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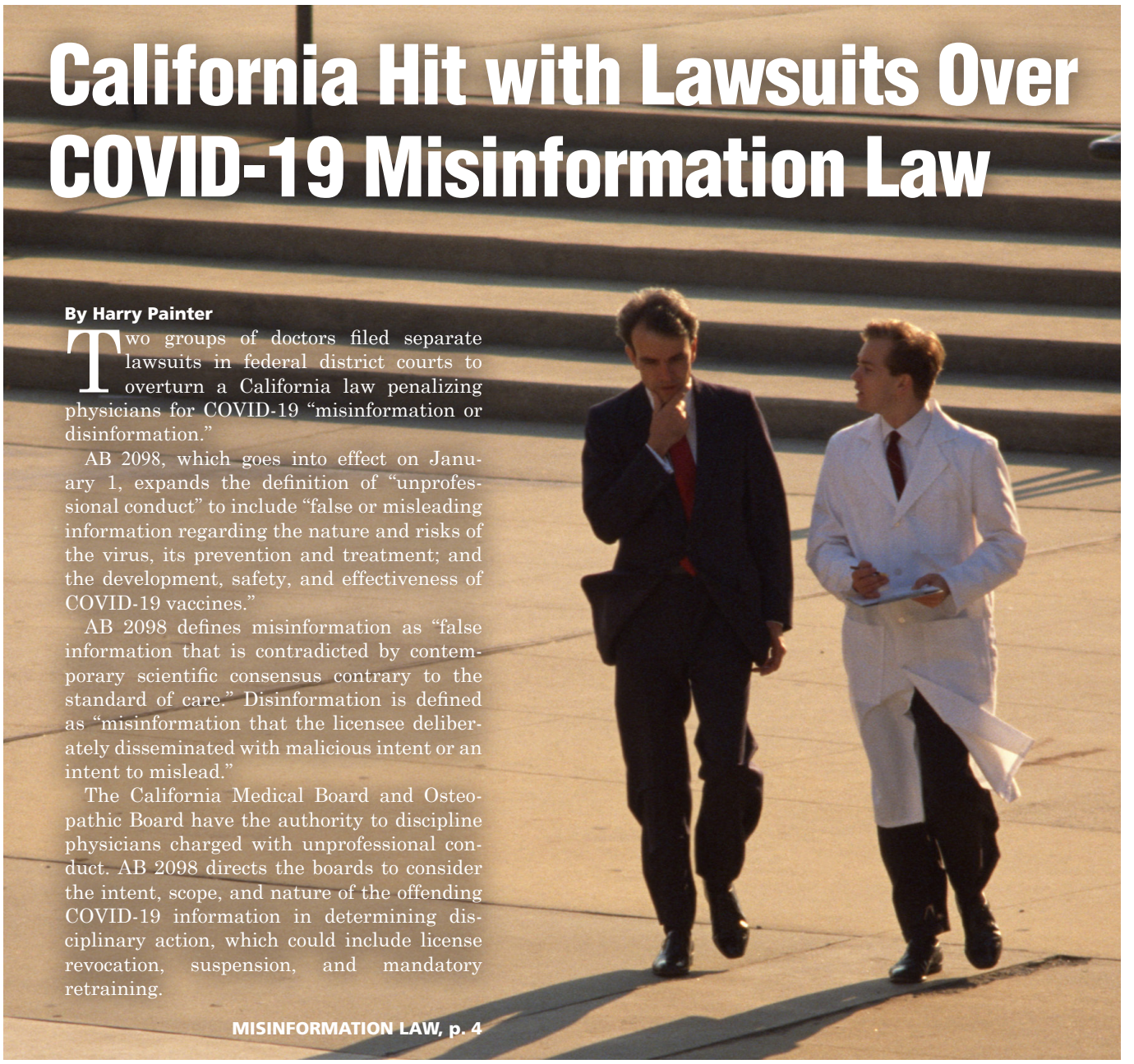
The Pulse

California Hit with Lawsuits Over COVID-19 Misinformation Law



By Harry Painter

Two groups of doctors filed separate lawsuits in federal district courts to overturn a California law penalizing physicians for COVID-19 "misinformation or disinformation."

AB 2098, which goes into effect on January 1, expands the definition of "unprofessional conduct" to include "false or misleading information regarding the nature and risks of the virus, its prevention and treatment; and the development, safety, and effectiveness of COVID-19 vaccines."

AB 2098 defines misinformation as "false information that is contradicted by contemporary scientific consensus contrary to the standard of care." Disinformation is defined as "misinformation that the licensee deliberately disseminated with malicious intent or an intent to mislead."

The California Medical Board and Osteopathic Board have the authority to discipline physicians charged with unprofessional conduct. AB 2098 directs the boards to consider the intent, scope, and nature of the offending COVID-19 information in determining disciplinary action, which could include license revocation, suspension, and mandatory retraining.

MISINFORMATION LAW, p. 4

Fungal Pathogens Pose Increasing Challenge, Says WHO

By Kevin Stone

The incidence of invasive fungal infections among hospitalized patients increased significantly during the COVID-19 pandemic, states the World Health Organization (WHO).

Fungal infections pose a growing threat because of their increasing resistance to the four available classes of antifungal medications and the lack of alternatives being developed, the WHO says.

Fungal pathogens are ubiquitous and not much of a concern for healthy

FUNGAL PATHOGENS, p. 6

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HHS Report Encourages Return to Mask Mandates

By AnneMarie Schieber

A U.S. Department of Health and Human Services (HHS) report raises the specter of a return to mask mandates.

The 57-page report, "Health+ Long COVID Human Centered Design Report," recommends public policies to "protect everyone," including mask mandates and social distancing in public spaces, and lists ways to "increase public awareness" of Long COVID.

The report states the long-term effects of COVID-19 can "be mild and barely perceptible, or they can be ever-present and wholly debilitating." Long COVID can affect not just physical health but also "social determinants of health" such as "financial stability, the report states. Other concerns cited in the study are "discrimination from health care providers due to race, ethnicity, age, gender, or sexual orientation" and a disproportionate effect on people "of color."

The report, published in November, is one of three released after President Joe Biden directed HHS in April to coordinate a government-wide strategy to deal with Long COVID.

"Scientifically, I put no weight into this report. It was not designed by health care professionals or scientists. It was created by a team of visual graphic designers."

RIKIN MEHTA, PHARM.D., J.D.

Visual Appeal

The HHS report, compiled by the design agency Coforma, is filled with eye-catching graphics, photographs, and personal anecdotes from people who describe their continuing fear of COVID-19 and how the disease has victimized them and hurt their personal relationships and finances.

The report is not credible, says Rikin Mehta, Pharm.D., J.D., a biotech entrepreneur, former consumer safety officer at the U.S Food and Drug Administration, and adjunct professor at Georgetown University Law Center.

"Scientifically, I put no weight into this report," said Mehta on the *Heartland Daily Podcast* on November 30. "It was not designed by health care professionals or scientists. It was created by a team of visual graphic designers."

'A Frivolous Report'

The report is a waste of time and money, says Doug Badger, a senior research fellow at the Center for Health and Welfare Policy at The Heritage Foundation and author of an April 2021 report titled "The CDC and Mask Mandates: Unmasking the Truth."

"[The HHS report] includes no medical data on Long COVID and offers no therapeutic advice to people with Long COVID," said Badger. "Instead, its 'human-centered design' produced a collection of quotes from people who told interviewers they have Long COVID."

Badger cites a student named Shannon who told the report's authors, "I don't have time to be a professional patient. I'm still living my life."

"The report is filled with similar vacuities, including 30 definitions of Long COVID that patients contributed," said Badger. "'I used to be a Lexus, and now I'm a broken Honda' is among those definitions. Long COVID is a vaguely defined and poorly understood condition. It demands rigorous scientific inquiry, not a frivolous report of this kind."

Possible Policy Effects

In addition to mask mandates and social distancing, the report recommends employers and schools accommodate people with Long COVID, including workplace training, hiring incentives, hazard pay, financial assistance for current and former students, mandated insurance benefits, more staffing to accommodate Social Security Disability claims, and Long COVID ratings for health providers.

The public should be concerned because the recommendations can easily become policies of the Biden administration, says Mehta.

"Given the unpredictability, the flip-flopping we've seen with the [Centers for Disease Control and Prevention], I think these types of reports that would normally be shelved may come back to be used as foundational guidance to push mandatory restrictions or serve as the basis for some outlandish public policy," said Mehta.

Debatable Priorities

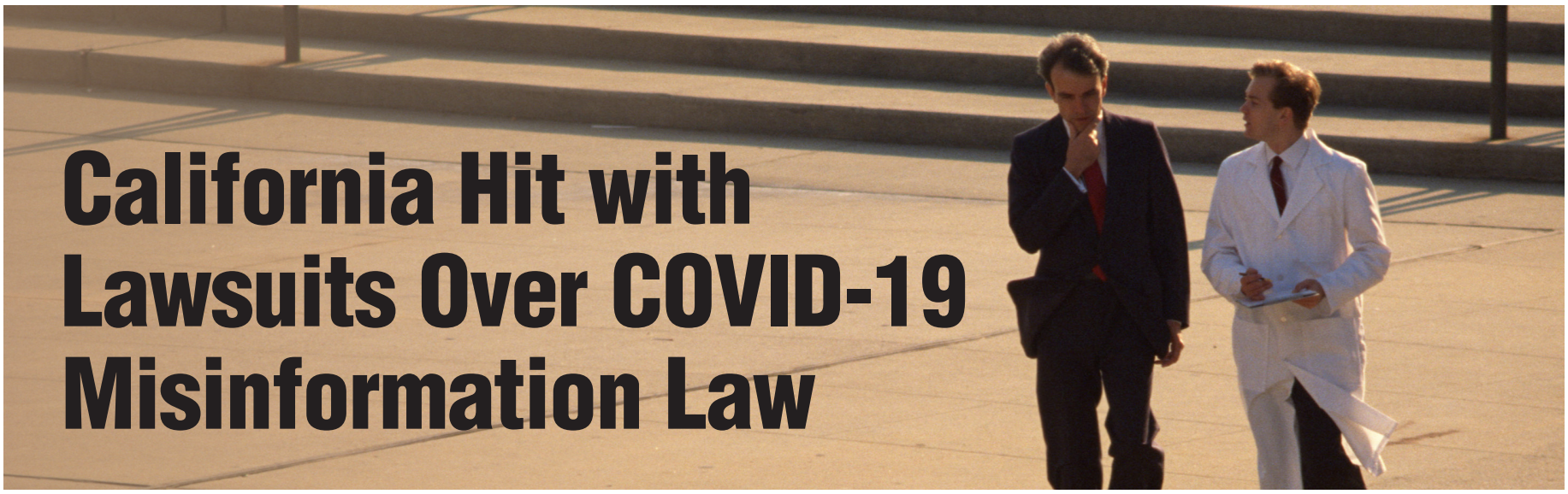
If the government really wants to do something meaningful to address Long COVID, it should bring back hard science and statistically significant research reports with study designs, not compile anecdotes, says Mehta.

"Not what we call 'customer journey' experiences," said Mehta. "Unfortunately, what this report has done is taken a narrow subset of patients, such as those who suffer from Long COVID, and make that the most important health issue, ignoring the other health issues we face—whether it's mental health challenges, suicide rates, or social isolation."

Badger says the public is unlikely to accept mask mandates again.

"Public health authorities failed to establish the value of mask mandates, and most people have moved on," said Badger. "People view masking as a personal choice. That's unlikely to change. Mask mandates would not be well-received, especially if they involved the masking of children."

AnneMarie Schieber (**amschieber@heartland.org**) *is the managing editor of* Health Care News.



California Hit with Lawsuits Over COVID-19 Misinformation Law

Continued from page 1

'Weapon to Intimidate'

McDonald v. Lawson, filed in October by the Liberty Justice Center (LJC) against the California Medical Board and the state's attorney general on behalf of two California physicians, alleges AB 2098 violates the First and Fourteenth amendments.

An article on the LJC's website states, "Two doctors are standing up against the power grab by California bureaucrats to protect physicians' free speech rights and to ensure they can advise their patients without interference."

Høeg v. Newsom, filed in November by the New Civil Liberties Alliance (NCLA) representing five California doctors, also alleges First and Fourteenth Amendment violations.

The NCLA's "case summary" for *Høeg* argues AB 2098 infringes on the doctors' rights to free speech and due process of law and prevents them from providing quality care.

"The law not only interferes with the ability of doctors and their patients to freely communicate but it has already been used as a weapon to intimidate and punish doctors who dissent from mainstream views," states the summary on NCLA's website.

