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HEALTH CARE NEWS

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The Pulse

Delaying Diabetes Type 1: Worth $200,000?
Page 7

Did the CDC scrub a study on defensive gun use?
Page 18

New patient code now identifies language deemed 'offensive.'
Page 13

Electronic health records to include multiple gender terms.
Page 14

New death definition could help organ transplant industry.
Page 11

Stanford deplatformed lockdown skeptic.
Page 19

Mandatory health training teaches toddlers have 'implicit bias.'
Page 12

U.S. leads in child gender surgery, hormone treatment.
Page 15

Medicaid, Obamacare Subsidies Spurred Labor Shortage: Study

By Bonner Russell Cohen

Employers across the country are struggling to fill job openings, particularly for lower-wage positions, in part because COVID-19 pandemic policies still pay potential employees not to work, a study concludes.

The labor shortage first emerged during the pandemic-related lockdowns in 2020-21, and it has lingered for a variety of reasons but mainly because of government payments to nonworkers, write Casey Mulligan and E. J. Antoni, authors of "Paying Americans Not to Work," a study published by the Committee To Unleash Prosperity (CTUP).

"The U.S. is 'missing' more than three million workers of working age that could be working and were working prior to COVID but are not today,"

LABOR SHORTAGE, p. 4

Attorneys General Warn Drug Chains Against Mailing Abortion Pills

By Harry Painter

Twenty state attorneys general sent a letter warning pharmacy retail giants against mailing abortifacient drugs.

"The text could not be any clearer," the letter states. "Federal law expressly prohibits using the mail to send or receive any drug that will 'be used or applied for producing abortion.'" The attorneys were led by Missouri Attorney General Andrew Bailey.

ABORTION PILLS, p. 6

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Mother Accused of Killing Children Was Overmedicated, Attorney Claims

By AnneMarie Schieber

A woman accused of killing her three children before attempting suicide was prescribed 12 drugs that turned her into a "zombie," according to her lawyer.

Lindsay Clancy and her husband complained to doctors about her mental state while she was being treated for post-partum depression, her attorney, Kevin Reddington, told the *Boston Herald*.

"It's absolutely staggering," said Reddington. "She had homicidal and suicidal ideations that she couldn't control. She was in a living hell, and the husband did the best he could."

Clancy, a nurse, is charged with strangling to death her three young children before jumping out of a second-story window of her Massachusetts home, while her husband was away for about 20 minutes, Reddington said.

'Black-Box Suicide Warnings'

Clancy received medical care and treatment on a regular basis, and her husband was proactive in trying to get her help, Reddington told the *Herald*.

According to the *Herald*, Clancy was prescribed several mood-altering drugs, including diazepam (Valium) and fluoxetine (Prozac), which are selective serotonin reuptake inhibitors (SSRI) used to treat depression.

The drug connection should be a first consideration for investigators, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"Psychotropic drugs, especially SSRIs, may have black-box suicide warnings and have been associated with unprecedented violent behavior and murder-suicides," said Orient.

Clancy was also prescribed Klonopin (clonazepam), used for panic disorder; lamotrigine (Lamictal), a mood stabilizer; lorazepam (Ativan), an anti-anxiety drug; mirtazapine (Remoron), a tetracyclic antidepressant; quetiapine fumarate (Seroquel), used in treating psychotic disorders and schizophrenia; trazodone, an antidepressant; and zolpidem (Ambien), used for insomnia.

'Easy Way Out'

Physicians should be leery of overprescribing drug treatments, says Marilyn Singleton, M.D., J.D.

"Drugs are an easy way out in the era of seven-minute patient visits," said Singleton.

"The public health intervention of the past three years exacerbated social isolation, significant parts of it unnecessarily, in my opinion, but the social isolation was already there in our culture."

ROBERT S. EMMONS, M.D.
PSYCHIATRIST

There are parallels between current-day use of mind-altering pharmaceuticals and illicit drugs and the dystopian novel *Brave New World*, by Aldous Huxley, Singleton wrote in an article titled "Soma-tizing America."

"The lockdowns proved how easily we can be manipulated to follow ridiculous orders," Singleton told *Health Care News*. "There will be a whole generation that thinks drugs, legal and illegal, are the answer to all their problems."

Lockdowns 'Exacerbated Social Isolation'

Social isolation is a likely major contributing factor to cases of extreme despair, says Robert S. Emmons, M.D., a private psychiatrist, clinical ethics advocate, and policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"The public health intervention of the past three years exacerbated social isolation, significant parts of it unnecessarily, in my opinion, but the social isolation was already there in our culture," said Emmons.

Clancy's isolation was treated with drugs because of poor public health policy, says Emmons.

"Certain types of public policy are set into motion with good intentions but without deep thought about potential deleterious side effects," said Emmons. "When government intervenes in medicine, I see hubris, carelessness, ignorance, and a certain kind of intellectual and moral dishonesty that refuses to engage with critiques, in the service of ramming policy through. Unintended bad consequences invariably result."

'It's a Nightmare'

The difficulty in getting timely appointments with health care professionals is also a problem, says Emmons.

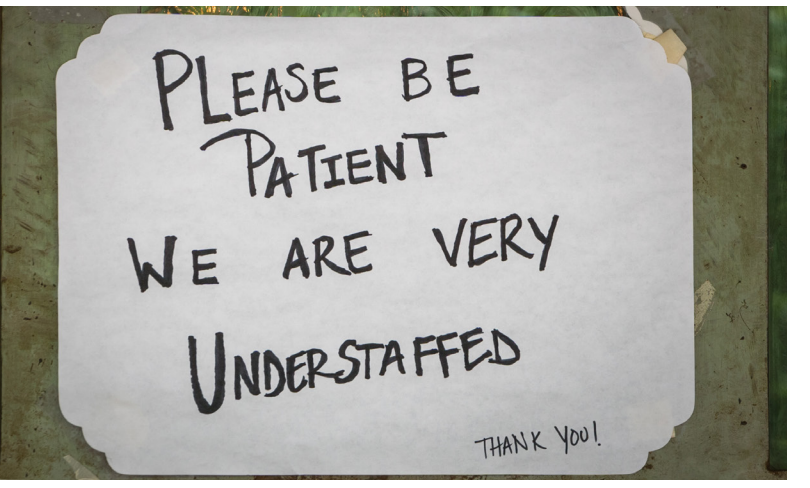
"Third-party payment for medical care, whether it is corporate or taxpayer-funded, is organized in a way that exacerbates wait times for all kinds of medical care," says Emmons. "I'm not sure the parties involved in extreme cases of despair would have sought psychiatric care on their own initiative prior to extreme events, but for people who do want psychiatric care, it's a nightmare to get into treatment."

The federal government's expanding role in health care must be reversed, says Emmons.

"Because it seems unlikely that public policymakers will search their souls and mend their ways, I think the best we can do is stop looking to government to solve these problems," said Emmons. "We are all well-advised to nurture our social networks as an important part of maintaining well-being. No institution or organization is going to ride to the rescue and provide the resources we need to heal."

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

Medicaid, Obamacare Subsidies Spurred Labor Shortage: Study



Continued from page 1

write Mulligan and Antoni. "Many factors could help explain this disappearance of workers from the workforce, including continuing fears of COVID, early retirement, 'long COVID,' the decision by many to never return to work and instead retire early, among others. But this study shows that one factor contributing to the dearth of workers is the generous benefits paid to families without workers."

Millions of Job Openings

The Bureau of Labor Statistics (BLS) reported the number of job openings in the United States increased by 6.7 percent in one month, to 11 million, in December. Most of these open positions are in hospitality, food service, and retail trade, which are typically lower-wage jobs, and construction, the BLS reports.

BLS data show the seasonally adjusted labor force participation rate of around 62.2 percent remained static throughout 2022 after most COVID restrictions were lifted and is still below the pre-pandemic level.

'Work May Not Pay'

Work requirements for federal health and welfare programs were suspended for the duration of the pandemic emergency declaration, which has been extended 12 times, the February issue of *Health Care News* reported.

The CTUP study found there are 14 states where a family of four can receive unemployment payments, Obamacare subsidies or health coverage through Medicaid, and Supplemental Nutrition Assistance Program (Food Stamp) benefits equivalent to the wages and benefits of a job paying $80,000 a year and, in 10 other states, equal to $70,000 in employment income.

"The expansion of food stamps, health insurance subsidies, and unemployment benefits, along with the relaxation or elimination of [Medicaid] work requirements, kept millions of people from returning to the workforce in 2020 and 2021," write Mulligan and Antoni. "For these families, work may literally not pay."

"Almost immediately after taking office, the Biden administration took the unprecedented step of revoking the agreements with those states wishing to require able-bodied Medicaid enrollees to work or search for work as a condition of receiving Medicaid benefits. This was followed by their continuing COVID emergency policies suspending the enforcement of existing work requirements in other welfare programs well beyond when the economy reopened and people were needed back at work."

NINA SCHAEFER
DIRECTOR
CENTER FOR HEALTH AND WELFARE POLICY
THE HERITAGE FOUNDATION

Obamacare Factor

Obamacare subsidies are a key factor in many families' decision to forgo employment, say the study's authors.

"Since it was first passed into law, the ACA [Affordable Care Act] has been expanded considerably to include those with relatively high incomes," write Mulligan and Antoni. "The American Rescue Plan temporarily expanded ACA subsidies and the Inflation Reduction Act extended those subsidies through 2025."

That expansion is at the root of today's labor shortage, says Rea S. Hederman, executive director of the Economic Research Center and vice president of policy at The Buckeye Institute.

"Obamacare's Medicaid expansion allowed healthy, working-age adults to enroll in Medicaid," said Hederman. "The effect was to discourage some of the enrollees from earning more, which means these enrollees will work fewer hours as a result of Medicaid expansion."

Benefits of Work

The Trump administration invited states to submit plans to the U.S. Department of Health and Human Services (HHS) under Section 1115 of the Social Security Act to institute work and reporting requirements for able-bodied Medicaid recipients, with the approval of the HHS.

HHS granted work requirement waivers for 13 states, but only Arkansas fully implemented a plan, and it was struck down by a federal court. Other states' initiatives, which allowed job training to satisfy the work requirement, were tied up in litigation or put on hold by the pandemic.

Implementing the waivers would have been good for workers, says Hederman.

"Our research has found that with work requirements, the average Medicaid expansion enrollee would work over 20 hours more each week," said Hederman. "By working more, these enrollees would get more work experience and command higher wages throughout their career as well as boosting the economy by increasing the supply of labor."

The Biden administration reversed course and began the process of withdrawing approvals for state work requirements in February 2021.

'Unprecedented Step'

The Biden administration's elimination of Medicaid work requirements is part of a larger social agenda, says Nina Schaefer, director of The Heritage Foundation's Center for Health and Welfare Policy.

"Almost immediately after taking office, the Biden administration took the unprecedented step of revoking the agreements with those states wishing to require able-bodied Medicaid enrollees to work or search for work as a condition of receiving Medicaid benefits," said Schaefer. "This was followed by their continuing COVID emergency policies suspending the enforcement of existing work requirements in other welfare programs well beyond when the economy reopened and people were needed back at work."

These policies have been bad for low-income workers, says Schaefer.

"Despite all the talking points about getting people back to work, this administration seems to be more interested in discouraging work than promoting it among those who need jobs the most," said Schaefer.

