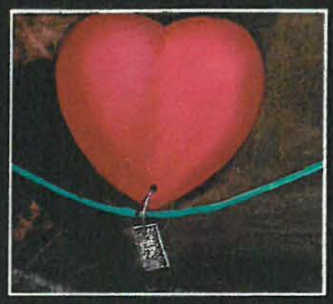
MEDICAL GENOCIDE

PART SIX

Evidence shows that there is a safe, easily administered alternative to drugs and surgery when treating heart disease. Why hasn't the medical establishment endorsed it as an effective therapy?

CHELATION THERAPY: A TREATMENT UNDER SIEGE

BY GARY NULL



Since the early sixties, when the pioneering articles about chelation therapy first appeared, the treatment has been the object of a carefully waged and highly damaging attack from nearly all components of the medical-industrial complex: physicians, their professional organizations and journals, government regulatory boards, and insurance companies.

Chelation therapy, the process of infusing EDTA (ethylenediaminetetraacetic acid) into the bloodstream, is used to treat cardiovascular disease. As EDTA moves through blood vessels, it removes excess deposits of iron, copper, and various other heavy metals that are implicated in the formation of plaque. Once this plaque is reduced, a normal flow of blood can resume.

The attack on chelation has not only made it difficult for physicians to use the therapy, it has also made it nearly impossible for those knowledgeable about it to present their experiences through the conventional media.

As the cardiologist Dr. R. H. Casdorph has put it, "Medicine, unfortunately, has its fads and fashions. Chelation therapy has become a political football, and it is very difficult to get it judged on the basis of scientific merit alone."

In this context, we will look at some "fields" on which this political football game is being played: in American Medical Association and American Heart Association propaganda mills, in supposedly objective state medical association "hearings" on the therapy, in systematic and persistent attempts by agencies of the U.S. government to put chelation therapists out of business, and in insurance companies' refusal to reimburse patients for chelation treatments.

In our previous article, we outlined some of the evidence for chelation therapy's efficacy and safety in the treatment of heart disease, and pointed out that none of the conventional treatments for cardiovascular disease are geared toward arterial

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health but, rather, toward arterial disease. This applies most obviously to coronary-bypass surgery, heart transplants, and the use of artificial hearts. All these conventional treatments are based on the premise that the degeneration of cardiovascular tissue is irreversible.

Even the most effective drugs treat only the symptoms. Nitroglycerine increases cardiac output in some patients, and beta blockers diminish the effects of adrenaline, reducing angina and arrhythmia. Calcium blockers prevent spasms by preventing calcium absorption into the heart muscle. None of these drugs, however, does anything to reverse the basic problem, coronary occlusion. Balloon angioplasty, the latest experimental surgery, is at least less invasive than coronary bypass, and blowing up a small balloon inside the artery does reduce occlusion at the site for some patients. But, while cardiologists practicing it caution patients to change their lifestyle to avoid new occlusion, angioplasty itself does nothing to change the biochemistry behind arterial degeneration.

Chelation therapy is a safe, easily administered alternative to drugs and surgery. It is inexpensive and appears to deal with the biochemical causes of heart disease, including arterial plaque buildup and heavy-metal toxicity.

If the evidence shows that chelation is a safer, more effective, far less expensive alternative to coronary-bypass surgery—that it is capable of ameliorating hardening of the arteries and other conditions associated with aging—why hasn't the medical profession endorsed it as an effective therapy? Why does a powerful faction of the medical establishment continue to label this proven therapy as "quackery"? Why do the leading medical journals continue to turn down articles about chelation authored by eminent physicians experienced in administering chelation therapy? Why won't most insurance companies reimburse patients for chelation treatments?

As a general rule, it usually takes a long time for a radically different approach to the treatment of disease to filter into common acceptance and usage. Chelation therapy is no exception.

Yet it isn't that simple. Consider the cast of characters in the medical-industrial complex: physicians trained in the conventional treatment of heart disease; the medical schools that teach the same approaches; medical-equipment manufacturers who continue to reap huge profits from promoting high-tech medicine; giant pharmaceutical firms racing against each other to obtain patents on the newest heart drugs; insurance companies profiting from the continually rising costs of high-tech health care. If chelation therapy works, as its proponents contend, no one in the medical-industrial complex stands to profit from it—except the patients and their therapists.