'Severe Chilling Effect'

AB 2098 violates doctors' constitutional rights, says Jenin Younes, lead counsel on the *Høeg* case.

"By subjecting doctors to discipline for communications with their patients, the law infringes doctors' First Amendment rights to free speech," Younes told *Health Care News*. "Moreover, because they may be disciplined for saying anything about COVID that diverges from the 'scientific consensus'—which term is not defined—this creates a severe chilling effect."

Based on the way the law is written, physicians cannot know whether the advice or treatment they are giving clashes with a scientific consensus, says Younes.

"That presents Fourteenth Amendment problems since the Due Process Clause requires laws be clearly defined so people know whether or not they are acting lawfully," said Younes.

"Any law that tries to dictate a physician's conversation with his or her patient is destructive to the privacy of the patient-physician relationship."

MARILYN SINGLETON, M.D., J.D.

Shifting Consensus

The forced adherence to "scientific consensus" also raises philosophical and medical concerns, says Younes.

"Advances are made when doctors use their experience and knowledge to pursue treatment avenues that may currently not be within the 'consensus,'" said Younes. "As we've seen with COVID, the so-called consensus at any given point in time has turned out to be bad practice or untrue—for instance, ventilating those presenting with severe illness, or the concept that the vaccines stopped transmission, which we now know they do not."

The law is already limiting doctors' speech, says Laura B. Powell, an attorney working on Høeg.

"The law already has had real-world effects," said Powell. "It sends a message to doctors that if they say anything about COVID that has not clearly been sanctioned by government officials, they risk losing their licenses. Doctors are already self-censoring, and that chilling effect on constitutionally protected speech is one of the reasons the law is unconstitutional."

Informed Consent, Privacy Concerns

AB 2098 violates several principles of health care, including informed consent, says Marilyn Singleton, M.D., J.D., a board-certified anesthesiologist who has practiced in California.

"The speech AB 2098 seeks to regulate is the exact speech engaged in during a patient's consultation with his or her physician," said Singleton. "Informed consent means discussing all aspects of a condition with a patient. COVID-19 is no exception to our duty to provide informed consent to treatment."

Another principle at stake is protected conversation between doctor and patient.

"Any law that tries to dictate a physician's conversation with his or her patient is destructive to the privacy of the patient-physician relationship," said Singleton.

Scientific consensus is also a problematic concept, says Singleton.

"Scientific consensus is useful in evaluating patients' symptoms and potential treatments, but it doesn't apply neatly to every case," said Singleton.

CDC Info Lag

Singleton says the assumption in the law that doctors should follow advice from the Centers for Disease Control and Prevention (CDC) is flawed.

"Often, the CDC's newsletters lag behind what clinicians see in their daily practice," said Singleton. "A physician's job is to do what is best for his or her patients, not wait for CDC newsletters—which may or may not have correct information."

'Test Case for Other States'

Although AB 2098 is a state law, it is being challenged in federal court and could have national implications, says Powell.

"AB 2098 is the first law of its kind and represents a test case for other states," said Powell. "There is an organized national effort to pass laws like this one, which was launched by the Federation of State Medical Boards in July 2021. If AB 2098 is not struck down by the courts, it is much more likely that other states will pass similar laws."

"Hopefully, the lawsuit will end in favor of the plaintiffs," said Singleton. "This may discourage other states from enacting similar legislation. On the other hand, it may educate states on the precise language to use to pass constitutional muster."

Plaintiffs in both cases sought preliminary injunctions against enforcement of AB 2098 while the courts consider the merits of their complaints. No judicial ruling had been made as of press time.

Harry Painter (**harry@harrypainter.com**) *writes from Oklahoma.*

INTERNET INFO

Complaint, "*Høeg v. Newsom*," U.S. District Court for the Eastern District of California, November 1, 2022: **https://nclalegal.org/wp-content/uploads/2022/11/Complaint_Hoeg-v.-Newsom-final-complaint.pdf**

Complaint, "*McDonald v. Lawson*," U.S. District Court for the Central District of California, October 4, 2022: **https://libertyjusticecenter.org/wp-content/uploads/2022/10/2022-10-04-McDonald-v-Lawson-Complaint.pdf**

Novavax Booster Now Available

By AnneMarie Schieber

There are four options for COVID-19 immunity protection in the United States after the Food and Drug Administration (FDA) granted an Emergency Use Authorization (EUA) for the first booster for Novavax in October.

Novavax, which uses a more traditional, protein-based approach to viral immunity, received an EUA in July, 18 months after the FDA gave emergency approval to the two inoculations using messenger RNA technology (Pfizer-BioNTech and Moderna shots), and one that delivers the virus's DNA via a weakened version of another virus (Johnson and Johnson).

Anyone aged 12 years or older can get the Novavax two-dose series. The booster shot can be taken by adults six months after completion of the first shots.

Unlike the other vaccines, Novavax triggers the body's immune system with a small piece of the virus itself, the SARS-CoV-2 spike protein, produced in insect cells. Similar technology is used in vaccines for shingles, hepatitis B, and human papillomavirus (HPV). AstraZeneca's vaccine for COVID-19 is also protein-based and is available in 170 countries. It has not been approved for use in the United States.

'More Adaptable'

Another vaccine platform such as Novavax and its booster couldn't have come at a better time, said Raymond March, an assistant professor at North Dakota State University and research fellow at the Independent Institute, on the *Heartland Daily Podcast*.

"A novel virus often starts out very strong and can be very destructive," said March. "When it mutates, it does so in a way to get around current immunization. It loses its oomph but becomes a lot more contagious. Novavax—because it is made from protein-based materials—is a lot more adaptable and amenable to subvariants."

Novavax can be stored at higher temperatures than the mRNA vaccines. That could make it more accessible in harder-to-reach communities.

America is fighting two new omicron subvariants, BQ 1 and BQ 1.1, and the World Health Organization has warned of new and even more threatening COVID-19 variants.

'May Be Preferable'

Although there are more options now, all the current COVID-19 vaccines are risky, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"Novavax may be preferable," said Orient. "It is still a spike protein, but your own body doesn't keep making it for who knows how long. We still don't have long-term safety data and won't for years. There have been no tests of vaccines versus early or prophylactic treatment."

Ivermectin and hydroxychloroquine are two generic drugs that have been used safely for years, and many physicians found them to be effective against COVID-19. There are also newer early treatment drugs such as Paxlovid.

Orient says the performance of the vaccines has been disappointing.

"With new variants, this vaccine [Novavax] may be like the flu vaccine: at best 30 percent efficacy in some years," said Orient. "Why take an as-yet-unknown risk for an unimpressive benefit?"

'We're Not Sure'

Novavax, based in Maryland, developed its COVID-19 vaccine early during the pandemic, in 2020, but in the interest of getting a vaccine to market quickly, the federal government's Operation Warp Speed (OWS) focused on mRNA technology.

OWS removed regulatory obstacles and provided financial guarantees so manufacturing development could begin before the vaccine demonstrated efficacy and safety.

Focusing on one technology might have been the fastest course to get a vaccine out while the virus was at its most destructive point, but it was a risky approach, says March.

"When you put all your eggs in one basket, like having vaccines only with mRNA, you risk the problem of when the virus mutates and you need a new vaccine to address a different strand," said March. "When that happens, you have government policies focused on this kind of vaccine which may not be what the pandemic needed or what we need to address COVID going forward.

"We have a lot more strains that can cause harm, and we're not sure what that is going to look like going forward," said March.

"A novel virus often starts out very strong and can be very destructive. When it mutates, it does so in a way to get around current immunization. It loses its oomph but becomes a lot more contagious. Novavax—because it is made from protein-based materials—is a lot more adaptable and amenable to subvariants."

RAYMOND MARCH
ASSISTANT PROFESSOR
NORTH DAKOTA STATE UNIVERSITY

'Free the Market'

The experience with COVID-19 has provided lessons on how we should respond to public health crises, says March.

"There were a lot of mistakes, and some very serious, which cost lives, livelihoods, and made public health worse in some instances," said March. "There are two lessons we should remember when dealing with widescale emergencies like this. First, it is generally better to free the market than control people. Instead of going into lockdowns and protective measures and trying to restrict economic and personal freedom, it is generally better to deregulate and let the supply side of the market, the innovation of medical professionals or scientists, try to address the problem."

COVID-19 testing was one area where the private sector came forward quickly when regulators got out of the way. Although the Moderna and Pfizer vaccines have helped and were developed at record speed, it is shortsighted for government to pick winners and losers, says March.

"We can't expect a policy to possibly predict what COVID-19 or any [other] pathological virus might be three or four years in the future," said March. "Only the market can possibly anticipate that."

AnneMarie Schieber (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

Fungal Pathogens Pose Increasing Challenge, Says WHO

Continued from page 1

people. However, serious fungal infections afflict 300 million people worldwide, with 25 million at high risk for death or blindness, according to Global Action for Fungal Infections.

Many fungal infections are opportunistic and occur in patients who are immunosuppressed because of other illnesses. The WHO says the greatest risk is for those with cancer, HIV/AIDS, chronic respiratory disease, or post-primary tuberculosis infection or who have received organ transplants.

The WHO released a list of fungal pathogens posing "the greatest threat to human health" on October 25, 2022. The list of 19 fungal pathogens is prioritized based on unmet research and development needs and perceived public health importance.

COVID Connection?

One of the two primary drugs used to treat COVID-19 patients in hospitals is Olumiant (baricitinib), a last-resort treatment for acute rheumatoid arthritis, which can reduce resistance to fungal infections.

The drug's information sheet states, "Patients treated with baricitinib are at risk for developing serious infections that may lead to hospitalization or death," including "invasive fungal infections, candidiasis and pneumocystosis."

Nearly one million COVID-19 patients have been treated with baricitinib in approximately 15 countries, according to Eli Lilly, the drug's developer.

The WHO and other global health organizations recommended the use of Olumiant for hospitalized COVID-19 patients. The WHO claimed baricitinib "improved survival and reduced the need for ventilation, with no observed increase in adverse effects."

The WHO attributes the sudden rise in fungal infections to climate change and globalization.

"Emerging evidence indicates that the incidence and geographic range of fungal diseases are both expanding worldwide due to global warming and the increase of international travel and trade," states the WHO.

"Throwing money at this problem and rushing to develop antifungal drugs, which have all had progressively terrible safety profiles resulting in serious morbidity and mortality, is not a practical solution. It will be a no-win situation as long as illegal immigration into the United States exists."

DAVID GORTLER
PHARMACOLOGIST, PHARMACIST, AND DRUG SAFETY EPIDEMIOLOGIST

Questions About Effectiveness

The U.S. Food and Drug Administration (FDA) granted an emergency use authorization (EUA) for baricitinib to treat COVID-19 patients in certain circumstances, on November 19, 2020.

The EUA was met with skepticism. Four physicians expressed concerns about the clinical trial used to justify the EUA in a December 5, 2020 article published by the Insider LifeStyles website. The article quoted researcher Ilan Schwartz, M.D., Ph.D. of the University of Alberta as calling baricitinib a "nothing burger."

"We're talking about adding a drug that reduces the time to clinical improvement by one day, in a disease that takes weeks to recover," Schwartz said.

Schwartz, now at Duke University, told *Health Care News* he was mistaken.

"I was very wrong, and I very much regret that comment," said Schwartz. "The totality of evidence, which is quite robust, supports that baricitinib is life-saving in carefully selected patients with severe COVID-19."

Others have found baricitinib to be of minimal therapeutic value in treating COVID-19. A 2021 top-level panel of medical professionals in India investigating the drug for the Indian Council of Medical Research found the clinical evidence unconvincing and recommended against its use, *The Economic Times* reported on May 14.

Olumiant's high price tag has raised questions about why the drug was given an EUA. Olumiant costs $2,497.20 for a 30-day supply of 2 mg tablets, or $4,994.40 for a 30-day supply of 4 mg tablets, according to Eli Lilly.

Containment Policy

David Gortler, a pharmacologist, pharmacist, and drug safety epidemiologist who served as a senior advisor to the FDA commissioner from 2019 to 2021 and is a scholar and fellow at the Ethics and Public Policy Center, questions the WHO's push for new fungal infection drugs as well as its earlier recommendation of baricitinib.

"This is not the first time the WHO has given terrible or flat-out wrong and highly political and wasteful policy advice, which is why the Trump administration correctly cut off their funding after they spread false information about COVID-19," said Gortler.

"While inherent and acquired resistance to antifungals has been reported worldwide, the focus should be on preventing the spread of [fungal] disease: not allowing the disease to spread, then developing a cure for it," said Gortler.

