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On December 13, 1975, I visited the Meadowbrook Hospital in Belle Chasse, Louisiana, at the request of the Bureau of Health Insurance. The purpose of my visit was to assist and advise a survey team who were conducting an inspection of the hospital. The team members were: Kenneth Winters, Division of Quality Assurance, DHEW, a hospital administrator; Martha Clark, Division of Quality Standards, a dietician; Tillie Rogers, Division of Quality Standards, a registered records administrator; William Young, Division of Quality Standards, a registered nurse; Robert Brown, Division of Quality Standards, a registered pharmacist; William Phillips, Department of Health, Education, and Welfare, an engineer and Physical Environment Safety Expert; and Mary Corley, a staff assistant for Bureau of Health Insurance, who coordinated the survey. I was impressed with the thorough, professional, and dedicated conduct of the survey. Several sources of information were available: I was able to interview Dr. Ray Evers, the founder of Meadowbrook Hospital; I was able to examine the hospital records; visit the physiotherapy department; interview several patients; and I was able to direct the survey team to obtain the answers to a number of specific questions for me during the course of their investigations.

Section A - Interview with Dr. Evers:

These questions were written down before the interview, and Dr. Evers' answers were recorded by me in longhand. Quotation marks are omitted where I was able to record the substance of the answer but not the exact wording.

Question #1: Did you write this paper on chelation therapy? [I held up a paper entitled "Chelation of Vascular Atheromatous Disease," written in 1973 at Andalusia, Alabama by Dr. Evers.]

Answer: "Yes."

Comment: This was a seven-page statement describing and purporting to document a rationale for infusion of disodium EDTA, a chelating agent, in order to improve vascular atheromatous disease. In this paper he documents that he understands that chelation therapy can cause renal parenchymal damage, that chelation therapy is contra-indicated in renal disease, and that his standard procedure in Andalusia, Alabama,

and on which he founded Meadowbrook Hospital, was to carefully monitor patients for the development of parenchymal renal damage, by periodic measurements of BUN and creatinine, and urinalysis.

Question #2: What is the purpose of this hospital?

Answer: To treat chronic diseases characterized by impairment of the circulation; such as diabetes, arthritis, and multiple sclerosis. Not to treat acute diseases.

Question #3: Do you mean that diabetes, arthritis, and multiple sclerosis are caused by impairment of the circulation?

Answer: No, that they are often associated with it.

Comment: Despite Dr. Evers' statement that the hospital does not treat acute diseases, it was evident from the examination of the hospital records, as will be further described, that the hospital rather frequently becomes involved in the management of acute medical problems; such as renal failure developing after EDTA infusion, and congestive failure, following EDTA infusion, and does not transfer these patients to acute care hospitals nor consult with specialists in internal medicine or nephrology to a degree consistent with safe medical practice.

Question #4: What proportion of patients get EDTA?

Answer: "Seventy-five to eighty percent."

Question #5: What are the indications for EDTA therapy in this hospital?

Answer: If there is any degree of impairment of blood flow due to arteriosclerosis, as demonstrated by a stress EKG, plethysmograph, oscillograph, or arteriosclerotic survey on x-ray. We also treat stones in the kidney, lead toxicity as diagnosed by hair analysis for mineral content, and hypercalcemia.

Question #6: How do you hope to benefit the patients with EDTA?

Answer: "Improvement in circulation, tissue nutrition, and oxygenation."

Question #7: What are the contra-indications in this hospital to EDTA therapy?

Answer: "Ah, TB and, of course, renal." The patients all receive a KUB, IVP, BUN, creatinine, and urinalysis. Hospital policy is that patients with a BUN greater than 25 to 35, or creatinine of greater than 2 mg % will not receive EDTA therapy.

Comment: Review of the charts reveal that a number of patients received EDTA therapy before and after a rise in BUN and creatinine which exceeded

the hospital policy, and that several patients with BUN and creatinine levels far exceeding the criteria outlined even before EDTA therapy, had EDTA administered intravenously. A number of patients had a rise in BUN and creatinine after EDTA was discontinued, and died in renal failure, without the possibility of iatrogenic disease being raised in the records.