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

INTERNET INFO

Casey Mulligan and E. J. Antoni, "Paying Americans Not to Work," Committee to Unleash Prosperity, December 2022: **https://committeetounleashprosperity.com/wp-content/uploads/2022/12/Paying-Americans-Not-to-Work.pdf**

White House Pressured Facebook to Censor, AGs' Lawsuit Reveals

By AnneMarie Schieber

Facebook and other Big Tech companies bowed to White House pressure in censoring content known to be true, to discourage "vaccine hesitancy" during the COVID-19 pandemic, proceedings in a lawsuit have revealed.

In a series of emails, White House Director of Digital Strategy Rob Flaherty reprimanded executives at Facebook, Google, and other social media companies in 2021 for not acting more forcefully to remove content questioning the efficacy or safety of the COVID-19 vaccines.

The emails surfaced during the discovery phase of *Missouri v. Biden*, a lawsuit by the attorneys general of Missouri and Louisiana and four individuals.

The emails were clearly threatening, Jenin Younes, a litigator from the New Civil Liberties Alliance who is representing the private plaintiffs, told *The Heartland Daily Podcast* on January 20.

"He is constantly berating the companies," said Younes. "He is aggressive. His tone is, basically, do what I want you to do or else."

'Often-True Content' Censored

Flaherty accused Facebook of promoting reluctance to take the COVID-19 shots in a March 14, 2021 email to a company executive.

"We are gravely concerned that your service is one of the top drivers of vaccine hesitancy—period. ... We want to know that you're trying, we want to know how we can help, and we want to know that you're not playing a shell game," Flaherty wrote.

The Facebook executive detailed changes to the company's censorship policies in a March 21, 2021 email to Flaherty.

"[W]e have been focused on reducing the virality of content discouraging vaccines that does not contain actionable misinformation," said the executive. "This is often-true content … [that] can be framed as sensation, alarmist, or shocking. We'll remove these Groups, Pages, and Accounts… ."

'Same Thing Again'

Flaherty said Facebook's previous, less-complete censorship approach was responsible for doubts about the integrity of the 2020 election and for the January 6 riot at the U.S. Capitol, in an April 9, 2021 email quoted in an op-ed by Younes and Aaron Kheriaty, one of the private plaintiffs in the lawsuit, in *The Wall Street Journal* on January 8.

Flaherty blamed the platform for "an election that you helped increase skepticism in, and an insurrection which was plotted, in large part, by your platform," wrote Flaherty. "I want some assurances, based in data, that you are not doing the same thing again here."

"The executive's response: 'Understood,'" Younes and Kheriaty write.

> **"I think it's really important that we get the courts to recognize the government can't circumvent the First Amendment by getting the tech companies to censor people based on whether they express unfavorable viewpoints."**
>
> **JENIN YOUNES**
> **NEW CIVIL LIBERTIES ALLIANCE**

First Amendment Applies

Social media companies have stated publicly their eagerness to combat what they and the White House call COVID-19 misinformation, but the emails demonstrate the Biden administration violated what is known as "state action theory," says Younes.

"The government can't use private companies to get around the Constitution," said Younes.

Until now, "state action theory" often came up in the context of the Fourth Amendment, which limits government search and seizure actions, says Younes.

"The government can't hire a company or threaten a private company or individual [to] break into your home, or tell a private company to do it voluntarily because they don't have a warrant," said Younes.

The lawsuit gives the court an opportunity to affirm this principle, says Younes.

"That is why this is new terrain," said Younes "I think it's really important that we get the courts to recognize the government can't circumvent the First Amendment by getting the tech companies to censor people based on whether they express unfavorable viewpoints."

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

Biden Administration Pushes Medicaid Social Services

By AnneMarie Schieber

The Centers for Medicare and Medicaid Services (CMS) is encouraging state Medicaid directors to spend health-care money on other things that might improve recipients' health.

The CMS in January clarified requirements for state Medicaid programs choosing an "innovative option" to "reduce health disparities and address unmet health-related social needs."

Medicaid managed care contracts can "address social determinants of health" by providing non-health benefits to enrollees for housing, food, education, transportation, air conditioners, or electric replacements for gas stoves "in lieu of a service or setting (ILOS)" usually provided by state health plans, states a CMS guidance letter to state health directors.

ILOSs can "improve access to health care and help address many of the unmet physical, behavior, developmental, long-term care and other [health-related social needs] of Medicaid enrollees," states the CMS.

'Agenda Is Radical'

The goal of providing these social services is not to improve the health of Medicaid recipients but to reduce economic inequality, says *The Daily Skirmish*, an online blog.

"The real agenda is radical egalitarian redistribution of income," stated the blog on January 18. "No one is asking how much this is going to cost."

Tax-exempt hospitals spent $2.5 billion from 2017 to 2019 on social programs presumed to improve the overall health of the population served, according to a *Journal of the American Medical Association* study cited by the blog.

"Other researchers found no association between overall community benefit spending and hospital readmission rates," the article states.

'Questions Get Nosier'

Spurred by the federal government, providers increasingly probe patients for information unrelated to medicine, says Matt Dean, senior fellow for health care policy outreach at The Heartland Institute, which co-publishes *Health Care News*.

"It seems like those questions get nosier every year," said Dean on *The Heartland Daily Podcast* on January 26. "They might ask you things that have nothing to do with health care at all—like where you live, who lives with you, whether you have a gun in the house, whether you have a family member returning from the military."

The answers to the questions generate a score which is then recorded in a patient's medical record, says Dean.

"The scores might play into whether or not you get care or the kind of care you get, or how much money is reimbursed to the hospital system, or to the insurance company, or to the provider," said Dean. "It's a great idea if you're a lobbyist and you're trying to get information that will build a metric so that you can get more money in your area."

Using social scores in health care allows money to be diverted to other programs such as the Office of Climate Change and Health Equity in the U.S. Department of Health and Human Services, says Dean.

"It always seems to come back to that," said Dean.

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

AGs Warn Drug Chains Against Mailing Abortion Pills

Continued from page 1

FDA Opened Door

In January, the Food and Drug Administration (FDA) declared pharmacies could stock abortion pills for customers with a prescription and even mail them. CVS and Walgreens announced they would participate in the program.

A group of 22 attorneys general sent a letter to FDA Commissioner Robert Califf requesting the agency reverse its decision.

"The Food and Drug Administration's decision to abandon commonsense restrictions on remotely prescribing and administering abortion-inducing drugs is both illegal and dangerous," the letter states.

The FDA had expressed concern in October about abortion pills being provided to women who are not pregnant. Mifepristone must be taken during a narrow window of gestation, one reason a physical visit had long been required for dispensation.

There were 6,158 adverse event reports involving mifepristone between 2000 and 2019, according to a report in *Issues in Law & Medicine*. Of those, 20 resulted in death and 529 were described as "life-threatening."

Mailing Prescriptions Drugs

Current U.S. Postal Service (USPS) standards decree prescription drugs may be mailed by "drug manufacturers or their registered agents, pharmacies, or other authorized dispensers" in compliance with applicable laws.

President Joe Biden issued a presidential memorandum in January to protect access to abortion pills in the states. On the 50th anniversary of *Roe v. Wade*, Vice President Kamala Harris announced the memo during a speech in Tallahassee, Florida.

The memo "directs the Secretary of Health and Human Services (HHS), in consultation with the Attorney General and the Secretary of Homeland Security (DHS), to consider new guidance to support patients, providers, and pharmacies" in providing or obtaining mifepristone.

The Department of Justice (DOJ) announced in December it interprets federal law to allow mailing abortion pills. The USPS had asked the DOJ to clarify whether the two-drug series, mifepristone and misoprostol, used in chemical abortions could be legally mailed or would violate the Comstock Act of 1873.

That law criminalized the sending of "obscene, lewd or lascivious," "immoral," or "indecent" publications by mail, and "instruments" that could lead someone to use contraception or undergo abortion.

"The chemical abortion regimen has four times more complications than surgical abortions, with approximately one in 20 women requiring surgery for hemorrhage or retained tissue, even when used under the FDA's prior requirement of in-person supervision. The abortion pill does not help women. It was developed and promoted to benefit the abortion industry, which has trouble actively recruiting physicians to perform surgical abortions. Most physicians do not want to actively destroy human life."

INGRID SKOP, M.D.
DIRECTOR OF MEDICAL AFFAIRS
CHARLOTTE LOZIER INSTITUTE

'Public Health Emergency'

HHS Secretary Xavier Becerra is considering declaring a public health emergency, which could increase access to abortion by triggering more funding and relaxed regulations on chemical abortions, Axios reported on January 31. Doing so could increase access to abortion by triggering more funding and relaxed regulation of chemical abortions.

Such a declaration would be an abuse of his authority, says Rik Mehta, a former FDA Consumer Safety Officer who teaches health law at the Georgetown Law Center.

"HHS has the authority to declare a public health emergency when the Secretary determines that a 'disease or disorder presents a public health emergency,'" said Mehta. "The Supreme Court has already made it clear that abortion is not a right protected by the Constitution. This would be an egregious violation of separation of powers to infringe on the authority of the judicial branch."

A public health emergency declaration raises red flags, says Ryan Bomberger, cofounder and chief creative officer of The Radiance Foundation.

"Biden has no use for the separation of powers but loves promoting the violent separation of child from mother," said Bomberger. "In direct violation of the Constitution, Biden wants to deny states' and the people's rights, to ensure that the violence of abortion is easily accessible."

'Long Abandoned Medical Fidelity'

Financial incentives trump ethical concerns regarding abortion, says Bomberger

"Health agencies are a moneymaking business," said Bomberger. "On abortion, they have long abandoned medical fidelity and chosen politics and profits over people."

The FDA is supposed to protect the public, says Ingrid Skop, M.D., an obstetrician and director of medical affairs at the Charlotte Lozier Institute.

"Unfortunately, the FDA has a long history of removing restrictions designed to improve safety, relying on biased or incomplete studies published by the abortion industry and ignoring higher-quality international studies which document frequent failures of chemical abortion," Skop said. "The FDA's record speaks for itself."

In December 2021, the FDA made permanent a COVID-19 measure that lifted the requirement for patients to receive abortion pills in person from a physician.

Skop says the move can be summed up as a "trojan horse to remove the in-person restrictions on mifepristone."

'Does Not Help Women'

The FDA's approval of mifepristone in 2000 is currently being challenged in a federal court. A U.S. District Judge in Texas is expected to decide soon whether to suspend approval of the drug. Lawsuits challenging abortion restrictions, focusing on mifepristone, are also underway in North Carolina and West Virginia.

The Guttmacher Institute, a pro-abortion rights research organization, says chemical abortions make up more than half of all abortions in the United States.

Skop says chemical abortions are far more dangerous than surgical abortions.

"The chemical abortion regimen has four times more complications than surgical abortions, with approximately one in 20 women requiring surgery for hemorrhage or retained tissue, even when used under the FDA's prior requirement of in-person supervision," Skop said.

Abortion drugs replace physicians, who are reluctant to perform surgical abortions, says Skop.

"The abortion pill does not help women," said Skop. "It was developed and promoted to benefit the abortion industry, which has trouble actively recruiting physicians to perform surgical abortions. Most physicians do not want to actively destroy human life."

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

New Diabetes Drug Costs Nearly $200,000 Per Patient

By Kevin Stone

The first approved drug that delays the onset of Type 1 Diabetes (T1D) is raising eyebrows because of its $193,900 price tag.

