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RESEARCH ARTICLE

The Unhappening of Heart Disease

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ABSTRACT:

Most of the major diseases, and atherosclerotic cardiovascular disease (ASCVD) in particular, are made to happen by patient actions. Relevantly, it has been said that 95% of ASCVD, diabetes, hypertension and lipid disorders are curable: made to unhappen. Cardiovascular disease (CVD) is the leading cause of mortality and morbidity in industrialized countries including the United States. Healthcare inflicts a significant societal burden in terms of cost, and accounts for one-fifth of the gross domestic product expenditure in the United States. CVD is a disease primarily brought on by lifestyle factors, underlying genetic susceptibility becoming manifest in time (aging). Given the significant burden of health care, a major focus is now on the preventive aspects to reduce the incidence and prevalence of not only CVD, but multiple other diseases. Most diseases occur if, and ONLY if, the person with a particular genetic tendency does what is necessary to express that genetic tendency. The American public has the same genetic make-up as all other populations, but our behavioral patterns are what have activated our disease-causing genes, resulting in the major diseases and costs of our culture. By changing our behaviors, we can prevent the expression of those genetically-originated and behaviorally induced medical conditions and costs. This includes the basic requirements: clean air, clean water, a 90+% minimally-processed, high-fiber and ideally organic whole foods, diet with any pleasure-generating food once in a while, exercise to the point of developing abdominal clear lines of definition and demarcation, and the avoidance of unrealistic expectations. This article provides the Preventive Medicine Center's (PMC) philosophy and outlines guidelines that would lead to significant regression of ASCVD and reduce the disease burden in our communities as a whole. These recommendations are an invitation to consider and provide the reasonable probability of freeing the patient from the risk of disease by the "unhappening" of (heart) disease.

Introduction:

CVD is the predominant disease and cost-generator in our Western and other industrialized cultures. CVD is the leading cause of death and disability in industrialized societies including the United States,¹ due in large part to the lack of a comprehensive approach for the control of atherosclerotic risk factors.² The incidence of CVD is on the rise as the population ages, and as a result, the focus of major health organizations across the world has shifted to prevention rather than treatment of individual diseases. The Framingham Heart Study³ is the longest running epidemiological study that identified the risk factors for the development of atherosclerosis. Lifestyle has significant impact on the development of mental and physical illness.⁴ And by adopting a healthy lifestyle, quantity and quality of healthy span can be increased successfully.⁵ CVD, moreover, is associated with multiple other diseases as well. For example, according to the online Cancer Epidemiology, Biomarkers & Prevention study, “heart disease may be a risk factor for prostate cancer.”⁶ Men with coronary artery disease had a 35% greater risk of developing prostate cancer and a 24% greater risk of being diagnosed with prostate cancer compared to men who did not have heart disease. Such information suggests that the risk factors that cause one disease may also cause other maladies. Therefore, measures aimed at the prevention of CVD development will also make other diseases less likely to occur.

The cost of health care in America exceeds \$4.1 trillion per year as of 2020,⁷ and is 20% (one-fifth) of all goods and services produced in the United States. Preventive care reduces healthcare expenditures⁸, and it promotes the general benefits of being well. This article presents a “comprehensive approach” for risk factor reduction for the prevention of not just the CVD but also “The Simultaneous Prevention of Multiple Other Diseases,” because, as Sutton’s rule states (regarding the robbing of banks), that is where the money is. The PMC’s position is that the necessary, adequate, and sufficient solution to the current healthcare crisis will not come from the political and business approaches to how payment methods are made, but will, in fact, come from controlling the preventable origins of diseases and costs. Rather, this paper will be about recognizing the proper goals to strive for so that, ideally, risk factors are absent, with the clear implication that the diseases and costs as a result of these currently and commonly uncontrolled risk factors will cease to occur. This leads to the concept of “abolitionist medicine,” which is the near (if not absolute)

abolition of the major diseases and medical costs in our, and other technologically developed, cultures.

This ability to reduce diseases and costs requires unique knowledge and skills that are based on acceding to the answer to the question: “What are the essential/basic requirements for the human biology?” Moses ben Maimon was a 12th-13th century Egyptian physician and philosopher whose 13-volume exegetic work of positive and negative recommendations was responded to by his vociferous critics with the following question: “Who asked you [to do this]?” My reply would have been, “No one else had put it all together.” Such a question, and its answer, may well apply to the below.