The medical community does *not* find chelation acceptable. The few articles that have appeared in widely read journals, such as the *Journal of the American Medical Association,* have been overwhelmingly negative. The AMA has consistently refused to publish articles about current studies on chelation, thereby preventing physicians from evaluating the research and drawing their own conclusions. As a consequence, most doctors will state unequivocally that it does not work. The fact is that no study has ever proved any such thing.

Because the AMA maintains a stranglehold on governmental administrative agencies, such as the Food and Drug Administration (FDA), on county medical societies, and on the insurance companies, it is difficult for physicians who want to use chelation therapy to practice it with impunity, and for patients who benefit from such therapy to collect insurance coverage.

A substantial part of the opposition's case against chelation rests on the fact that double-blind, controlled studies of chelation's efficacy have not yet been performed. Still, coronary-bypass surgery was widely accepted by the medical community long before controlled studies of any sort were undertaken. Such studies have since been completed and show that coronary-bypass operations have little beneficial effect. But this dangerous and costly operation continues to be the fastest-growing type of surgery in the country.

> While the American Medical Association claims it has no official position on chelation therapy, it is overwhelmingly against it.

The public should have a full range of safe, effective health-care techniques from which to choose. Yet, chelation therapy remains either unknown or is unjustifiably regarded as quackery.

The principal component of chelation therapy, EDTA, was first synthesized in Nazi Germany in 1935 as a substitute for citric acid. It was used in the German textile industry to prevent fabric stains due to the calcium present in hard water. Meanwhile, chelating agents were also being studied in the United States. It was not until 1952 that EDTA was first used in the treatment of lead poisoning. Chelation with EDTA has since become the approved method for treating lead poisoning, as well as other heavy-metal toxicity in humans.

Doctors soon noticed that their elderly patients, whom they treated with EDTA for lead poisoning, showed marked improvement in health. In addition to the removal of lead from their bodies, EDTA seemed to relieve many of their atherosclerotic symptoms, as well.

Observation of factory workers he was treating for lead poisoning led Dr. Norman Clarke, director of research at Providence Hospital in Detroit, to research the utility of EDTA in the treatment of occlusive vascular disease—a condition in which blood vessels become progressively blocked. He is now recognized as one of the pioneers of EDTA chelation therapy for heart and circulatory disease.

In a landmark article published in the *American Journal of Cardiology* in August 1960, Dr. Clarke reported, "For several years we have been administering intravenously to patients with advanced occlusive vascular disease three to five grams of EDTA. An accumulated experience with several hundred patients has demonstrated that overall relief has been superior to that obtained with other methods. In occlusive vascular disease of the brain there has been uniform relief of vertigo, and the signs of senility, even when advanced, have been significantly relieved. . . . In summary, the treatment of atherosclerotic vascular complications with the chelating agent EDTA is supported by a large volume of information."

However, Dr. Clarke's work and the future of chelation therapy were dealt a reeling blow shortly after his article appeared.

Two medical researchers, Dr. Lawrence E. Meltzer and Dr. J. R. Kitchell, of Philadelphia's Presbyterian Hospital, received a grant from the John A. Hartford Foundation to investigate the long-term use, side effects, and toxicity of EDTA. Heart patients participated on a voluntary basis, paying the doctors nothing for treatment. In July 1961, they reported in the *American Journal of Medical Science* that no serious side effects had been observed over a four-year period, during which 2,000 infusions of the substance were given.

Two years later, Dr. Kitchell told *Medical World News* that "eleven of twelve patients with vascular disease secondary to diabetes have improved, and considering the absence of any valuable method for treating diabetic vascular disease, chelation therapy assumes great importance. But the improvement was only temporary."