Question #8: Are you aware of any controlled studies of chelation therapy, in which the placebo effect been taken into account by proper experimental design?

Answer: He waved a list of references at me, but on going down the list was not able to identify one single paper as a controlled study.

Comment: I have spent several days of concentrated research in the University of California Medical Library, studying the literature on chelation therapy. It is replete with anecdotal accounts, but there is absolutely no properly designed experimentation in the available literature which gives any documentation of efficacy.

Question #9: How much sodium is there in a vial of EDTA?

Answer: "You mean in milligrams? I don't know."

Comment: The package inserts for andrate warns that EDTA infusions must be given slowly so as not to exceed the patient's cardiac reserve. The 1973 addition of AMA Drug Evaluations points out that 5 grams of disodium EDTA contains 1 gram of sodium. This means that the standard dose of 3 grams which was administered to 80 percent of the patients in Meadowbrook Hospital contains 600 milligrams of disodium EDTA. The standard method of administration in this hospital was to dilute the 3 grams of disodium EDTA in 300 milligrams of normal saline, or in Ringers solution. This means that the patients receiving infusions of disodium EDTA were receiving an intravenous solution with greater than 2 percent sodium. This practice is specifically contra-indicated in congestive heart failure. Review of the charts indicated that a number of patients already in congestive failure, and death.

Section B - Questions directed to members of the survey team:

These questions were directed to the survey team by me during a team meeting before this survey was conducted, so that the answers could be determined during the course of the team members' investigations.

Question #1: How frequently were vital signs and patient observations made during EDTA infusions at the hospital?

Answer: Blood pressures were measured once daily, and there was no provision in the routine of EDTA infusion for more frequent measurement of vital signs, nor special provision for increased availability nursing staff during EDTA infusions.

Question #2: Was any electronic cardiac monitoring available during EDTA infusions?

Answer: No such monitoring is available in the hospital, nor is there any provision for such monitoring during EDTA infusion.

Question #3: Is calcium gluconate or other intravenous calcium preparation available, drawn up at the bedside, during EDTA infusions?

Answer: No. Patients routinely receive a bolus injection of 1 gram of calcium gluconate following EDTA infusions, but no calcium preparation is available at the bedside throughout the infusion.

Question #4: How is the rate of EDTA infusion controlled?

Answer: There is no special provision for controlling the rate of infusion, such as infusion pumps.

Comment: Rapid infusion of EDTA is cautioned against both in the package insert, and in the AMA Drug Evaluations. EDTA infusion can cause hypotension, and frequent monitoring of blood pressure, pulse, and cardiac monitoring is recommended, particularly in patients with angina and arteriosclerosis. (Precisely the group of patients in whom Meadowbrook Hospital routinely employs EDTA therapy.) Quite apart from the questionable indications for which this therapy is routinely used in this hospital, there is abundant evidence that the manner in which the therapy is used is itself dangerous. Rapid infusion of EDTA can cause a sudden drop in blood calcium, causing tetany and convulsions. The AMA Drug Evaluations recommends that parenteral calcium preparations be drawn up and available for immediate injection in the event of such adverse reaction. Any intravenous therapy administered by infusion, which is capable of causing hypotension, arrhythmias, tetany, and convulsions, should be administered under strict control of the infusion rate, in the setting of constant nurse observation, with mechanical devices such as infusion pumps, and electronic cardiac monitors. The setting of a lightly staffed hospital with 20 to 30 patients at one time routinely receiving infusions of this nature with no control over infusion rates, and not cardiac monitoring, is fraught with hazard. This is precisely the setting at Meadowbrook Hospital.

Question #5: Were consultations obtained when necessary?

Answer: Only one consultation was evident in the charts of the 21 patients who died, although there was abundant evidence that they were critically ill, and many of them were receiving a variety of acute medical therapies. Only two patients were transferred for dialysis.