The drug, Tzield (teplizumab-mzwv), is designed to delay the onset of T1D stage 3—when a patient is symptomatic, which is when the disease is usually diagnosed.

In clinical trials, Tzield delayed the progression of T1D to stage 3 for two years in adults and patients aged eight years and older at stage 2, when asymptomatic patients can be diagnosed with a blood test.

This is a significant therapeutic benefit of the drug, said Ashleigh Palmer, cofounder and CEO of Provention Bio, the drug's maker, in a news release.

"It cannot be emphasized enough how precious a delay in the onset of Stage 3 T1D can be from a patient and family perspective; more time to live without and, when necessary, prepare for the burdens, complications and risks associated with Stage 3 disease," said Palmer.

"The pricing issue with Tzield is similar to debates over the appropriate pricing of gene therapies that are very expensive but purport to save costs elsewhere in the health care system. Drug companies often justify an extreme price on a drug that essentially 'cures' an ailment with the promise of savings achieved in the future. However, when comparing Tzield's potential cost to the savings achieved, the $194,000 price point is completely unjustifiable."

GREGG GIRVAN
RESEARCH FELLOW
FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY

Pricy Treatment

Provention Bio announced Tzield's price immediately after the U.S. Food and Drug Administration (FDA) approved it: $13,850 per vial, $193,900 for the full course of 14 treatments.

Tzield is an anti-CD3-directed monoclonal antibody given by injection. Monoclonal antibody treatments are notoriously expensive. For example, treatment with the popular anti-cancer antibody Rituxan (rituximab) for an average-weight adult carries a wholesale price of $7,724 per dose or $31,000 for a typical course.

'Completely Unjustifiable'

New disease therapies are often not cost-effective, says Gregg Girvan, a research fellow at the Foundation for Research on Equal Opportunity.

"The pricing issue with Tzield is similar to debates over the appropriate pricing of gene therapies that are very expensive but purport to save costs elsewhere in the health care system," said Girvan. "Drug companies often justify an extreme price on a drug that essentially 'cures' an ailment with the promise of savings achieved in the future. However, when comparing Tzield's potential cost to the savings achieved, the $194,000 price point is completely unjustifiable."

The cost of Tzield should be compared to conventional treatments, says Girvan.

"According to a study published by the American Diabetes Association, the average cost of diabetes treatment per patient was just under $16,750 per year, of which $9,600 was for diabetes treatment specifically," said Girvan. "Given the drug only delays the onset of T1D by two years, the drug's wholesale price exceeds the cost of delayed conventional treatment by more than 10 times."

'Not Effective for Everyone'

Research on Tzield began in 1986 and was pursued by other companies before Provention acquired the rights to it from Eli Lilly in 2011 after the drug failed to show a therapeutic benefit in a late-stage clinical trial.

Provention conducted new clinical trials, but questions about the efficacy of Tzield remain, especially given its price tag, says Girvan.

"The FDA's advisory committee narrowly recommended the drug's approval on a 10 to 7 vote," said Girvan. "In part, this is due to the low statistical power of the results since the phase III study used for approval had only 76 participants, of which 44 received the drug. Among those, the median time delay in T1D diagnosis was roughly two years compared to placebo. Some had a longer delay, but some also had less. In other words, the drug is not effective for everyone."

Roughly 30,000 U.S. patients are eligible for the treatment, according to Provention, but there may be a much larger population of undiagnosed patients. An estimated 1.4 million people in the United States have stage 2 T1D, and most of the cases have not been diagnosed.

'Because They Can'

The cost of research, testing, and FDA approval of a new drug is about $1 billion on average.

The median annual price of new drug treatments is $257,000, according to an analysis by Reuters. Launch prices for new patented drugs rose by 20 percent every year for 14 years, and nearly half of all new prescription drugs cost more than $150,000 per year.

Consumers might expect insurers to help limit the cost of increasingly expensive new drugs such as Tzield, but that is unlikely, says David Hyman, M.D., J.D., a professor at Georgetown School of Law, scholar at the Cato Institute, and coauthor of *Overcharged: Why Americans Pay Too Much for Healthcare*.

"Drug companies charge high prices because they can," said Hyman. "Health insurance, both public and private, makes patients less price-sensitive. The drug companies know that and set their prices accordingly.

"I expect few insurers will try to push back," said Hyman. "Insurers, with a few high-profile exceptions, have generally not pushed back on previous examples of high-priced drugs. Instead, they just pass the costs on. I would expect more of the same."

'The Reality of Rationing'

The third-party payment system, in which governments or private insurers pay the bills, is responsible for the rising cost of health care, says Charles Silver, J.D., a professor at the University of Texas-Austin School of Law, a Cato scholar, and coauthor of *Overcharged*.

"The willingness of payers to cut enormous checks incentivizes drug makers to produce expensive drugs like cancer treatments that cost thousands or millions of dollars but extend patients' lives for only a couple of months," said Silver.

Insulated from costs, patients are unaware there are limits to the resources that can be devoted to their care, says Silver.

"People want these treatments and think payers should cover them," said Silver. "Americans refuse to face the reality of rationing, and in our politically controlled, third-party payer-dominated payment system, they don't have to."

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

Congress Agrees to Smaller Cut in Medicare Payments to Doctors

By AnneMarie Schieber

The Centers for Medicare and Medicaid Services (CMS) cut payments to physicians by 2 percent on January 1.

The reductions would have been deeper had Congress not intervened.

The CMS had proposed a phased reduction of 4.5 percent in payments to specialists, in addition to the 2 percent cut in physicians' fees. Physician groups lobbied heavily to block or delay the larger cuts, citing the harm to providers and their patients in a letter to congressional leaders signed by medical associations in all 50 states and the District of Columbia.

"Burnout, stress, workload, and the cumulative impact of COVID-19 are leading one in five physicians to consider leaving their current practice within two years," the letter states. "Payment cuts will only accelerate this unsustainable trend and undoubtedly lead to Medicare patients struggling to access health care services."

The 2 percent reduction Congress included in the 4,000-page government spending package approved in December will rise to 3.5 percent in 2024. Adjusting for inflation, physician pay declined by 22 percent from 2001 to 2021, the physicians' letter states.

"Medicare needs reform, but there are areas besides doctors' fees that could be cut. Hospitals are the biggest cost driver, where the most Medicare funds are spent. Cutting physician fees could have the opposite effect from saving money if physicians sell their practices to hospitals, which can charge higher fees for the same services."

DEVON HERRICK, PH.D.
EDITOR
GOODMAN INSTITUTE HEALTH BLOG

Physician Shortage

The fee cuts could reduce Medicare patients' access to care, says health economist Devon Herrick, Ph.D., editor of the Goodman Institute Health Blog.

"There is already a shortage of physicians, which is expected to grow worse in the coming years as Baby Boomers retire and qualify for Medicare," said Herrick. "Some of those retiring Boomers will be doctors, who will stop treating patients and become patients themselves. The risk isn't just doctors declining to accept Medicare patients, it is doctors reducing the number of new Medicare patients they accept or shortening appointments to squeeze in more patients."

Spending Growth

In 2021, Medicare benefit payments totaled $829 billion, up from $541 billion in 2011, according to the Kaiser Family Foundation. Funding comes from general federal government revenue, payroll taxes, and premiums paid by beneficiaries.

Average annual spending growth is projected to be 5.4 percent between 2020 and 2030, in line with private health insurance. The Part A hospitalization trust fund is projected to be depleted by 2028.

The physician fee cuts could have the unintended consequence of increasing Medicare spending, says Herrick.

"Medicare needs reform, but there are areas besides doctors' fees that could be cut," said Herrick. "Hospitals are the biggest cost driver, where the most Medicare funds are spent. Cutting physician fees could have the opposite effect from saving money if physicians sell their practices to hospitals, which can charge higher fees for the same services."

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

Big Pharma Plans Hefty Price Hikes for COVID-19 Shots

By Kevin Stone

Drug makers Moderna and Pfizer plan to charge more than $130 for their COVID-19 shots, a big price jump from the government rate of $26.36.

Big Pharma is trying to profit further from the pandemic, said Lauren Aronson, executive director of the Campaign for Sustainable Rx Pricing, in a news release.

"Moderna's decision to hike the price of the company's COVID-19 vaccine by nearly 500 percent as payment shifts to the private market is a brazen demonstration of Big Pharma's greed," said Aronson. "Moderna is just the latest of several Big Pharma companies seeking to price-gouge COVID-19 treatments and vaccines as payment for these critical medications' transitions from the federal government to the private market."

The cost of producing the coronavirus vaccines ranges from 54 cents to 98 cents a dose, estimate Donald W. Light and Joel Lexchin in an article published in the *Journal of the Royal Society of Medicine*.

Government Subsidized, Set Prices

The federal government subsidized vaccine development and set the prices, notes Gregg Girvan, a health care policy researcher at the Foundation for Research on Equal Opportunity.

"The government set the price for the vaccines in negotiating what it would pay," said Girvan. "One could rightly argue that because they funded the development of the vaccines, they were entitled to set the price."

Government health programs are the largest drug buyers in the United States, but they usually don't negotiate prices, says Girvan.

"Medicare and Medicaid are required to cover virtually any drug approved by the FDA, regardless of the price set by manufacturers. The list goes on with the ways the system is tilted in favor of drug companies setting their own price," said Girvan.

'Because They Can'

The COVID-19 shot price hikes are part of a broader cost issue of pharmaceutical companies raising prices on popular drugs, says Girvan.

"The biggest driver of high drug spending in the U.S. is drug companies raising prices on existing products," said Girvan. "We have seen this with drug products from the COVID vaccines to Humira—the best-selling drug of all time—to Lipitor. They do this because they can. In other words, flawed government policy, particularly for biologic drugs, allows companies to exploit their monopoly position to charge higher prices."

"We have a patent system that rewards drug companies for filing frivolous patents to extend drug monopolies far longer than intended by the law," said Girvan. "The FDA (Food and Drug Administration) grants marketing exclusivity to biologics for 12 years because the industry successfully lobbied for it in the Biologics Price Competition and Innovation Act, which, not so ironically, was enacted as part of the Affordable Care Act."

Price of Innovation?

Drug companies claim the prices they charge are necessary to fund development of new drugs, but there are alternatives, says Girvan.

"Our research shows that we can achieve cost savings through reforms … without substantially harming future innovation and drug development," said Girvan. "The result is a drug industry that focuses on truly innovative medicines while making our health care system more fiscally sustainable for generations to come."

Consumers 'Not Price Conscious'

The lack of price competition in the drug market is caused by government involvement, says Michael Cannon, director of health policy studies at the Cato Institute.

"The reason pharma is able to charge such outrageously high prices is that the government has intervened in the health sector in ways that defeat any price competition or other discipline the market would impose on such practices. The government purchases half of all health care in the United States. Employers purchase another quarter or more. Consumers are therefore not price conscious. Pharma knows it, so they charge outrageously high prices, and they keep getting away with it."

MICHAEL CANNON
DIRECTOR OF HEALTH POLICY STUDIES
CATO INSTITUTE

"The reason pharma is able to charge such outrageously high prices is that the government has intervened in the health sector in ways that defeat any price competition or other discipline the market would impose on such practices," said Cannon. "The government purchases half of all health care in the United States. Employers purchase another quarter or more. Consumers are therefore not price conscious. Pharma knows it, so they charge outrageously high prices, and they keep getting away with it."