Border Control

Drug-resistant fungal infections have emerged in developing countries and may be on their way to the United States, says Gortler.

"Extensive public health research shows that these types of drug resistances exist because of inadequate or incompetent public health policies in immunocompromised patients in poorer countries," said Gortler. "With rampant illegal immigration already a major problem in the United States, and with the end of Title 42 restrictions under Biden, it is almost a certainty fungal resistance will present itself as a major problem to Americans in the United States. Development of emerging antimicrobial drugs could also take away the focus of research into America's leading causes of death, such as cancer, Alzheimer's Disease, and heart disease."

Instead of rushing to send money to drug companies, the federal government should ensure infected people are not crossing the nation's borders illegally, says Gortler.

"Throwing money at this problem and rushing to develop antifungal drugs, which have all had progressively terrible safety profiles resulting in serious morbidity and mortality, is not a practical solution," said Gortler. "It will be a no-win situation as long as illegal immigration into the United States exists."

Kevin Stone (**kevin.s.stone@gmail.com**) *writes from Arlington, Texas. AnneMarie Schieber* (**amschieber@heartland.org**), *managing editor of Health Care News, contributed to this article.*

States, Parents Reject Forcing Vaccines on Children

By Harry Painter

Numerous states have rejected the Centers for Disease Control and Prevention's (CDC) recommendation that children get COVID-19 shots.

The CDC recommended giving COVID-19 shots to children along with standard immunizations in October after the CDC's Advisory Committee on Immunization Practices unanimously voted to add them to the vaccine schedule.

Although the CDC recommendations aren't binding, many states and schools use the CDC childhood immunization schedule to create their own vaccine requirements.

After the CDC's announcement, Arizona, Arkansas, Florida, Indiana, Iowa, Mississippi, Montana, Oklahoma, South Carolina, West Virginia, and Wyoming stated they would not add COVID-19 shots to their government-school vaccine schedules.

Currently, 21 states have banned COVID-19 vaccine mandates, according to the National Academy for State Health Policy.

States Cautious About Mandates

Policymakers in many states have been cautious about instituting widespread mandates, says Joel Zinberg, M.D., J.D., a senior fellow at the Competitive Enterprise Institute and director of the Health and American Well-Being Initiative at the Paragon Health Institute.

"Throughout the pandemic, many states have been reluctant to mandate vaccines for anyone outside of medical care and other limited settings," said Zinberg. "State and local authorities are undoubtedly cognizant of parental concerns over the limited benefit of the vaccines for healthy young people and the uncertain safety profile."

The Food and Drug Administration (FDA) distinguishes between its regular approval process and emergency use authorization (EUA), which means a shot is not approved but is allowed because of a public health emergency. The Moderna and Pfizer-BioNTech shots have received EUAs for six-month-old babies, teens, and adults.

State vaccine mandates have been limited to groups specified in the EUAs, says Zinberg.

"The few jurisdictions that have, or are discussing, mandates are only doing so for age groups that the FDA has approved the vaccine for, not merely authorized it," said Zinberg.

Children's COVID Risk Low

Widespread vaccination of children is not medically indicated for COVID-19, says Zinberg.

"COVID is a relatively benign disease for healthy young people," said Zinberg. "Outside of people who are immune-suppressed or have underlying medical problems, the risk of death from COVID for young people is negligible. In addition, the safety profile for kids is still not completely clear."

COVID-19 vaccines are not like the other vaccines required for children to attend government schools, says Zinberg.

"COVID vaccines are different than other vaccines since they do little to limit transmission of disease with the newer viral variants," said Zinberg. "The primary benefit of COVID vaccines is in reducing disease severity."

Vaccine Safety Concerns

Safety concerns are a key reason parents are saying no to shots for their young children, says Twila Brase, president of the Citizens' Council for Health Freedom.

"Studies show children face more risks from the shot than from the virus," said Brase. "COVID variants are less impacted by the shot, the shot's effectiveness is waning, studies point to immune imprinting as a problem with effectiveness, and there's never been research on the long-term effects."

Severe side effects of the vaccines have been reported in children, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"The long-term effects on fertility, birth defects, and carcinogenesis cannot possibly be known," said Orient. "Testing on children has been extremely limited. Serious safety signals, including death, are being ignored or denied."

Calls for Informed Consent

Instead of mandating vaccines, informed consent should be the standard, says Zinberg.

"A rational policy for states regarding COVID vaccines and children is to make the vaccines available, disseminate safety and efficacy information as it becomes available, and to leave the decision-making up to parents," said Zinberg. "Parents and their pediatricians have the most information on children's underlying health conditions and whether they create increased risk of severe COVID disease for a particular child."

Orient says every state should refuse to mandate COVID-19 shots and should prohibit them outright for children.

"Jabbing children with a product that is of no proven benefit to them and can kill them or cause grievous permanent harm is an outrageous violation of human rights and medical ethics," said Orient. "All states should be refusing to mandate these. The United States should follow the example of Denmark and prohibit them."

'The End of Freedom'

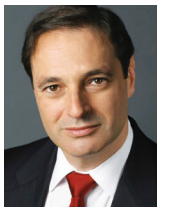
States should eliminate all vaccine mandates, not just mandates for COVID-19 vaccines, says Brase.

"Bodily autonomy is essential for individual freedom," said Brase. "If the government can violate a person's body at will, that person has no freedom, except at the pleasure of the state. There should be no vaccine mandates."

Technology has made it possible for governments to push the limits on health rights, says Brase.

"Diseases have affected others since time began," said Brase. "Only now, with expanded technologies, do the capabilities exist to suppress human rights *en masse* under the guise of protecting humanity. This kind of mandate leads inexorably to the end of freedom, the end of human and inalienable rights, and the imposition of a totalitarian biosecurity state."

Harry Painter (**harry@harrypainter.com**) *writes from Oklahoma.*



"A rational policy for states regarding COVID vaccines and children is to make the vaccines available, disseminate safety and efficacy information as it becomes available, and to leave the decision-making up to parents. Parents and their pediatricians have the most information on children's underlying health conditions and whether they create increased risk of severe COVID disease for a particular child."

JOEL ZINBERG, M.D., J.D.
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INTERNET INFO

"States Address School Vaccine Mandates and Mask Mandates," The National Academy for State Health Policy, November 3, 2022: **https://www.nashp.org/states-enact-policies-to-support-students-transition-back-to-school/**

Ambulance Shortage Plagues Texas

By Kenneth Artz

A shortage of new ambulances is preventing fire departments in Dallas and other north Texas cities from updating their fleets, resulting in slower emergency response times and increased fleet maintenance costs, says Dallas Mayor Eric Johnson.

The delays jeopardize public safety in Texas and other states across the nation, said Johnson in a letter to U.S. Transportation Secretary Pete Buttigieg in October.

"From order to delivery, obtaining a new ambulance now takes at least 24 months, compared to a 90-120 day wait time pre-pandemic," Johnson wrote.

Slowdown in Manufacturing

The shortage of emergency vehicles is happening because everything that is manufactured has been delayed significantly during the last two years, says John Dale Dunn, M.D., J.D., an emergency physician in Brownwood, Texas.

"Delays in the supply chain are so common now you could write a book on this subject," said Dunn.

Anything requiring a significant manufacturing effort takes longer, sometimes months longer, than it used to, says Dunn.

"Let's say you decided to go out tomorrow and buy a generator for your house: you would wait months," said Dunn. "Five years ago you could have had it the next day; you could have even had it overnighted. Now there's just no supply, no manufacturing going on."

Parts supplies are a big problem for vehicles made in the United States, says Dunn.

"The economy is in the tank, and they can't make ambulances because they can't make cars, trucks, generators, and so forth," said Dunn. "These are not things built in Asia, then shipped overseas. These are things that have a lot of parts going into them, so you end up with local assembly being delayed by parts supply."

Increased Response Times

Problems with manufacturing and the shortage of parts for repair and maintenance are reducing the numbers of ambulances on the street, and that slows response times, says Dunn.

"When the ambulances aren't functioning, then it obviously reduces the number of response units that are available, which guarantees longer response times and [reduces the] adequacy of the emergency network," said Dunn. "A reduction in the number of ambulances is definitely going to impact the ability of ambulance services to provide good response times."

The shortage of emergency vehicles causes critical delays in treatment, says Dunn.

"If you don't care, then it's no big deal," Dunn said. "But if you do care, then you have to say ambulance response times in big cities are important."

Kenneth Artz (**KApublishing@gmx.com**) w*rites from Dallas, Texas.*

"The economy is in the tank, and they can't make ambulances because they can't make cars, trucks, generators, and so forth. These are not things built in Asia, then shipped overseas. These are things that have a lot of parts going into them, so you end up with local assembly being delayed by parts supply."

JOHN DALE DUNN, M.D., J.D.
EMERGENCY PHYSICIAN

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Lockdowns Blamed for Surge in Respiratory Illness

By Ashley Bateman

An early seasonal surge in a common pediatric respiratory virus could be the result of COVID-19 lockdowns and over-sterilization during the pandemic.

Although the number of cases of respiratory syncytial virus (RSV) infections varies from year to year, this season's levels appear to be five to 10 times higher than similar periods in 2018, 2019, and 2020, according to the RSV Hospitalization Surveillance Network.

RSV can cause severe health complications, particularly for infants, children, and older adults. Reported cases and hospitalizations have been rising in multiple regions throughout the United States.

Cases of influenza are also up. According to the Center for Infectious Disease Research and Policy at the University of Minnesota, 47 states reported increases in hospitalizations and outpatient care for the flu. Rates have been highest for those aged 85 and older and children under age four. Preliminary data shows 4.32 percent of patients who were hospitalized have also tested positive for COVID-19.

Lockdown Connection

The surge in RSV cases is no accident, says Chad Savage, M.D., an internist and founder of Your Choice Direct Care, president of DPC Action, and policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"The immune system learns to defend against viral respiratory infection through exposure to low levels of virus," said Savage. "Thus, attempts to mitigate COVID spread by sterilizing the environment may have inadvertently caused the immune systems of children, isolated from their peers, to become 'naive' toward many common infections."

That can lead to severe symptoms after children are re-exposed, a deficiency known as an "immunity gap."

Spike in Infections, Severity

The United States and other nations that mandated widespread lockdowns, increased sterilization practices, and social distancing experienced a wave of unusually severe respiratory and influenza infections in 2021. In the summer of 2021, the Centers for Disease Control and Prevention (CDC) confirmed numbers nearly 200 times higher than the previous year.

Authorities knew the lockdowns would lead to a spike in other viral infections, says Savage.

"All of this was known pre-pandemic, yet [public authorities] did this anyway," said Savage.

The lockdowns may also cause an increase in sensitivity to allergens, says Savage.

"Atopic conditions, [such as] asthma, allergies, and eczema, are also known to be much worse in children raised in hyper-sterilized environments," said Savage. "Thus, the next most predictable thing may be that we could expect to be causing an atopic generation of children. Children may grow to have higher rates of asthma than prior generations."

'A Very Powerful Tool'

SARS-CoV-2 has a lower fatality rate than RSV in the pediatric population. On average, 60,000 to 80,000 children less than five years old are hospitalized for RSV each year. Although the infection is mild for most people, RSV may be responsible for one in 50 pediatric deaths.

Although this year's RSV numbers are much higher, the CDC has reassured the public "most of the time RSV will cause a mild, cold-like illness."

"I would actually contend that this tone is correct, as for most people RSV is mild," said Savage. "However, the same is true for COVID, but the tone is one of fear instead of reassurance with caution about what to monitor for in case you are the rare severe case."

Authorities hyped up concern about COVID-19 while downplaying RSV and other diseases that are less lucrative for governments, pharmaceutical companies, and health care providers, says Twila Brase, president and cofounder of the Citizens' Council for Health Freedom and a policy advisor to The Heartland Institute.

"Public health proved to be a very powerful tool in the hands of those who wanted to seize power over the American people [during the pandemic]," said Brase.

"Some states have learned lessons and changed their emergency health powers laws in the past two years or will change them in the coming legislative session," said Brase. "Other states, whose political leadership did not change, will likely hold on to those powers for future restrictions on human rights."

Ashley Bateman (**bateman.ae@googlemail.com**) *writes from Virginia.*

"The immune system learns to defend against viral respiratory infection through exposure to low levels of virus. Thus, attempts to mitigate COVID spread by sterilizing the environment may have inadvertently caused the immune systems of children, isolated from their peers, to become 'naive' toward many common infections."