Comment: This failure to obtain consultations, or transfer patients for dialysis, is in conflict with the hospital director's statement that the hospital exists to provide care to patients with chronic illness. If the patients were all very advanced in age, and had died of hopeless

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diseases for which they were receiving no therapy; a consultation rate of one in twenty-one deaths might be considered within the realm of acceptable medical practice. (In a setting where such facilities are scarce.) However, there were patients as young as 47 years of age are permitted to die in congestive failure, and patients as young as 34 years of age are allowed to die of renal failure, without consultation or transfer to an acute care hospital, (several of which are readily available innearby New Orleans), the standard of medical practice in this hospital must be considered not only dangerous but negligent, in my opinion. Because this questions was so serious, I wanted to be sure that lack of availability of dialysis beds in the area was not at the root of this failure to transfer patients for standard life-saving dialysis therapy. I, therefore, telephoned Dr. Stanley Carbus, Chief of Nephrology at Louisiana State University School of Medicine, New Orleans. (Only a half-hour drive from Meadowbrook Hospital.) He informed me that at his own dialysis unit, 450 dialyses a month are performed, and that in New Orleans there are units at Tulane Charity Hospital, Baptist Hospital and Ochsner Hospital, which carry out both acute and chronic dialysis, and units at the Hotel Dieu and Methodist Hospital which offer acute dialysis therapy. In addition, there is a 20 bed private chronic dialysis unit available in the New Orleans area. He assured me that there is no difficulty in the area in obtaining acute hemodialysis for patients in acute renal failure.

Section C - Visit to the Physiotherapy Department:

A visit to the physiotherapy department revealed that a person in a white uniform, who is not a registered physiotherapist, was administering to several patients a "therapy" called Myoflex therapy. I had a brief Myoflex stimulation to my hand in order to experience its effect: It caused tingling in the fingers. I read the manual of instructions which accompanies the Myoflex machine, and discovered that this machine is designed to deliver an electrical current, up to a calling of 50 milliamps, between two electrodes. On questioning the "technician," I discovered that these electrodes are applied to the back of the neck, and called Cranial Myoflex; over the flanks bilaterally, and called Kidney Myoflex; anteroposteriorly across the thorax, and called Cardiac Myoflex; or, with a patient immersed in water, with one electrode applied to the back, and the other electrode loose in the water, called General Myoflex. I questioned Dr. Evers about this therapy, and received the following statements: Cranial Myoflex "increases blood flow to the brain, and kidney Myoflex increases blood flow to the kidneys." Dr. Evers stated that on several occasions in his lifetime, he has seen this therapy cause urine to flow in the patient's catheter, and stated "it's a joy to see the urine flow." I phoned Mr. M. J. Edwards, technical consultant for the Edwards Myoflex Corporation, at Dr. Evers' suggestion, at telephone number 318-635-5834, in Shreveport, Louisiana. Mr. Edwards stated that he is aware of no evidence indicating that Myoflex therapy can increase blood flow to the brain or kidneys, nor is he aware of evidence that there is any way to direct the Myoflex therapy so as to increase blood flow in deep organs such as the kidney or the heart.

Section D - Interviews with patients:

At the urging of Dr. Evers, and on his introduction, I interviewed several patients and took the opportunity to examine the question of informed consent. I obtained from the ward clerk on the ward I visited, a copy of the informed consent form which is signed by all patients admitted to the hospital. The patients routinely consent to the following:
1) "Complete diagnosis" 2) "Chelation therapy" 3) "Enzymatic therapy"
4) "Physical medicine including the use of the "Edward Myoflex Neuro-muscular Stimulator" 5) "Nutritional and metabolic." The next line of this form states "I have been told of the adverse reactions and understand them thoroughly."

I interviewed an elderly lady, chart #0442. Her chart stated that she has been admitted for "complete examination, diagnosis, and treatment." The chief complaint on admission was fatigue. She had come from Alaska to accompany her husband, chart #0443, who had had chelation therapy from Dr. Evers previously in Andalusia, Alabama. I questioned the patients about chelation therapy, and they were well versed in the rationale of removal of calcium from atherosclerotic plaques in order to affect a medical endarterectomy. Both patients specifically denied any knowledge of any complications or adverse effects of chelation therapy.