Eliminating private and public third-party payers in medicine would allow consumers to compare prices and bring down costs, says Cannon.

"If you want to bring those prices down, give consumers and workers the money that government and employers now control," said Cannon. "The industry would howl because prices would plummet, bringing health care within reach of those who currently cannot afford it."

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

POLL

Political Parties Are Missing the Mark on Health Care

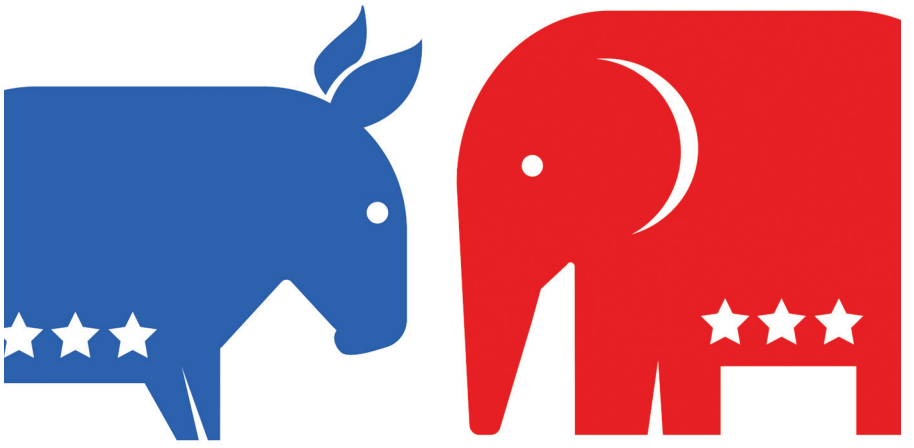
By AnneMarie Schieber

On health care, the public believes Democrats are too focused on abortion, lowering drug costs, and expanding government coverage, and Republicans have no message or at most an inconsistent one, opinion research by the Council for Affordable Health Coverage (CAHC) found.

The CAHC revealed the poll results at its fifth annual summit in Washington, D.C. on January 31. The public opinion research has been an important feature at the summit, says CAHC President Joel White.

"We rejected the idea of drafting policies in Washington [and] then trying to sell them to voters," said White. "Our goal was to identify peoples' concerns and offer 'kitchen table' solutions that made sense to middle-of-the road voters."

Among the poll findings: 30 percent of businesses with 50 or fewer employees offer health care coverage, and most people have coverage (91 percent) and like it a lot (82 percent). Seven in 10 voters think the current health care debate is off-track. Respondents said Congress should concentrate on finding ways to reduce premiums and out-of-pocket costs without new spending and expansion of entitlements.



'Expand Competitive Markets'

The summit brought together policy leaders, reform advocates, and decision makers to discuss the health care challenges facing the country, says White.

"We uncovered several solutions," said White. "First, we should expand, not limit coverage options. Second, there should be opposition to the public option and single payer model. We need to support a revised small-business tax credit to support employers offering coverage to workers."

Driving down prices and improving access should also be top priorities, says White.

"We need to support policies to expand competitive markets, limit anti-competition rules, and expand the supply of the clinical workforce, telehealth, and site of service," said White. "We need to spend less, allow more choice, and make transparency work."

Beyond Obamacare, Price Controls

One of the most revealing results of the polls has been how far off track Congress has been on addressing voters' concerns about health care.

"We uncovered a host of issues that are ignored in the current debate over Obamacare and price controls, a debate that seven in 10 voters say does not address their real concerns," said White. "People are ready for a new health discussion, and Congress has the opportunity to shape it."

The polls also show the public thinks Congress is spending too much time addressing Obamacare.

"It isn't where the vast majority of voters are," said White. "While Obamacare certainly needs reform, it covers just 5 percent of Americans—less than 14 million people—and should not be the centerpiece of health policy."

> **"People are ready for a new health discussion, and Congress has the opportunity to shape it."**
>
> **JOEL WHITE**
> **PRESIDENT, COUNCIL FOR AFFORDABLE HEALTH COVERAGE**

Poor Bang for the Buck

The United States spends about 20 percent of its gross domestic product on health care (France is second, at 12 percent), and much of it is wasted, says White.

"The former top Medicare official in the Obama administration and other academics estimate that up to 30 percent of all care delivered is ineffective, wasteful, low-value, or harmful to the patient," said White. "In Medicare, this totals almost $300 billion.

"Congress should end payments for wasteful care that does nothing to improve patient outcomes, by first identifying the waste and then refusing to pay," said White. "Incentives to identify and lower hospital-acquired conditions and infections should be realigned with payments to encourage better outcomes," said White.

Divergent Views

Two keynote speakers at the summit represented widely divergent views on health care. Rep. Kevin Hern (R-OK), supports free-market reforms. Rep. Pramila Jayapal (D-WA) introduced the Medicare for All Act of 2021.

Jayapal was a "no-show" at the last minute, according to summit organizers, but provided a short video. White says Hern and Jayapal were "light years apart" in their presentations.

"Hern recognized the value of the private sector to respond quickly to changing and evolving needs of the workforce and individual needs of patients and the need for innovation to drive down costs," said White. "He pointed to how some government-run systems, most notably in the U.K., are struggling to stay afloat and provide access to care.

"Jayapal wants one system, determined by federal decision-makers, that seemed more pie in the sky than realistic," said White.

AnneMarie Schieber (**amschieber@heartland.org**) *is the managing editor of* Health Care News. *Heartland Institute staffer Aaron Stover contributed to this article.*

Redefining Definition of Clinical Death Under Consideration

By Kevin Stone

An influential nongovernmental organization is considering a revised definition of clinical death that would make it easier to declare a patient dead and harvest the person's organs.

A group of lawyers, medical professionals, and ethicists in the nonprofit Uniform Law Commission (ULC) met in December to discuss updating the prevailing definition of death and revising family notification procedures. The ULC develops model statutes in a drafting process that can take several years. Many state legislatures have established ULC recommendations as law.

At issue is the Uniform Determination of Death Act (UDDA), a 1981 model state law defining clinical death.

"An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead," states the UDDA. "A determination of death must be made in accordance with accepted medical standards."

"According to the American Academy of Neurology, the reason that these revisions are being proposed in the first place is to make it more difficult to challenge a brain death diagnosis in a court of law. Clearly, the revisions to the UDDA will stack the deck against families and will only promote the interests of the transplant industry."

HEIDI KLESSIG, M.D.
PAIN MANAGEMENT SPECIALIST

'Irreversible Coma' Definition

The current "brain death" standard in the UDDA was established more than 50 years ago and is based on the recommendation of a group at Harvard Medical School.

"Brain death was introduced into medical practice by the Harvard Ad Hoc Committee in 1968," Doyen Nguyen, O.P., M.D., S.T.D., author of *The New Definitions of Death for Organ Donation: A Multidisciplinary Analysis from the Perspective of Christian Ethics,* told *Health Care News*. "The opening sentence of the Harvard Report, which states, 'our primary purpose is to define irreversible coma as a new criterion for death,' clearly indicates that brain death is none other than a state of coma deemed to be irreversible based on an arbitrary set of clinical tests put forth by the Harvard Committee."

Defining Death Down

Two changes to the UDDA appear to be under consideration: replacing the word "irreversible" with "permanent" and changing "entire brain" to "brain stem," says Heidi Klessig, M.D., a retired anesthesiologist and pain management specialist, a vocal patient advocate, and host of the Respect for Human Life website.

"Irreversible is commonly held to mean 'not capable of being reversed,'" wrote Klessig in the *American Thinker* on October 25. "The term permanent is being offered as meaning that 'no attempt will be made to reverse the situation.' So, because doctors are not going to attempt to correct the patient's problem, it now becomes 'permanent.'"

Redefining clinical death by narrowing the criteria to loss of brain stem function will make it easier to declare someone dead, says Klessig.

"This change recognizes that current practice does not test all functions of the entire brain, since most people diagnosed as brain-dead still have a functioning hypothalamus, a part of the brain," wrote Klessig. "Many also still have electrical activity on an electroencephalogram (EEG), which is one of the reasons that EEG testing as a requirement for a brain death diagnosis was dropped in the 1970s."

Organ Harvesting Motive

Organ transplantation, rationing of intensive care beds, and lawsuits by families challenging brain death declarations appear to be reasons driving the change. Live organ harvesting has become a big business.

"As much as the defenders of brain death claim otherwise, it remains a fact that the introduction of brain death into clinical practice was tightly connected to the need for fresh and viable organs for transplantation," said Nguyen.

"Even Dr. Eelco F. M. Wijdicks, a leading brain death proponent, freely admitted in 2006 that 'the diagnosis of brain death is driven by whether there is a transplantation program or whether there are transplantation surgeons,'" said Nguyen. "I do not think brain death examination now, in practice, would have much, if any, meaning if it were not for the sake of transplantation."

Informed Consent Right

Lack of informed consent is another concern about broadening the clinical definition of death, says Klessig.

"If passed into law, the revised standards will remove the right to informed consent regarding brain death testing and the ability to refuse such testing," Klessig told *Health Care News*.

Transplant centers want the rule change for more protection from lawsuits, says Klessig.

"According to the American Academy of Neurology, the reason that these revisions are being proposed in the first place is to make it more difficult to challenge a brain death diagnosis in a court of law," said Klessig. "Clearly, the revisions to the UDDA will stack the deck against families and will only promote the interests of the transplant industry."

Process 'Essentially Hidden'

Nguyen says she is concerned the redefinition of clinical death will reduce patients to "commodities and spare parts" and Americans will be none the wiser.

"Death is a universal, factual reality that affects every person sooner or later," said Nguyen. "If death affects every citizen, then the general public should be involved in the discussions and debates leading up to the establishment of a legal definition of death."

The public wasn't included in the deliberations of The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, which endorsed the Harvard group's definition in 1981, or those of the current ULC group, says Nguyen.

"No involvement of the general public took place during the process that led up to the promulgation of the UDDA," said Nguyen. "The whole process was under the control of the President's Commission and essentially hidden from the eyes of the general public. Likewise, this time it is controlled by the ULC and the general public is basically excluded from the decision-making process."

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

INTERVIEW

States Mandate 'Implicit Bias Training' for Health Professionals

California, Maryland, Michigan, Minnesota, and Washington now require all licensed public health professionals to undergo "Implicit Bias Training." *Health Care News* talked about this trend with Gabriela Eyal, Ph.D., a licensed clinical psychologist in Michigan who has practiced for decades in the United States and abroad and conducted psychological evaluations of more than 1,000 children through Child Protective Services and the Head Start program. Eyal recently completed her first three-hour course of implicit bias training.

> **"It is one reason I tell younger professionals to avoid speaking out about their objections to this kind of forced training. They have too much at risk. Also, I was born in a Communist country. This is not new to me, and I feel better equipped to resist."**
>
> **GABRIELA EYAL, PH.D.**
> **LICENSED CLINICAL PSYCHOLOGIST**

***Health Care News*:** Where do you sign up for "Implicit Bias Training," how much time does it take, and what does it cost?

Eyal: Unlike most continuing-education courses, unconscious bias training must go through a specific accreditation process. I had a choice of four or five training programs. I chose the one through the Michigan Psychological Association, mostly because I was familiar with that organization, it was reputable, and I trusted it.

Beyond the initial course, we are required to receive one hour of training each year while we hold a license, and the cost is about $25. My training was offered in an online course module.

