Waking Up the Nation,
One Reader at a Time...

FREE

# Public Health Alert

Vol. 6, Issue 4 | Investigating Lyme Disease & Chronic Illnesses in the USA | April 2011

# Lyme Disease History and Comprehensive Homeopathic Therapy

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Lyme disease is a unique disease with many diverse symptoms. It is caused by infection from the spirochetal germ Borrelia burgdorferi, and its cousin germs Bartonella henselae, Babesia microti, and bacteria of the Ehrlichia species cause related diseases. These germs all have characteristics that are similar to the spirochete that causes syphilis, Treponema pallidum. Lyme disease is thought to be transmitted from the bite of a tick carried by deer (just as syphilis is transmitted by lice carried by rats). It has recently been found to also be transmittable in the saliva of other animals including pet dogs.

**History**

The source of the Borrelia organism has a checkered history that seems to come from the pages of a John Le Carre novel. One wonders how a new germ was discovered so late in human history when most other germs were discovered and named centuries earlier. Its cousin syphilis was known in the days of antiquity, but this germ was brought to light relatively recently. It is thought to be a manmade weapon of mass destruction from the laboratories of unhinged Nazi scientists sanctioned by Adolph Hitler and masterminded by Josef Mengele, the butcher doctor of holocaust death-camps.

At the end of World War II, the US Department of Agriculture was given custody of any remaining Nazi doctors. The USDA housed these doctors in a facility conducting ongoing research off the north shore of New York's Long Island. This remote location, called Plum Island, happens to be 20 miles due south of Old Lyme, Connecticut, which is just across the Long Island Sound.

Doctors apparently carried out ongoing experiments on Plum Island, and it is believed that this germ was accidentally released and carried either by birds or wind currents across the sound to infect its first victims in Lyme, Connecticut. The disease was first given its classic name by Dr. Willy Burgdorfer in 1981.

There are other sources, such as the book *Lyme Disease and the SS Elbrus* by Rachel Verdon, that claim that a boatload of tick-infected furs was delivered by a ship that left Russia in 1946. This ship sailed to the port of Philadelphia, and ticks from the coats infected every part of North America as fur coats were sold across the continent. These sources claim that the first coat sale was made to a socialite in Lyme, Connecticut.

**Lyme Disease**

As with syphilis, Lyme disease has three distinct phases:

* Bite Phase: The patient may have a classic bull's-eye rash (only seen in 25 percent of cases). Arthritis symptoms are common as well. The transmitted germs are exquisitely sensitive to antibiotics in this phase. In syphilis this corresponds to the classic chancre seen in the genital area.

* Latent Dormant Phase: The patient has minimal symptoms and seems to recover from the rash and arthritis.

* Full-Blown Phase: The disease returns in its full-blown glory as it attacks the nervous and immune systems with many diverse and varied symptoms and pains, including anxiety, fibromyalgia, GI disorders, heart and lung disease, and depressive states. This may

***"Homeopathy"...cont'd pg 5***

# The Subversion of Medicine Through Treatment Guidelines

*by Jerry Leonard and Tina J. Garcia*

A recent article published in the medical journal Archives of Internal Medicine concluded that recommendations for treatment contained in guidelines published by the Infectious Diseases Society of America (IDSA) were largely based upon opinion. The assumption that the IDSA's Practice Guidelines for treatment of various infectious diseases represent the best that science has to offer was found to be false by the authors of the article, entitled Analysis of Overall Level of Evidence Behind Infectious Diseases Society of America Practice Guidelines.

The conclusions drawn by the authors of the study are that IDSA Practice Guidelines are only partially based upon scientific evidence. Yet, the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC) and the IDSA promote the Practice Guidelines as "evidence-based."

**Results**

In the 41 analyzed guidelines, 4218 individual recommendations were found and tabulated. Fourteen percent of the recommendations were classified as level I, 31% as level II, and 55% as level III evidence. Among class A recommendations (good evidence for support), 23% were level I ( 1 randomized controlled trial) and 37% were based on expert opinion only (level III).

Updated guidelines expanded the absolute number of individual recommendations substantially. However, few were due to a sizable increase in level I evidence; most additional recommendations had level II and III evidence.

**Conclusions**

More than half of the current recommendations of the IDSA are based on level III evidence only. Until more data from well-designed controlled clinical trials become available, physicians should remain cautious when using current guidelines as the sole source guiding patient care decisions." http://archinte.ama-assn.org/cgi/content/abstract/171/1/18

Isn't this exactly what Lyme disease patients and their treating physicians have been saying for years about the Infectious Diseases Society of America Practice Guidelines for Lyme disease? Didn't then Connecticut Attorney General Richard Blumenthal state that, as a result of his antitrust investigation of the IDSA and its 2006 Lyme Disease Practice Guideline authors, he found numerous conflicts of interest held by those authors? (Other researchers have shown these guidelines to be largely based on the opinions of a few manufactured "thought-leaders," who largely cited their own flawed studies.) We simply cannot emphasize and distribute widely enough what Attorney General Blumenthal revealed in his May 1, 2008 press release: "The IDSA guidelines have sweeping and significant impacts on Lyme disease medical care. They are commonly applied by insurance companies in restricting coverage for long-term antibiotic treatment or other medical care and also strongly influence physician treatment decisions.

Insurance companies have denied coverage for long-term antibiotic treatment relying on these guidelines as justification. The guidelines are also widely cited for conclusions that chronic Lyme disease is nonexistent.

This agreement vindicates my investigation -- finding undisclosed financial interests and forcing a reassessment of IDSA guidelines," Blumenthal said. "My office uncovered undisclosed financial interests held by several of the most powerful IDSA panelists. The IDSA's guideline panel improperly ignored or minimized consideration of alternative medical opinion and evidence regarding chronic Lyme disease, potentially raising serious questions about whether the recommendations reflected all relevant science."

Blumenthal added, "The IDSA's 2006 Lyme disease guideline panel undercut its credibility by allowing individuals with financial interests -- in drug companies, Lyme disease diagnostic tests, patents and consulting arrangements with insurance companies -- to exclude divergent medical evidence and opinion. In today's healthcare system, clinical practice guidelines have tremendous influence on the marketing of medical services and products, insurance reimbursements and treatment decisions. As a result, medical societies that publish such guidelines have a legal and moral duty to use exacting safeguards and scientific standards."
http://www.leaparizona.com/ctagpressrelease.htm

In the case of the IDSA recommendations for treatment of Lyme disease, which is an infectious disease caused by the bacterium Borrelia burgdorferi, the guideline authors disregarded concerns raised by eight infectious disease specialists. The specialists initially corresponded in writing on October 12, 2005 to then IDSA President, Martin J. Blaser, M.D. Subsequent correspondence back and forth also involved IDSA Executive Director Mark Leasure and Chair of the IDSA Standards and Practice Guidelines Committee, Thomas M. File, Jr., M.D., M.S. It is interesting to note that Lyme Practice Guideline Committee Chairman, Gary Wormser, M.D., was copied on IDSA correspondence, so he was well aware of the fact that the Committee he chaired and the opinion he espoused was called into question prior to the 2006 publication of the Lyme Guidelines.

Dr. Joseph G. Jemsek, an infectious disease specialist with extensive experience in HIV and Lyme Borreliosis treatment, wrote the letter to IDSA. Dr. Jemsek and the seven supporting signatories requested the opportunity to provide input into the formulation of the 2006 IDSA Practice Guidelines for Lyme Disease. Dr. Jemsek and his colleagues brought to the attention of the key individuals involved with the formulation and publication of those Guidelines the fact that the Guidelines did not reflect the vast amount of evidence of persistent infection post antibiotic treatment. The ID specialists also pointed out the fact that divergent medical opinion on the subject of Lyme Borreliosis was available and requested that such opinions be seriously considered and made a part of the IDSA Guidelines recommendations. They also suggested that the Lyme Disease Guidelines Committee should have included members who have experience with chronic Lyme infection and its treatment in the clinical setting.

Although Drs. Blaser

***"IDSA" ...cont'd pg 3***

# FEATURE

# Dr. William Rea Exonerated In Texas

*by Mary Budinger*

The Texas Medical Board has ended its prosecution of one of the deans of environmental medicine. William J. Rea, M.D., founder of the renowned Environmental Health Center in Dallas, now stands exonerated of all charges.

The battle began when an anonymous complaint against Dr. Rea was filed with the Board. Most cases get settled before a formal complaint is filed. But in this case, the Board issued a formal complaint in 2007 accusing Dr. Rea of "failure to practice medicine in an acceptable professional manner consistent with public health and welfare."

The Board claimed that his testing methods "are more properly described as pseudoscience" and that "injections of neurotransmitters, mycotoxins, jet fuel, natural gas, and other chemicals can be a dangerous practice."

Dr. Rea, a board certified cardiovascular surgeon, established the Environmental Health Center in 1974. More than 30,000 people from all over the world have come for treatment - people who became ill after exposure to Alaskan oil spills and fallout from the World Trade Center, time spent as a soldier in Desert Storm, as well as people who become ill at home or work from exposures to carpets, paints, pesticides, solvents, formaldehydes, pollens, molds, dust, and foods. Dr. Rea has written four books on chemical sensitivity that are considered the classic textbooks in the field.

Physicians trained in environmental medicine often use antigens, very diluted amounts of an offending substance. It is both an allopathic and a homeopathic approach to treatment. Doctors will typically find the level just below that which causes a reaction, and give patients regular doses of antigens so the body can "learn" how to tolerate the substance(s) again. Jet fuel antigens, for example, would be used to desensitize some patients who fell ill from flying after 9/11 and others who work or live near airports.

"The Board did not understand antigens and perhaps still does not," said Dr. Rea. "They accused us of injecting jet fuel into patients. They eventually analyzed the homeopathic solution we use and didn't find anything in it. Finally they had to accept it was homeopathic-like."