I interviewed a man in his fifties, admitted from Palm Springs, California. He stated that he was offered chelation therapy as an alternative to coronary artery by-pass surgery. He was told that surgery would cost \$12 - 15,000 dollars, whereas chelation therapy only costs a thousand dollars a week, for three to five weeks. I showed him a copy of the consent form. He read it, and stated that he had signed it at the admissions desk, after it was explained by a nurse. I pointed to the line regarding "adverse reactions," and asked what he understood by the adverse reactions. He stated that he was told only about "nausea, and slight dizziness." He specifically denied any knowledge of such adverse effects as kidney damage or exacerbation of congestive heart failure. The patient stated that on his admission, he was seen by Dr. Evers, who put him to bed, and examined him, including listening to his heart with a stethoscope. Dr. Evers told him that tests would be performed on him, including x-rays. The patient was sent for x-ray examination, and he was not examined by Dr. Potter until after the x-rays were done. I put several questions to verify that the above sequence of events was as described, and that there was no mistake.

Comment: These interviews indicate clearly that the patients in signing the so called informed consent form, are not giving informed consent, and that they are not properly informed of the adverse effect of chelation therapy. Further, the interview with the man from Palm Springs indicates that Dr. Evers is continuing to practice medicine without a license.

Section E - Examination of Hospital Records:

I studied in detail the hospital records of 21 patients who have died at Meadowbrook Hospital, and the charts of the only two patients who have been transferred from Meadowbrook Hospital for dialysis. I was shocked at the extent to which, in my opinion, the principles of rational therapy are neglected at this hospital, and the extent to which standard medical therapy, such as hemodialysis which in some cases could have been life-saving, was withheld in favor of the unscientific therapies which are offered routinely at Meadowbrook Hospital, namely: chelation therapy, nutritional therapy, and electrical stimulation with the Edwards Myoflex machine. Computer print-outs appear to sanctify failure to apply the standard basis for medical diagnosis and therapy, namely, a thorough interactive taking of the patients history, and physical examination. Instead, in Meadowbrook Hospital, patients fill out a questionnaire, which replaces the history. A physical examination checklist is ticked off, and the so called history and physical are submitted to a computer for a print-out of findings and diagnostic interpretations. Patients routinely have hair clippings taken, which are sent for analysis in a distant laboratory, resulting in a computer print-out which purports to diagnose a variety of nutritional and mineral imbalances. This computer print-out selects from a preprinted sheet of nutritional "therapies" a battery of nutritional supplements which the patients take on a daily basis, in large quantities. These nutritional supplements include such things as Wa-mel, which the Meadowbrook Hospital pharmacist identified as freeze-dried watermelon. Standing orders are routine and violate the principle of individualization of therapy. They include the following: In addition to a battery of biochemical estimations and the hair clippings mentioned above, all new patients receive x-rays of their entire body, designated an "arterio-sclerotic survey", an intravenous pyelogram, barium enema, esophagogram, GI series, small bowel studies, and a cholecystogram. Medications ordered routinely to be reordered every 31 days include Placidyl 500 milligrams HS and repeated if necessary in 2 hours, Demerol 50 milligrams to 100 milligrams, PO or IM every 4 - 6 hours p.r.n. Medications that do not require reordering include aspirin, Tylenol, laxative of choice, Dramamine 2 cc's IM every 4 hours p.r.n. for nausea or vomiting, Tygan 250 milligrams PO every 4 hours p.r.n. for nausea. Orders for restraints p.r.n. and Histadyl 2 cc's IM 30 minutes before blood transfusion are included on this list of routine standing orders. Such an extensive list of standing orders is dangerous not only because in certain circumstances where patients require such medications as ordered here a doctor should be notified, (for example when a patient is experiencing chest pain,) but they demonstrate excessive indiscriminate use of risky x-ray investigations, without regard to the principle that x-ray and other laboratory investigations are ordered to test a hypothesis based on clinical diagnosis. An example of the dangers of such standing orders was afforded by chart 00291. This 78 year old man was admitted October 15, 1975 at 11 a.m., and expired October 15 at 4:15 p.m. He was admitted with the diagnosis of general arteriosclerosis, malignant hypertension, and carotid insufficiency.