Soon afterward, Meltzer and Kitchell zapped the use of chelation therapy for coronary-artery disease in an article they published in *The American Journal of Cardiology.* The article, reappraising previous findings, stated that no measurable long-term benefits had been ob-

served in a control group of patients with coronary-artery disease who had been treated by EDTA chelation. They supported their conclusions by results they said they had obtained by using a plethysmograph, an instrument which records variations in blood flow in different parts of the body. However, it is interesting that in the same article they reaffirmed the temporary benefits of chelation therapy in the treatment of peripheral vascular disease, particularly below the patients' knees.

Drs. Meltzer and Kitchell discontinued their research on chelation therapy when they couldn't demonstrate any long-term benefits based on measuring techniques available at the time. They explained that, at first, the 11 patients they had mentioned "had not seemed to be any better. Then several weeks or months after the treatments were completed, these people reported back that they *were* better. There were certain electrocardiographic improvements, but over a matter of time they were not sustained. The people didn't live longer than would be anticipated. It was true," they admitted, "that we took very difficult people who had been referred because other treatments had failed."

As a final concession, Dr. Meltzer said, "It would be stupid to say that chelation has no benefit at all since there are some drugs now being introduced that do have a chelating effect. It's not inconceivable that this has some benefit."

In a telephone interview, Dr. Kitchell reiterated Dr. Meltzer's reservations. Their final report, he said, reflected their belief that chelation therapy "wasn't worth anything, the results didn't last, and they had no real meaning." When asked to comment on the good results obtained in patients treated with chelation, he said that he had heard from professors of medicine that there were no good results.

Shortly after the Meltzer-Kitchell reappraisal appeared, chelation therapy suffered another blow. For many years, Abbott Laboratories and other manufacturers of EDTA were allowed to state on the package insert that it was "possibly effective in the treatment of occlusive vascular disease." But the Kefauver-Harrison Act of 1962 compelled the pharmaceutical manufacturer to prove conclusively that the product is effective for the conditions stated on the package insert. At that time, the additional tests required to prove EDTA effective by FDA standards for the treatment of atherosclerosis would have cost Abbott about a million dollars. Abbott's patents on EDTA were about to expire, so the company chose not to conduct the study.

Thus, when arguing against chelation, the AMA, the American Heart Association (AHA), the insurance companies, and the nonchelating doctors quote the disclaimer on the EDTA package insert: "Not recommended for the treatment of generalized arteriosclerosis associated with advancing age." But the text of the package insert did not explain the animated vigor of the attacks on chelation by the AMA and other chelation opponents.

The cynical argument that chelation therapy has not undergone double-blind trials for efficacy is a hollow one; since the patent rights on EDTA have expired and the substance is in the public domain, there exists no motivation for any commercial or private interest to fund such trials.

But the absence of double-blind or controlled studies of chelation therapy does not mean that there is no scientific evidence for its efficacy. Because of the sophisticated radioisotope and other techniques now available for studying blood flow, chelation therapists can measure improvement in the health of their patients with modern technological, noninvasive methods, before and after treatment, and several studies based on these methods have been published.

Dr. Lloyd Grumbles was among the first physicians to use radioisotope blood-flow studies to test the efficacy of chelation. A scientific paper he authored that demonstrated increased blood flow following chelation created a great deal of excitement among his colleagues. But despite the blood-flow studies showing that chelation improved circulation to the brain and the extremities, the medical establishment has continued to denigrate chelation as scientifically unfounded.

While the AMA claims it has no official position on chelation therapy, when asked for information about the treatment, it sent two reprints and an AMA bulletin, all critical of chelation. One reprint was from a September 1975 issue of the *Journal of the American Medical Association:*

"There are several sites in the United States and Canada where this therapeutic fad currently is in vogue and where the zealot peddles these wares to the naive afflicted. Symposia and miniconventions have been organized to extol its virtues. . . . We have been startled and chagrined . . . to learn that a number of physicians ascribe to this drug an efficacy that has not been established by fundamental clinical investigation. . . . I endorse completely the current position of the AMA Department of Drugs that 'until adequate evidence becomes available to establish the therapeutic worth of (EDTA) in atherosclerosis, its status in respect to this condition must be regarded with skepticism.' "

A second article sent by the AMA was reprinted from a 1975 issue of the *Western Journal of Medicine.* Based on research that took place in the fifties and sixties, the article specifically mentions one of two deaths linked to the therapy. Both occurred before any safety procedures for administering EDTA chelation had been established. The article concludes, "Because of the risk of severe renal toxicity, and the lack of objective evidence suggesting therapeutic benefit from EDTA therapy for atherosclerotic disease, such therapy should be regarded as investigational and conducted under carefully controlled conditions in an academic institution by experienced investigators."