The Board's final ruling came last September and merely concluded that from now on, Dr. Rea must have his patients sign an informed consent explaining that treatment with a few chemical antigens, such as jet fuel and car exhaust, are not FDA-approved, and that the antigens have only the "electromagnetic imprint" of the original substance. And that's fine with Dr. Rea. "About two-thirds of the practice of medicine is not FDA-approved," he said. The therapeutic value of the therapy was not disputed.

**THE ANOIYMOUS COMPLAIIT**

The case against Dr. Rea started with an anonymous complaint about the treatment of five patients. However, none of the patients initially knew that they or their information was being used because none had filed a complaint nor consented for their medical files to be used in an investigation. "In fact, all five patients specifically told the Board they had no allegations to make, and two of the patients told the Board I had saved their lives," Dr. Rea recounted. To this day, the anonymous source is still officially unknown.

"Wild guess as to who did it? The insurance company because they didn't want to pay the claims for the patients," said Jacques Simon of New York, the lead attorney on the case. All five patients were from New York City and all five shared the same insurance company. Dr. Rea does not take insurance, which meant all five patients filed for reimbursement of their expenses - a manual process that is more labor intensive for insurance companies than automated claims.

"In Texas, anonymous complaints are allowed and that is very different from a confidential complaint," explained attorney Laurie York of Austin, who was part of Dr. Rea's defense team. "So an insurance company which might make an anonymous complaint could never be prosecuted for maliciously intended complaint. There is no accountability. Not even the Texas Legislature can find out who is behind anonymous complaints to the Board."

**THE ANOIYMOUS REVIEWER**

It is common during an investigation that a medical board will initiate a peer review of the patient records in question to determine whether accepted standards of care have been met. The Texas Medical Board allows for reviewers to remain anonymous. But what happens when medical boards do not choose a peer? In Dr. Rea's case, the Board chose a conventional, allopathic allergist who does not specialize in environmental medicine and had never used homeopathic remedies or the provocation neutralization titration process.

"This reviewer gave a negative review of the treatment of the five patients, despite the fact that all the people improved, several of them substantially so, while under my care," Dr. Rea explained. "I had 17 actual peers, physicians who practice environmental medicine, review all five of these cases as well. To a person, these 17 reviewers found that my treatment of these patients was not only adequate, but that it met or exceeded the standard of care for treatment in our specialty. The state board reviewer was uninformed about the specialty of environmental medicine, clearly did not understand the complex nature of the diagnosis and treatment of patients who suffer from chemical sensitivities, grossly misunderstood many of the facts in the medical records, and was antagonistic towards and biased against the specialty of environmental medicine. Nonetheless, the Board dismissed the review done by 17 actual peers."

Dr. Rea's case is now part of a long-simmering controversy over whether medical peer review has been used as a competitive weapon in turf wars among physicians, hospitals, HMOs, and other entities.

In Dr. Rea's case, it appears the medical board was used by an out-of-state insurance company trying to trim costs by denying claims.

"Many of us who have been turned in to state medical boards do not take insurance assignment," Dr. Rea explained. "It appears that health insurance companies want to be the sole arbiter of what types of treatments are available to patients, and thus what they will be required to pay. They clearly do not want new diagnoses and treatments established because they will then have to pay for these."

That is a dynamic known all too well to physicians who treat chronic Lyme patients with long-term courses of antibiotics.

**THE CONTROVERSIAL TEXAS MEDICAL BOARD**

*William J. Rea, MD; founder, Environmental Health Center*

The modus operandi of the Texas Medical Board came to the attention of the Texas Legislature and an investigative hearing was held in 2007. It lasted 11 hours; the crowd overflowed the hearing room. Doctors flew in from other states to testify about the Board's pattern of abuse and unaccountability. Attendees recall that what stood out was that every doctor was terrified of blowback from the medical board for even being there. Under questioning from State Representative Debbie Riddle, former Board president Dr. Roberta Kalafut admitted that she had her husband had filed a confidential complaint against another doctor in her area. It turned out that 12 of Dr. Kalafut's competitor physicians had anonymous complaints filed against them.

Subsequently, there was a series of hearings where doctors came foreword again to tell the Texas Legislature that the medical board has serious problems. "Many of the complaints filed against physicians appear to be malicious," reported Steven F. Hotze, M.D., of the Hotze Health and Wellness Center in Katy, Texas. "Once the complaint is filed, experts are hired by the Texas Medical Board to review the record and tend to discredit the physician. These experts are anonymous to the accused physician, but the physician's identity is known to the experts. Secret proceedings, known as Informal Settlement Conferences (IFC), are conducted without providing the same legal due process that is afforded to common criminals. The physicians are intimidated and often forced to sign agreements under the threat of license revocation."

(See January's issue of PHA regarding the lawsuit by the Association of American Physicians and Surgeons against the Texas Medical Board.)

York points out that there is also a problem with

*"Exonerated" ...cont'd pg 5*




## Public Health Alert

The PHA is committed to researching and investigating Lyme disease and other chronic illnesses in the United States. We have joined our forces with local and nationwide support group leaders. These groups include the chronic illnesses of Multiple Sclerosis, Lou Gehrig's disease (ALS), Lupus, Chronic Fatigue, Fibromyalgia, Heart disease, cancer and various other illnesses of unknown origins.

PHA seeks to bring information and awareness about these illnesses to the public's attention. We seek to make sure that anyone struggling with these diseases has proper support emotionally, physically, spiritually and medically.

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# "IDSA" ... cont'd from pg 1

and File and Mr. Leasure indicated in conversation and return correspondence that scientific evidence and divergent medical opinions were considered, the final publication of the 2006 IDSA Practice Guidelines for Lyme disease failed to include any recommendations which support the existence of chronic infection or persistence of infection post antibiotic treatment. Informed input that favored the clinical-experience-based view that persistent Lyme infection and extended courses of antibiotic therapy be included within the Guidelines was blatantly ignored.

Even though the IDSA subsequently ridiculed then Attorney General Blumenthal for investigating the organization, the AG's investigation confirmed the validity of Dr. Jemsek and his colleagues' concerns about IDSA bias of opinion, financial conflicts of interest and exclusion of evidence in the formulation of IDSA's Practice Guidelines for treatment of Lyme disease.

As part of the 2008 legal agreement signed by Attorney General Blumenthal and the IDSA, an independent Review Panel was selected to review the IDSA Practice Guidelines for Lyme Disease, along with public submissions of medical research. Sixteen scientists and physicians, representing both sides of the debate, were selected to present testimony before the Review Panel at a hearing held in Washington, D.C. on July 30, 2009. Two patient representatives also testified; Tina J. Garcia was one of the advocates selected.

The letters written by Dr. Jemsek and his colleagues were presented to the individual IDSA Review Panel members by Tina Garcia as part of her testimony before the Panel. PJ Langhoff's book, *The Baker's Dozen and The Lunatic Fringe,* which is a huge compilation of patents and other conflicts of interest held by the 2006 IDSA Lyme Guideline authors, was also presented to the Review Panel.

Through their vote to uphold the IDSA Practice Guidelines for Lyme Disease, the Review Panel members ignored the content of the letters and the book, along with the desperate plight of Lyme patients, which was presented in testimony by both patient representatives. The Review Panel upheld each recommendation in the 2006 IDSA Practice Guidelines for Lyme disease, despite being presented with voluminous evidence from a number of Lyme researchers and physicians which clearly demonstrated persistent infection, the Bb pathogen's ability to undergo antigenic variation and its use of biofilm for survival.

During a break at the IDSA hearing, Tina Garcia spoke with Dr. David Mushatt of Tulane University, one of the Review Panel members charged with reviewing the Guidelines. Tina asked Dr. Mushatt if he had read PJ Langhoff's book. Dr. Mushatt told her that he had read some of it and in response to her query about what he thought of the content of the book, Dr. Mushatt told her, "It appears to be a good 'ol boys network and that doesn't sit well with me."

Also at the hearing, Tina spoke with another Review Panel member, Dr. Paul Lantos of Duke University, who apologized profusely for the suffering Tina and other Lyme patients have experienced. Yet, despite these spoken sentiments, the IDSA Guidelines were rubberstamped by the Review Panel anyway.

The IDSA Guidelines create a climate of opinion that Lyme disease is hard to catch and easy to cure. Further, the IDSA Lyme Practice Guidelines have been officially adopted by the NIH and CDC and unofficially adopted by insurance companies as the prevailing wisdom.

Although research has been published by the IDSA Guideline authors proving persistence of infection post antibiotic therapy, those same authors deny the existence of persistent Borrelia infection in the Guidelines. Additionally, the Guidelines ensure treatment claim denials by the insurance industry and boost pharmaceutical profits through lifelong drug sales, through the promotion of treatments that address only the symptoms and not the underlying cause of infection and autoimmune/inflammatory response.

The IDSA Lyme Disease Practice Guidelines serve the insurance industry by promoting the least expensive standard of care, which allows the insurance companies to save huge sums of money through claim denials based on the treatment guideline recommendations. It appears that it is relatively easy for industry "thought leaders" to create treatment guidelines for a disease, which allows the infectious agent to go largely undiagnosed, while the symptoms are profitably treated, in perpetuity, all at the same time insurance claims are denied.

The IDSA Lyme Guidelines severely limit the amount of antibiotics a doctor can prescribe to patients, and physicians who dissent are often destroyed through insurance company complaints filed with state medical boards. Such heavy-handed actions render useless the IDSA Disclaimer that the Guidelines should not supplant physician judgment.

Of particular interest, is CDC's apparent involvement with state medical board proceedings against Lyme physicians. In 1993, Dr. David T. Dennis, Director of the CDC Division of Vector-Borne Infectious Diseases (DVBID) in Ft. Collins, Colorado received a fax from Dr. Mary Grace Stobierski of the Disease Surveillance Section at the Michigan Department of Health. The fax, which was reportedly obtained through a Freedom of Information request, indicates that the prosecution of Michigan Lyme doctor, Joseph Natole, had been discussed by the Michigan Health Department and the CDC prior to the proceedings initiated against Dr. Natole. The fax stated the following: "This press release concerns a physician being investigated for inappropriate treatment of Lyme disease. You may recall that we discussed this matter a few weeks ago."