***Health Care News*:** So, this is new to you. What did you think when you began the training?

Eyal: I couldn't believe my eyes. One of the things this teaches is that children as young as three years old have implicit bias. I have evaluated more than one thousand children at this age in my career, and I have never seen [bias] toward other toddlers. …

It is ridiculous to assume you know what goes on in the mind of a three-year-old. They don't have the verbal skills to express bias. You can't have a discussion with them. And what worries me is professionals who are not discerning will believe this.

***Health Care News*:** How do they describe unconscious bias among adults?

Eyal: They presented a survey from the Pew Research Center, a reputable organization, that showed 50 percent of white people have a bias toward other whites and 45 percent of African Americans have a bias toward other African Americans. I wondered, why are they making us take this course when their own survey shows about half of those surveyed have no bias.

Furthermore, we all have an inborn tendency to gravitate to the familiar, but it doesn't mean dislike or negative bias [against others]. Maybe 20 percent of people have a real, conscious bias, but this is not the majority.

Furthermore, "implicit bias" isn't just about race, according to this training. They have a long list of victims. Implicit bias can exist against obesity, age, or gender, and the list is so long no one can escape it. Basically, it suggests you're biased no matter what. You're guilty before opening your mouth.

***Health Care News*:** In the field of mental health, there is so much demand for help. People who may be a threat to themselves or others roam the streets. There is such an uptick in violence, especially after two years of lockdowns and forced masking. How does this affect you, that your time is being taken to address a problem that isn't well-documented?

Eyal: The demand for help is overwhelming. I am unable to take on new clients. There is such a shortage of mental health services. These courses waste our time, but that is not the biggest objection. Instead of supporting us so we give what we can to our clients, these courses try to make you feel guilty and doubt yourself.

Suicide rates are up, over 100,000 people are dying each year from drug overdoses, and "implicit bias" is the focus? This makes no sense.

I've been around long enough that I'm not persuaded by this. But I could see how this could easily erode the confidence of someone new to the field. They might now doubt themselves or second-guess anything they say. The classes offer no opportunity for debate or chance to defend oneself.

***Health Care News*:** How concerned are you that you could face additional legal liability given this emphasis on victimhood? Do you fear you could be accused of implicit bias, sued, or lose your license?

Eyal: It is one reason I tell younger professionals to avoid speaking out about their objections to this kind of forced training. They have too much at risk. Also, I was born in a Communist country. This is not new to me, and I feel better equipped to resist.

Sample Exam Question from Mandatory Implicit Bias Training

The question below offers no "none of the above" answer. It was in the section on domestic violence.

Question number 84: historical trauma is caused by

a) disruptions to entire cultural communities as the results of colonization or outside control.

b) individual reactions to learning about history.

c) specific cultures' responses to improvements made to their communities without their input.

d) laws and policies that protected minorities.

Is Mass General Brigham's Patient Conduct Code 'Woke'?

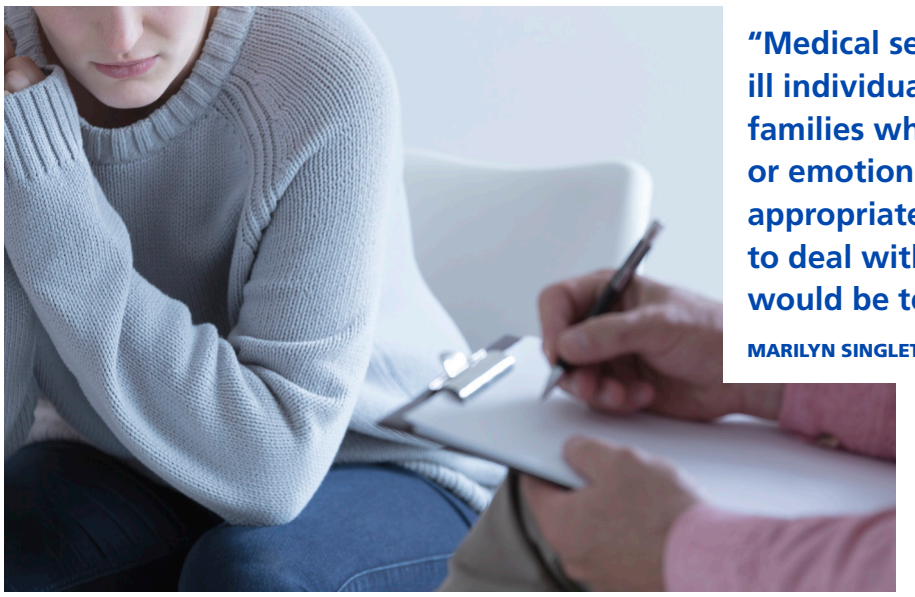
By Bonner Russell Cohen

Patients seeking care in the Boston-based Mass General Brigham (MGB) health system had better watch their language, lest they risk being told to get help elsewhere.

MGB released a "Patient Code of Conduct" in the fall that is being criticized for its vague language and "wokeness."

"Everyone should expect a safe, caring, and inclusive environment in all our spaces," MGB's code states. The code includes five examples of "words or actions that are disrespectful, hostile, or harassing" (see sidebar).

Hospitals have traditionally had codes of conduct. Threats and violence have never been welcome. MBG is now calling "offensive language" a patient violation.



"Medical settings include mentally ill individuals and patients and families who are in physical pain and/or emotionally vulnerable. A more appropriate administrative response to deal with verbally unruly patients would be teaching staff de-escalation."

MARILYN SINGLETON M.D., J.D.

'Make Other Plans'

The hospital warns it might kick out patients, family members, visitors, or research participants if someone complains about them.

"If we believe you have violated the Code with unwelcome words or actions, you will be given the chance to explain your point of view," the code states. "We will always carefully consider your response before we make any decision about your future care at Mass General Brigham. Some violations of this code may lead to patients being asked to make other plans for their future care. ..."

The code advises patients to report objectionable behavior by others to care team members.

'National Rise in Violence'

MGB says it adopted the code to deal with a growing threat of violence and abusive behavior by patients and visitors, citing a 2022 survey in which 48 percent of nurses reported an increase in workplace violence, more than double the percentage from a year earlier.

"In response to the national rise in violence and hostile behavior at healthcare facilities, Mass General Brigham has implemented a systemwide code of conduct for visitors and patients," MGB states on its website.

Another goal is to create "a safe, caring, and inclusive environment," states MGB. "Our Patient Code of Conduct helps us to meet this goal. Words or actions that are disrespectful, racist, discriminatory, hostile, or harassing are not welcome."

An internet search found one other hospital, Houston Methodist, that classifies offensive language as a patient violation. That hospital uses the exact same language as the new MGB code.

Serves 'Woke Ideology'

The vague language in the code makes it ripe for abuse, says the physician advocacy group Do No Harm in an article on its website, titled "Will Mass General Kick Non-Woke Patients To The Curb?"

"Everyone can agree that racism, discrimination, and harassment don't belong in a medical setting, much less anywhere else," the article states. "But the problem is that Mass General fails to define these terms, so there's no indication who decides what constitutes a violation."

In practice, the code could be used against patients who use the wrong pronouns or "misgender" their caregivers, says Do No Harm.

"As we've seen, medical leaders are thoroughly steeped in woke ideology," the article states. "They are likely to take a dim view of anyone who doesn't toe the party line."

'Another Big Brotherism'

MGB's code goes beyond traditional hospital protocols in attempting to police speech, says Marilyn Singleton, M.D., J.D.

"We all strive for civility in our society," said Singleton. "Physical attacks and threats are clearly a matter for hospital security officers or law enforcement. A patient speech code is yet another Big Brotherism."

Threatening to send people away is unnecessary and unfeeling, says Singleton.

"Medical settings include mentally ill individuals and patients and families who are in physical pain and/or emotionally vulnerable," said Singleton. "A more appropriate administrative response to deal with verbally unruly patients would be teaching staff de-escalation."

'You Have No Choice'

Patient behavior should be judged in the context of a hospital setting, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"In case anyone thinks they have a 'right' to medical care, think again," said Orient. "Suppose you request a different nurse to care for a family member because a nurse was neglectful, cruel, or for some reason frightening—and the nurse happens to be black. Or you don't want your child to be cared for by someone attired like a drag queen."

The code is insensitive toward patients in overemphasizing workers' feelings, says Orient.

"You have no choice of caregiver, and lack of acceptance of a 'minoritized' person might get you excluded," said Orient. "Patients are there because they need help, not to be enforcers of a political agenda. The hospital is there to meet patients' needs, not to use patients to meet the staff's needs."

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

Mass General Brigham's Patient Code of Conduct

Below is a list of things patients should not do or say if they wish to get care.

- *Offensive comments about others' race, accent, religion, gender, sexual orientation, or other personal traits*
- *Refusal to see a clinician or other staff member based on their personal traits*
- *Physical or verbal threats or assaults*
- *Sexual or vulgar words or actions*
- *Disrupting another patient's care or experience*

Source: https://www.massgeneralbrigham.org/en/patient-care/patient-visitor-information/patient-code-of-conduct

Medical Groups Promote 'Gender Inclusive' Electronic Health Records

By Bonner Cohen

Advocacy groups and a growing number of medical associations and journals want electronic health records (EHRs) to replace the biological categories of male and female with "a more inclusive model" that includes alternative gender identities.

'Gender Harmony'

One of the groups spearheading the effort to move away from what activists call the "binary construct" of male and female is the Gender Harmony Project (GHP). The organization calls for medical practices and language geared toward "improving outcomes for sex- and gender-marginalized people."

GHP developed a "gender-inclusive" model for use in payments, data analysis, quality measurement, and EHRs, authors associated with the group explain in an article published in the *Journal of the American Medical Informatics Association* (*JAMIA*).

"Most clinical systems and current standards in health care do not meaningfully address, nor do they consistently represent, sex and gender diversity, which has impeded interoperability and led to suboptimal health care," the authors write. "The Gender Harmony Model provides the informative guidance for standards developers to implement a more thorough technical design that improves the narrow binary design used in many legacy clinical systems."

Science isn't served by twisting the meaning of terms to suit political ends, says Merrill Matthews, Ph.D., a resident scholar at the Institute for Policy Innovation.

"It's a sad day when medical science works so hard to deny biological science," said Matthews. "The irony in trying to 'improve' on the 'human binary design' in health [information technology] is that the computer code itself is almost certainly binary."

'A Person's Inner Sense'

GHP is a project of Health Level Seven International (HL7), a nonprofit organization with members in more than 50 countries that develops information technology standards to support clinical care, giving the GHP model a global digital platform.

The GHP model standardizes terminology, the *JAMIA* article states.

"Within our model, sex is used to classify individuals as female, male, or specified (neither female nor male) and can be based on an infant's anatomy, other biological characteristics, or can be associated with physical and physiological features," the authors write.

"It's a sad day when medical science works so hard to deny biological science. The irony in trying to 'improve' on the 'human binary design' in health [information technology] is that the computer code itself is almost certainly binary."

MERRILL MATTHEWS, PH.D.
INSTITUTE FOR POLICY INNOVATION

"Gender is defined as a person's inner sense of being a girl/woman/female/feminine, boy/man/male/masculine, nonbinary…, something else, or having no gender."

Using these different terms could reduce bullying of patients and providers, states the APP Committee on Pediatric Workforce.

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

New Glossary Terms for Electronic Health Records

The Gender Harmony Project activist group has created a glossary of key terms intended to change how people think about differences between the sexes. Listed below are some examples making their way into electronic health records, data analysis, and billing statements.