That the AMA should have disseminated such outdated materials calls into question the AMA's motivation and credibility. In the past 20 years, numerous studies have been conducted that prove EDTA is not renal-toxic. One such study, which appeared in *Toxicology and Applied Pharmacology* in 1967, stated that "advice to the effect that renal function should be followed in patients receiving these chelates is consistent with good medical practice, but the label 'nephro toxin' is unjustified." In 1982, *The Journal of Holistic Medicine* reported that chelation "is not neurotoxic. There is even a suggestion that this treatment procedure may improve kidney functions."

The AMA bulletin sent with the two reprints contained a mere summary statement of the factional bias against chelation therapy. Noting that chelation therapy for atherosclerosis "is controversial," it questioned chelation's effectiveness and safety, quoting some anonymous writer in a 1982 medical newsletter as saying that the adverse effects of EDTA "can be lethal." The AMA bulletin piled hearsay upon hearsay, and dropped lots of names: "The American Heart Association has also reviewed the data and found no scientific evidence to support the claims of benefit in patients with atherosclerosis. This opinion is shared by the American College of Physicians, the American Academy of Family Physicians, the American Society for Clinical Pharmacology and Therapeutics, the American College of Cardiology, and the American Osteopathic Association." Virtually all of these organizations are closely affiliated with the AMA, no attributions are provided, and no scientific studies or objective research are cited. In other words, while the AMA has "no official stand on the use of chelation therapy," it is overwhelmingly against it.

The position of the top echelon of the AHA is hardly more liberal. But there are indications of wide dissent on the county level. This became particularly apparent in two articles that appeared in a spring 1983 issue of a publication disseminated by the Nassau County, New York, chapter of the AHA.

One of these articles concluded that chelation therapy "might be a very potent supplemental treatment, along with proper diet and nutrition, to use in addition to medical treatment before utilizing the last recourse of surgery."

The other article summed up the AMA's stand on chelation: "They tell the public that because there isn't enough scientific data (after they have excluded studies which they refused to print in their journals) the therapy should not be used until vigorously tested in properly controlled

clinical trials. Yet, according to the report entitled 'Assessing the Efficacy and Safety of Medical Technologies' published by the Office of Technology Assessment as commissioned by the United States Congress, 'it has been estimated that only 10 to 20 per cent of all procedures currently used in medical practice have been shown to be efficacious in controlled trial.' Therefore, '80 to 90 per cent of all procedures have been evaluated by informal methods . . . personal experience [being] perhaps the oldest and most common informal method of judging the efficacy and safety of a medical technology.' And then they tell the inner circle [of the medical establishment] that clinical trials are not warranted and don't even ask for them! In fact, if anyone gets too insistent, they refer the media and professionals to two different sources within the AHA National Center. Evidently to get two versions of the truth."

The AHA also claims it has no "official position" on chelation therapy, but it circulates some of the same material issued by the AMA.

In 1976, a group of antichelation doctors—members of the California Medical Association—introduced a resolution before its governing body to prohibit the use of chelation therapy in the treatment of atherosclerosis, and to expel any member who used it. But before the resolution could be passed, there was a demand for a fair hearing by chelating physicians.

A number of prochelation physicians testified about the results in their patients, and extensive clinical documentation was presented. But the governing body deemed EDTA an "experimental drug," and recommended that its use for atherosclerosis be reported to the FDA for prior approval. As a result of the committee's decision, every doctor in California received a letter from the state board regulating medical practice advising that physicians who administered chelation therapy were subject to losing their license unless they had prior permission from the FDA.