CHAD SAVAGE, M.D.
FOUNDER
YOUR CHOICE DIRECT CARE

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Lawsuit Aims to Reverse Abortion Drug Approval

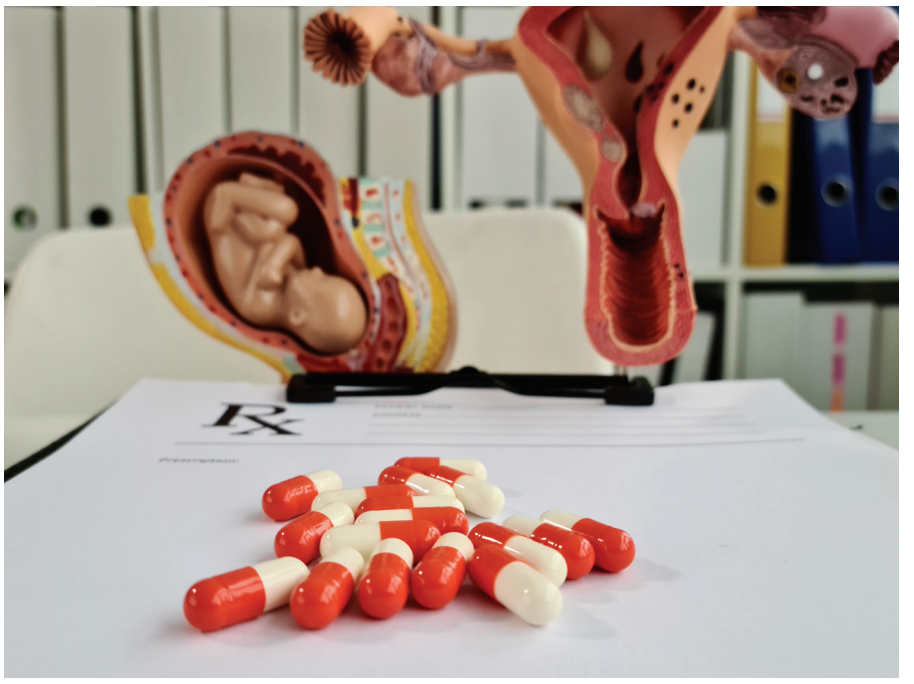
By Harry Painter

A coalition of doctors and medical groups is suing the Food and Drug Administration (FDA) and the U.S. Department of Health and Human Services to reverse the agencies' approval of the abortion-inducing drug mifepristone in 2000.

The Alliance Defending Freedom (ADF), a public interest law firm, is representing the plaintiffs, who are led by the Alliance for Hippocratic Medicine. The ADF successfully challenged the U.S. Supreme Court's 1973 *Roe v. Wade* decision, which was overturned by the Court's June 2022 decision in *Dobbs v. Jackson Women's Health Organization*.

The ADF filed the complaint in the U.S. District Court for the Northern District of Texas, on November 18.

"By illegally approving chemical abortion drugs, the U.S. Food and Drug Administration failed to abide by its legal obligations to protect the health, safety, and welfare of girls and women," the ADF states on its website.



"By illegally approving chemical abortion drugs, the U.S. Food and Drug Administration failed to abide by its legal obligations to protect the health, safety, and welfare of girls and women."

ALLIANCE DEFENDING FREEDOM

'Advanced Provision'

Chemically inducing abortions at home became more prevalent as a way to terminate pregnancies when FDA regulations were relaxed during the COVID-19 pandemic, reports *The Wall Street Journal*.

The FDA says it is "concerned" about health care providers prescribing abortion medication to women who aren't pregnant, "an FDA spokesperson granted anonymity to describe sensitive agency policies told Politico," *Politico* reported on October 31.

Prescribing mifepristone in advance of pregnancy is an unauthorized and potentially dangerous practice that prevents proper oversight of safety and effectiveness, the spokesperson told *Politico*.

"Advanced provision" is the explicit policy of some telemedicine providers, such as Choix, as well as some in-person providers, in reaction to state restrictions on abortion, according to a Bloomberg report.

In December 2021, the FDA began allowing physicians to prescribe abortion pills via telemedicine appointments and to ship them by mail to the patient, according to *Politico*.

'Was All Very Predictable'

Concerned doctors have been warning the FDA for a long time about the advance provision of abortion pills, says Ingrid Skop, M.D., an obstetrician and senior fellow and director of medical affairs at the Charlotte Lozier Institute.

"I'm glad they're finally recognizing [the danger], but this was all very predictable," said Skop. "We're no longer making sure the person who gets the pills is the person who wants to get an abortion."

The FDA has loosened the standards for abortion prescriptions over time, says Skop.

"When the FDA approved mifepristone in the year 2000, they had very strict criteria," said Skop. "The doctor who was going to prescribe it had to intentionally register to be an abortion provider. They had to get specific training. They were required to give it directly to the woman. They were required to be available if the woman had complications."

If an abortion failed, "someone who was able to perform surgery needed to be available," said Skop.

'Surprised When It Fails'

Non-doctors such as nurse practitioners and physician's assistants can now prescribe mifepristone, and although a doctor is supposed to be available as a backup, that is not the reality, says Skop.

"What happens is these women are surprised when it fails [or] when they have a complication," said Skop. "Many times, they don't go back to the abortion provider, but they are afraid and [then] go to an emergency room."

According to data from Europe, about 5 percent to 8 percent of women who undergo a chemical abortion fail to evacuate all the material, says Skop.

"They either hemorrhage or they have an infection, and they need to have surgery," said Skop.

'Dangerous for the Woman'

Advance prescribing of the abortion pill "is a very hazardous idea that has been under consideration by the abortion industry for some time," said Genevieve Marnon, legislative director for Right to Life of Michigan,

"In 2019, abortionist Daniel Grossman applied for a clinical trial of advanced prescription of mifepristone; the trial has subsequently been withdrawn," said Marnon.

Marnon said the risks of chemical abortions are underplayed.

"Self-diagnosed pregnancies in the absence of an ultrasound providing proper gestational dating and ruling out ectopic pregnancy makes chemical abortion dangerous for the woman," said Marnon. "In the case of ectopic pregnancy, taking mifepristone could lead to a missed diagnosis and subsequent rupture of the fallopian tube."

'Removed These Restrictions'

Skop says part of the increased danger of chemical abortions is caused by changes to the Risk Evaluation and Mitigation Strategy (REMS) regulations that apply to certain drugs, such as mifepristone.

"What we have seen over time is that the FDA has progressively removed these restrictions little by little," said Skop. "In 2016, they changed some of the REMS restrictions. It used to be that you could only do the abortion pill up until seven weeks' gestation. They changed it to 10 weeks."

The FDA also loosened its requirements for reporting complications, says Skop.

"They no longer required complications to be reported unless someone died," said Skop.

'Cut Doctors Out'

The requirement for the prescribing doctor to see the patient in person was eliminated because of the COVID-19 pandemic, says Skop.

"There's no longer a physical exam required," said Skop. "There's no longer an ultrasound required. There are no longer labs required."

Marnon says the pandemic renewed the push for self-managed abortions.

"For years, abortion supporters said an abortion decision should be between a woman and her doctor," said Marmon. "Now they want to completely cut doctors out of the process."

The arrangement also happens to be financially convenient for the industry, says Skop.

"They [abortion doctors] have charged historically about the same amount [for prescriptions] as they do for a surgical abortion," said Skop.

Harry Painter (**harry@harrypainter.com**) *writes from Oklahoma.*

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Millionaires Can Get Medicaid for Long-Term Care

By AnneMarie Schieber

In six years, baby boomers will start reaching the age of 85, when the need for long-term care (LTC) spikes, and more families will turn to a government health program, primarily Medicaid, to foot the bill.

Government programs fund 72.3 percent of all long-term care in the United States, according to data cited in a report by the Paragon Health Institute.

Medicaid is the largest source of taxpayer funding, at 42.1 percent, or $200.1 billion. Medicare funds 18.2 percent of all LTC costs.

Dependence on these programs for LTC spells trouble ahead. Medicaid, which covers individuals of all ages, already covers a disproportionate share of seniors, while Medicare is facing insolvency.

"The key is for Congress to make it more difficult for people with significant income or assets to qualify for Medicaid to finance their long-term care expenses. Removing Medicaid as a long-term care safety net for the relatively affluent will incentivize people to properly plan for potential long-term expenses in the future."

BRIAN BLASE
PRESIDENT
PARAGON HEALTH INSTITUTE

'Fallacy of Impoverishment'

Medicaid is the government's health care safety net, but for LTC it has become a hammock, says Stephen Moses, president of the Center for Long-Term Care Reform and author of the Paragon report "Long-Term Care: The Problem."

"The common wisdom is you have to become impoverished before the government helps you with long-term care, but the truth is very different," Moses told the *Heartland Daily Podcast* on November 1. "I call it 'the fallacy of impoverishment.'"

The 40-page report shows how liberal enrollment policies disincentivize families from saving for LTC and how dependence on Medicaid and Medicare has compromised care and driven out more innovative, cost-efficient options.

"It behooves analysts and policymakers to consider how public financing created and worsened LTC's problems before proposing more of the same to fix those problems," Moses writes.

Many attempts have been made to fix LTC, but proposals often rely on payroll tax-funded social insurance programs such as Medicare, said Moses.

"Before adopting a new government program, policymakers should confront several questions [such as]: How did LTC become so dysfunctional in the first place?" said Moses.

Medicaid LTC Workaround

Moses describes how higher-net-worth individuals can qualify for Medicaid to pay for LTC.

"Income is rarely an obstacle to qualifying for Medicaid for long-term care, because most states allow you to subtract your private health and long-term care costs from your income," said Moses on the podcast. "Other states allow you to divert money into something called a Miller 'income-diversion' Trust, and then you qualify. Assets, likewise, are rarely a problem because most are exempt from Medicaid eligibility [guidelines]."

In many cases, families gravitate to Medicaid when they discover the cost of private LTC and the limits of Medicare coverage. The bill could easily exceed income, and many families don't think about it until it is too late. Families often turn to "Medicaid planning" law firms that find ways to protect assets legally and exploit loopholes.

The paper gives real examples of cases documented by state governors. In one case, a North Dakota couple sheltered $700,000 in liquid assets by purchasing a more expensive house, car, and annuity. Another couple qualified for Medicaid for the husband after purchasing a $900,000 annuity for the wife to receive $8,900 a month. The wife's income was exempt from the income calculation.

"The sole purpose of those annuities is to 'impoverish' the Medicaid applicant as quickly as possible by transferring the funds to the spouse," said Moses.

Cost of Care

When a senior requires care, families have several options, but all of them come with shocking price tags.

A private room in a nursing home can cost $297 a day, according to the report. There is assisted living at $4,500 a month or home health aides at $27 an hour. Some families provide care on their own, but that can come with an opportunity cost because caregivers may leave the workforce.

"A third of aging people won't need long-term care at all, but 20 percent will need five or more years," said Moses.

Although families can qualify easily for government financing, Medicaid is notorious for low reimbursement rates. That has a big effect on the industry, as the report states only 7.6 percent of nursing home residents are paying privately. Home health care is not much different, with 10.2 percent of the bill paid by private sources.

To manage low reimbursements, nursing homes have become more institutional. Over time, state Medicaid programs encouraged home-based care, which faces several challenges, ranging from worker shortages and poor quality of care to more risk of waste, fraud, and abuse.

Private LTC Insurance

Families can purchase LTC policies, but they are costly, says Moses.

"Long-term care policies are more expensive than they would have to be if it weren't for government policies," said Moses. "At government-imposed interest rates near zero, the insurers couldn't get the anticipated and needed return on their reserves, so they had to raise premiums."

It is critical for Congress to start pushing for private options now, says Brian Blase, president of the Paragon Health Institute.

"The key is for Congress to make it more difficult for people with significant income or assets to qualify for Medicaid to finance their long-term care expenses," said Blase. "Removing Medicaid as a long-term care safety net for the relatively affluent will incentivize people to properly plan for potential long-term expenses in the future."

One selling point for lawmakers would be to remind voters there is a trade-off when government foots the bill, says Blase.

"Medicaid has a longstanding bias toward nursing home care that is often of low quality," said Blase. "Private financing would open up more alternatives for people if they need long-term care, including a greater ability to receive services in their home."

Moses is working on a second report on solutions.

AnneMarie Schieber (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

INTERNET INFO

Stephen A. Moses, "Long-Term Care: The Problem," Paragon Health Institute, October 2022: **https://paragoninstitute.org/wp-content/uploads/2022/10/202208_Moses_LongTermCareTheProblem_FINAL_2.pdf**

U.S. Lab Accused of Gain-of-Function Research

By Bonner Russell Cohen

Republicans on the U.S. House Committee on Energy and Commerce are calling for answers about oversight and funding of Boston University (BU) research that created a highly transmissible COVID-19 strain with the original virus's potential for serious illness.

