure me because of my "background." Neither the incident's remoteness in time nor my exoneration matters.

Waite[1] cited the so-called Health Care Quality Improvement Act of 1986 (HCQIA). In hearings preceding enactment,[7] *Patrick* dominated the slanted discussions. Dr. Patrick had then lost in his peers' appeal to the Ninth Circuit Court of Appeals, and nobody expected the U.S. Supreme Court to grant him certiorari, so the tenor of the discussion was righteous indignation at the emblematic instance Dr. Patrick represented of why the pending legislation was necessary to preclude "bad doctors" from thwarting proper peer review by retaliatory litigation against diligent, upstanding peer reviewers. Not *one* discussant mentioned the point that probably motivated the U.S. Supreme Court eventually to grant certiorari, that Patrick had prevailed at his jury trial on the merits against his "shabby and unprofessional" peer-secutors.

Waite[1] cited *Pinhas* but omitted the related U.S. Supreme Court decision.[8] Justice Stevens wrote the 5-to-4 majority opinion, stating that HCQIA mandated "a congressionally regulated peer-review process." An adverse report in the National Practitioner Data Bank (NPDB) results in a boycott of the physician's practice and excludes him from marketplace competition, so granting and renewing hospital privileges entails interstate commerce. Thus, federal antitrust jurisdiction applies to conflicts over physicians' hospital privileges. Congress was hoist by its own petard. Congress intended HCQIA to *preclude* antitrust litigation in conflicts with the hospital over physicians' privileges. But the NPDB let slip the law of unintended consequences and actually opened the door to such litigation.

Yet pundits, e.g., Hentoff[9], speculate that physicians conspire to protect each other behind a White Wall of Silence in a Brotherhood of *omertá*!

Eric N. Grosch, M.D.
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[1] Waite VS. Sham peer review: Napoleonic law in medicine. *J Am Phys Surg* 2003;8:83-86.
[2] Waller E. Peer pressure: doctor competition seen fueling rise in bad-faith review–foreigners and physicians in glutted specialties most common victims. *Physicians Financial News* 1988; 16(21):1,21.
[3] Trankina TJ. Peer review immunity for bad faith activities. *Patrick v. Burget* fails to provide an answer. *J Med Assoc Ga* 1988;77:724-726.
[4] Anon. *Patrick v. Burget*: will the state action doctrine protect bad faith peer review? *Healthspan* 1988;5(2):20-22.
[5] Walton DN. The witch hunt as a structure of argumentation. *Argumentation* 1996;10: 389-407.
[6] Bedell SE, Delbanco TL, Cook EF, Epstein FH. Survival after cardiopulmonary resuscitation in the hospital. *N Engl J Med* 1983;309:569-576.
[7] Medical Malpractice Hearings Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, 99th Congress, Second Session, including H. R. 5110, March 18 and July 15, 1986 (Y4. En 2/3: 99-152 (99-2)).
[8] *Summit Health, Ltd, v. Pinhas,* 111 SCt 1842 (1991).
[9] Hentoff N. The white wall of silence. *The Village Voice*, April 6, 1986, p. 41.

Most physicians believe that peer review, by doctors of the same specialty who are best able to critique each other, is a tool hospitals use to improve quality of care. It is not supposed to be a tool for removing competitors from the medical staff, but if it is, suing the hospital is believed to be a remedy for abuse.

In my experience, reality can be quite different.

My first experience with abusive peer review occurred when I was due for advancement to active staff after successfully completing 10 proctored procedures. My neurosurgical competitor, who was also chief of staff, demanded observation of 20 additional cases. He himself and a seasoned orthopedic surgeon served as the proctors.

Following these 20 cases, I received a letter from the orthopedic surgeon recommending me to active staff. But at the neurosurgeon's recommendation, the credentials and medical executive committee would not elevate me, and forced me to undergo a peer review following the guidelines of the Health Care Quality Improvement Act of 1986 (HCQIA).

Suddenly I was in a different world with different sets of rules, all written to protect the hospital. This hearing could affect my ability to practice not only at that facility but anywhere else because of the requirement to report adverse actions to the National Practitioner Data Bank (NPDB). The "hearing" is considered a civil trial, but there are no rules of evidence. In my case, the primary accuser was my competitor. No outside experts reviewed information for the hospital. Most of the physicians on the panel knew little about my specialty's standards.

Despite testimony on my behalf by several expert neurosurgeons, I was not advanced to active staff. Even though the state board of medical examiners cleared me of any wrongdoing, the hospital administrator reported me to the NPDB.

Several months later, a similar situation occurred at another hospital where my main competitors were orthopedists who, incidentally, were friends of my neurosurgeon competitor at the other facility. Through political manipulation they had my privileges suspended for a false allegation, and later tried to cover their tracks with 13 "cases," 11 of which had never been considered by the Quality Assurance department prior to the suspension.

Once again I was forced into a sham peer review hearing–which costs, on average, $6,000. The hospital's only expert was one orthopedic competitor. Five outside experts as well as several satisfied patients testified on my behalf. The hearing panel ruled in my favor and recommended that I be given active staff status. But my orthopedic accusers/competitors, who were also on the credentialing and medical executive board as well as the board of

trustees, overruled the hearing panel's decision, as allowed by HCQIA and hospital bylaws. My privileges were terminated and the adverse action reported to the state board.

Many other physicians have had similar experiences. Legal recourse is very limited. Information obtained at a hearing and anything said by the accuser is considered privileged. The accuser has immunity under HCQIA, even if his testimony is false. As long as the hospital follows its bylaws and gives the accused a hearing, the facility and accusers are protected by the courts.