On behalf of independent physicians justly fearful of such ironfisted control of medicine, a committee of the American Academy of Medical Preventics (AAMP) turned to the attorney general of California. The attorney general let it be known that the federal Food, Drug and Cosmetic Act didn't preclude a physician from administering EDTA for a condition not specified in the claims filed by the manufacturer with the FDA or the parallel state agency. However, they labeled it an "experimental drug."

The California Board of Medical Examiners retaliated with a ruling that superseded its previous notice. After quoting the attorney general, the board nevertheless required any physician administering EDTA "or any other drug, for an 'unapproved use' " to "provide a full explanation of the risks and benefits of the therapy, alternatives thereto, and make an explicit statement to the patient that clearly informs him that the manufacturer does not make any claims regarding the effectiveness or safety of the drug when it is used for these unapproved indications."

In this uneasy atmosphere, physicians using chelation therapy in California have been able to continue their practice. Yet others have not been so lucky. There is more than one case in which a chelating physician has been harassed and/or prosecuted for treating his or her patients with EDTA. Let's look at the case of Dr. H. Ray Evers, a licensed practicing physician in Alabama since 1940, who began using chelation therapy in 1964 with himself as his first patient. Over time, he observed excellent results in treating cardiovascular disease and degenerative conditions with EDTA.

Dr. Evers was operating a hospital and nursing home in Andalusia, Alabama,

> Dr. Eckerly believes that the ability of chelation to help with cardiovascular symptoms is the key to a greater understanding of aging and health.

when years of unsuccessful harassment by the state finally culminated in 1978 with the involvement of the FDA. As the court's decision reads: "The case was spearheaded against Dr. Evers by the Food and Drug Administration and alleged 1) that Dr. Evers had been engaged in promoting and administering EDTA in the treatment of atherosclerosis; 2) that the labeling of the drug, namely the package insert . . . approved by the FDA, indicated that the drug is recommended for treatment for heavy metal poisoning but not for the treatment of atherosclerosis; 3) that patients treated by Dr. Evers were being subjected to an unwarranted risk of grave physical injury or death as a result of the treatment; and 4) that the promotion and administration of EDTA amounted to mislabeling of the drug in violation of [standing] interstate commerce regulation.

"Dr. Evers contended that as a licensed physician . . . he has the right and duty to use and prescribe drugs which in his opinion are in the best interest of the patient. Dr. Evers also contended that the FDA does not prohibit a licensed physician using a drug for a disease in a patient in any manner which is not contraindicated on the package insert. . . . The court established the fact that the legal issue in this case was . . . whether a licensed physician may be enjoined from prescribing for his patients a drug of which the package insert is silent as to whether the drug is indicated or contraindicated for the patient's illness."

Contrary to the AMA line that chelation has not been clinically shown to help atherosclerosis, the overwhelming evidence submitted to the court made short shrift of that theory. The court found that many reputable medical experts in the United States and abroad are convinced that atherosclerosis may be satisfactorily treated with chelation therapy, that the risks when the therapy is properly administered to select patients are minimal, and that, in many cases, the probable benefits outweigh the probable risks of treatment.

The court said that Congress did not intend the FDA to interfere in a physician's treatment of his patient. It stated that "when physicians go beyond the directions given in the package insert, it does not mean they are acting illegally or unethically, and Congress did not empower the FDA to interfere with medical practice by limiting the ability of physicians to prescribe according to their best judgment." The court decided that Dr. Evers was not misbranding the drug in question, and the FDA lost its case against him.

Even though the FDA lost the case, its harassment of doctors practicing chelation therapy continues unabated. Peer pressure, media harassment, and sheer frame-ups have forced some physicians to either cease practicing chelation or risk losing their licenses.

Dr. Alan Grossman (not his real name), a surgeon practicing in Salt Lake City since 1958, had never had any problems with the Utah medical community until February 1976, when he began treating a few patients with chelation. He was then visited by a representative from the Salt Lake City Medical Board. The message was clear that Grossman must stop practicing or risk losing his license.

Trained as a surgeon, and with a wife and family to support, Dr. Grossman decided that he could not afford to continue using chelation therapy, even though his patients had shown significant improvements after treatment. He wrote the medical societies a letter to that effect, and has not practiced chelation therapy since. In spite of his acquiescence, he still feels the sting of ostracism. Dr. Grossman says, "They don't forget. They feel threatened because chelation might cause them to lose money. Double the money, that would wake them up fast!"