The leading Republican on the committee, Rep. Cathy McMorris Rodgers (WA), and subcommittee leaders H. Morgan Griffith (R-VA) and Brett Guthrie (R-KY), said the research had not been cleared by the National Institute of Allergy and Infectious Diseases (NIAID), in a letter to BU President Robert A. Brown on October 25.

"Dr. Emily Erbelding, director of NIAID's division of microbiology and infectious diseases, said the BU team's original grant application did not specify that the scientists wanted to do this precise work," the legislators wrote. "Nor did the group make clear that it was conducting experiments that might involve enhancing a pathogen of pandemic potential in the progress reports it provided to NIAID."

"Let's first look at the vaccine safety features, not at esoteric BU research. Shutting the place down and destroying its cultures and data would accomplish nothing but might destroy needed data and expertise."

JANE ORIENT, M.D.
EXECUTIVE DIRECTOR
ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Review Need Disputed

The letter acknowledges BU's claim the research did not require NIAID clearance because the experiments were carried out with funds from BU and did not involve gain of function research. The lawmakers said Erbelding is concerned.

"Asked if the research team should have informed NIAID of its intention to do the work, Dr. Erbelding said: 'We wish that they would have, yes,'" states the congressional letter. "Recent news reports indicate that the NIH is examining whether experiments in the study should have triggered a federal review."

The committee's GOP leaders will have the power to hold hearings and issue subpoenas in the 118th Congress.

Lab Used Transgenic Mice

BU's National Emerging Infectious Diseases Laboratories (NEIDL) created the new hybrid, Omi-S, by grafting the Omicron strain's spike protein onto the ancestral SARS-CoV-2 virus.

Researchers used different sets of transgenic mice specially bred to be susceptible to SARS-CoV-2. No mice infected with the Omicron variant died. All the mice exposed to ancestral COVID-19 died, and 80 percent of the mice infected by Omi-S died.

BU's research was published in the form of a preprint, which means it was not peer-reviewed.

Lawmakers Request Safety Protocols

The GOP lawmakers asked BU to provide them with numerous documents, including all proposals and progress reports referenced in the preprint or sent to NIAID, and a list of all funding streams related to the study, including support for facilities, equipment, and personnel.

Mohsan Saeed, Ph.D., DVM, who oversaw the BU research, was supposed to stop the study if it created a version of the COVID virus more harmful than the original strain and notify NEIDL Director Ronald Corley, said the lawmakers, citing a report in *STAT News*.

"Dr. Corley said that BU safety protocols require that if researchers produce a pathogen that is more virulent than the Wuhan strain, they must immediately report it to the Institutional Biosafety Committee (IBC)," states the Republicans' letter. "Dr. Saeed's study protocol further stipulated that if such an event occurred, he would immediately stop the work and destroy the viruses, Corley noted."

They also asked Brown to provide a copy of the BU safety protocols, including the reporting requirement to the IBC and a copy of the study protocol for stopping research.

Funding 'Potentially Dangerous Research'

BU says it received no federal funding for the study, but the study credited the National Institutes of Health (NIH) with support to "help develop the tools and platforms used in this research," the university acknowledged.

The importance of the study remains unknown, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"Potentially dangerous research on bioweapons—generally claimed to be 'defensive'—is going on in thousands of laboratories worldwide, possibly including Ukraine," said Orient. "Much of it is funded by the NIH, which is hardly a trustworthy watchdog. The significance of the BU research is controversial, and a high level of expertise in molecular biology would be required to evaluate the claims."

Calls for Different Focus

Policymakers should not let the debate over the BU study distract them from needed actions they could take now, says Orient.

"The furor is a diversion from the two critical issues we can do something about: early treatment with safe repurposed drugs, and the dangers of the vaccines," said Orient. "We can immediately stop suppression of treatment and stop the massive global campaign to 'get a shot in every arm.' We have no idea how many people have heart damage, impaired fertility, or greater susceptibility to cancer."

Orient cautions against taking a wrecking ball to the BU research.

"Let's first look at the vaccine safety features, not at esoteric BU research," said Orient. "Shutting the place down and destroying its cultures and data would accomplish nothing but might destroy needed data and expertise."

'Lost Faith in Scientific Integrity'

We no longer have confidence in medical experts because of the pandemic, says California-based physician Marilyn Singleton, M.D., J.D.

"Amid researchers' claims to ward off the next pandemic, new cures, and the like, sadly we have lost faith in scientific integrity in the age of COVID-19," said Singleton.

"There will always be controversial research," said Singleton. "CRISPR [Clustered Regularly Interspaced Palindromic Repeats] technology that allows the correction of mutant genes or of genetic diseases by slicing out sections of DNA and replacing that removed section with a new, updated sequence of DNA is hailed as a life-changing miracle by many but seen as 'playing God' by others. We don't want to halt advances in science, but we must demand transparency regarding funding sources and a risk/benefit analysis of potentially dangerous research."

Bonner Russell Cohen, Ph.D. (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research.*

Health Care Workers' Ethical Convictions Under Assault: Attorney

By AnneMarie Schieber

Health care workers across the nation could be at risk of losing their jobs over conscience objections, says Kevin Theriot, senior counsel at the Alliance Defending Freedom (ADF).

The ADF is representing Paige Casey, a licensed nurse practitioner in Virginia who was terminated from her job at the CVS drugstore chain for declining to provide abortion-inducing drugs and certain contraceptives to patients.

"I definitely think there will be more of these kinds of cases," Theriot told the *Heartland Daily Podcast* on October 11. "One of the driving reasons is there is a lack of respect for the ethical convictions of health care professionals. We're seeing that across the board, not just with abortion but also with physician-assisted suicide."


Paige Casey

The ADF, a public interest law firm, was one of the legal teams involved in arguing *Dobbs v. Jackson Women's Health Organization* before the U.S. Supreme Court in 2022. The court's decision in *Dobbs* reversed the *Roe v. Wade* decision that had legalized abortion in every state in 1973.

Spotless Record

Casey worked at a CVS MinuteClinic for three and a half years before she was fired on March 29, 2022, says Theriot.

"She let them know early on that she can't prescribe abortifacients, and they accommodated her," said Theriot. "They decided they were no longer going to do that and informed her that they weren't going to accommodate her beliefs, even though there were no complaints from coworkers, patients, or supervisors. She had a spotless record, and two days before she was fired she received a merit-based [pay] increase."

In the lawsuit, *Paige Casey v. MinuteClinic Diagnostic of Virginia*, filed in the Virginia Circuit Court in Prince William County, Casey claims CVS violated the Conscience Clause in Virginia law prohibiting employers from discriminating against health care professionals who ask in writing not to participate in abortions because of religious or ethical beliefs.

Casey is asking for a declaratory judgment, compensatory damages not to exceed $100,000, legal fees, a jury trial, and other relief.

'Super-Woke CVS'

MinuteClinics do not currently prescribe the abortion pills, mifepristone and misoprostol, says Theriot.

"But I could see them attempting to do so in the future," said Theriot. "They are going down that path, and they want their medical professionals to be able to prescribe anything that could be considered a prevention of pregnancy."

News reports have singled out CVS for other "woke" behavior, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute, which co-publishes *Health Care News*.

"Super-woke CVS was in the news for mandating hourly employees 'inventory' their biases against their fellow employees and customers," said Dean. "Retailers like CVS were also able to mandate hourly workers take the COVID-19 vaccine even if the employee believed doing so would violate their religious beliefs."

The COVID mandate and nonspecific accusations of racism set precedents for CVS to limit employees' freedom of thought, says Dean.

"CVS's vaccine mandates might have bolstered Health and Human Services Secretary Xavier Becerra in his threat to hold drugstores liable for civil rights violations against women seeking abortifacients from employees who are currently not forced to dispense such drugs," said Dean. "Paige Casey was fired despite the fact Virginia law specifically protects her right to refrain from dispensing abortifacients, as well as the fact CVS honored her clearly defined exception for over three years without a single customer complaint."

'Convenient Battering Ram'

Objections to vaccine mandates are about more than physical safety, says Dean.

"COVID-19 vaccine mandates are providing a convenient battering ram for the woke Left to bash the religious liberties of devout Catholics and other prolife workers," said Dean. "Had the vaccine mandates been successfully challenged, this unprecedented move would likely never have been taken.

"Religious leaders are on notice that they are next, as the abortion lobby moves its battle line from the town drugstore to the church," said Dean.

This legal battle should concern everyone, says Theriot.

"What places like CVS are doing is driving medical professionals [out] from an already taxed medical profession," said Theriot. "You want a medical professional that is ethical."

AnneMarie Schieber (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

"COVID-19 vaccine mandates are providing a convenient battering ram for the woke Left to bash the religious liberties of devout Catholics and other prolife workers. Had the vaccine mandates been successfully challenged, this unprecedented move would likely never have been taken."

MATT DEAN
SENIOR FELLOW
THE HEARTLAND INSTITUTE

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

INTERVIEW

Medical Students Pressured to Go Woke

Increasingly, medical students are required to demonstrate allegiance to a radical progressive ideology. A student at a medical school in Oklahoma discussed with Health Care News *the pressure on students to follow a woke agenda.* Health Care News *agreed not to disclose the student's name to protect the individual from retribution.*

Health Care News: Tell us why you came forward and why you don't want us to disclose your name.

Medical Student: I know how bad things have gotten in medical schools with the woke agenda, and if we are to save the future of health care in America, physicians and others trying to promote freedom in our health care system must recognize the importance of reaching medical students, who are the future of our health care.

As for my name, I'm not afraid to speak about my views, but having my name surface on the internet could hurt me as I apply for residencies.

Health Care News: There is an organization called the Benjamin Rush Institute (BRI), for medical students who want to learn more about free-market practice models. Are chapters welcomed on campus?

Medical Student: Medical schools in more-liberal states won't let students organize a chapter.

Here we have a lot of students now involved with BRI, and it's harder for people to write us off because there are more and more of us, and it takes a willingness to be called radical by 90 percent of your classmates to find the 10 percent who will join you.

BRI recently sent emails to a group of medical students about an upcoming info session on direct primary care (DPC). A school administrator found out about it and emailed everyone in the group warning them BRI is a radical, right-wing, conservative group and urged students not to engage.

Health Care News: Let's talk about the 90 percent of your fellow students who describe you as radical. Do you think that you must watch what you say or do?

Medical Student: They assume everyone is on board. The students in my lab, for example, who participated in protests over the trans surgery [funding ban] assumed everyone agreed with them and would participate.

Health Care News: You're in a conservative state, Oklahoma. How is it the medical students are mostly woke?

Medical Student: Many of them come from conservative families but are brainwashed in college. And now, indoctrination is starting earlier, in high school and middle school. I saw a change in the four years I was in college.

"A lot of people don't realize it, but the higher-profile residency programs have paid staff whose job it is to scrub social media platforms and [perform] Google searches to learn about what applicants have posted. They say it is to address 'professional' concerns, but it is likely to identify the social justice warriors and to make sure they pick someone who won't rock the boat."

MEDICAL STUDENT

Health Care News: What is medical school teaching about the "trans" movement?

Medical Student: We have had to take an entire semester in clinical medicine on gender. We had to learn all the "genders" and "sexual orientations." We had to learn about the pronouns, including simulated conversations with patients about their pronouns.

They talk to us about "big medicine" and how under corporate medicine, or socialized medicine, we will likely have 15 minutes with a patient, but I must spend five of those minutes playing alphabet soup trying to learn about gender preferences.

We are taught to use "assigned at birth" when describing biological sex and some of the lectures use the term "chestfeeding" to describe "breastfeeding." As for the treatments—puberty blockers and cross-sex hormone treatments—we are taught they are harmless and reversible. This is what really worries me, because our next generation of doctors will be treating patients with this kind of training.

Health Care News: If you challenge this thinking, could it impact your career?

Medical Student: A lot of people don't realize it, but the higher-profile residency programs have paid staff whose job it is to scrub social media platforms and [perform] Google searches to learn about what applicants have posted. They say it is to address "professional" concerns, but it is likely to identify the social justice warriors and to make sure they pick someone who won't rock the boat.

We are aware of what has happened to physicians who spoke out on the pandemic, with their licenses being threatened.