"Inappropriate treatment of Lyme disease" must mean treating patients with long-term antibiotics, which is contrary to the IDSA Guidelines. Why was the Director of the DVBID at CDC discussing the prosecution of a doctor for the treatment of Lyme disease? Apparently, the CDC oversteps its jurisdiction and responsibility when it comes to bringing Lyme-treating physicians before medical boards for prosecution.

"So now we have…a pandemic fueled by political motives coupled with a consummate disregard for public health, and a pandemic which, when the sources, motives, and

***"IDSA" ...cont'd pg 4***

# A New & Living Way

*by Joan Vetter*

Finally it seems like my war on the white dust is over. A thin layer seemed to blanket everything in our bedroom. Our grandson Micah just replaced the carpet and some outdated little white tiles in our master bath with new ceramic flooring. It looks beautiful now, but as anyone who has gone through remodeling knows it is pretty messy during the process.

We discard outdated clothes or things that no longer fit. We get rid of sour milk or moldy bread.

But somehow we feel we can't touch the religious ideas passed down to us by parents or our church even if they are no longer working for us. I remember so clearly when I had an encounter with the living God. It was birthed from frustration and questioning. I poured out my doubts to my Methodist Minister, and all he did was smile at me and say, "I will pray for you and the Holy Spirit will show you the truth." Just a few minutes later my room filled with God's glory and I knew what I was reading in the book of John was true. The Bible calls this being translated out of the kingdom of darkness and into the kingdom of light.

However, after years of studying the Bible and prayer I realize more than ever there are still things I need to discard in my belief system to make room for truth. In the same way that Micah couldn't just put down the ceramic tile on top of what was already there, we need to do the messy work of demolishing the old.

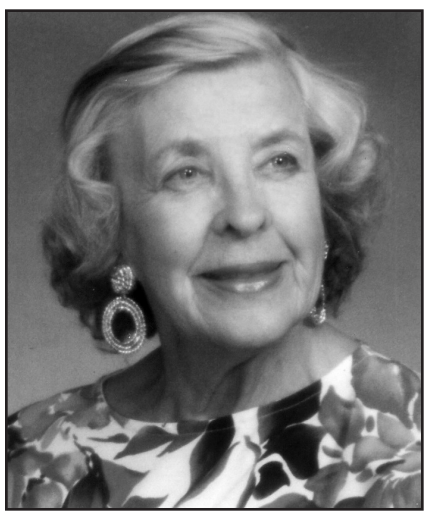
Contentment is usually viewed as a good thing, but if we are content with our old ways we may be missing the new and living way Jesus speaks of. We may need healing, but we've been taught God heals some and not others, or that He heals in a certain way. Then one day we are reading John 5:5 where a certain man is lying next to a pool of water, waiting for someone to put him in. Jesus asked him a startling question, "Do you want to be made well?" He does not say a quick "yes". Instead he answers with excuses. Jesus simply instructed him to get up and walk. So the old mindset of needing the angel to move the water before he could get in and be healed was replaced with the new and living way led by the Lord Himself. So the Holy Spirit begins to tug on our heart with the thought perhaps we need to stop living with excuses.

Actually, what I am sensing today after forty four years of knowing the Lord, takes me right back to the beginning. Yes, I have heard some wonderful teaching. Yes, I feel I have "grown" wiser about the Lord. But, the foundation of it all has to be what I experienced at the very onset - the presence of the living God. For instance Joshua was Moses' understudy. When Moses died God instructed Joshua to cross over the Jordan with all the children of Israel. Joshua had seen God part the Red Sea under Moses' leadership, but he couldn't rely on yesterday's miracle.

The key for Joshua, and for us, is the presence of the living God. He couldn't just believe that God could part the sea the same way He did before. Joshua needed to hear God speak to him and say, "As I was with Moses, so I will be with you. I will not leave you nor forsake you." In the entire scenario, God was speaking instruction and Joshua was hearing and relaying it to the people.

Today so many voices contend for our attention. How do we learn to hear His voice among all the others? That will be the subject of next month's article. *pha*

# To Touch a Cloud



*by Nawanna Rodgers-Gazin*

**TO APRIL**

So hard to close a door
On giggles, jokes and laughter;
The urge to run and
Share these things
Stay with us ever after.
The warmth of someone
Sharing
A bowl of chicken soup,
Sounds ridiculously funny
But can throw us for a loop.
If this is where our memories
Propel us through each day -
We miss you darling April
As you enter Heaven's Way.

**PICK A CLOUD**

Just read the oatmeal package,
(Low in saturated fat)…
A healthy start,
You've now designed
A beneficial hat!
Now, stop and look around you,
Your day has just begun -
That flood of light is sunshine,
Your blues are on the run.
And now, look up into the sky,
And find a favorite cloud -
Tell it your plans for
Health and Wealth,
AND MAKE IT CLEAR AND
LOUD!

**TINA'S HOUSE**

Tina's house is filled with
treasures,
Mushroom tables,
gray stone chairs;
Pink Arbutus,
fragrant, growing,
All around her hill-house stairs.
Roofed by leafy,
Sunlit branches
That protect and rustle o'er,
Changing her pine-needle rug
To patterned, tessellated floor.
Cracks of light
Make shadow graphs
That look like Damask,
Celtic lace;
Treestump furniture,
Free-flowing,
Disengaged from
Commonplace.

After time has culled its
Moments into years,
May Tina find,
Treasures in some later house,
As nice as those she left
behind.

*Nawanna Rodgers-Gazin is a talented artist who worked for many years as head of the Graphic Arts Department at William Rainey Harper College in Palatine, Illinois. She retired in 1986 and moved to Arizona. After her retirement, Nawanna designed a line of greeting cards and home-made jewelry and sold her wares at craft shows for twenty years. She has enjoyed writing poetry, playing the piano and singing professionally since she was very young. At age 88, she is still a supportive wife and mother, and active homemaker, who prepares all meals and does her own housekeeping. Contact: NawannaJ@aol.com*

# "IDSA" ... cont'd from pg 3

actions that led to the…pandemic come to light, will be incomprehensible in its amorality and foolishness."
Anonymous, MD

**Treatment Guidelines: A Story of Corruption and Collusion**

"It is difficult enough for someone suffering debilitating symptoms due to late-stage Lyme disease to get well with the judicious, but adequate, use of long-term antibiotics. Almost no one gets better without these. To deny patients access [to] this care is a travesty. But this happens all the time and patients often travel hundreds to thousands of miles to see one of the small numbers of Lyme experts in this country. How can that be?" Jon Sterngold, M.D.

Lyme disease patients are being denied long-term antibiotics, under various pretexts, by a very well-connected minority of academics with ties to the CDC and biowarfare-related research agencies. The IDSA Guidelines were written by this group of academics and are inappropriately used by insurance companies to deny treatment (actually, the IDSA Guidelines are non-treatment under the pretext of treatment). These individuals also serve as "expert" witnesses in medical board prosecutions, testifying against doctors who treat chronic, persistent Lyme disease with long-term antibiotics. The academics use the arbitrary "standard of care" they have dictated and published in the IDSA Guidelines as the basis for their testimony. Amazingly, they get away with this, even though their published treatment standard directly contradicts their previously published research.

Connecticut Lyme pediatrician Dr. Charles Ray Jones was disciplined for years by the Connecticut Medical Examining Board for minor technical violations in the way he diagnosed and treated three children suspected of having tick-borne disease. None of Dr. Jones' treatments have resulted in patient harm; in fact, he has treated thousands of children with Lyme disease from around the world and restored their health. His medical decisions were motivated by his desire to begin, as soon as possible, the treatment of those three very sick children. Dr. Jones (now in his eighties) has had $20,000 in fines levied upon him. The Connecticut Medical Examining Board certainly is not ignorant of the cost of attorneys' fees incurred by Dr. Jones in defending the minor charges.

Yet, the same Medical Board punished other Connecticut physicians for very serious charges, such as substance abuse, sexual misconduct, mental illness and negligence, and not one of those physicians received a fine larger than $5,000. The inequity of fines imposed by the Connecticut Medical Examining Board is obviously biased against Lyme-treating physicians.

The message being hammered into the minds of doctors who treat Lyme disease with long-term antibiotics is this - if you treat Lyme disease longer than the IDSA recommends, you risk being brought before your state medical board for possible fines and suspension or loss of license. Many physicians have too much invested in their practices to take such a risk, so instead, they refuse to treat Lyme patients and pawn the patients off on other physicians. With Connecticut Lyme cases on the rise, children suffer without treatment for a chronic infection that has the potential to debilitate them for life.

"There is a core group of university-based Lyme disease researchers and physicians whose opinions carry a great deal of weight…They work with government agencies to bias the agenda of consensus meetings and have worked to exclude from those meetings and scientific seminars those with alternate opinions… Because of this bias by this inner circle, Lyme disease unfortunately is both underdiagnosed and undertreated in this country to the great detriment of many of our citizens." Dr. Joseph Burrascano, Congressional Testimony, 1993

"Physicians who have cared for persons with chronic Lyme disease have faced harassment at a minimum and for some, their careers have been ruined. Researchers who have seriously dedicated themselves to the scientific study of chronic Lyme disease in humans and/or animals have often found themselves attacked or marginalized. To persist in their researches would have resulted in virtual career suicide and some have been forced, by exigencies of survival, to leave the field." Kenneth B. Liegner, M.D.