Although there has never been a suit against a physician using chelation in North Carolina, three doctors in the state were charged by the state board of medical examiners in November 1984 with

using EDTA for vascular disease. The board claimed that this was grounds for revoking the doctors' licenses. Drs. John Laird, Ted Rozema, and Logan Robertson responded to these charges by requesting a hearing where they could present evidence that chelation was a safe and effective treatment for vascular diseases. Lawyers for the physicians and the state board are now negotiating the terms under which the hearings will be held. Dr. Laird told *Penthouse* that shortly after the board brought charges, his malpractice-insurance carrier notified him that his coverage would be reconsidered if he continued to practice chelation. It should be noted that the state board has yet to pass a rule prohibiting physicians from practicing chelation.

The Minnesota state licensing board recently succeeded in driving two chelationists out of the state and "persuading" a third to stop practicing it.

Dr. Jeanne Eckerly was the last chelation therapist tackled by the Minnesota board. It was not the first time she had heard from her state licensing board. When one of her patients submitted Blue Cross/Blue Shield claims, they were refused on the grounds that the drug is experimental—and the state attorney general's office, on behalf of the state licensing board, began investigating by calling her patients. Finally, this past May, she was called before the state board's disciplinary committee.

She showed up with two lawyers, described the results she had obtained with chelation, presented incontrovertible evidence that it is efficacious, ethical, and legal, and urged the board to obtain more education on it.

They agreed to hold a forum and did. Despite the overwhelming evidence in favor of chelation presented by AAMP expert Dr. Garry F. Gordon, and the paucity of data by the opposing expert, at its next meeting the board proposed a rule declaring chelation unprofessional. When one board member cited a Florida Supreme Court decision that a licensing board does not have the right to so limit the practice of medicine, the rest modified the proposed rule to allow for a controlled, double-blind study.

The proposed rule is now before a hearing officer. If it is approved, Dr. Eckerly said, she will probably take them to court.

The Minnesota Medical Association also has passed a resolution describing chelation as unproven and enjoining its members from practicing it. (Dr. Eckerly is not a member; so, she said, it doesn't affect her.) That action, together with the licensing board's, has intimidated other physicians in the state. Dr. Eckerly knows of a physician whose patient would have had to travel to a distant state for chelation. The patient implored the physician to administer the treatment. The doctor finally agreed to do so—but only on the condition that the patient would safeguard the doctor's anonymity and would not discuss the treatment with others!

One moving aspect of all these cases is the loyalty chelation patients have shown their doctors. Every one of Dr. Robertson's patients has given him an affidavit to present to his medical board stating how satisfied they are with his chelation treatment; several state unequivocally that he saved their lives. Dr. Eckerly, too, said she was moved to read the letters written on her behalf by her patients, particularly those who had been previously diagnosed by other physicians as hopeless. Reading those letters confirmed her conviction of the value of chelation therapy. She continues to feel that if there is a strong likelihood that chelation therapy will help a patient, it is unethical *not* to use it.

In Indiana, the state licensing board held a hearing to discuss a proposal to limit the use of chelation to cases of digitalis overdose, hypercalcemia (an excess of calcium in the blood), and heavy lead poisoning. Dr. Gordon of the AAMP testified at the hearing, citing both research data and international authorities, one of them the highest-ranking cardiovascular surgeon in Holland, in support of chelation. Nonetheless, Gordon reported, a prominent witness against chelation got "really testy," accusing chelationists of killing people.

The board was presented with a petition signed by over 3,000 chelation patients asserting their right to choose chelation over coronary bypass. However, the board refused to hear more than ten minutes of what they called "anecdotal evidence."

No decision was made at that meeting. At a subsequent one, a proposal "allowing" physicians to practice chelation if they informed patients of the risks was suggested. It is unlikely that even this condition will be part of the final proposal. More likely, according to informed sources, the final proposal will be to prohibit chelation. If it's approved, the proposal will go to the state attorney general and the governor to be signed into law.