Health Care News: Starting in 2022, the Step 1 exam, which is taken at the end of the second year of medical school and used as a criterion in selecting medical students for residency programs, became a pass-fail test. There is also a push to get more diversity in medical school admissions. What impact do you think those changes will have in attracting the best candidates to be our future doctors?

Medical Student: I imagine they are going to start doing away with the MCAT [Medical College Admission Test], which is troubling because it will lower the bar. Is the MCAT or Step 1 test an indication of how good of a physician you will be? No, but that information, like any standardized test, can be critical in showing discipline, commitment, and focus.

In terms of entering medical school, I applied a few years ago and most of my essays were diversity-based. I felt like I was simply writing to what they wanted to hear. Some of it was vague, like how a list of diversity factors could define me.

Health Care News: What is the next step for your chapter of BRI?

Medical Student: The school allows our [BRI] chapter to exist as an approved student group, but I know of medical schools that have banned chapters. To be safe, we decided not to meet on campus, and we don't want to take any medical school money.

The group is not political, and we don't lobby. All we want to do is use it to help students understand all the practice models out there and to think more critically about what they're being taught in medical school.

U.S. News & World Report Develops Hospital Wokeness Rankings

By Kevin Stone

U.S. News & World Report (USN) has developed a "health equity" ranking it may include in its annual ranking of best U.S. hospitals.

The ranking, titled "Best Hospitals: Health Equity Measures," is based on racial disparities in unplanned readmission, charity care provision for uninsured patients, community residents who accessed care at a ranked hospital, and preventive care for black residents in the community.

Data Limitations

In an October 28 article in *Becker's Hospital Review*, USN editors admitted health equity is difficult to measure accurately and it is hard to assign the correct level of responsibility to health care providers.

"We work primarily with Medicare data," said Harold Chen, a health data analyst for USN, the article reports. "For example, if we wanted to look at health equity along the lines of disparities for queer, trans people [sic]. That's really difficult with the data we have. We just don't get that kind of information with what we have."

Tavia Binger, a senior health data analyst, reportedly told *Becker's* COVID-19 and the "racial reckoning" of 2020 "catalyzed conversations around health equity." Becker's did not directly quote Binger.

The criteria for the rankings have come under criticism as vague and representing factors beyond the reasonable control of the ranked hospitals. The term "community," for example, appears to be undefined within the published methodology, and it is unclear how a hospital is supposed to regulate charity to justify the charity care metric.

Politics and Subjectivity

USN's equity rankings are based on highly subjective and politically charged criteria, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute, which co-publishes *Health Care News*.

"When dealing with social determinants of health, how you look, where you live, and how much money your parents make may impact your health, but they don't determine it," said Dean. "Public health experts often get this wrong. Disparities are real, and we should work to make sure that we eliminate upstream drivers of those disparities. However, the thorny root causes are more difficult to tackle than the politically expedient fallback positions of the 'demographics is destiny' caucus who seek to impose identity politics on your medical chart."

Dean has also criticized the inclusion of codes now being used in Electronic Health Records (EHR) labeled "Social Determinants of Health."

The codes include what Dean says are highly subjective criteria such as inadequate housing, housing instability, lodgers and landlord problems; unwanted pregnancy, multiparity, and discord with counselors; and stress on the family caused by the return of a family member from military deployment.

Information vs. Determination

Collecting information about disparities is a good idea as long as analysts recognize all treatment should be tailored to the individual, says Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation.

"On the one hand, I don't see a problem at all with researchers looking at the questions raised for informational purposes," said Matthews. "It's completely appropriate to ask if certain racial minorities have worse outcomes, or whether the data show that certain racial minorities were treated with X while others were treated with Y."

There are many explanations for less-than-optimal outcomes, but racial bias has little to do with it, says Matthews.

"For example, let's say there is a homeless minority patient with a substance abuse problem who may not be up to following a medical regimen," said Matthews. "The standard of care is to provide pills to be taken over several days. The second-best option is a shot given while he is at the hospital. So, the doctor gives him a shot. That decision has everything to do with providing the best care appropriate to this specific patient who may be unlikely to reliably take oral medication, but a ranking might see it as substandard."

A focus on race is of little value in evaluating health care, says Matthews.

"It strikes me as very unfortunate that the media and medicine, in general, are taking this equity turn," said Matthews. "Ironically, most hospitals I am familiar with, especially in the cities, are heavily staffed by minorities who are providing the care."

Concerns: Corruption, Control

Robert Graboyes, an economist and president of RFG Counterpoint, LLC, says equity rankings of hospitals could have some very negative effects on the delivery of health care.

"The Health Equity Measures (HEMs) document is troubling because, one, 'equity' is now a shapeshifting catchall inviting politicization and racialization of health care; two, HEM components are arbitrary and subjective; and, three, HEMs will encourage hospitals to act in ways that improve rankings while denigrating care—perhaps incentivizing corruption," said Graboyes. "[Finally,] four, HEMs inevitably rank hospitals in part on variables over which they have little or no control—such as patient behavior."

"The Health Equity Measures (HEMs) document is troubling because, one, 'equity' is now a shapeshifting catchall inviting politicization and racialization of health care; two, HEM components are arbitrary and subjective; and, three, HEMs will encourage hospitals to act in ways that improve rankings while denigrating care—perhaps incentivizing corruption. [Finally,] four, HEMs inevitably rank hospitals in part on variables over which they have little or no control—such as patient behavior."

ROBERT GRABOYES
PRESIDENT
RFG COUNTERPOINT, LLC

There are racial disparities in health, says Graboyes.

"In 'Tempering Systemic Racism in Healthcare,' I said that slavery and Jim Crow did terrible damage to African Americans' health and that vestigial effects of that legacy still persist," said Graboyes. "But I also said, 'Many of the policy prescriptions aimed at rectifying these patterns fail to consider the magnitude of their present-day impact, the efficacy of proposed solutions, or the tradeoffs with other societal concerns.'

"'*U.S. News & World Report*'s Best Hospitals: Health Equity Measures' will likely worsen those problems," said Graboyes.

Kevin Stone (**kevin.s.stone@gmail.com**) *writes from Arlington, Texas.*

COMMENTARY

Heart Damage Link to COVID-19 Shots: Tip of the Iceberg?

By Peter McCullough, M.D. and John Leake

The Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA) warned America and the world the mRNA COVID-19 vaccines could result in heart inflammation, or myocarditis, in 2021.

Past incidences of this medical problem unrelated to vaccines occurred at a low rate of approximately four per million population per year, as reported by Arola et al. from Finland. In general, approximately 90 percent of cases occur in men and approximately 10 percent in women.

Managing myocarditis includes stopping all forms of exercise, which can be a driver of the development of heart failure and a trigger for sudden death. In cases where there is a progression to heart failure, cardiac biopsy is commonly performed to establish or rule out a diagnosis of giant cell myocarditis, which has a markedly worse prognosis than the other forms, such as the inflammation caused by parvovirus and other diseases.

Rapid Rise in Cases

COVID-19 vaccination has been thrust on the world with such vehemence that physicians and hospitals have been hesitant to voluntarily report myocarditis cases to regulatory agencies.

The vast majority of physicians took COVID-19 vaccines themselves and may be having trouble personally coming to grips with the threat of heart damage and other risks of vaccination.

In 2021, as agencies received spontaneous reports that predominantly young men were developing myocarditis after COVID-19 vaccination, a pattern emerged. First, the highest risk group was males aged 18 to 24 years, with a skewed distribution and a long tail extending to men in their seventies. Second, approximately 90 percent of cases required hospitalization. Third, the risk exploded after the second injection, and deaths directly due to myocarditis were confirmed by autopsy.

Studies by Independent Scholars

In biological licensing agreement letters to Pfizer and Moderna, the FDA requested prospective cohort studies of myocarditis, including blood tests, electrocardiography (ECG), and cardiac imaging before injections and periodically afterward. The studies would aim to detect the real rate of heart damage and to ascertain how much of the problem could be asymptomatic and potentially present a future risk of sudden death in an unsuspecting patient.

Neither company was forthcoming, so the answer came from Mansanguan et al. from the Bhumibol Adulyadej Hospital in Bangkok, Thailand. Adolescents, ages 13 to 18, were studied in a prospective cohort manner just after the second injection of the Pfizer vaccine, and seven out of 301 (23,256 per million) developed myocarditis according to a clinical definition based on blood tests, ECG, and cardiac imaging.

Data from multiple sources suggest the condition can be subclinical in about half of cases, meaning neither the patient nor the parents bring it to clinical attention. Patone et al. recently reported on 100 fatal cases of vaccine-induced myocarditis in the United Kingdom, and such papers are expected to continue in larger numbers as the medical community begins to fully recognize cause and effect.

Generation at Risk

The spontaneous reports of myocarditis to public health agencies represent the tip of a very large iceberg.

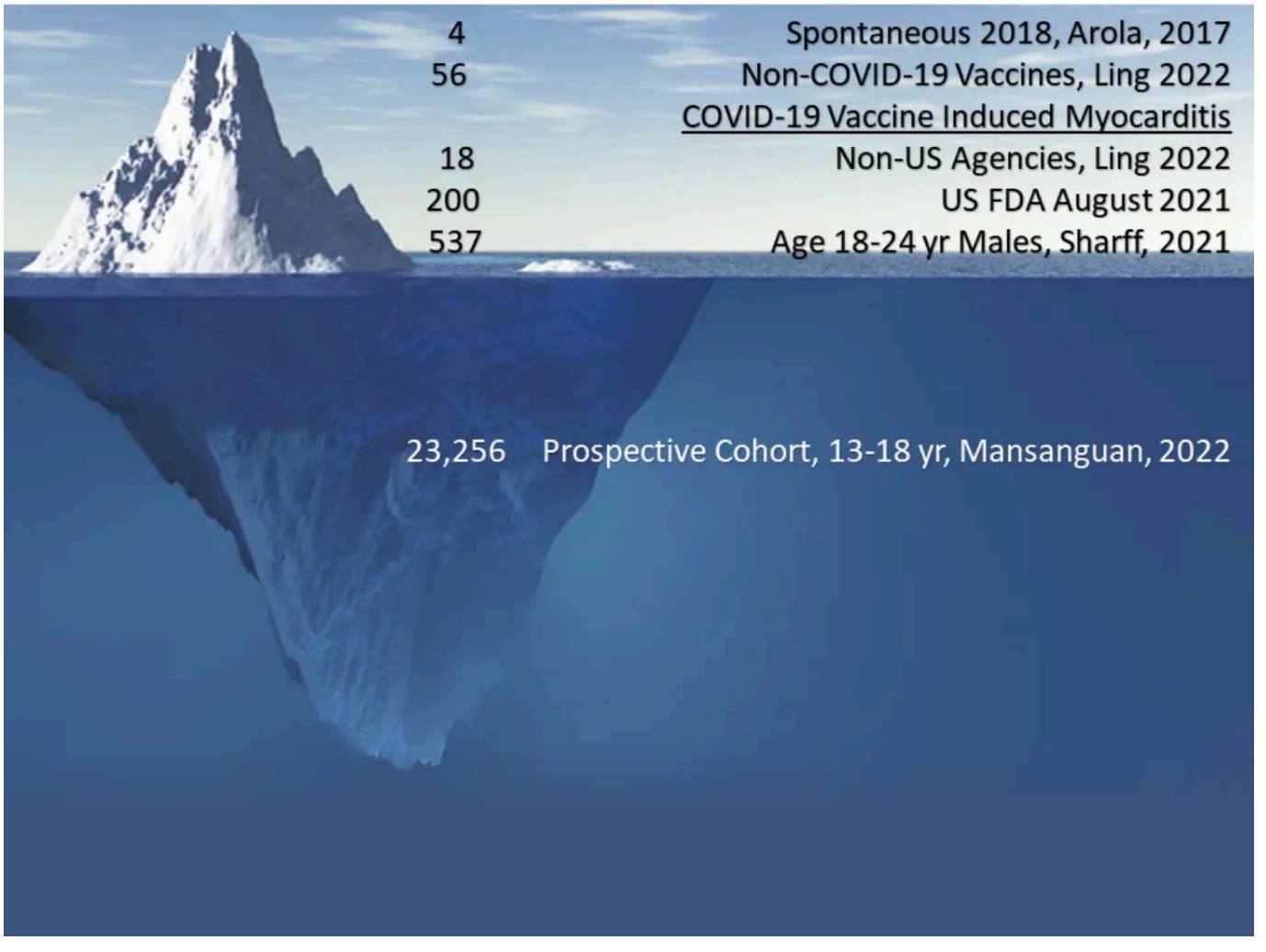
If the estimated incidence of vaccine-linked myocarditis in the Mansanguan study is confirmed, or anywhere close to approximately 25,000 per million, a million young Americans may have sustained heart damage from COVID-19 vaccination, and some of them will be at risk for cardiac arrest and future heart failure.