How is this being accomplished? Control over treatment is dominated by giant corporations with a vested interest in not treating the underlying disease - pharmaceutical and insurance companies. These corporations are, in fact, practicing medicine without a license through third-party "information laundering." They utilize private medical societies, such as the IDSA, and fund "thought leaders" to create business-friendly fraudulent science as a basis for treatment denial. The disease and its treatment are defined in a commercialized, symptom-treatment version that perpetuates the symptom cycle, rather than a patient-centered version that would treat the underlying cause of disease.

Treatment guidelines published by so-called independent medical societies are the perfect vehicle for third-party organizations to emphasize symptom-treatment for a disease, while ignoring the underlying infection that caused it. Without adequate treatment, those suffering with Lyme disease may have their symptoms treated in perpetuity by doctors who blindly and foolishly follow the IDSA guidelines.

The denial of chronic Lyme disease by IDSA is an important factor in pharmaceutical marketing. According to the IDSA Lyme guideline authors, regardless of how long one has had the infection, how entrenched it is in immune protected sites, or how disabling it is, a short course of antibiotics will eradicate the disease from the body. This has never been proven. Numerous scientific studies have shown IDSA's claims to be false…according to IDSA, after a few weeks of antibiotic treatment a person is "cured" of Lyme disease. Then, suddenly, ongoing symptoms are due to some other unidentified problem which can be managed with ongoing drug treatment. IDSA Lyme guideline authors have known financial ties with pharmaceutical companies, making perfect financial sense for this false claim of cure.

It is only the undeserved clout of the CDC and IDSA and the gullibility of the media that give this incredible information

***"IDSA" ...cont'd pg 6***

# "Exonerated"... cont'd from pg 2

patients' rights. "Patients have no privacy. There are patients who get their records used in these kinds of Board actions even though they were completely satisfied with their doctor and their care."

Simon says, unfortunately, the Board probably didn't learn much from its war with Dr. Rea. "That is not the way it works. Texas has the biggest board I've ever seen, one of the more active in terms of disciplinary actions, and at the end of the day, they don't learn lessons. They are bureaucrats, there to prosecute."

Simon is a member of the so-called Quartet - four American attorneys who specialize in defending doctors who practice complementary and alternative medicine. All four are legal counsels for the American College for the Advancement of Medicine (ACAM).

"I think it would be wrong to draw the conclusion from this case that all complementary and alternative (CAM) doctors are under fire. That is true for many who treat chronic Lyme disease, but not all CAM."

York is hopeful that a good precedent has been set with Dr. Rea's case. "They saw we are more than willing to stand up to the Board and win. The Board's actions were a huge overreach, way out of proportion, and we fought back. I think that medical boards tend to think of the public as unsophisticated. That's not true anymore - people are sophisticated consumers of medical care and people have a right to choose what medical care they want."

**ENTER STAGE LEFT: QUACKWATCH**

One of the forces against consumer choice showed up to testify against Dr. Rea. Robert Baratz of the National Council Against Health Fraud (NCAHF) projects himself as the president of a nonprofit, tax-exempt group "focused upon health fraud, misinformation, and quackery." The organization often uses medical boards and litigation to discourage the practice of complementary and alternative medicine.

But they don't often win their legal battles. For example, NCAHF lost a court case in 2003, NCAHF v. Botanical laboratories, et al. The judges ruled that although NCAHF believes no one should be allowed to market homeopathic remedies, "Congress has decided otherwise, and officially recognizes the Homeopathic Pharmacopoeia. Appellant's broad-brush approach of sweeping all homeopathic remedies into a single bag marked 'undesirable' simply does not work in the courts."

Simon said Baratz did not make a compelling showing in Dr. Rea's case either. "Baratz was unable to back up any of his opinions with peer-reviewed medicine. He really didn't come off too well."

NCAHF members have included William T. Jarvis, a retired professor of public health; Stephen Barrett, a retired psychiatrist; and Victor Herbert, M.D., J.D., who fought Linus Pauling's "quack promotion" of vitamin C. All are affiliated with the Quackwatch organization which sprang up after the historic Supreme Court decision, Wilk v. American Medical Association, a federal antitrust suit brought against the American Medical Association (AMA) by the Doctors of Chiropractic. The Supreme Court ruled in favor of the chiropractic profession in 1990 saying the AMA had engaged in a "lengthy, systematic, successful and unlawful boycott designed to restrict cooperation between M.D.s and chiropractors in order to eliminate the profession of chiropractic."

The AMA had taken a very public beating. Many, including author Dr. James P. Carter, feel that the AMA subsequently created third party entities like Quackwatch to carry on the fight between allopathic medicine and its competitors. Barrett and his associates work to discredit businesses that make alternative health therapies or products available, and doctors who practice a wider standard of care than allopathic medicine provides.

Quackwatch will never say where its organization gets its funding so it has never been able to disprove allegations that they are a front group.
However, all eyes are on a current court case, Doctors Data versus Barrett et al. Doctors Data is an Illinois lab that provides specialty testing used in the assessment, detection, prevention, and treatment of heavy metal burden, nutritional deficiencies, gastrointestinal function, hepatic detoxification, metabolic abnormalities, and diseases of environmental origin. Steve Barrett claimed last year that their tests are used to defraud patients and noted that "several state licensing boards have taken action against doctors who used provoked urine testing as a prelude to chelation." Doctors Data filed suit, saying they were defamed.

Attorney Jacque Simon said, "If the case survives a motion to dismiss, the discovery process in federal court can be quite wide and they may be forced to reveal their funding. This would be the case to watch for this."

**ENVIRONMENTAL MEDICIṆE**

The understanding of environmental illness began in Chicago in the 1950s. Dr. Theron G. Randolph, a professor at Northwestern University, noticed that some of his patients got ill when they passed through heavily industrialized areas. He saw it as a "petrochemical problem." Dr. Randolph came to believe that chemical residues are not always eliminated from the body and can lodge in fatty tissue and act as continual irritants to the immune system. Once a person is sensitized to a substance, future exposures can lead to increasingly severe and debilitating reactivity.

"For those unacquainted with the effects of the environment on our lives, this process can be compared to carrying a load of bricks," Dr. Rea explains. "Just as we might fill our arms with bricks, our bodies are being filled with a variety of stressors, including biological, chemical, emotional and physical. As long as the amount of bricks, or stress factors, stays within a range our bodies can manage, everything is fine. But, when the load becomes more than our bodies can handle, down come the bricks. This collapse is represented physically as symptoms."

Dr. Rea's Dallas clinic was built with numerous unique features including porcelain walls, tile floors, full-spectrum lighting, organically grown cotton cushions, computers and printers encased in stainless steel to mitigate the outgassing of plastics into the air, special air handling systems, filtered water, and no use of pesticides or toxic cleaning products.

"Most of our patients have been to 20 or 30 doctors with no help," said Dr. Rea. "The world is getting dirtier; there is no question that the incidence of chemical sensitivity is growing. The more analysis people do, the more chemicals are found. We are working now on breath analysis to find more chemicals than we've been able to find in blood." A breath test would also cost a lot less than the expensive blood tests journalists like Anderson Cooper and Paul Moyers have done to determine their "body burden."

Dr. Rea's advice to avoid environmental illness? The number one thing we can do is practice avoidance. An educated consumer can avoid a lot of chemicals by learning how to read labels on everything from shampoo to kitchen cleaners - many of which can contain petroleum by-products to which people are increasingly sensitive.

One place to start might be the Environmental Working Group's "Body Burden." The group has documented the industrial chemicals that are building up in our bodies. Another place to look would be the PBS series "Trade Secrets," which followed a study of pollutant loads in the human body sponsored by the Mount Sinai School of Medicine in New York.

The second most important thing we can do, according to Dr. Rea, is to have enough nutrients on board so our body can detox. He regularly sees shortages of B vitamins, magnesium, chromium, and selenium. "Some of the chemicals affect absorption of them." A nutrient-dense diet has infinitely more advantages for health than a diet of processed foods.

Moms-to-be can also read up on how to create robust immune systems in their babies. (Hint: exposure to germs outdoors is good because this strengthens the immune system, so save your money and don't buy those bleach wipes.)

Unfortunately, medical schools have been slow to teach environmental sensitivities, metal toxicity, and nutrition. However, many are now starting and probably the next 20 years will see a burgeoning of research. There are already thousands of scientific articles from around the world.

It would appear likely that patients will have increasing need for the skills Dr. Rea has brought to the forefront; the national and global scale of industrial chemical production is expected to grow four-fold by 2050.

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*Mary Budinger is an Emmy award-winning journalist who writes about complementary and alternative medicine. She is the co-author of An Alphabet of Good Health in a Sick World.*

# "Homeopathy" ...cont'd from page 1

include autism in children.

Of interest is that Borrelia seems to selectively infect B lymphocytes, that key cellular part of the immune system that produces antibodies. Normal antibody (Western blot) tests may come out negative in the sickest Lyme patients. The only blood test of certainty is the PCR DNA test for Borrelia which reveals whether Borrelia DNA is in the body. If so, Lyme disease is a likely diagnosis.

Nerve cells are most susceptible to Borrelia infection if the body is also poisoned by mercury. Many autistic children are found to have mercury toxicity complicating their Borrelia infections. The source of this mercury may be mercury-preserved vaccines and/or mercury-based dental fillings.

**Treatment**

After the immune system is attacked, antibiotics have minimal effect. Despite this, infectious disease doctors treat this disease with as much as a five-part antibiotic cocktail administered orally and parenterally for up to several years running. These doctors claim good results. But it is the final phase where integrative medicine claims its best results and differs greatly from its allopathic counterpart treatment of massive administration of antibiotics.

Integrative treatment is based on detoxing the mercury and other environmental toxins and then recovering the immune system from its Borrelia and co-infection onslaught. Treatment steps are as follows. (Additional training and information about this course of treatment is available 24/7 at www.desbio.com. Contact DesBio personnel at 801-563-7448 or 800-827-9529 to access these resources.)