Lifestyle and Genetic Predisposition:

A comprehensive list of ideal risk markers for the prevention of CVD is described in Table 1 (vide infra). Most diseases occur as a result of choices the American public makes, including, but not limited to, overweight, a high-fat and low-fiber diet, lack of proper exercise, smoking, and overuse of salt and alcohol. In fact, as far back as 2009, 5% of the population with a confluence of the above behaviors and risk markers was responsible for 50% of these health (disease)-care costs, according to lead author Steven Cohen for this federal government report.⁹

The PMC offers the below starting point for an effective major disease and medical cost-reducing plan. The PMC recognizes that the study of the human genome has proven to be of great interest and clinical value as a basis of translational medicine. On the other hand, the focus of the PMC is revealed in the following Medieval riddle: “How many angels can dance on the head of a pin?” The answer is “an infinite number,” and this bears relevance to the human genome in another riddle: “How many things can go wrong with human body if behaviors are incorrect with respect to its genetically (genome)-coded, biological requirements?” Again, the answer is that an infinite number of needlessly provoked diseases can occur when behaviors, choices, and exposures are incorrect for the biologic requirements of the human genome. Another way of saying this is that “genes load the gun, but behavioral choices pull the trigger.”

For example, is our biology to breathe water? If we flap our arms and jump off a cliff, can we fly? Are humans able to safely eat carrion? The PMC’s position is that the necessity of studying the genome pales in comparison to the importance of the PMC’s

Real Preventive Medicine. This perspective does not rely on understanding the intricacies of the human genome, proteasomes, codons, single nucleotide polymorphisms, and so on, but rather depends upon identifying and avoiding those behavioral choices which activate or “anger” the relevant genes.

The PMC position on the genetic origin for most diseases is that a person’s specific disease-generating behaviors, interacting with their genetic predispositions, is what generates “genetic” diseases, exactly as a lighted match creates an explosive fire, but only when brought to gasoline. The clear implication is that if the match is not brought to the gasoline, or if there is no disease-generating behavior, then no explosion or genetically-originated disease will occur.

An example of a common fatalistic attitude about the genetic origin of disease is when a patient states that heart disease or high cholesterol or diabetes or cancer “runs in my family” or that “all the men¹⁰ on my father’s side”¹¹ have had it, whatever the genetic diathesis “it” happens to be.

It is posited that when diseases occur in families with a specific genomic makeup, it is because of what these families chose to eat, or drink, if they were exposed to smoke, if they did not exercise adequately, and so on. Such improper behaviors eventually activate the disease-generating genome for that particular disease. There are obvious exceptions to this insight, including, but not limited to: sickle-cell disease and other hemoglobinopathies, alpha-1 antitrypsin deficiency, Tay-Sachs disease, trisomy, and so on.

Perhaps such may not be the case for systemic lupus erythematosus, multiple sclerosis, amyotrophic lateral sclerosis, mumps, measles, and some other conditions of the standard differential diagnosis mnemonic “Pvt Mat Mindec.” However, these just listed diseases also appear to have an

epidemiology, and therefore likely have identifiable causes other than just genetics or gene activation. These latter important, tragic, and devastating exceptions to obvious genetic origin are a miniscule portion of current diseases and healthcare costs.

Any given disease-producing behavior may cause more than one disease, e.g., smoking predisposes to chronic obstructive pulmonary disease, cancers, CVD, and other conditions, while curiously being occasionally protective.^{12,13} Regarding this “benefit” from smoking, the PMC’s “Law of Probability” states that “if you do things right, most of the time they will turn out right, but occasionally they will turn out wrong. And if you do things wrong, most of the time they will turn out wrong, but occasionally they will turn out right.”

The Essential Requirements of the Human Biology

From the perspective of the PMC, the five most recognizable (Table 1) and frequent disease-inducing and genome-activating biological misbehaviors include:

1. Breathing other than clean air;
2. Drinking other than clean water;
3. Eating a 90+% vegetarian, whole foods “Liv-it”, as opposed to a “die-t”;
4. Not exercising to the point of having visible muscle connections on the abdominal wall due to the absence of underlying subcutaneous fat; and
5. Unrealistic attitude; one must accept and persevere through the difficulties of reality while limiting wishing, wanting, and hoping.