These data suggest we should not be surprised by rising rates of sudden death among young people while playing sports or during daily life, including sleep. There can be no more urgent need than to halt vaccination and commit a substantial research effort into screening, detection, prognosis, and management of COVID-19 vaccine-induced myocarditis.

The stakes are high: an entire generation is at risk.

Peter McCullough, M.D., M.P.H. (**petermcculloughmd@substack.com**) *is an internist, cardiologist, epidemiologist, and the chief scientific officer of The Wellness Company. John Leake is coauthor, with McCullough, of the book* The Courage to Face COVID-19. *A version of this article appeared in the Courageous Discourse Substack on October 18, 2022. Reprinted with permission.*

Reports of Incidence of Myocarditis Per Million Population Per Year, Compared to Potential Total



California Voters Reject Costly Rules for Kidney Dialysis

Nearly 70 percent of voters in California turned down a November ballot proposal that would have required a physician, physician's assistant, or nurse practitioner to be present during treatment at privately owned kidney dialysis centers in the state.

Proposition 29 was the third attempt by the Service Employees International Union-United Healthcare Workers West union to alter clinic operating rules.

In addition to mandatory staffing, Proposition 29 would have required all physicians to disclose whether they had an ownership share of 5 percent or more in a clinic. The plan would also have limited who could be turned away because of payment problems.

Clinics Would Close

By increasing clinics' operating costs, the proposal would have caused many clinics to close, says Devon Herrick, a health care economist, editor of the health care blog at The Goodman Institute for Public Policy Research, and advisor to The Heartland Institute, which co-publishes *Health Care News*.

"It's not clear what the union hoped to achieve with Proposition 29," said Herrick. "It would have led to the closure and consolidation of many dialysis clinics, inconveniencing patients.

"I can only assume it was a scare tactic to coerce the dialysis industry in California to unionize or face regulations damaging to the industry," said Herrick.

Hardship for Patients

On the blog, Herrick wrote about some of the hardships patients would have faced if the ballot initiative passed.

"Some elderly patients cannot drive and have to be transported to and from clinics," wrote Herrick. "One patient told the LA Times it's not always easy to find open slots and the process is exhausting. Driving an hour to a center, lying hooked to a machine for hours, and driving an hour home is not something patients look forward to."

Opponents and supporters of the measure advertised heavily before the election.

—Staff reports

COMMENTARY

Side Effect of a Public Health Crisis: Bigger Government

By Raymond J. March

A side effect of never-ending declarations of "public health emergencies" is a consequence few people notice at first: an expansion of government known as the "ratchet effect."

Consider the last two years. COVID-19 is likely endemic and will remain with us for the foreseeable future. Fortunately, it is also becoming milder. Some medical research argues current dominant variants are less deadly than the flu. Hospitalizations have also steeply declined in recent weeks. Regardless, President Joe Biden announced he is extending the COVID-19 public health emergency for another 90 days, placing the country under a public health emergency into early 2023. The United States is also under a public health state of emergency for monkeypox.

The extended emergency arrives at a surprising time. On October 21, 2022, there were about 7,100 new COVID-19 cases. Ten months before that, there were one million new COVID-19 cases, according to data collectors at Johns Hopkins University. This reduction occurred despite COVID's continual mutation into more-contagious variants and dramatic curtailing of recommended public health guidelines to contain the spread of the disease.

Why, then, extend the state of emergency? Sadly, the answer probably has more to do with power than public health.

Ratchet Effect

Robert Higgs' masterful book *Crisis and Leviathan* explains that governments rapidly expand their size and power during crises. Through a mechanism called the ratchet effect, governments rarely return to their pre-crisis size, instead often retaining their newly granted powers. Higgs' chilling conclusion is that government growth allowed by a concerned public to end a crisis far outlasts the actual crisis.

One of the simplest ways for a state to expand and extend its control during a crisis is to extend the crisis, even when it is unwarranted.

Government responses to COVID-19 provide one of the clearest losses of liberty in recent memory. As economist Benjamin Powell writes at Real Clear Markets, "U.S. economic freedom fell 3.5 percent in 2020—to its lowest level since 1975."

Permanent Losses of Liberty

Many of these losses to our freedom show signs of becoming permanent. Consider some of the following examples.

Student loan payment moratoriums have been extended continuously since 2020. Most public discourse has transitioned from when to resume payment to how much to forgive.

The emergency use authorization process for medical goods transformed from a "test now, approve later" approach in early 2020 into a way to grant favors to politically connected drug producers.

According to the Committee for a Responsible Federal Budget, the federal government has authorized about $14.1 trillion in COVID-related spending. Recent estimates indicate only $11 trillion has been spent, with most remaining funds categorized as "administrative."

When COVID-19 vaccines became available, the government assumed an unprecedented role in distributing vital medical goods across the country. Without significant pushback, it took the same position in distributing monkeypox vaccines—and failed just as spectacularly.

Executive Traction

President Biden has signed 102 executive orders since taking office. President Trump signed 74 in the last year of his presidency. The previous two presidents signed 276 and 291 over both terms.

Governments tasked with deciding when to end a crisis have ample opportunities to expand their influence. The Biden administration granted itself three more months to prolong and extend the ratchet effect to secure more power and less freedom.

Tragically, the longer government extends the crisis, the less likely it is to relinquish control.

Raymond J. March (**raymond.j.march@ndsu.edu**) *is a research fellow at the Independent Institute and an assistant professor of agribusiness and applied economics at North Dakota State University.* *A version of this article was published on the Independent Institute blog on October 31, 2022. Reprinted with permission.*

COMMENTARY

Conflicting Health Policy Visions in the U.S. Senate

By John C. Goodman

The U.S. Senate committee dealing with health policy will be chaired by a Democrat who shares two major goals with the ranking Republican member. Both believe we should have universal health care coverage, and both believe it can be done with money already in the system.

Yet their views on how the health care system should function are so profoundly different there is hardly any overlap.

Bernie Sanders (I-VT) is slated to become chair of the Committee on Health, Education, Labor, and Pensions (HELP), and Bill Cassidy (R-LA) is expected to be the ranking member. Sanders will need help from Cassidy if anything is to be done in a closely divided Senate.

Sanders and Cassidy tend to have amiable natures, so some observers are optimistically predicting a lot of bipartisan cooperation in the HELP committee over the next two years. They are overlooking how differently the two think about health care.

Bernie Sanders (left) and Bill Cassidy (right)

PHOTOS COURTESY GAGE SKIDMORE/FLICKR.COM

Sanders' Views

Most people are vaguely aware Sanders advocates Medicare for All. Yet what Sanders has in mind is very different from what the elderly and the disabled experience today.

For example, almost half of Medicare participants are enrolled in private Medicare Advantage plans, and traditional Medicare routinely contracts with for-profit hospitals and medical facilities.

If Sanders had his way, "profit" would be completely expunged from every aspect of the health care system. That means no doctor, no hospital, no insurer, and no participant of any sort would receive an economic reward for making health care less costly, more efficient, more accessible, or of higher quality.

Cassidy's Views

By contrast, Cassidy has long believed most of our problems in health care exist because the United States, and most of the rest of the developed world, has succeeded in suppressing normal market forces.

As a result, none of us—patients, doctors, employers, and employees—ever sees a real price for anything.

Adam Smith taught us that in a well-functioning marketplace producers strive to meet the needs of their customers because it is in their economic self-interest to do so. The more needs they meet, the greater the economic reward they get.

Over the last 250 years, economists have produced an enormous body of research showing how well markets actually work. There has been surprisingly little research on how non-market systems function, however. Still, there are certain things we know.

If you suppress the price system and insulate providers from economic penalties and rewards, self-interest does not vanish. It is just redirected. One reason the British and Canadian health care systems perform so poorly is because it is not in anyone's self-interest to make them work better.

Without Prices, Patients Wait

If you suppress the price system, you inevitably increase the importance of nonmarket factors—principally, rationing by waiting for appointments, tests, treatments, and surgeries.

In general, the lower the money price of care, the higher the time price will be.

In the United States, nonmarket barriers to care are apparently a greater obstacle to primary care than the fees doctors charge—even for low-income patients. This form of rationing is an even greater problem in Canada (where patients wait an average of 11 weeks to see a specialist) and in Britain (where 6.4 million people are on waiting lists for hospital care).

Several years ago, Sen. Cassidy introduced a bill with Rep. Pete Sessions (R-TX) that would have given every American a refundable tax credit for health care. Markets would be deregulated so that meeting people's needs would be in everyone's self-interest.

If you combine the average premium with the average deductible faced last year by people in the (Obamacare) exchanges, a family of four not getting a subsidy had to pay $25,000 before getting any benefit at all from their health plan. In contrast, the Cassidy bill would allow people to buy insurance meeting their financial and medical needs.

How Cassidy's Bill Works

Instead of the Obamacare practice of forcing insurers to be all things to all enrollees, Cassidy's bill would allow plans to become centers of excellence, specializing in such conditions as diabetes and heart disease.

Instead of the Obamacare requirement insurers receive the same premium for all enrollees, regardless of health condition, Cassidy would allow the kind of risk-adjusted premiums we see in the Medicare Advantage program. This is the foundation for a robust, competitive market for taking care of the sick.

Instead of the Obamacare practice of making health care even more bureaucratic than it was, Cassidy would liberate the market, allowing patients to compare prices. And we know when providers compete on price, they also compete on quality.

Are Incentives Real?

One way to think about all this is to see Sanders thinks incentives shouldn't matter in health care. Cassidy accepts the fact incentives always matter, and that is why we need to get them right.

In Sen. Cassidy's world, government would have two functions: (1) to make sure everyone has the financial means to enter the health care system and reap the benefits of market competition; and (2) to serve as a safety net, meeting any needs the private sector doesn't.

Ironically, in Sen. Sanders' world there would be no safety net. If the Canadian government doesn't provide a mammogram or a hip replacement or heart surgery in a timely manner, it is illegal for the private sector to provide those services. In 2016, 63,459 Canadians traveled outside their country for medical care.

Clearly, for there to be a meeting of the minds on the HELP committee, there is a lot of ground to cover.

John C. Goodman (**johngoodman@johngoodmaninstitute.org**) *is president of the Goodman Institute for Public Policy Research and co-publisher of* Health Care News. *An earlier version of this article appeared in* Forbes *on December 8, 2022. Reprinted with permission.*

Is Composting the Dead Ghoulish?

By Bonner Russell Cohen

California is joining four other states that allow the composting of human corpses, an alternative to cremation or burial, to protect the planet from climate change.

California followed Colorado, Oregon, Vermont, and Washington in legalizing human composting when Gov. Gavin Newsom signed AB 351 into law on September 18.

California Assemblywoman Christina Garcia (D), the bill's sponsor, said if all residents opted for composting over cremation, "the state would see 2.5 million fewer metric tons of carbon within a decade; that's the equivalent of energy output required to power 225,000 homes for a year."

The California law will go into effect on January 1, 2027, after a licensing scheme and health regulations are in place.

The New York State Legislature has also passed a human-composting bill (A382), which Gov. Kathy Hochul had not signed into law as of press time.

Converted to Fertilizer

The process of composting, or natural organic reduction (NOR), involves placing a human body in a contained vessel and covering it with organic material such as wood chips, alfalfa, and straw to accelerate the decomposition process, according to the California Assembly Floor Analysis.

The body undergoes "mixing at several intervals," and after 30 days, it is broken down, including bones and teeth. Nonorganic materials such as dental and surgical implants are removed.

"The transformation results in soil—defined as 'reduced human remains' under this bill—that is dark brown in appearance and considered safe for disposal," which can then be used as "a soil amendment for trees or plants," states the analysis.

'An Area of Conscience'

The practice of composting bodies raises religious and ethical concerns, wrote John M. Grondelski at Crisismagazine.com on November 2.

"The 'recomposting' perspective sees man as being raised up by being turned back into soil," wrote Grondelski. "Judaism and Christianity still see value in what had been a man; recomposting sees value in what will be topsoil."

How we dispose of the dead should be a personal matter with limits, says Heidi Klessig, M.D., a retired anesthesiologist and founder of respectforhumanlife.com, a website that discusses the ethics of live organ transplants.

"We have freedom in how we dispose of our dead as long as we don't stumble on one another," Klessig told *Health Care News*. "For example, we probably shouldn't throw our dead into volcanoes, because of the association with pagan practices. For me, composting would fall into this category, but I wouldn't preclude this practice for others. It's an area of conscience in which we have freedom and in which we should respect that freedom of conscience for others."