Patients are discussing filing a class-action suit against the board if the proposal is adopted. In Florida and California, similar legislation was overturned by the state supreme courts. Indiana would be the first to make chelation illegal. Michigan's state licensing board, too, is moving to try to make chelation illegal, but they have decided to postpone their decision until after a hearing.

Why are all these attacks on chelation therapy and its practitioners occurring at this particular time? Many chelating doctors, experiencing heat from local medical societies or licensing boards, feel that the AMA is behind the present "reign of terror."

There is some evidence to support that view: Two of the authorities most often quoted in newspaper and magazine articles attacking chelation are William Jarvis and John Renner. Both are associated with the American Council on Science and Health (ACSH), a private organization that receives funding from the AMA and the pharmaceutical and chemical industries.

Jarvis, quoted in a *Science News* article, called chelation a fraud and accused chelationists of avoiding a discussion of safety or efficacy. Renner was quoted in the same article as saying that chelation therapy will exceed laetrile "in misery and money."

Evidence that a national campaign may be afoot to outlaw chelation and other alternative therapies includes Renner and Jarvis's participation last fall in a National Health Fraud Conference sponsored by the U.S. Postal Service, the Federal Trade Commission (FTC), and the FDA. The conference featured Renner and Jarvis as speakers as well as another member of the ACSH's Board of Scientific Advisers—Stephen Barrett, M.D. Interestingly, the biographies of these ACSH board members distributed at the conference did not mention their ties to the ACSH.

The Evers case, the harassment of Dr. Grossman, and the current actions by state licensing boards are all manifestations of the opposition to change in organized medicine. The health-insurance companies also wish to preserve the status quo. Therefore, any new or innovative therapy has a difficult time becoming established. The long-term solution is to have the public sufficiently educated to ask their orthodox physicians to learn about chelation therapy.

Probably the most enlightening commentary about this situation was given by Judge Ernest G. Barnes, on November 13, 1978, resulting from the FTC's lawsuit against the AMA and some of its medical affiliates. After a legal battle lasting nine months, the judge determined that the AMA has produced a "formidable impediment to competition in the delivery of health care services by physicians in this country. That barrier has served to deprive consumers of the free flow of information about the availability of health care services, to deter the offering of innovative forms of health care and to stifle the rise of almost every type of health care that could potentially pose a threat to the income of . . . physicians in private practice. The costs to the public in terms of less expensive . . . more improved forms of medical services are great."

In view of Judge Barnes's decision and the continued difficulty of many doctors in practicing chelation therapy without harassment, some chelating doctors are going on the offensive.

Commonsense dictates that the medical community should explore chelation therapy as an alternative treatment for atherosclerosis and other degenerative diseases. By now, massive clinical data to warrant such exploration have accumulated. However, most of the existing data are not available to physicians

through the major medical journals. Some of them have appeared in *The Journal of Holistic Medicine*. Unfortunately, this journal is not indexed by the National Library of Medicine. So, although articles have been written and papers published about chelation therapy, there is virtually no way of informing the country's physicians of the existence of these data, and the widely circulated medical journals continue to refuse to publish research on chelation therapy.

But chelating physicians are hopeful. The medical community has always been conservative and slow to change, but many dedicated physicians are now beginning to take more interest in chelation therapy. Some chelating physicians report that the number of patients referred to them by cardiologists is definitely on the rise; others report an increase in curiosity about chelation from their colleagues. The time is ripe for an objective evaluation of chelation therapy by the medical community at large.

Dr. Eckerly, the only remaining chelation therapist practicing in Minnesota, says she considers chelation therapy an "intriguing phenomenon." She is continually amazed at the results she gets with patients. Ultimately, she believes, the value of chelation therapy will lie in what it will tell us about how the body really functions. Whatever EDTA is doing, she says, is the result of some principle that we don't know how to name yet. She believes that the ability of chelation to help with cardiovascular symptoms is the key to a door—a door that will open into a greater understanding of aging and health: "It must be investigated further. Here we've got ahold of something that's having a positive effect on about 80 percent of the people we give it to. You can't just say, 'Well, no.' "

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