Physical findings on the chart include orthopnea, dyspnea, chest pain, and mark elevation of the blood pressure. Statements in the medical record included the following: "There is some edema of the ankles, he is suffering from mild congestive heart failure." "When he came to hospital he was critically ill." His orders at 2 p.m. included cardiac myoflax daily, Hydargine, (this drug is contra-indicated) and nitroglycerin p.r.n. The nurse's notes stated "arteriosclerotic studies to be done." Later that afternoon, during an intravenous pyelogram, part of the routine standing orders, he had an attack of chest pains and died suddenly. There is no documentation in the record of any reason other than routine standing orders, why this critically ill man was subjected to the risk of an intravenous pyelogram. The charts demonstrated excessive use of verbal and telephone orders, as opposed to written orders. It is a generally accepted principle of good medical practice that orders for therapy for hospitalized patients will generally be written by the doctor ordering such therapy. Telephone and verbal orders are used sparingly, because of the risk of error in transcription, and because of possible confusion about the identity of the patient for whom the therapy is being ordered. In reviewing the charts, I became aware of an excess of verbal and telephone orders, and conducted an actual count on the last three charts I reviewed. These were charts #0320, 0319, and 0249. On these three charts there were a total of 135 verbal or telephone orders, and only six written orders. That is, written orders constituted less than 5 per cent of the total orders for therapy given. On chart #0432, there was evidence that the extent to which this transmission of orders by telephone occurs, is truly dangerous in this hospital: a telephone order for intravenous adrenaline, 1 cc of a strength of 1 in a thousand, was taken by telephone by M. Richardson, LPN, and was administered by "I.V. push given stat" by E. L. McWhinney, RN, at 6:45 a.m., on November 20, 1975. The same chart indicated the possibility that the widespread use of verbal and telephone orders which are routinely countersigned by Dr. Potter, may be used to conceal the continued practice of medicine by Dr. Evers; this patient, a 56 year old woman with metastatic breast cancer, was admitted "critically ill and a terminal cancer patient" on November 15, 1975. On November 20, 1975, the day in question, she became suddenly moribund at 6 a.m. The nurse's notes record the following: at 6 a.m. "Dr. Evers called by beeper" by E. L. McWhinney, RN. Beginning at 6:10 a.m., she carried out a series of orders as follows:

- 6:10 - O-2 by mask, then canula.
- 6:25 - patient positioned
- 6:30 - 1000 cc's lactated Ringer's IV started
- 6:33 - B.P 70 over -; Aminophylline 250 milligrams IV push.
- At 6:35 Aminophylline 250 to present IV. 6:43 - breathing better, less labored, BP 80/-
- 6:45 - "adrenalin 1 in a thousand 1cc IV push, given stat!" (This is a dangerous procedure not used by prudent physicians, and not permitted by nurses under any circumstance, much less on a telephone order taken by an L.P.N.)

- 6:45 - B.P. 100 - better
- 6:53 - B.P. 115 over 60 - alert, responding
- 6:55 - a note that Dr. Potter was notified at 6:30 a.m. and the nurse received orders for the above therapy given to relieve the patient's discomfort.
- 6:58 - the records show that respirations were faint and difficult, and at 7:05 she stopped breathing and expired. At that time the note shows that Dr. Potter was in transit to Meadowbrook Hospital. This last note was signed by A. LaBlanc, R.N.

The same chart, 0432, recorded that one of this lady's metastatic tumors was excised and sent to a Dr. Livingston in San Diego, so that he could manufacture auto-immune serum. This was the only sample of this particular experimental therapy in use at Meadowbrook Hospital, which appeared in the charts I reviewed.

USE OF EDTA IN PATIENTS IN WHOM IT WAS CONTRA-INDICATED: The records reviewed revealed that chelation therapy was routinely given at Meadowbrook Hospital, and I was able to document a number of instances in which chelation therapy was given in the face of definite and clear-cut contra-indications to its use.