1. Treat the patient with Smart Silver in sufficient oral dosing based on size of the patient. This helps kill the germs as they are released from bio-slime layers that coat blood vessels and mucous membranes. Usual dose is two teaspoons twice daily throughout treatment.

2. Start the patient on Basic 6 Part Comprehensive Homeopathic Detox:

a. Cerebromax + Spinalmax + Matrix Support: Ten drops each added to every liter of water consumed by the patient (1-2 liters a day for children and 2-4 liters a day for adults) on Friday, Saturday and Sunday.

b. Detox I + Detox II + Detox III: Ten drops each added to every liter of water consumed Monday through Thursday. Continue these drops for at least 6 months.

3. Start patient on specific LYM Detox drops: Ten drops each added to every liter of water consumed EVERY day of the week for at least 6 months.

4. Start patient on DesBio Borrelia Series Kits: Kit 1 vials 1-10 every third day for month one; Kit 2 vials 1-10 every third day for month two; the next 1M series Kit weekly for ten weeks; and finally the next 10M kit one vial weekly for ten weeks.*

5. Add Mineral+ Energy (Energy Catalyst) drops as well throughout therapy: The Mercurious Corrosivus Content to Detox Mercury added to Detoxamin Suppositories every other night safely Detox heavy metals without resorting to a DMPS product for mercury elimination.

6. Put patient on Equilib (powder in children, capsules in adults) to restore the brain and nervous system to balance and normal function as the nervous system has germs, antibodies, and heavy metals eliminated from the system. This also adds back needed minerals and other important nutrients that a patient requires. This very complete nutrient formula is geared to the needs of patients with compromised nervous systems.

7. Consider adding Homeopathic Chemtox or Addiclenz to eliminate environmental chemicals, drugs, and pesticides from the delicate nervous system tissues to make detoxing complete.

*There are separate Series kits for each of the Lyme co-infections. They would ideally be tested for by using proper testing methods like Kinesiology or properly programmed EAV equipment like Zyto or MSA.

This is a complete, well-thought-out protocol that safely treats patients without resorting to side-effect-laden antibiotic therapy.

# "IDSA" ... cont'd from pg 4

any credibility. The market for symptomatic treatment of Lyme disease through pharmaceuticals is undoubtedly immense. The pharmaceutical market for arthritis alone generated $15.9 billion in revenues in 2008. Worldwide sales of Parkinson's disease therapies will increase modestly from $2.5 billion in 2008 to $2.8 billion in 2018 in the United States, France, Germany, Italy, Spain, the United Kingdom and Japan. According to PharmaLive, pharmaceutical industry experts expect the fibromyalgia drug market to quadruple to $2 billion by 2016. Leonard Sigal, a rheumatologist and contributor to the IDSA Lyme guidelines, is heavily involved with promoting fibromyalgia as an alternative diagnosis. Sigal, a former academician, now works for a pharmaceutical company. He has also testified in legal cases, on behalf of insurers, against Lyme disease doctors and victims." Miguel Perez-Lizano, Pharmaceutical Windfalls, June 2010.

It is important to understand that a Lyme Borreliosis infection, depending upon genetic factors and where in the body the infection takes hold, can manifest as Multiple sclerosis, rheumatoid arthritis, fibromyalgia, chronic fatigue, lupus, Crohn's disease, autism, ALS, Parkinson's, Alzheimer's and other autoimmune or neurodegenerative diseases. It also manifests as a number of psychiatric disorders and research has shown that Lyme infection can cause certain lymphoma cancers.

"In recent years, drug companies have perfected a new and highly effective method to expand their markets. Instead of promoting drugs to treat diseases, they have begun to promote diseases to fit their drugs." said Marcia Angell, Former Editor of the New England Journal of Medicine, New York Review of Books, Volume 56, Number 1, January 15, 2009.

A select group of academic physicians, who serve as pharmaceutical consultants and CDC spokespersons, are involved in eliminating other doctors for treating a pandemic the academicians claim doesn't exist. Disinformation is being spread under the guise of education. The IDSA, with funding from CDC, offers continuing education for Lyme disease on its website. They claim that the case studies contained in the educational course "are designed to educate clinicians regarding the proper diagnosis and treatment of Lyme disease and also provide an opportunity to better understand the IDSA guideline." The IDSA claims that the "cases included in this course were written by expert faculty members, some of whom authored the guideline." At the completion of the course, IDSA claims that participants will be able to evaluate and diagnose Lyme disease, utilize effective therapy to treat Lyme disease and review and interpret the IDSA Guidelines.

The IDSA workgroup and independent reviewers who created the course with CDC funding consist of the following. Please note that Drs. Shapiro, Steere and Wormser are the kingpins who authored the IDSA Lyme Disease Practice Guidelines.

Eugene Shapiro, M.D., Professor of Pediatrics, Epidemiology & Public Health, and Investigative Medicine, Yale University; Metropolitan Life Insurance Company: Reviewing claims of disability related to Lyme disease; Served as an expert witness in medical-malpractice cases related to Lyme disease, (including the Connecticut Medical Board prosecution of Lyme pediatrician Dr. Charles Ray Jones); SUNY Downstate: Honoraria.

Allen Steere, M.D., Professor of Medicine, Harvard Medical School; NIH, the Dana Foundation, G Harold and Leila Y. Mathers Foundation, CDC: Research Grants/Contracts. Allen Steere was the Chief Clinical Trial Investigator for the Lymerix vaccine that caused Lyme disease in a subgroup of recipients. It was known prior to FDA approval of the Lymerix vaccine that it would have this effect on recipients with a certain gene.

Allen Steere was the Chief Clinical Trial Investigator for the Lymerix vaccine that caused Lyme disease in a subgroup of recipients. It was known prior to FDA approval of the Lymerix vaccine that it would have this effect on recipients with a certain gene.

Dr. Steere also used European, high-passage, lipid-free strains of Bb when conducting the research utilized by CDC and other agencies in establishing what is known as the Dearborn serological testing standard (ELISA as a screening test with Western blot for confirmation and only certain bands designated in the criteria by CDC's Lyme Medical Cartel). This testing standard was accepted in 1994 and is still utilized today, despite the fact that the Western blots at the time were unreadable and Dr. Gary Wormser found that only 14% of patients tested positive with this standard. The carefully-designed, current Dearborn testing standard allows the remaining 86% of patients to fall through the cracks of the inaccurate and deceiving testing scam.

Gary Wormser, M.D., Chief of Infectious Diseases and Vice Chair Department of Medicine, New York Medical College; Department of Justice; Expert testimony in a medical malpractice case related to Lyme disease; Retained in other medical-malpractice cases involving Lyme disease; NIH, Bio-Rad, and Diasorin: Research Grants; Merck, Astra Zeneca, and Pfizer.

Paul Mead, M.D., Medical Officer, Centers for Disease Control and Prevention; Nothing to disclose.

Paul Auwaerter, M.D., Clinical Director, Division of Infectious Diseases, Johns Hopkins University School of Medicine; Expert testimony in medical malpractice cases related to Lyme disease.

Harry Gallis, M.D., Consulting Professor of Medicine, Duke University Medical Center; Genentech: Advisor/Consultant; Fortis-Spectrum: Advisor/Consultant.

"Some of the doctors receiving the most money sit on committees that prepare guidelines instructing doctors nationwide about when to use medicines." said Gardiner Harris and Janet Roberts, *Doctors' Ties to Drug Makers Are Put on Close View,* New York Times, March 21, 2007.

**The CDC "Expert" Myth**

Lyme disease is hard to catch, easy to cure, tests are accurate, it is a non-chronic infection and short-term antibiotics are adequate.

**The Lyme Patient and Treating Physician Reality**

Lyme disease is easy to catch, difficult to cure, is relapsing-remitting and debilitating, can exist as a chronic infection, tests are inaccurate, disseminated medical information is politically dumbed-down, the disease is sophisticated and requires long-term antibiotic regimens.

One pretext that the NIH, CDC and IDSA Guideline authors use is that antibiotics can have dangerous side-

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# "IDSA" ...cont'd from pg 6

effects. However, Lyme physician Dr. Joseph Burrascano stated,

"You're not going to withhold treatment for a potential side effect, which may never occur, and ignore a known infection that desperately needs to be treated."

Another pretext is that long-term antibiotics create drug-resistant strains of diseases. However, it is also the undertreatment of infection that perpetuates drug-resistant strains of Lyme disease.

"Patients infected with many other kinds of common bacteria - such as those that cause tuberculosis, bronchitis, or UTIs - can experience relapses after an initial course of antibiotic treatment fails or proves inadequate. Doctors routinely retreat patients who relapse in order to achieve a cure and prevent chronic symptoms. Why should patients with Lyme disease be treated differently?" Daniel J. Cameron, M.D., Proof That Chronic Lyme Disease Exists, http://www.ilads.org/news/lyme_news/73.html

**Tuskegee Then and Tuskegee Now**

The following is a direct quote from the CDC website at http://www.cdc.gov/tuskegee/timeline.htm:

"In 1932, the Public Health Service, working with the Tuskegee Institute, began a study to record the natural history of syphilis in hopes of justifying treatment programs for blacks. It was called the "Tuskegee Study of Untreated Syphilis in the Negro Male." The study initially involved 600 black men - 399 with syphilis, 201 who did not have the disease. The study was conducted without the benefit of patients' informed consent. Researchers told the men they were being treated for "bad blood," a local term used to describe several ailments, including syphilis, anemia, and fatigue. In truth, they did not receive the proper treatment needed to cure their illness. In exchange for taking part in the study, the men received free medical exams, free meals, and burial insurance. Although originally projected to last 6 months, the study actually went on for 40 years.

**What Went Wrong?**

In July 1972, an Associated Press story about the Tuskegee Study caused a public outcry that led the Assistant Secretary for Health and Scientific Affairs to appoint an Ad Hoc Advisory Panel to review the study. The panel had nine members from the fields of medicine, law, religion, labor, education, health administration, and public affairs.