Gender Expression: "How a person chooses to outwardly express their gender, including behavior, speech, clothing, names, and pronouns used. Gender expression is context-dependent. People may not feel safe expressing their felt gender in certain places or with certain people because of the risk of discrimination."

Gender Identity (GI): "Personal identification with a gender such as man, woman, nonbinary, transgender, and Two Spirit. A person may have a gender identity or identities. Gender identity cannot be an externally applied label. It is something that is shared when a person feels safe to share it."

Nonbinary: "Describes a person whose gender identity falls outside of the traditional gender binary structure of girl/woman and boy/man."

Sex for Clinical Use: "A newly proposed sex characteristic defined within the HL7 gender harmony model. Used to represent a clinical sex value for use in considering a specific clinical observation or activity."

Two-Spirit: "The term Two-Spirit was created by Indigenous people for use by Indigenous people, and may be used as an Indigenous gender, sexual, or spiritual identity."

—Staff reports

U.S. Leads the World in Child Sex Change Treatment, Surgery

By Ashley Bateman

State governments across the nation are increasing oversight of child sex-change clinics and medical personnel.

Missouri Attorney General Andrew Bailey is investigating the Transgender Center at St. Louis Children's Hospital based on a whistleblower's sworn affidavit and supporting documents about what she witnessed, which included continuing treatment after parents revoked consent. Multiple state agencies are involved in the probe, said Bailey in a February 9 news release.

The investigation could lead to revocation of medical licenses, *The Daily Signal* reported on February 10.

Legislatures in other states are taking action. The Virginia House of Delegates on February 7 passed Sage's Law (HB 2432), which would require public school personnel to notify parents if a child self-identifies as a sex different from the individual's biological sex. Utah Gov. Spencer Cox signed into law S.B. 16, which restricts hormonal transgender treatment and allows individuals to bring medical malpractice actions over some procedures, on January 28.

'Listen to Them'

Nearly 20 other states are considering legislation to restrain gender treatments, says Jay Richards, director of the DeVos Center for Life, Religion, and Family at The Heritage Foundation.

"States that are working to restrict and prohibit these treatments without criminalizing it are doing the best thing, in my view," Richards said. "For example, a state legislator can pass a law stating that a doctor who performs these surgeries on minors loses their license. Then the state can extend the statute of limitations."

Allowing patients to sue later in life could change the motivations of doctors, insurance companies, and drug makers, says Richards.

The most powerful voices are those of "de-transitioners" who say they were manipulated into these treatments, says Ginny Gentles, director of the Education Freedom Center at the Independent Women's Forum.

"The young adults who have been harmed by 'gender-affirming care' are speaking up and demanding that this stop," said Gentles. "Society and legislators must listen to them."

'Put the Brakes On'

U.S. laws regarding child sex change procedures are the most permissive among a dozen of the most developed countries, states a report titled "Reassigned," published by Do No Harm, a physician-led policy group.

The United States has relatively few restrictions on gender transition, insurance coverage, and minimum ages for gender-altering hormones when compared to 11 other countries in northern and western Europe. America also leads Europe by having the highest number of youth gender clinics, the report states.

"The fact that more progressive countries have already put the brakes on these treatments is really important for legislators and for courts," Richards said.

Dutch Studies' Protocols

The scientific justification for "gender-affirming" care in the United States is based primarily on two Dutch studies that have major flaws and do not apply to the U.S. system, says Richards.

"Even if you believed the original Dutch protocol was really well-done, what we're doing in the U.S. has nothing to do with it," said Richards. "[Americans] have had no guardrails. Kids with psychological comorbidities were excluded from the Dutch studies. In the U.S., we're completely off-base."

The researchers in the Dutch studies screened participants and disqualified youth with psychological comorbidities, such as attention-deficit/hyperactivity disorder, anxiety, depression, obsessive rumination, and challenges from autism or social pressure at home or at school. American practitioners have not applied those protocols, says Richards.

'Irreversible Damage Inflicted'

Responses to gender dysphoria in children might include therapy, love, and attentive care, but professional medical groups are promoting radical treatments, says Gentles.

"In the case of the American Academy of Pediatrics, a handful of activists set the policies followed by the nation's pediatricians, and the organization refuses to address the concerns of practicing pediatricians about the irreversible damage inflicted on children by puberty blockers, hormones, and surgeries," Gentles said. "Anyone even gently questioning the [activists'] agenda is labeled a bigot and accused of wanting gender-confused children to kill themselves."

There are no long-term studies on the benefits and harms of these interventions, any comparing them to alternative treatments, or randomized trials to isolate effects, says Richards.

"All these groups claiming to work for medicine and science aren't basing guidelines on scientific knowledge," said Richards.

'Directly Benefiting Financially'

The gender movement raises big questions on the cozy relationship between regulators and the industries they're supposed to be overseeing, says Richards.

"The American medical establishment's adoption of so-called 'gender-affirming' care, more accurately called 'sex-denying' intervention, is the most obvious example of medical capture since the eugenics craze," said Richards.

Medical specialists and drug companies involved in these transitions are directly benefiting financially, as the people who transition must take specialized maintenance drugs for the rest of their lives and receive further health care consultations. Even so, health care providers and drug makers are driven primarily by a commitment to an unscientific idea, says Richards.

"Gender ideology as applied to medicine is probably the most toxic and existential expression of a perverse ideology," said Richards. "It denies basic biology and replaces it with this completely unverifiable notion that people select their gender."

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

"In the case of the American Academy of Pediatrics, a handful of activists set the policies followed by the nation's pediatricians, and the organization refuses to address the concerns of practicing pediatricians about the irreversible damage inflicted on children by puberty blockers, hormones, and surgeries. Anyone even gently questioning the [activists'] agenda is labeled a bigot and accused of wanting gender-confused children to kill themselves."

GINNY GENTLES
INDEPENDENT WOMEN'S FORUM

Hospital That Refused to Perform Transgender Surgery Loses in Court

By AnneMarie Schieber

A federal court ruled against a hospital that refused on religious grounds to perform an elective hysterectomy on a transgender person.

U.S. District Judge Deborah K. Chasanow ruled the University of Maryland Medical System (UMMS) violated Section 1557 of the Affordable Care Act (ACA), which prohibits discrimination in health care based on sex, by refusing to remove Jesse Hammons' uterus, in the case of *Hammons v. UMMS*.

Religious Provision

Jesse Hammons, who was born female, wants to transition into a man. St. Joseph Medical Center in Towson, Maryland, which is operated by the UMMS, declined to perform the surgery.

UMMS merged with St. Joseph Medical Center in 2012. The deal included a provision that allowed St. Joseph to continue following a protocol known as the "Ethical and Religious Directives for Catholic Health Care Services."

The Directives state, "Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available."

'A Dangerous Principle'

Hammons shows the problematic nature of mergers and contractual agreements between religious and secular hospital systems, and the more troubling issue of religious freedom under Section 1557, says Jon Scruggs, a senior counsel at Alliance Defending Freedom, a public interest law firm that is not involved in the case.

"The 1557 rule applies, effectively, to any private medical institution that accepts insurance, like Medicare and Medicaid," said Scruggs. "It requires medical groups to provide these dangerous procedures in violation of their conscience. That is a dangerous principle. It applies to both medical judgment and religious grounds."

UMMS is reportedly considering its legal options and had not appealed Chasanow's decision as of press time.

'Lawsuits through the Roof'

Scruggs says Section 1557 is creating multiple problems as courts and now the Biden administration create expansive interpretations of what it requires.

"Section 1557 relies on Title IX, which says you can't discriminate on the basis of sex," said Scruggs. "This same understanding is also compelling doctors to provide these dangerous procedures. This is an element of this that is going underreported."

The comment period for a final rule proposed by the Biden administration for its interpretation of Section 1557 closes on March 6, says Tommy Valentine, national field director for Catholic Vote, which opposes the new rule.

"If this rule is finalized, there are going to be lawsuits through the roof."

TOMMY VALENTINE
NATIONAL FIELD DIRECTOR
CATHOLIC VOTE

"If this rule is finalized, there are going to be lawsuits through the roof," said Valentine.

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

INTERNET INFO

U.S. District Judge Deborah Chasanow, *Jesse Hammons v. University of Maryland Medical System Corporation, et al.*, Memorandum Opinion, January 6, 2023: **https://storage.courtlistener.com/recap/gov.uscourts.mdd.483434/gov.uscourts.mdd.483434.121.0.pdf**

COMMENTARY

Congress Should Investigate AARP

By Chris Jacobs

Why would an organization that claims to advocate for seniors support a bill that raided nearly a quarter of a trillion dollars from Medicare? As with most things in Washington, the answer comes by following the money.

In passing the inaptly named Inflation Reduction Act last year, Democrats reduced Medicare spending by more than $250 billion, most of which lawmakers used to fund climate pork, the hiring of 87,000 IRS agents, and other unrelated matters.

With Medicare facing insolvency in just a few short years, using the program as a slush fund to pay for unrelated spending exposes the hollowness of the Democrats' supposed commitment to seniors. The nonprofit interest group AARP eagerly supported the measure, suggesting the organization may prioritize its own finances over its members' needs and interests.

"With the AARP leviathan growing larger than ever, action by lawmakers to expose and eliminate the organization's gravy train from UnitedHealth would actually help seniors—unlike Democrats' raid on Medicare."

CHRIS JACOBS
FOUNDER AND CEO
JUNIPER RESEARCH GROUP

Nonprofit Gravy Train

AARP makes more than a billion dollars each year by selling products to its members, generally people over age 50. The most significant source of AARP's "royalty" money by far comes from UnitedHealth Group, the nation's largest insurer.

UnitedHealth doubly benefited from the legislation Democrats rammed through Congress last year. Provisions in the legislation permitting the federal government to dictate drug prices will lower health insurers' expenses, even as they limit patients' access to potential breakthrough drugs and therapies. In addition, the law's $64 billion in subsidies to insurance companies will benefit businesses such as UnitedHealth that sell products on the Obamacare exchanges.

AARP's endorsement of the raid on Medicare is the latest episode in the organization's sordid treatment of seniors. To generate its more than $1 billion in annual "royalty fee" income, AARP slaps a 4.95 percent surcharge on every Medicare supplemental insurance policy it sells. And although AARP claims to support transparency for health insurers, it does not disclose this financial conflict of interest to members buying insurance, some of whom blindly and incorrectly place their faith in AARP's endorsements.

By withholding this important information from its members and the public, AARP has shown itself willing to violate its stated principles when doing so advances its financial objectives.

Congressional Cooperation

The Medigap surcharge demonstrates how AARP puts its bottom line ahead of its members' interests. Simply put, AARP makes more money whenever its members pay more in premiums—a clear recipe for overcharging seniors.

While passing legislation that purports to reduce seniors' drug costs, congressional Democrats did nothing to rein in the way AARP jacks up insurance rates to pad its own bottom line. So much for the inflation reduction part of the Inflation Reduction Act.

Call for Change

With Democrats having done nothing to investigate AARP while controlling Congress, the new House Republican majority should take the opportunity to examine these questionable business practices.

Congress has explored the organization's practices in the past but has never placed a sustained focus on how it overcharges seniors. With the AARP leviathan growing larger than ever, action by lawmakers to expose and eliminate the organization's gravy train from UnitedHealth would actually help seniors—unlike Democrats' raid on Medicare.