1. Because EDTA causes fluctuation in Insulin requirements, it is contra-indicated in diabetes. This contra-indication is stated in the package inserts and in the AMA Drug Evaluations. Two patients, charts #0093 and 0137, received chelation therapy while receiving Insulin, and had wide fluctuations of their blood sugars. One patient, chart #0093, a 67-year old adult onset diabetic, controlled as an outpatient on diet and Diabetes was started on Insulin after five days of EDTA therapy. Five days later, following her morning dose of Insulin, she was found cool and clammy and unconscious. The physician's progress notes and nursing notes failed to reflect any awareness of the likelihood of hypoglycemia, and her therapy did not include administration of intravenous glucose, which should be routine in such circumstances. Instead she received Coramine, Lanoxin, and Aramine. Two days later, she was given 100 units of regular Insulin stat at 10:30 a.m. and expired in a coma later that day. The diagnosis of hypoglycemia, and the question of her insulin requirements, were never raised in the progress notes or chart summary.

2. EDTA is contra-indicated in patients in congestive failure because in the way it is being used at Meadowbrook Hospital, the administration of three grams of disodium EDTA in 500 ml of normal saline or Ringer's solution, constitutes a two percent saline infusion. I was able to document the administration of this two percent saline solution to patients already in congestive failure on the following charts: 0123, 0266, 0085, and 0004. Chart #0085 was the record of an 81-year old man who was admitted August 20, 1974, and expired August 26, 1974. His admitting record noted that on admission he had thrombophlebitis, congestive heart failure, ascites, anasarca, and was complaining of orthopnea, and dyspnea. His

physical examination revealed cardiomegaly, congestive heart failure, ankle edema, and rales and ronchi in the chest. He was prescribed cranial myoflex two times daily, and received several infusions of EDTA from the 23rd of August to the 25th of August. The nurse's notes revealed that the patient was dyspneic, and that there was suctioning of mucous on August 26, 1974; on August 27, 1974, the patient was perspiring profusely, unresponsive, with small pupils, and the nurses were suctioning thick mucous. On August 28, he was unresponsive at 4:00 p.m., and unchanged at 8:00 p.m. At 10:25 p.m., the family called the nurse because the patient had expired. Thus the nurse's notes documented the patient was in acute distress for several days prior to his demise. In contrast, the doctor's note, dictated by Dr. Evers on August 28, 1974, and signed by Dr. John Potter, stated the following: "his general condition seemed to be improving, when he expired suddenly as though he had an acute coronary thrombosis."

3. EDTA infusion is contra-indicated in patients with renal failure. This contra-indication is stated in the package insert, in the AMA Drug Evaluations, and is clearly outlined in Dr. Evers' own paper, which he admits to having written. (See above, interview with Dr. Evers.) Dr. Evers, the founder of the hospital, stated that the hospital policy prohibited the use of EDTA therapy in patients with a BUN of greater than 25 to 35, or a Creatinine greater than 2 mg %. In spite of this, I was able to document that EDTA continued to be given in a number of patients after a rise in BUN and Creatinine above those criteria was documented on the chart: charts #0137, 0121, and 0142. In addition, a patient #0370 and 0148 developed an increasing BUN and Creatinine after therapy was stopped. Patients #0148 and 0142 died in renal failure. There was no mention in any of these charts of the possibility of iatrogenic renal disease.