The panel found that the men had agreed freely to be examined and treated. However, there was no evidence that researchers had informed them of the study or its real purpose. In fact, the men had been misled and had not been given all the facts required to provide informed consent.

The men were never given adequate treatment for their disease. Even when penicillin became the drug of choice for syphilis in 1947, researchers did not offer it to the subjects. The advisory panel found nothing to show that subjects were ever given the choice of quitting the study, even when this new, highly effective treatment became widely used.

**The Study Ends and Reparation Begins**

The advisory panel concluded that the Tuskegee Study was "ethically unjustified"--the knowledge gained was sparse when compared with the risks the study posed for its subjects. In October 1972, the panel advised stopping the study at once. A month later, the Assistant Secretary for Health and Scientific Affairs announced the end of the Tuskegee Study.

In the summer of 1973, a class-action lawsuit was filed on behalf of the study participants and their families. In 1974, a $10 million out-of-court settlement was reached. As part of the settlement, the U.S. government promised to give lifetime medical benefits and burial services to all living participants. The Tuskegee Health Benefit Program (THBP) was established to provide these services. In 1975, wives, widows and offspring were added to the program. In 1995, the program was expanded to include health as well as medical benefits. The Centers for Disease Control and Prevention was given responsibility for the program, where it remains today in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. The last study participant died in January 2004. The last widow receiving THBP benefits died in January 2009. There are 16 offspring currently receiving medical and health benefits.

**Timeline**

1895 Booker T. Washington, at the Atlanta Cotton Exposition, outlines his dream for black economic development and gains support of northern philanthropists, including Julius Rosenwald (President of Sears, Roebuck and Company).

1900 Tuskegee educational experiment gains widespread support. Rosenwald Fund provides monies to develop schools, factories, businesses, and agriculture.

1915 Booker T. Washington dies; Robert Motin continues work.

1926 Health is seen as inhibiting development and major health initiative is started. Syphilis is seen as major health problem. Prevalence of 35 percent observed in reproductive age population.

1929 Aggressive treatment approach initiated with mercury and bismuth. Cure rate is less than 30 percent; treatment requires months and side effects are toxic, sometimes fatal.

1929 "Wall Street Crash"--economic depression begins.

1931 Rosenwald Fund cuts support to development projects. Clark and Vondelehr decide to follow men left untreated due to lack of funds in order to show need for treatment program.

1932 Follow-up effort organized into study of 399 men with syphilis and 201 without. The men would be given periodic physical assessments and told they were being treated. Motin agrees to support study if "Tuskegee Institute gets its full share of the credit" and black professionals are involved (Dr. Dibble and Nurse Rivers are assigned to study).

1934 First papers suggest health effects of untreated syphilis.

1936 Major paper published. Study criticized because it is not known if men are being treated. Local physicians asked to assist with study and not to treat men. Decision was made to follow the men until death.

1940 Efforts made to hinder men from getting treatment ordered under the military draft effort.

1945 Penicillin accepted as treatment of choice for syphilis.

1947 USPHS establishes "Rapid Treatment Centers" to treat syphilis; men in study are not treated, but syphilis declines.

1962 Beginning in 1947, 127 black medical students are rotated through unit doing the study.

1968 Concern raised about ethics of study by Peter Buxtun and others.

1969 CDC reaffirms need for study and gains local medical societies' support (AMA and NMA chapters officially support continuation of study).

1972 First news articles condemn studies.

1972 Study ends.

1973 Congress holds hearings and a class-action lawsuit is filed on behalf of the study participants.

1974 A $10 million out-of-court settlement is reached and the U.S. government promised to give lifetime medical benefits and burial services to all living participants. The Tuskegee Health Benefit Program (THBP) was established to provide these services.

1975 Wives, widows and offspring were added to the program.

1995 The program was expanded to include health as well as medical benefits.

1997 On May 16th President Clinton apologizes on behalf of the nation.

2001 President's Council on Bioethics was established.

2004 CDC funds 10 million dollar cooperative agreement to continue work at Tuskegee University National Center for Bioethics in Research and Health Care.

2004 The last U.S. Public Health Service Syphilis Study at Tuskegee participant dies on January 16.

2006 Tuskegee University holds formal opening of Bioethics Center.

2009 The last widow receiving THBP benefits dies on January 27."

**Similarities Between Tuskegee I (Syphilis) and Tuskegee II (Lyme disease)**

* Syphilis is caused by Treponema pallidum, a spirochete bacterium.

* Lyme disease is caused by Borrelia burgdorferi, a spirochete bacterium.

* Tuskegee I studied the epidemiology, or natural history of Syphilis.

* Tuskegee II is studying the epidemiology, or natural history of Lyme disease.

A study of the natural history of a disease is epidemiology. Such a study cannot be accomplished if patients receive treatment and become well. If Lyme disease patients receive treatment, the final outcome of the effects of the chronic disease cannot be studied. Through establishment of the present fraudulent disease parameters (treatment guidelines), free reign has been granted for the U.S. Public Health Service/CDC Epidemiology Intelligence Service (EIS) to monitor long-term effects - the natural history -- of untreated Lyme disease.

This is a sophisticated method of continuing and expanding the Tuskegee Experiment (Part II), using the medical system as a whole. The disease parameters designed by the NIH, CDC and IDSA, through the IDSA Practice Guidelines for Lyme Disease, allow this vast epidemiological study to be carried forth without accountability for safety in bioethical human experimentation. USPHS/CDC EIS member, Dr. Allen Steere, withheld antibiotic treatment for years from children while he conducted a study of the "natural history" of Lyme arthritis. Yet, he still gets millions in government grants, capitalizing on studying a complex disease he trivializes when it comes to treatment. http://xa.yimg.com/kq/groups/15466188/1455360058/name/1.pdf

* Participants in Syphilis "study" did not give informed consent. Information was not forthcoming and did not allow the participants to make an educated, informed decision.

* Participants in Lyme disease "study" have not given, nor have they been asked for their informed consent. Information is not forthcoming from the NIH, CDC, IDSA, IDSA Practice Guidelines or the majority of physicians who receive misinformation about the disease from the NIH, CDC and IDSA. Lyme patients are forced into submissive participation in this widespread "study," despite a public outcry that they choose not to participate and despite a public demand for antibiotic treatment.

* Syphilis is transmitted to spouses through intimate contact and to offspring. Transmission to family members and offspring was ignored.

* Lyme disease is transmitted to spouses through intimate contact and to offspring. Transmission to family members and offspring is being denied.

* Syphilis "study" was coordinated by the United States Public Health Service and the CDC, with cooperation from medical societies, including the American Medical Association.

* Lyme disease "study" is being coordinated by the United States Public Health Service, the NIH and the CDC, with cooperation from medical societies, most notably, the Infectious Diseases Society of America and the American Academy of Neurology, an organization who published guidelines nearly identical to those of IDSA and whose guideline committee consisted of three of IDSA's Lyme treatment guideline authors.

* Syphilis "study" participants did not receive adequate treatment for their disease. Local physicians asked to assist with "study" and instructed not to provide treatment to "study" participants.

* Lyme disease "study" participants are not given adequate treatment for their disease. All physicians are asked to assist with "study," through the unspoken threat of medical board prosecution should they provide long-term treatment and through receipt of NIH, CDC and IDSA Practice Guidelines -- misinformation that discourages adequate treatment for the disease.

* During syphilis "study," decision was made to follow the participants until death.

*During Lyme disease "study" participants have been followed for more than 35 years, nearing the 40 year mark of the Tuskegee "study." CDC is following the participants until death, as evidenced by a recent CDC study assessing the death of Lyme disease patients.

http://www.reuters.com/article/2011/01/06/us-lyme-disease-rare-cause-death-study-idUSTRE70553O20110106

**Summary of Lyme Pandemic**

Lyme Borreliosis is a pandemic of misinformation, misdiagnosis and misery for Lyme patients and their treating physicians. Yet, the same CDC "experts," who have been wrong from the beginning, are still running the show and calling the shots. These CDC spokespersons have created a nightmare of disease and suffering for patients. If you count the numbers of people who have been diagnosed with Multiple sclerosis, rheumatoid arthritis, fibromyalgia, chronic fatigue, lupus, Crohn's disease, autism, ALS, Parkinson's and Alzheimer's, realizing that the majority of people suffering with diagnosed chronic Lyme infection were first misdiagnosed with these other diseases, there is high probability that many suffering with these other diseases may actually be infected with Borrelia bacteria as the cause of these disease manifestations.

It is an ambitious marketing effort assisted by drug and insurance company consultants who, as so-called independent scientists, publish cherry-picked research in journals

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such as the New England Journal of Medicine. This group of consultants is known as the Steere-Camp (after Dr. Allen Steere) aka the Lyme Medical Cartel. The goal of these crypto-lobbyists is to generate an artificial demand for pharmaceutical products (which they and their employers may hold patents on). This is accomplished through creating a man-made, expanding pandemic based on misinformation about the contagious nature of a disabling and deadly disease, which is listed as a Level II biowarfare agent.

IDSA Guideline author, Mark Klempner, M.D., also authored what is known as the Klempner Study funded by NIH, which is used to rationalize the non-treatment of Lyme patients. Klempner was an editor for the New England Journal of Medicine, which published his "Tuskegee Study," which discredits the long-term treatment of Lyme disease with antibiotics. It is noteworthy that his research was halted before long-term treatment could even be administered. Yet, NIH, CDC and IDSA use Klempner's study as the gold standard of "evidence-based medicine," which Lyme victims bear the brunt of. Remarkably, after Mark Klempner completed the "definitive treatment study" that ended all further NIH/CDC-funded Lyme treatment studies, he was positioned as Director of a biowarfare lab in Boston, Massachussetts.