'Another Way to Devalue Life'

Governments could transform composting from an option into a demand, says Grondelski.

"[W]hile 'recomposting' advocates (and their more radical allies pushing 'alkaline hydrolysis') now talk about 'choice,' when will the 'choice' be compulsion?" wrote Grondelski. "In the name of public health, Gavin Newsom imposed on Californians some of the most stringent COVID restrictions of any state. In the name of the 'climate catastrophe,' when will 'choice' shift to 'choice with the government's finger on the scale' to 'required'?"

"The religion of Mother Earth now supersedes all cultural decency," wrote Marilyn Singleton, M.D., J.D. in an article posted in August 2019 after the state of Washington approved the composting of human corpses.

"We knew it would only get worse," Singleton told *Health Care News*.

Singleton says there is now widespread contempt for life at the beginning, with infants, and now at the end, with the elderly.

"We store our elders in nursing homes, routinely offer hospice care before offering treatment options," Singleton wrote. "Human composting is yet another way to devalue life—we are the same as kitchen scraps that don't fit in the garbage disposal."

Faith in government institutions is in freefall, says Harley Price, Ph.D., a lecturer at the University of Toronto.

"With elected officials now advocating for human composting to reduce carbon emissions, should anyone be surprised that growing numbers of people will ignore the pronouncements and policies of a ruling class no longer tethered to reality?"

'Ethically Abhorrent'

Reducing human remains to a commodity in hopes of saving the Earth is absurd, says Tom Harris, executive director of the International Climate Science Coalition.

"Composting of the human body to help 'stop climate change' is both ethically abhorrent and scientific nonsense," said Harris. "It is repugnant because it reduces the remains of a previously living human being to a material resource for which no respect or reverence is due.

"Treating the human body as simply a resource in this way is also a slippery slope because it opens the door to further abuses such as cannibalism, a practice that has been nearly universally condemned throughout history," said Harris. "Composting the human body shocks and appalls most people today," said Harris.

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TOM HARRIS
EXECUTIVE DIRECTOR
INTERNATIONAL CLIMATE SCIENCE COALITION

Harris says NOR could be considered a felony punishable by up to seven years in prison and a fine of $8,000 in Oklahoma, citing OK Stat 21-1161 (2014) regarding the desecration of a human corpse.

'Entirely Without Merit'

There is no environmental benefit in composting corpses, says Harris.

"The idea that human activity is responsible for significant climate change is not backed by reputable science," said Harris. "Consequently, the rationale behind the new law—to reduce so-called 'carbon emissions'—is entirely without merit."

Bonner Russell Cohen, Ph.D. (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research.*

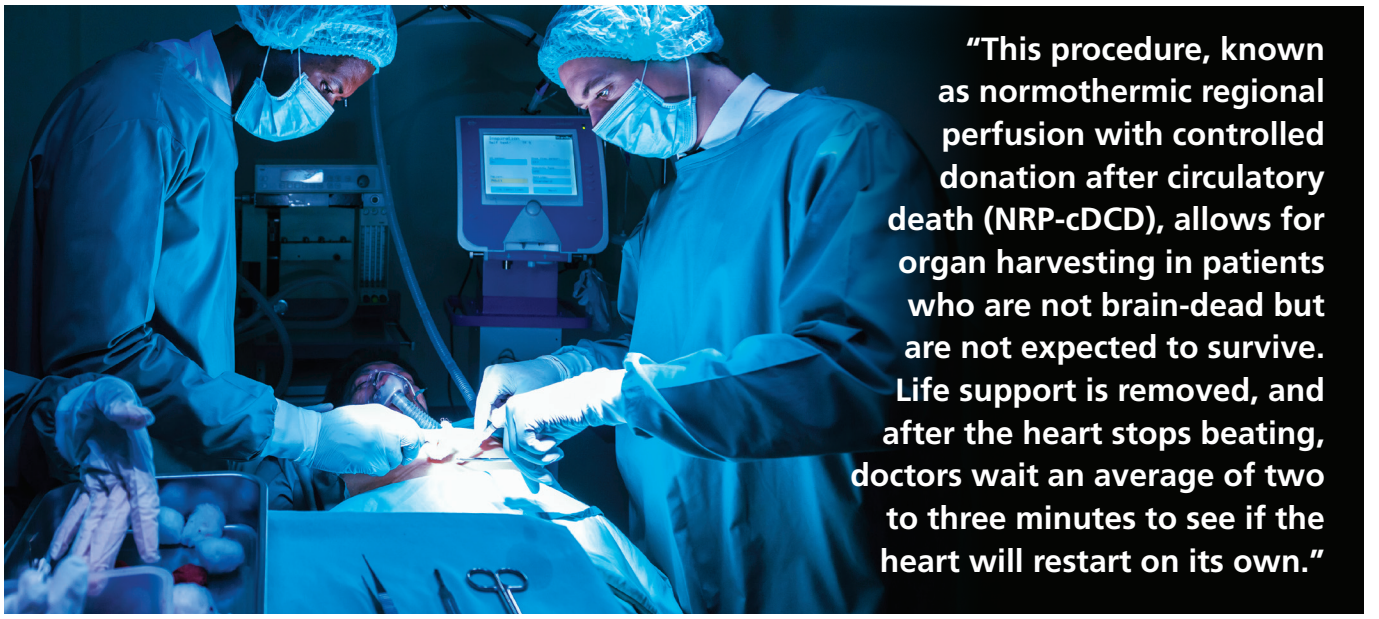
COMMENTARY

Doctors Have a Macabre Way of Harvesting Organs

By Heidi Klessig, M.D.

In the never-ending quest for viable organs, doctors have found a way around criteria for brain death and circulatory death.

Transplant centers around the country are removing organ donors from life support, clamping off the blood flow to their brains, and then restarting their hearts. Thus, the organs are resuscitated and viable for transplant, but the person doesn't wake up.



"This procedure, known as normothermic regional perfusion with controlled donation after circulatory death (NRP-cDCD), allows for organ harvesting in patients who are not brain-dead but are not expected to survive. Life support is removed, and after the heart stops beating, doctors wait an average of two to three minutes to see if the heart will restart on its own."

Heart-Stopping Procedure

This procedure, known as normothermic regional perfusion with controlled donation after circulatory death (NRP-cDCD), allows for organ harvesting in patients who are not brain-dead but are not expected to survive. Life support is removed, and after the heart stops beating, doctors wait an average of two to three minutes to see if the heart will restart on its own.

If it doesn't, surgery begins with clamping off of the blood flow to the patient's brain. When the rest of the body is resuscitated, the brain is excluded from the returning blood flow, and the body is effectively made "brain-dead" on purpose. After brain circulation is occluded, the rest of the body is hooked up to a cardiac bypass machine to deliver warm, oxygenated blood to the organs.

According to the University of Nebraska protocol, "once blood flow to the heart is established, the heart will start beating."

The remaining organs are thus resuscitated and can be harvested for transplantation. The NRP-cDCD protocol allows harvesting organs, such as the heart and intestines, which would quickly become nonviable and unsuitable for transplant with previous circulatory death harvesting techniques.

Preventing Recovery

Many medical professionals are uncomfortable with donation after circulatory death because they know patients are routinely resuscitated after two to three minutes of cardiac arrest.

Ari Joffe, M.D., a clinical professor of pediatrics and critical care at the University of Alberta, found at least 12 patients whose hearts restarted without any medical intervention after as much as 10 minutes of cardiac arrest. Some of these patients made a complete recovery.

In 2020, the heart of a young woman who had been declared dead by circulatory criteria was noted to have restarted during the removal of her kidneys, and she began to gasp for breath. The coroner declared her "second" death a homicide.

In light of concerns such as these, in 2021 the American College of Physicians (ACP) recommended pausing the practice of NRP-cDCD because "the burden of proof regarding the ethical and legal propriety of this practice has not been met." Other nations, such as Australia, have banned NRP-cDCD altogether. Despite ongoing ethical concerns, this type of organ harvesting is continuing and expanding in the United States.

The model Uniform Declaration of Death Act (UDDA) was approved by the Uniform Law Commission in 1981 and has been enacted into law in most states. Under the UDDA, a person may be declared legally dead after the irreversible cessation of circulatory and respiratory functions, or the irreversible cessation of all functions of the brain, including the brainstem. The current practice of NRP-cDCD restarts the heart well within the time normal resuscitation can still occur.

Medical-Legal Sleight-of-Hand

How is circulatory function irreversible if the heart can be restarted in the patient's own chest? These patients can still be claimed as dead, according to the UDDA's cessation of brain function criteria. This medical-legal sleight of hand is used to obfuscate the fact physicians are violating the dead donor rule which states organ donors cannot be killed to obtain their organs, and organ procurement cannot cause death.

Matthew DeCamp, M.D., Ph.D., a bioethicist at the University of Colorado, wrote in the journal *Chest*, "Restarting circulation reverses what was just declared to be the irreversible cessation of circulatory and respiratory function. It is no defense to suggest the patient was already dead when the action negates the conditions upon which the determination was made."

Wes Ely, M.D., M.P.H., a critical care physician and transplant pulmonologist at Vanderbilt University, told *MedPage Today*, "We're so hungry for organs right now we are pushing all the limits. I just want us to be supercautious. We need to press the pause button on this and have some more conversations so we can set up boundaries and stay in the right lane. The dignity of the human who donates the organs should never be sacrificed."

Donors, Families Aren't Told

Transplant physicians who perform NRP-cDCD are playing fast and loose with both the spirit and letter of the law as spelled out by the UDDA. Because these patients could still be resuscitated, they are not yet dead, and they are being actively harmed by physicians pursuing their organs.

Given that these donors are not brain-dead, do they have some level of awareness as they are taken to have their brain circulation cross-clamped? How many families would give their loved ones over to transplant teams if they knew the grisly reality taking place behind the operating room doors?

While medical professionals debate the ethics of "circulatory death," the American people continue to sign donor cards in ignorance of these facts. Physicians and organ procurement organizations must come clean on the many controversies surrounding both "brain-dead" and "circulatory death" organ harvesting. It is critical patients receive a full explanation of the many ethical questions involved in organ harvesting before giving their informed consent.

Don't become a victim of unethical organ harvesting practices. Don't sign that donor card!

Heidi Klessig, M.D. (**heidi@respectforhumanlife.com**) *is a retired anesthesiologist and pain management specialist who writes and speaks about organ donation. Her work may be found at respectforhumanlife.com. A version of this article appeared in* American Thinker *on October 2, 2022.*

INTERNET INFO

"Ethical Considerations in Organ Transplants, with Heidi Klessig, M.D.," *America Out Loud podcast*, November 1, 2022: **https://www.americaoutloud.com/ethical-considerations-in-organ-donation-with-heidi-klessig-md/**

Doctors Take FDA to Court for Interfering in COVID-19 Treatment

The Association of American Physicians and Surgeons (AAPS) is fighting to move forward on a lawsuit it filed against the U.S. Food and Drug Administration (FDA) for allegedly misleading the public on ivermectin and interfering with the practice of medicine.

The FDA filed a motion to dismiss the AAPS lawsuit, *Apter et al. v. Department of Health and Human Services,* in the U.S. District Court for the Southern District of Texas. On September 29, the AAPS filed a motion and an amicus brief asking the court to allow the suit to proceed

"Defendant FDA has improperly exploited misunderstandings about the legality and prevalence of off-label uses of medication in order to mislead courts, state medical boards, and the public into thinking there is anything improper about off-label prescribing," wrote the AAPS in the amicus brief. "Not only is off-label prescribing fully proper, legal, and commonplace, but it is also absolutely necessary in order to give effective care to patients."

Statements by the FDA gave the impression ivermectin should not be used to treat COVID-19, says the AAPS.

"It has never been proper for the FDA to interfere with that essential part of the practice of medicine," wrote the AAPS.

The FDA filed a reply to the motion and amicus brief on October 21, restating arguments it made earlier to dismiss the case: the AAPS has no standing, has not demonstrated the FDA acted without authority, and failed to complain about the statements to the agency before going to court.

"For the foregoing reasons, and those stated in Defendants' motion, the Amended Complaint should be dismissed for lack of subject matter jurisdiction or, in the alternative, for failure to state a claim," stated the reply.

The AAPS is seeking a declaratory judgment the FDA violated federal law.

—Staff reports

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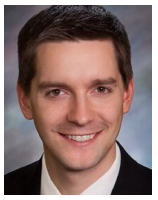

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1

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2

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4

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