In several cases, EDTA was administered in the face of a pre-existing elevation of BUN and Creatinine far in excess of what any physician would consider normal: charts #0266, 0004, and 0393. Patient #0004, a 50-year old man was admitted on July 1, 1974, and expired July 10, 1974. His admitting diagnosis included hypertension, congestive heart failure, generalized arteriosclerosis and "cerebral degeneration." He had documented edema of his feet and ankles, orthopnea, dyspnea and rales and ronchi in his chest. The chart stated: "the patient definitely is in congestive heart failure." His therapy included myoflex treatment to his kidneys. Despite the presence of documented congestive heart failure on admission, and a BUN of 57, he was started on EDTA infusions on July 3. His BUN on July 3 was 60, and his Creatinine on July 3 was 3.7 mg. percent. Despite congestive heart failure and this evidence of renal impairment, he continued to receive EDTA infusions on the 4th, 5th, 6th, and 7th of July. On July 8, his BUN was 86.6, his Creatinine was 2.7 mg. percent. His BUN rose to 89.6 on the 9th and 114.8 on the 10th of July when he expired. This man was only 60-years old, and died of acute renal failure and congestive failure following EDTA infusion. Instead of being transferred for dialysis at readily available dialysis units in the area, he received myoflex "treatment" to his kidney and was permitted to die. There was no consultation.

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Patient #0393, a 37-year old woman, was admitted October 17, 1975, and transferred to Hotel Dieu Hospital on October 22, 1975. Her admitting note on October 17, 1975, by Dr. John Potter, stated: "admitted for examination and treatment in lieu of dialysis which she was scheduled to start the 17th in San Antonio, Texas." Her admission BUN was 120 mg %, Creatinine 20 mg %. On October 18, 1975, the records stated "the patient is seriously ill. Prognosis seems almost fatal. X-rays were made and we decided to treat her the best we could, so she was placed on intravenous fluids and given half dose of disodium edetate intravenously, given diuretics and patient given medication for anti-nausea. She took a little fluid and looked a little better. Catheter was placed in bladder." On October 19, 1975, she was given myoflex over her kidneys, and given Thiomaris and Lasix. October 22, 1975, 1975 her BUN was 143, Creatinine 17.4 mg %. She was transferred finally to Hotel Dieu Hospital in New Orleans for dialysis.

Comment: This patient had standard lifesaving medical therapy in the form of dialysis postponed for five days, at a time when she was critically ill because of renal failure. Dialysis was withheld in order to try myoflex therapy over her kidneys, and disodium edetate infusion, in spite of the fact that hospital policy prevents the use of disodium edetate in patients with renal failure.

These last two cases, in my opinion, constitute strong evidence of dangerous negligence in the way disodium edetate infusion is practiced as a routine therapy at Meadowbrook Hospital.

I was able to document that myoflex therapy, the electrical stimulation delivered by means of the Edwards Myoflex machine, was applied: to the kidneys, in patients #0148, 0123, 0142, and 0004; "Cranial myoflex" was given to patients #0093, 0142, 0085, and 0185; "Cardiac myoflex" was given to patients #0391, and 0424. "Ocular myoflex" was given to patient #0137, and myoflex to the prostate was given to patient #0123.

Summary:

It is evident that Meadowbrook Hospital acts as a referral center for chelation therapy, the patients coming from as far away as Florida, California, and Alaska. Eighty percent of the patients admitted to the hospital receive disodium edetate infusion, for medically unacceptable indication; the therapy is administered routinely, in an unsafe way, and it is administered in patients in whom it is contra-indicated because of diabetes, congestive failure and renal failure. Patients have been allowed to die in renal failure and congestive failure without consultation or transfer. Patients are routinely given "nutritional supplements" for unscientific reasons, and frequently given electrical stimulation to the heart, kidneys or neck, to increase "blood flow." The device used for the electrical stimulation is not designed for that purpose, and there is no evidence that increased blood flow in the heart, kidneys or brain results from such stimulation. In some cases, the apparent adverse effects of one

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unacceptable therapy, EDTA. (renal failure, congestive heart failure,) are "treated" with another unacceptable "therapy," i.e. the electrical stimulation of the skin overlying the heart and kidneys. In some instances, standard medical therapy, such as hemodialysis has been withheld, in favor of these unscientific "therapies," and patients have been permitted to die in renal failure and congestive heart failure. The total picture is so appalling that I strongly urge the Bureau of Health Insurance not only to withhold certification for Medicare, but to take all steps possible within the law to expedite the closing of this hospital and to protect future patients from being subjected to these dangerous practices.

John David Spence, M.D.