Chris Jacobs (**chris@juniperresearchgroup.com**) *is the founder and CEO of Juniper Research Group and author of* The Case Against Single Payer. *A version of this article appeared in* DC Journal *on January 22, 2023. Reprinted with permission.*

Media Now Calls Pregnancy Centers 'Anti-Abortion'

Media outlets now call organizations that help women with unplanned pregnancies "anti-abortion centers," after the Associated Press (AP) changed its style guidelines in December.

The *AP Stylebook*, the standard journalists use to provide consistency in language and style in news coverage, describes "Crisis Pregnancy Centers" as organizations "set up to divert or discourage women from having abortions," *The Daily Signal* reports.

The AP says the term is "misleading," the operations should be called anti-abortion centers, and any phrase describing their work should be put in scare quotes.

"The *AP Stylebook*, the standard journalists use to provide consistency in language and style in news coverage, describes 'Crisis Pregnancy Centers' as organizations 'set up to divert or discourage women from having abortions,' *The Daily Signal* reports."

Pregnancy centers are typically nonprofit organizations providing free ultrasounds, pregnancy tests, and material, moral, and educational support to women with unplanned pregnancies.

The *AP Stylebook* has an entire section devoted to abortion-related coverage, with guidance on the use of words such as "embryo" and "fetus."

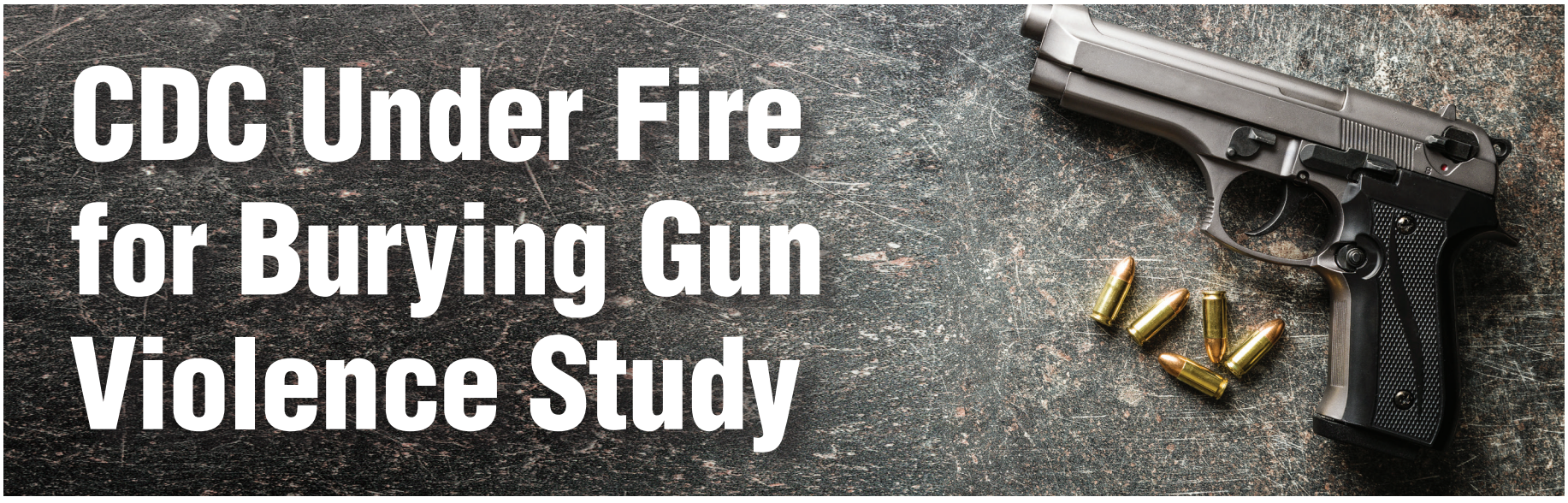
Media outlets are using the new guidelines. Examples include a February 6 ABC News article headlined "Tennessee Gov. Lee proposes $100M for anti-abortion centers." An article on the DocumentedNY website used the headline "City Council Member Funnels Taxpayer Dollars to Anti-Abortion Clinic."

Since the Supreme Court decision in June 2022 overturning *Roe v. Wade*, there have been 81 physical attacks on pregnancy centers, according to Catholic Vote, which tracks cases of pro-abortion vandalism and fire bombings.

U.S. House Republicans and three Democrats voted for a resolution condemning such attacks. In August, U.S. Senators Elizabeth Warren (D-MA) and Bob Menendez (D-NY) demanded a crackdown on "deceptive and misleading practices employed by many crisis pregnancy centers."

—Staff reports

CDC Under Fire for Burying Gun Violence Study



By Ashley Bateman

Members of Congress are demanding the Centers for Disease Control and Prevention (CDC) restore data on its website from a study that found law-abiding citizens protect themselves with 2.5 million defensive gun uses per year in the United States.

In a letter to the CDC published on December 19, Reps. August Pfluger (R-TX) and Elise Stefanik (R-NY) requested all data on defensive gun use (DGU) in the United States be immediately made available to the American public. The letter criticized the agency's decision to remove a CDC-commissioned study titled "Priorities for Research to Reduce the Threat of Firearm Related Violence."

"Removing studies without explanation in an apparent effort to curry favor with political allies … will only further deteriorate public trust," the lawmakers wrote. "The gun control debate is not about hobbies or sports. It is about protecting one of the most fundamental rights afforded to the American people. There is a difference between providing information to educate consumers, and censoring facts that third-party groups may disagree with politically."

'Shamefully Lying'

In a separate press statement, Stefanik decried the CDC's "far left anti-gun agenda" and accused the Biden administration of lying to the public.

"The Biden Administration is shamefully lying to the American people and hiding the facts of how law-abiding citizens use their constitutionally protected Second Amendment rights to keep our families and communities safe," Stefanik said. "The American people deserve the truth, not more partisan action from the CDC," Stefanik said.

Millions of Cases, Ignored

The hallmark study on DGU, conducted by Florida State University criminologist Gary Kleck in 1992, is considered foundational by groups supporting the right to bear firearms. Subsequent studies over the years have produced similarly high numbers, conservatively calculated at between one and two million cases of defensive gun use per year.

> **"The CDC has an internal agenda to push for gun control. They were coming out with very one-sided studies, not just for specific policies that [claimed] having fewer guns was a good thing. This has been an ongoing thing with the CDC. Now you're seeing it rear its ugly head again in such a profound way. This is historical."**
>
> **AMY SWEARER**
> **LEGAL FELLOW**
> **THE HERITAGE FOUNDATION**

The most comprehensive dataset released in recent years found an annual DGU rate of about 1.6 million cases.

The CDC was discovered to have removed the data in December 2022, after *The Reload* obtained emails between gun control advocates and the CDC. A December 15 opinion piece on the topic at *Bearing Arms* focused more attention on the CDC's action. Fox News also reported on the removal of the data.

The activists would not tolerate even a lowball estimate, instead demanding the entire subject of defensive gun use be purged from the CDC website, Kleck told *Health Care News*.

"There are now 21 professional surveys using probability samples of the U.S. adult population, including surveys conducted by very pro-gun-control organizations," said Kleck. "It's pretty clear that the [study's] sponsorship doesn't affect the results. The CDC's response to unfavorable data is to remove it from the public eye."

'Trying to Get Their Own Data'

Kleck's study has been criticized by gun-control proponents but remains an authentic benchmark of DGU over time, says Amy Swearer, a legal fellow at The Heritage Foundation.

"Kleck's study is not an outdated dataset," said Swearer. "This is something that's continued to be found time and time again by a number of researchers. When the CDC pulled these numbers, they took away any benchmark and said no one actually knows the exact number [of DGUs] per year. … I've never seen an agency do that."

The CDC also removed references from a 2013 report by the Obama administration which surveyed not only Kleck's study but nearly two dozen others and found similarly high numbers of DGU across the country. Swearer says this is an unprecedented action.

"[The CDC] was doing their own studies and surveys, trying to get their own data on gun defensive use, and then decided not to publish it [when results] were not favorable for gun control," said Swearer.

'Very One-Sided Studies' at CDC

In the early 1990s, Congress passed the Dickey Amendment, a statute forbidding the CDC and other federal agencies from using federal funding to advocate gun control. In what Swearer calls a "decades-long battle," the CDC has continued to do just that.

"The CDC has an internal agenda to push for gun control," said Swearer. "They were coming out with very one-sided studies, not just for specific policies that [claimed] having fewer guns was a good thing. This has been an ongoing thing with the CDC. Now you're seeing it rear its ugly head again in such a profound way. This is historic."

The CDC is doing an end-run around Congress because it can't get what it wants through honest means, says Swearer.

"When you address the right to bear firearms as a constitutional right, ensuring that law-abiding Americans can defend and protect themselves, it is a hard angle for gun control," said Swearer. "So instead, the CDC continues to frame gun violence as a public-health issue."

'The Result Was Censorship'

"It distorts the public's view of the public health issue if [data] is removed for political reasons," Kleck said. "Email exchanges indicated CDC staff caved to external pressure from gun control advocates. So it was for political reasons. The result was censorship."

With continuing reports of significant declines in the public's trust of the CDC, the censorship of a politically charged topic such as gun control exemplifies how the agency has "shot itself in the foot politically," said Kleck.

"It corrodes public trust in what should be a credible agency," said Swearer.

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

COMMENTARY

How Stanford Harassed a Lockdown Skeptic

By Jay Bhattacharya, M.D.

Three epidemiologists—the eminent Sunetra Gupta of the University of Oxford and Martin Kulldorff of Harvard University, and I—wrote and distributed the Great Barrington Declaration (GBD) on October 4, 2020.

That one-page document proposed a very different way to manage the COVID-19 pandemic than had been used until then. The lockdown-focused strategy much of the world followed mimicked the approach Chinese authorities had adopted in January 2020.

Governments imposed lockdowns on the premise there was nearly unanimous scientific consensus in support of them. Yet an extraordinary policy like a lockdown should require an extraordinary scientific justification. Only near-unanimity among scientists, backed by solid empirical data, should suffice.

We wrote the GBD to tell the public there was no scientific unanimity supporting the lockdowns. Instead, the GBD proposed a focused strategy to protect the elderly and other vulnerable populations.

Stanford University Campus

"Stanford faculty should worry whether their professional work will lead to deplatforming, excommunication, and political targeting. Academic freedom matters most in the edge cases when a faculty member or student is pursuing an idea that others at the university find inconvenient or objectionable. If Stanford cannot protect academic freedom in these cases, it cannot protect academic freedom at all."

JAY BHATTACHARYA, M.D., PH.D.
PROFESSOR OF HEALTH POLICY
STANFORD UNIVERSITY

PHOTO COURTESY HD./FLICKR.COM

Collins/Fauci Takedown

Four days after we wrote the GBD, Francis Collins, a geneticist and laboratory scientist who headed the National Institutes of Health, wrote to Anthony Fauci, an immunologist and lab scientist who headed the National Institute of Allergy and Infectious Diseases until the end of 2022, calling us "fringe epidemiologists" who needed a devastating public takedown.

At the NIH, Collins and Fauci sat atop tens of billions of dollars that fund the work of nearly every biomedical scientist of note in the United States.

I work at Stanford University, which receives hundreds of millions of dollars from the NIH, without which researchers would not have the resources to conduct many worthwhile experiments and studies. NIH funding also confers prestige and status within the scientific community. At Stanford, it is very difficult for a biomedical researcher to earn tenure without landing a major NIH grant.