Attempts to modify and/or rescind this law have not been a high priority with the AMA, AOA, and Congress. The major physician organizations have instead published "standards" in order to remove any bias from these hearings. Unfortunately, until these "recommendations" become law, hospitals and their staffs have no need to change.

To protect good physicians as well as their patients, HCQIA must be changed. The accuser and the hospital must bear the burden of proof to remove a physician–mere allegations and innuendo should be insufficient. Competitors should not be allowed to participate in the hearing. Those who are falsely accused must have redress in a court of law.

A professional license is a privilege. Through licensure, physicians have forfeited their civil rights to a fair trial. HCQIA has removed all checks and balances. Unscrupulous physicians in a position of power can inflict a professional death sentence on their competitors with impunity.

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The World Trade Center Collapse

I read with interest Andrew Schlafly's article regarding the World Trade Center (WTC).[1] I have a graduate degree in electrical engineering, which does not qualify me to be a civil or mechanical engineer but forced me to take courses in statics and mechanics, which are civil/mechanical courses.

The fundamental question is why the WTC collapsed so quickly. Schlafly quotes James Milke, an associate professor of fire protection engineering at the University of Maryland. A better source would be a civil engineer with a Professional Engineer (PE) designation.

The single most important feature that sets the WTC fire apart from that in the Meridian Bank Building, which was an electrical fire, is accelerant. The Meridian Bank Building fire did not involve tens of thousands of gallons of jet fuel coming from a fully loaded 767. The two fires cannot be compared because they burned at different temperatures. The fact of the matter is that no fireproofing could have prevented the collapse.

Schlafly also stated that steel reinforced by concrete as used in the Empire State Building would have survived. I am not aware of any structure of 100 stories that is built with concrete reinforcing because of the weight of the material. The higher the building, the more excessive loads the lower structural members are required to handle. The buildings cannot be compared. Theoretically, airliners constructed of steel would survive crashes better than those constructed of aluminum. In reality, they would never crash because they would be incapable of getting off the ground.

Schlafly hypothesized that the "partially asbestos protected" North Tower stood 68 percent longer than the South Tower. The problem with this logic is that it is assumed that both towers were hit at the same elevation, by the same approach, at the same speed by the same airliner.

It has been argued in the media that more consistent fireproofing "may have prevented" the WTC collapse. From an engineering standpoint, it is clear that inconsistent fireproofing may have expedited the WTC collapse, but knowing engineering design constraints and the amount of jet fuel involved, I as well as others highly doubt it have would prevented the collapse.

Finally, the WTC was specifically engineered to withstand the impact of a 747, the largest plane available at the time of its construction. It certainly survived the impact of a 767, but it did not survive the aftermath of the burning jet fuel. In the absence of jet fuel it might still be standing, though structurally unsound.

Lee Berkwits, M.D.
Kennett Square, PA

1. Schlafly A. Did flawed science and litigation help bring down the World Trade Center? *J Am Phys Surg* 2003;8:89-93.

As in most failures, there are many issues to be addressed in the WTC collapse, and one should not focus exclusively on a single one unless it stands out far beyond all others. Nor should we get too caught up in comparisons of different buildings on individual issues, lest we all end up living and working in caves and pyramids.

To be sure, the fire and fireproofing are significant factors in the WTC collapse, and they are being addressed. But there are other lessons and improvements to be made. I don't think we should focus so much on the fire that we neglect other structural factors, and I think the ongoing work is on target.

Rene Testa
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Engineering Mechanics
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In Reply: I appreciate the insightful comments. The hypothesis that jet fuel caused the premature collapse of the WTC is unsatisfactory for several reasons. For starters, the WTC Building 7 collapsed without any jet fuel, as it was never hit. Moreover, the airplane crashing into the South Tower expelled much of its fuel in an external fireball, yet it collapsed much more quickly than the North Tower. Also, it is worth noting that the temperature of a fire propelled by jet fuel is not significantly higher than that of other office fires.

Although I doubt the assertion that "no fireproofing could have prevented the collapse," we can surely agree that fireproofing does delay collapse and thereby save lives. The original WTC design anticipated a collision by a 747, which would inevitably cause a fire. The design used asbestos, a well-known and superb fire retardant. Yet exaggerated claims of environmental danger forced a hasty substitution. A government entity built and owned the WTC, and thus there was no independent scrutiny of its resistance to fire. Nor are government-funded studies today likely to affix blame to their sponsors.

Privately built, the Empire State building has vastly superior fireproofing. The floors on the Empire State building have one inch of fire-retardant cement covering seven inches of cinder and concrete. Its steel columns, girders and floor beams are coated with one to two inches of brick terracotta and concrete.[1] It was constructed during the Great Depression, when our society was far less affluent than now.

How many other modern buildings, constructed after the ban on asbestos, are firetraps? Robust scientific debate on this topic is long overdue.

I'm gratified that Professor Testa agrees that the "fire and fireproofing are significant factors in the WTC collapse," but am less confident that "they are being addressed." More than two years after the September 11 attack, there is still no official admission that the WTC fireproofing was inadequate. It is difficult to find a scientist willing to question the hysteria over asbestos fireproofing, let alone criticize its insufficient use in the WTC.

Andrew Schlafly, Esq.
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[1] Dunn V. *Why the World Trade Center Buildings Collapsed: a Fire Chief's Assessment*. Available at: http://vincentdunn.com/wtc.html. Accessed October 23, 2003.