Klempner had previously published researched demonstrating the fact that Borrelia burgdorferi persists in fibroblasts after antibiotic treatment. The NIH-funded Klempner study not only contradicts Klempner's own research, but also contradicts treatment recommendations of other persistent bacteria as well. U.S. Department of Health and Human Services/CDC publication Questions and Answers about TB states the following:

"If you have TB disease, you will need to take several different drugs. This is because there are many bacteria to be killed. Taking several drugs will do a better job of killing all of the bacteria and preventing them from becoming resistant to the drugs."

**NIH, CDC and IDSA**

Guidelines recommend against using combination therapy for Lyme disease and "sell" this negligent recommendation on the opposite basis that long-term antibiotic therapy (only in the case of Lyme disease) causes antibiotic resistance. Again from the same publication:

"TB bacteria die very slowly. It takes at least 6 months for the medicine to kill all the TB bacteria. You will probably start feeling well after only a few weeks of treatment. But beware! The TB bacteria are still alive in your body. You must continue to take your medicine until all the TB bacteria are dead, even though you may feel better and have no more symptoms of TB disease.

If you don't continue taking your medicine after you feel better or you aren't taking your medicine regularly, this can be very dangerous. The TB bacteria will grow again and you will remain sick for a longer time. The bacteria may also become resistant to the drugs you are taking. You may need new, different drugs to kill the TB bacteria if the old drugs no longer work. These new drugs must be taken for a longer time and usually have more serious side effects….When TB patients do not take their medicine as prescribed, the TB bacteria may become resistant to a certain drug. This means that the drug can no longer kill the bacteria."

Let's analyze the recommendations made by these "highly-esteemed" government agencies:

If a person has TB infection, he or she must take all the medications (including potent antibiotics) long-term so as not to cause drug resistance.

However, if a person has Lyme infection, he or she must not take combination antibiotics long-term, because doing that will cause drug resistance?

Professor Garth Nicolson, Ph.D., a microbiologist, stated in an In Short Order radio interview that he found the antibiotic resistance argument to be "particularly lame." He also admitted that by administering only short-term antibiotics as treatment for Lyme disease, the government is, in fact, creating antibiotic-resistant germs under the pretext of not creating them.

The Lyme Cartel experts perpetuate the pandemic while appearing to treat it with deliberately-designed, ineffective treatment guidelines. Thus far, these charlatans have been successful in creating a fraudulent science-base (the Klempner study), as an intellectual justification for perpetuating the ineffective IDSA Practice Guidelines. This aids in limiting the number of doctors capable of administering effective treatments to halt the pandemic and also serves to emphasize the profitable treatment of symptoms, in lieu of curing the disease at its source.

Previous articles published in medical journals by these lobbyists proved the persistence of the organism despite antibiotic treatment. Recent contradictory articles published by these drug and insurance company consultants deny the persistent, pervasive and pleomorphic nature of the extraordinarily complex Borrelia organism. The articles also deny the plurality of devastating manifestations, which often result due to the deliberately-designed, ineffective treatment regimens recommended by NIH, CDC and IDSA. They previously referred to the disease in their research as "chronic Lyme disease." Now, they have the audacity to claim that chronic Lyme infection does not exist, and they refer to persistent symptoms as PLS (Post Lyme Syndrome) or MUS (Medically Unexplained Symptoms).

It is the Cartel's numerous connections to symptoms-proliferation interests, rather than an interest in eliminating the infectious etiology of the disease, that defines its ideology. This is why the Steere-Camp is so at odds with the component of the scientific community concerned with symptom-elimination. The symptom-elimination professionals are a threat to the profits of the symptom-proliferation industries that fund and publish the so-called research of the Steere-Camp Lyme Medical Cartel.

Following are additional conflicts of interest of members of the Lyme Medical Cartel who authored the New England Journal of Medicine article entitled A Critical Appraisal of 'Chronic' Lyme Disease.

Dr. Henry Feder reports receiving lecture fees from Merck and serving as an expert witness in medical-malpractice cases related to Lyme disease.

Dr. Barbara Johnson of the CDC reports holding patents on diagnostic antigens for Lyme disease.

Dr. Susan O'Connell reports serving as an expert witness related to Lyme disease issues in civil and criminal cases in England.

Dr. Eugene Shapiro reports serving as an expert witness in medical-malpractice cases related to Lyme disease, reviewing claims of disability related to Lyme disease for Metropolitan Life Insurance Company, and receiving speaker's fees from Merck and Sanofi-Aventis.

Dr. Allen Steere reports receiving a research grant from Viramed and fees from Novartis.

Dr. Gary Wormser reports receiving research grants related to Lyme disease from Immunetics, Bio-Rad, and biopeptides and education grants from Merck and AstraZeneca to New York Medical College for visiting lecturers for infectious-disease grand rounds, being part owner of Diaspex (a company that is now inactive with no products or services), owning equity in Abbott, serving as an expert witness in a medical-malpractice case, and being retained in other medical-malpractice cases involving Lyme disease. He may become a consultant to Biopeptides. No other potential conflict of interest relevant to this article was reported.

If one "Follows the Money Trail," it is clear that medical corruption and collusion is why Lyme disease patients are suffering and pleading for help.

We urge recognition of this deplorable situation by prominent, responsible journalists and government investigators who have the courage and the means to bring this dark chapter of medical history into the light of day. They also ask what mechanisms were put in place during the governmental investigation of the Tuskegee Phase I program to report the ongoing and expanding "Phase II" part of the program.

**Post Script: A Doctor Gets Lyme Disease and Stumbles Upon The CDC's Tuskegee Experiment, Part II**

The fact that Epidemiology Intelligence Service member Dr. Allen Steere values the study of the "natural history" of Lyme disease more than treatment for patients is evident in the following account from a physician who contracted Lyme infection on Shelter Island in the 1970's.

"Here is my story with Dr. Steere. It was the mid-1970's and Lyme Disease was not a household word. .….I rented a summer cottage on Shelter Island, on the Eastern End of Long Island. An idyllic place. It was strange to note that several of the locals had facial palsy - nice people all, but it was a great summer. There was a pond, many deer…….

One day, I happened to notice that I had a bright red mark on my forearm. A VERY bright red mark. It was a little hot, otherwise unremarkable, but odd because of its brightness. I ignored it. The next day it was still there. A day later, it was bigger. Over subsequent days, the "mark" became a coin shaped lesion, then bigger but oblong, and bigger and bigger and bigger. At some point I went to a local gp in New York who - like me - had no idea what was wrong - "Let's watch it," he said. The rash kept growing. It became larger than a silver dollar. And hot. Along with this, I was now really ill. I had fatigue, restlessness, malaise, and flu-like symptoms. Something was clearly wrong but I had no idea what!

That weekend, I was back on Shelter Island, on my wonderful porch, reading the local freebie paper. A tiny article caught my attention about a "new disease" discovered on Shelter Island. It was tick borne. THEN I REMEMBERED. The time, before the rash, back in New York City after a weekend on Shelter Island, when I awoke in the middle of the night with a stinging pain in my arm, and went into the bathroom, not clear what was wrong. There was nothing, no something small. A magnifying lens did the trick - a small tick!! Ugghh!! I removed it with Vaseline and tweezers, went back to bed, and promptly forgot the whole incident. But the red spot came precisely where the tick had bitten me.

So I went back to Cornell (my old medical school) and visited my old (real old - Professor Emeritus) parasitology teacher - the distinguished Dr. Ben Keen. Is this a Lyme tick bite? I will never forget his wizened smile as he raised his arm in triumph and pride!! "Congratulations, young man," he said - "You have made the correct diagnosis." What to do? Without hesitation, he told me that THE place to go to was Yale, where there was a doctor Steere who was THE expert in this emerging illness. He would help me as much as anyone could. This was the place to go.

But first I went to the library and read everything I could about Lyme. I did not like what I read. The facial palsy association, for example, was already there, but little about treatment or prognosis. No one knew!! However, it was known the causative organism was a spirochete - fine, I thought, syphilis. This upset me because I knew how hard syphilis was to treat - you thought you eliminated it and you didn't - it could come back, much worse, years later. And worse, come back not as the rash, or initial lesion, but come back anywhere - as brain disease, joint disease, and more and more and more. "Well," I thought, "like syphilis", so there ARE medications that treat syphilis - these must be the same medications to take - "but I bet you gotta blast it, like syphilis," "and your first shot is your best shot, like syphilis - you gotta blast it to smithereens so it doesn't come back and 'blast' you."

Off I went to Dr. Steere. He agreed to see me quickly, he was professional, busy, not particularly friendly. But he exuded all of the airs that one might expect from an international authority from Yale. The diagnosis was easily made. But he told me there was no treatment. It looked like syphilis but the antibiotics that I wanted to take were ineffective. They would not work. He would not give them to me, despite my requests. They were completely useless - he had studied this, had all the data, all the reports, and nothing good ever came from antibiotics in the case of Lyme. Even though there was this "family resemblance" to syphilis - even though a spirochete was causing the problem, this particular spirochete did not respond to medication. The only thing to do was join his clinic as a patient and have him follow me. They were studying Lyme, they would eventually have a treatment. There were some tantalizing leads concerning immunity and some possible things to do in that way. He could treat me with what they developed as they developed it. I was to see him from time to time and in time……For the present, nothing. Dr. Steere was adamant that this was the ONLY way to go. No treatment for now. I was stunned. But I trusted Dr. Steere, and Yale, and the powerful expertise regarding Lyme that he had assembled.

I had been EAGER to treat this "bug" with a "bug" medicine. But I was a doctor and I had learned to be a "good patient." You do what your doctor tells you. And he was the best in the world!! So quite miserably, but confident that I was doing all that I could, I got on the train and went home.

And I got sicker and sicker and sicker. Days passed, and more and more. The rash got larger and larger and larger. Finally it circled completely around my arm like a band-bracelet with one end overlapping the other. And I was incapacitated. Calls to Steere were unhelpful - just wait it out, he said, we are studying this.