These 5 Basic Activities, or 5 Basic Errors when not done correctly, are referred to by the PMC as “The Essential Requirements of the Human Biology” in order to avoid disease(s) and cost generation.

Table 1. 5 Basic Errors. The most recognizable and frequent disease-inducing and genome-activating biological misbehaviors appear below at left, with correct behaviors on the right.

Error	Correct Behavior
Breathing: being in smoke/dust/fumes.	Our air should be clean.
Drinking: drinking other than water or weak herb teas.	Our water should be clean. Limit alcohol to four drinks a week or less.
Eating: eating high-fat, low-fiber, and processed foods.	Our dietary goals should be very high fiber, whole, minimally-processed foods, low in fat, consisting mostly of grains, vegetables, and beans (GVB) with a little bit of anything else: a “Liv-it”, not a die-t.
Lack of adequate Exercise: being too sedentary and especially having too much “screen” time.	Swim, walk, especially Nordic Walking, at least three miles a day, 5 days a week, 50 weeks a year: the 5-5’s. Do so in 100-foot sections or all at once with neoprene-covered hand weights. Use the exercise machine of your choice or whatever activity. The goal is to exercise to the point of developing abdominal Clear Lines of Definition and Demarcation (CLOD/D) due to the absence of fat under the skin.
Unrealistic Expectations: refusing to accept the difficulties of reality.	“Stay” in reality and deal with problems as best possible, accepting failure, while remaining independent, optimistic, and determined.

The PMC guidelines in Tables 1 and 2 seem “better,” more effective, and are significantly disease-preventing.

PMC Philosophy

The actual in-office name of the one-page patient education handout (Table 2) is “Preventive Medicine Center’s Wellness Protecting and Disease Prevention Goal Numbers/Insights in the Walking Well and Modified Appropriately for Health Conditions.” This twenty-year-old table is just one page in a packet of patient education essays and recipes that have routinely been given to each new patient at the PMC in a predominantly inner-city practice with a suburban content.

This educational information is based on a comparative anatomist’s response to the question: “What are the requirements for the human biology?” These recommended goals and values also reflect a synthesis of the work of Burkitt¹⁴, Eaton¹⁵, Ornish¹⁶, Barnard¹⁷, the Framingham Heart Study³, Pritikin, Roberts¹⁸, and others, as well as personal insights¹⁹ gained during 150,000 office visits over 40 years of full-time clinical practice at the PMC.

Explanation of the entire packet takes about seven minutes during the first office visit. Next, the patient is told that he or she may call with questions about this information, or better yet, their questions will be answered during their follow-up visit after they have obtained the relevant laboratory tests. At that second office visit, the patient’s laboratory values are reviewed with the patient viewing his/her copy of that data via “My Chart” or furnished by the laboratory per our routine request. The goals are cited again, along with advice on how to achieve these goals naturally, and whether or not medicines are a necessity, or if an adjustment is necessary for those already on medications.

The selected values and recommendations in Table 2 are aimed at reducing incremental and residual risk in general, rather than focusing on single risk factors such as cholesterol, or blood pressure, or glucose intolerance, etc. It is an attempt at “Putting It All Together” for the purpose of “the simultaneous prevention, and reversal where possible, of multiple diseases.” The concept of incremental risk reduction has been recently studied in the meta-analysis of 257,384 Black and White men and women, “Lifetime Risks of Cardiovascular Disease.”²⁰ The conclusions were that a systolic BP of <120 millimeters of mercury, diastolic BP <80 millimeters of mercury in diastole, no diabetes, being a non-

smoker, and a total cholesterol of <180 milligrams per deciliter, had a cardiovascular lifetime risk that was approximately 83% less for men up to age 80, and 33% less for women up to the same age, compared to those having 2 or more of these major cardiovascular risk factors.

To that end, the PMC developed medical values and behavioral recommendations (Table 2), chosen in part for their truthfulness, simplicity, and clarity, but also for being memorable. Those requirements have been formulated by studying the common denominators for the absence of disease occurrence in “pre-technological” societies which had no automobiles, no electricity, and no grocery stores¹⁵. These values are also found in the active and healthy 85- to 95-year-olds seen at the PMC over the past 40 years.