The attacks by Collins and Fauci sent a clear signal to other scientists that the GBD was a heretical document.

Stanford Attacks

If you had asked me in March 2020 whether Stanford had an academic freedom problem in medicine or the sciences, I would have scoffed at the idea. Stanford's motto (in German) is "The winds of freedom blow," and I would have told you then that Stanford lives up to that motto.

I was naive then, but not now.

The most egregious violation of academic freedom was an implicit decision by the university to deplatform me. Although I have given dozens of talks in seminars at Stanford over decades, in December 2020 my department chair blocked an attempt to organize a seminar where I would publicly present the ideas of the GBD.

A former Stanford president, John Hennessey, tried to set up a discussion between me and others on COVID policy, but he was unable to do so, owing to the absence of support from the university.

I was not the only one to suffer. Stanford deplatformed other lockdown-skeptic academics, including John Ioannidis, one of the world's most highly cited scientists and the most prolific and influential Stanford faculty member on peer-reviewed COVID-19 publications; Michael Levitt, a Nobel Prize winner who made fundamental original contributions to modeling; and Scott Atlas, a former chair of neuroradiology at Stanford, widely acknowledged health policy expert, and key advisor to former President Donald Trump on COVID policy.

Slander, Threats, Abuse

The university's refusal to defend dissenting voices created an environment in which slander, threats, and abuse aimed at lockdown critics could flourish. In August 2020, when President Trump chose Atlas as a White House advisor on the pandemic, around 100 Stanford faculty members signed an open letter accusing him of "falsehoods and misrepresentations," without giving any specific examples.

In August 2021, Melissa Bondy, chair of epidemiology at Stanford, helped circulate a secret petition around the medical school asking the university president to censure me for accurate testimony I gave Florida Gov. Ron DeSantis at a publicly televised policy roundtable.

I testified that no randomized trials had demonstrated the efficacy of masks on children to contain COVID. Although the secret petition did not name me specifically, it quoted me and asked the university to suppress such speech by faculty members.

The people behind this petition imposed unethical pressure on faculty members—especially junior faculty members worried about tenure votes—to sign on.

Intimidation Campaign

An anonymous group on campus organized a campaign to intimidate me in response to a tweet by DeSantis, which included a picture of me from the policy roundtable and an accurate quote: "By vaccinating the old, we have protected the vulnerable."

The group glued posters all over campus with a picture of my face, the tweet from DeSantis, and a graph of the number of COVID cases in Florida, which at the time was high. (Florida's age-adjusted COVID mortality throughout the pandemic is lower than that of the average American state and on a par with California's.) The implication was that I was a thought criminal whose work was somehow responsible for the inevitable spread of a highly infectious respiratory virus.

On a progressive-dominated campus, these posters were clearly an incitement to violence. The group placed them on kiosks all over campus, including near a campus coffee shop I frequent.

Freedom for 'Edge Cases'

Stanford faculty should worry whether their professional work will lead to deplatforming, excommunication, and political targeting.

Academic freedom matters most in the edge cases when a faculty member or student is pursuing an idea that others at the university find inconvenient or objectionable. If Stanford cannot protect academic freedom in these cases, it cannot protect academic freedom at all.

Jay Bhattacharya, M.D., Ph.D. **(jay@stanford.edu)** *is a professor of health policy at Stanford University.* *A version of this article appeared at* Tablet *on January 11, 2023. Reprinted with permission.*

Caught on Camera: Pfizer Exec Discusses 'Optimizing' COVID Mutations

Project Veritas on January 25 released an edited video it identified as depicting Jordon Trishton Walker, M.D., described as a director of research and development for drug maker Pfizer Inc., speaking to Veritas' undercover videographer.

"One of the things we [Pfizer] are exploring is like, 'Why don't we just mutate it [COVID] ourselves so we could create—preemptively develop—new vaccines, right?'" said Walker.

"If we're going to do that, though, there's a risk of, like, as you could imagine, no one wants to be having a pharma company mutating f—ing viruses," said Walker.

'Figuring Out Future Mutations'

In the video, Walker also said Pfizer was "optimizing" the COVID mutation process.

"From what I've heard, … [Pfizer scientists] are optimizing it, but they are going slow because everyone is very cautious," said Walker. "Obviously, they don't want to accelerate it too much. I think they are also just trying to do it as an exploratory thing because you obviously don't want to advertise that you are figuring out future mutations."

Walker asked the person secretly recording him to keep his comments confidential.

"Don't tell anyone," said Walker. "Promise you won't tell anyone. The way it [the experiment] would work is that we put the virus in monkeys, and we successively cause them to keep infecting each other, and we collect serial samples from them."

'Revolving Door'

Walker suggested regulatory capture, in which big businesses encourage government regulators to tilt the market in their favor, is a benefit to Big Pharma.

"So, in the pharma industry, all the people who review our drugs—eventually most of them will come work for pharma companies," said Walker. "And in the military, defense government officials eventually work for defense companies afterwards."

The unidentified Project Veritas associate asked how Walker felt about "that revolving door."

"It's pretty good for the industry, to be honest," said Walker. "It's bad for everybody else in America. Because when the regulators reviewing our drugs know that once they stop regulating, they are going to work for the company, they are not going to be as hard towards the company that's going to give them a job."

Unexpected Side Effect

Walker also discussed how the COVID-19 shots were affecting menstrual cycles.

"There is something irregular about the menstrual cycles, so people will have to investigate that down the line," said Walker.

Walker said that is a surprising development.

"The [COVID] vaccine shouldn't be interfering with that [menstrual cycles]," said Walker. "So we don't really know. I hope we don't find out that somehow this mRNA lingers in the body and, like, because it has to be affecting something hormonal to impact menstrual cycles."

—*Staff reports*

"The [COVID] vaccine shouldn't be interfering with that [menstrual cycles]. So we don't really know. I hope we don't find out that somehow this mRNA lingers in the body and, like, because it has to be affecting something hormonal to impact menstrual cycles."

JORDON TRISHTON WALKER, M.D.
DIRECTOR OF RESEARCH AND DEVELOPMENT
PFIZER

COMMENTARY

Pfizer Executives Must Come Clean on COVID-19 'Mutation' Experiments

By Robert Moffit

Jordon Trishton Walker, M.D., a director of research and development for Pfizer Inc., recently became an overnight internet sensation.

The reason: in rambling remarks to an undercover Project Veritas reporter, Walker outlined how the company could mutate viruses in a lab and do so to create new vaccines, while speculating on the potential of the process to be a "cash cow" for the pharmaceutical giant and, presumably, others in the industry.

Then, realizing he was being recorded, Walker had a meltdown. It's not hard to see why (see opposite page).

Research to "mutate viruses" does sound inherently dangerous, suspiciously like viral "gain of function" research, the kind of research designed to genetically enhance the transmissibility and lethality of the virus and the kind of notorious lab work in Wuhan, China that may have been the source of the global COVID-19 pandemic.

Pfizer's Public Defense

Responding to Walker's allegations without mentioning him by name, Pfizer denied it has been conducting "gain of function" or "directed evolution" research.

"Working with collaborators, we have conducted research where the original SARS-CoV-2 virus has been used to express the spike protein from new variants of concern," stated Pfizer. "This work is undertaken once a new variant of concern has been identified by public health authorities. This research provides a way for us to rapidly assess the ability of an existing vaccine to induce antibodies that neutralize a newly identified variant of concern."

'Within the Law'

Pfizer says it is operating within the law. Federal regulations require such lab work to identify potential resistance to a therapeutic, in this case Paxlovid, the most prominent therapeutic for treating COVID-19, the company notes.

"With a naturally evolving virus, it is important to routinely assess the activity of an antiviral," stated Pfizer. "Most of this work is conducted using computer simulations or mutations of the main protease, a non-infectious part of the virus. In a limited number of cases when a full virus does not contain any known 'gain of function' mutations, such virus may be engineered to enable the assessment of antiviral activity in cells."

In those cases, Pfizer says, the mutation experiments are conducted in a secure lab to determine potential viral resistance. "It is important to note that these studies are required by U.S. and global regulators for all antiviral products and are carried out by many companies and academic institutions in the U.S. and around the world," Pfizer states.

Instead of assuming Pfizer's representations are truthful, congressional investigators should verify the company's claims. Lawmakers need to subpoena Walker, the appropriate Pfizer executives, and the relevant documents.

> **"A topline lesson is that lawmakers cannot simply depend on government administrators to do the right thing. The American people need peace of mind, not lax oversight of either corporate executives or government officials."**
>
> ROBERT MOFFIT, PH.D.
> SENIOR FELLOW
> THE HERITAGE FOUNDATION

Pressing Policy Questions

Congress should also drill down on several pressing policy questions.

First, is Pfizer's distinction between its "limited" viral mutation experiments and "gain of function" or "directed evolution" research—the kinds of research that the company denies conducting—a difference without a distinction?

Is there a difference, for example, between "gain of function" research on viruses that exist in nature to make them more contagious or lethal to humans, and inducing lab mutations of a pathogen already infecting millions of humans to enhance the power of vaccines or therapeutics?

Does a researcher's intent make a legal difference?

Is Public Safety Ensured?

Second, is there a difference in the risk to the public from a "gain of function" research effort to enhance the transmissibility or lethality of a pathogen in nature and an experimental mutation of a virus, as acknowledged by Pfizer, to enhance vaccines or therapeutics?

Third, is Pfizer "optimizing" this COVID "mutation" process? Walker referred to this in the video (see opposite page). If so, why?

Fourth, are existing federal regulations governing such pharmaceutical research studies that Pfizer cites sufficient to ensure public safety and protection from the kind of viral manipulation that Walker suggested in his remarks to Project Veritas?

Missed Opportunities

These questions are particularly relevant considering two recent developments within the Biden administration.

First, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services recently found that National Institutes of Health (NIH) officials bypassed a critical HHS review of coronavirus research conducted by EcoHealth Alliance, the firm at the heart of the debate over the origin of the COVID-19 pandemic in China.

The OIG report found several deficiencies, stating, "[W]e conclude that NIH missed opportunities to more effectively monitor research. With improved oversight, NIH may have been able to take more timely corrective actions to mitigate the inherent risks associated with this type of research."

Need for Congressional Oversight

Second, an expert panel of advisors to the NIH issued a comprehensive report on laboratory safety, with 13 findings and 13 recommendations to enhance government oversight over scientific research on dangerous pathogens, including "gain of function" studies.

Their primary finding: there should be a "department-level" review of these research projects and a broader definition of the pathogens that could lead to a pandemic. Though the recommendations were unanimous, they were not without controversy among scientists. Obviously, Congress needs to review this report.

The COVID-19 experience has taught us many hard lessons. To prepare for the next medical crisis, Congress must thoroughly probe the weaknesses in the federal government's pandemic response.

A topline lesson is that lawmakers cannot simply depend on government administrators to do the right thing. The American people need peace of mind, not lax oversight of either corporate executives or government officials.

Robert Moffit, Ph.D. (**Bob.Moffit@heritage.org**)*, is a senior fellow in domestic policy studies at The Heritage Foundation. A version of this article appeared in* The Daily Signal *on February 6.*

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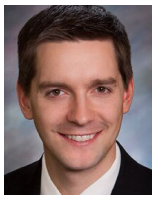

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SOUTH DAKOTA

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4

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