So, finally, I did what I had never thought that I would do - I got some antibiotics and treated myself. I really blasted myself. I felt very bad about doing this (and very fortunate that as a doctor, I could actually get antibiotics.). VERY, VERY quickly - very soon after I took these pills - the rash started to break up!! It got blotchy and weaker. It stopped growing. The next day blotchier still. Like a miracle!! And I started

*"IDSA" ... cont'd pg 9*

# "IDSA" ... cont'd from pg 8

to feel better, for the first time since this started. Much better.

Gleefully, I called Dr. Steere. Antibiotics helped after all!! I wanted to rush over to his clinic, show him the improvement in progress, have him follow this, have him test me, and have him offer this to others. I will never forget our phone conversation. First of all, he was obviously irritated that I had done this. His voice was strained and very, very cold. I had messed things up by doing this! He told me that the strong temporal association between my taking antibiotics and my dramatic improvement could have been a coincidence!! (There is no doubt that there was a VERY tight temporal relationship and remarkable rapidity of relief following medication --

After weeks - more than a month - of unrelenting misery.) He had heard of other such stories and such "cures", but he would not accept them - the placebo response, suggestibility, it was going away anyway, etc., etc. So I asked him why he had not told me earlier on that he "had heard of such cures". I had plainly, and repeatedly asked him about antibiotics and the very antibiotic class that I had taken - the one for spirochetes. And he had simply told me - with clear finality - that they just did not work. I asked him for medication and he told me it NEVER worked. He didn't tell me about these other cases. And now he was quite clear - what happened to me - and what happened to others like me - had nothing to do with medical science. Only data from clinical trials with placebo controls prove anything, and he was saving me for such a trial. In fact, what I did merely undermined his science!! My personal experience had no scientific value or clinical value. In fact, it was a bad thing. I should stop doing what I was doing immediately.

I was stunned. There was something very wrong with what this man was doing. He wouldn't even see me. He wouldn't even look at my arm or my blood as a natural work-in-progress. Further calls to him and his group clarified what he was doing and where he was coming from. He was a "scientist". He wanted me and the other "clinical material" to be pure for his "clinical experiments." The hell with patients as people - clinical reality and people's lives in the here and now. He was studying immunity in Lyme - (or some such thing) - the crusade was the thing - the science, and not his present patient's daily needs. I accused him of this and he (I suppose naturally) got colder and more distant. There was nothing left to say. So I "fired" him. He had felt that he was doing the clinical science. He wouldn't even see me as a "work-in-progress." Clearly there was room here - with disclosure about limitations - for an "open labeled clinical trial" (give some other people like me the same antibiotic that I and others had taken, and study what was happening). But he was saving us for bigger, more impressive studies. He didn't tell me what he knew, even in response to my direct questioning, and he was doing the same to his other patients (his other 'clinical material'). Our being sacrificed for others would be worth it - in his mind - our own needs and beliefs be damned. Talk about arrogance and playing God!!

"Alan", I had said (of course I am paraphrasing - over 20 years have passed - but like the Kennedy assassination, these horrible moments are burned into your brain with remarkable accuracy seemingly forever). "This antibiotic saved me from great misery and from God knows what horror in the future." The response to the medication was totally dramatic - the temporal sequence of what happened before my trial and afterwards - cure locked in step with treatment. I CERTAINLY WAS A BELIEVER IN WHAT HAPPENED TO ME. I, WHO LIVED THIS, WAS CONVINCED!! So why not at least present some patients with my syndrome with an open labeled trial of medication……But I was clearly wasting my time.

And within a few days, it was all gone. The rash and all the symptoms. And I felt fine for the first time since this all started. I FELT FINE!! Were there sequelae? Clinically, I don't think so. But with an insidious spirochete you never know. Is this aging or Lyme. This I live with but this is life. Years after the incident with Steere, the medication that I had taken was the standard treatment. At doses even higher than the ones I gave myself, so I got a titer, had high levels, and took a (then) standard treatment. And so it goes.

I think I became a better doctor. I think that I listen to patients more than I might have. I understand why the classic healers of Greek mythology - Aesclepius and Chiron - were ill themselves. Also, I have published an uncontrolled clinical trial myself, and I strongly endorse them. I have written about the value of the "single case study." So much in medical science has come from single case studies but there is a bias against this and in favor of large, double-blind placebo controlled studies. Of course they have their place, but they have drastic limits also (there are numerous papers in the scientific literature that describe the limits of these types of studies - but many, many academic leaders have blinders here and treat the "double-blind placebo controlled study - rather mindlessly - like a sort of 'Holy Grail.') I try to fight this mindlessness - that is part of why I founded AAPP. However, fighting the establishment on these issues is kind of like fighting the wind….

After all these years - and the fact that I avoided major tragedy by taking action myself - I still despise Alan Steere….He lied to me - he held back information - that antibiotics had helped others - information that HE didn't think was important enough but to me, the patient, what could be more important!! The b_____ was playing GOD with my life, and he was treating me like a child - I did not have the judgment to make up my own mind - he would do it for me. Also, he was deceiving himself - he thought that he was doing it correctly. He was saving me - in an untreated state - for his studies. The studies took priority over the "material" (human beings) who were being studied. I suppose that he felt that this was justified because knowledge gained could help much larger numbers of human beings. But if he felt this was justified - and I am merely surmising - who knows how he felt, or if he even can feel at all - he was wrong, tragically wrong, and he was deluding himself. His own career had too much to gain - and his patients too much to lose - for him to think that he could be objective in such a belief. I did call him once ( when I was taking my second course of medications - the very ones he had denigrated and now they were the standard treatment - but he had nothing to say - other than something such as "we didn't have the data then". The man clearly has no people skills.…The problem is the ethics and the view of science and the way researchers are rewarded…..I hope and pray that other patients have a better experience with Dr. Steere and his 'colleagues' than I did."

http://www.actionlyme.org/AAPP_STEERE.htm

*Jerry Leonard is a Lyme disease patient and author. He has written three books on unethical medical experiments conducted by the government -- including experiments involving injecting tumor cells and monkey cancer virus in humans so that model forms of cancer could be induced and maintained in human subjects for pharmaceuticals research. Jerry's books are available at Amazon.com. Contact Jerry at jerryleonard999@yahoo.com.*

*Tina J. Garcia is a Lyme disease patient and advocate who founded Lyme Education Awareness Program at www.leaparizona.com. Tina is a freelance writer, author and Patient Life Coach at www.kaleidoscope-health.net. Contact Tina at tinajgarcia@yahoo.com.*


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**WHO MAY ATTEND**
Although much of the lecture content will be geared toward medical professionals and scientists, we encourage patients and supporters to attend as well. Our goal is an informative, educational and inspiring event that will be beneficial to all!
SPEAKERS INCLUDE

**Rhonda L. Casey, D.O., F.A.C.O.P.**

Tulsa, OK,  Clinical Director OSU-CHS Center for the Investigation of Morgellons Disease;
Vice-Chair, Department of Pediatrics; Oklahoma State University, Center for Health Sciences.

Panelist for Q and A, Discussion

**Dr. Carsten Nicolaus, , MD, PhD**

Augsburg, Germany
Has had a very distinguished, multi-faceted medical career which spans over 20 yrs. He is Chief Medical Director of two treatment centers for tick-borne diseases in Germany. His medical experience and interests include Emergency Medicine, Family Practice, Geriatric & Preventive Health Medicine, Vascular Medicine, and P.A.I.N. Therapy complemented by Acupuncture and Neural Therapy.
Within recent years, Dr. Nicolaus has begun treating as well as researching Morgellons Disease in Germany..
Topic: Morgellons : Alternative Treatment Methods

**Ginger Savely, DNP**

Washington, DC
Certified Family Nurse Practitioner with a Doctorate in Nursing Practice. Dr. Savely has medically managed over 300 Morgellons patients in her medical practice.
Topic: “Examining the Morgellons Patient”

**Gregory V. Smith, MD, FAAP**

Gainesville, GA
Board Certified Pediatrician practiced in Gainesville, GA for 28 yrs. Member, AAP, American Academy of Pediatrics, GA Chapter ; Former Board of Director, AAP, GA Chapter; Morgellons Patient
Topic: "Examining the Literature and Photographic Evidence"

**Emily A. VanDegrift, M.S.F.S.**

Tulsa, OK
Graduated from OSU-CHS in December, 2010 with a Master of Science in Forensic Science. She joined the research team of Professor Wymore at the Center for the Investigation of Morgellons Disease (CIMD) January, 2011. Ms. VanDegrift brings with her the fresh, eagerness of a new graduate plus the skills of an experienced Forensic Scientist. An added advantage for Morgellons researchers is the grand opening in November, 2010 of the Forensic Sciences and Biomedical Research Facility, which is housed at OSU’s Center for Health Sciences. The 125,000 square foot facility is the state of the art forensic lab and, our very own Emily VanDegrift completed her degree there.  Topic: Quantitative PCR Testing

**Amelia M. Withington, MD**

Chester, PA
Attending Psychiatrist at Crozer-Chester Medical Center in Chester, PA
Board Certified in Psychiatry and Neurology
Residency completed at Hahnemann University Hospital, Philadelphia, PA, 1995
Graduated U of TX Southwestern Medical School, 1991
Topic: “Morgellons: A Case Study “

**Randy S. Wymore, Ph.D.**

Tulsa, OK
Director,OSU-CHS Center for the Investigation of Morgellons Disease
Associate Professor of Physiology and Pharmacology
Oklahoma State University Center for Health Sciences
Keynote Speaker and Topic: "Research Update"

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The owners of Nutramedix have been involved in international Christian ministry since the 1980s. Prior to starting the company in 1993, our Founder and President was a missionary pilot serving tribal groups in Peru. The Kairos Foundation was created in 1995 to fund projects that address both the physical and spiritual needs of people in some of the most disadvantaged areas of the world. The foundation provides ongoing financial support for organizations operating in Africa, Asia, Eastern Europe, North America and South America.


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