For the most part, these recommended values represent the “risk elimination” that occurs at the bottom of lines of regression regarding variables that are continuously, linearly, and directly associated with risk of morbidity or mortality from CVD and/or other diseases. “At some level of (blood) cholesterol, coronary artery disease does not occur”¹, a published observation by this author (HRS) in 2003, and which was also indirectly stated in 1990.²

Despite Sniderman’s³ well-thought-out, trenchant, eloquently, and elegantly stated proof showing that apolipoprotein B/A-1 ratio “was significantly better” than other indices, for the sake of familiarity, non-HDL cholesterol⁴ has been chosen to represent the measure of correct/ideal cholesterol level.⁵

Table 2 (a patient education handout).
Preventive Medicine Center’s Wellness Protecting
& Disease Prevention Goal “Numbers”/Insights
(In the Walking Well & modified appropriately for health issues)

1. Non-HDL cholesterol (is ALL of the bad cholesterol): goal less than 90 (subtract the good HDL cholesterol from the total = non-HDL cholesterol)
2. Triglycerides: goal less than 100, similar in effect to high cholesterol
3. A1C diabetes test: 5.5 or less at age 55 and not above 6.2 at age 62
4. Blood sugar: 90 at 90 minutes after a meal
5. Cardiac HS CRP: 1.0 or less, body inflammation test, similar in effect to high cholesterol
6. Blood Pressure: near 110/60 or so
7. Less than 12% sodium in any one serving that you eat
8. PSA: 1.0 or less, prostate test
9. TSH: 0.35-3.50, thyroid test
10. Hemoglobin: 14, measure of blood thickness
11. Lp (a): goal 15 or less, similar in effect to high cholesterol
12. Homocysteine: goal 7 or less, similar in effect to high cholesterol
13. Uric Acid: goal 5.5 or less, associated with high blood pressure, kidney stones
14. BUN: 12 or less, kidney test
15. Magnesium: 2.1+: relates to diet and diabetes prevention
16. Potassium: 4.1- 4.5: relates to diabetes, high blood pressure prevention and kidneys
17. 25 hydroxy (OH) vitamin D3: 50-66 ng/mL, measure of vitamin D levels
18. Percent body fat: 11-22% in men, 15-25 % in women (manifested as clear lines of definition / demarcation on the abdomen = “CLOD/D.” One can see where the muscles meet the muscles)
19. Virtually no one loses weight who eats chicken, turkey, rice, sandwiches, cereal, and much fruit
20. If overweight, keep a diet diary of ALL you eat or drink except tea, cooked vegetables, and vegetable soups and up to 8 ounces of beans/day: hence, your diary should be empty
21. Eat foods (exactly) as they grow in the field:
G-V-B (grains, vegetables, beans, fruit, nuts, and seeds)
22. The Food Mantra: Fresh (fruits & vegetables), Whole & Unprocessed (grains & beans), Organic (all) and Fiber (all) at the 90+% level is the goal; fermented foods recommended
23. If overweight, eat cooked vegetables and vegetable soups before any and all else whenever hungry, even breakfast (no potatoes, sweet potatoes, yams, plantain, yucca, jicama or calabaza)
24. In general, only eat out of a bowl
25. My healthiest patients are vegan (no eggs, fish, fowl, dairy, or meat)
26. Learn about Aerobic and High Intensity Interval Training

27. Smoking is best dealt with by a combination of support and medication including Chantix, Wellbutrin (bupropion), cytisine and the nicotine patch/inhaler/gum
28. Limit alcohol to 4 six ounce glasses of red wine (or beer or whiskey equivalent) per week or less
29. Accept and deal with reality: wishing, wanting and hoping are like alcohol, only safe in small doses
30. If you have high blood pressure, purchase an Omron wrist blood pressure cuff; have it validated at your doctor's office; check your blood pressure variously before, after, and in between meals
31. Many conditions are vastly improved with 100% avoidance of ALL wheat (rye), dairy, and soy.

Key to abbreviations listed:

1. NON-HDL CHOLESTEROL is measured in milligrams per deciliter. 2. Triglycerides are measured in milligrams per deciliter. 3. Lp (a) is lipoprotein (a) and is measured in nanomole per liter. 4. Homocysteine is measured in micromole per liter. 5. A1C is measured as a percent. 6. Blood sugar (glucose) is measured in milligrams per deciliter. 7. Cardiac HS CRP is defined as cardiac highly sensitive C reactive protein and is measured in milligrams per deciliter. 8. Blood pressure is measured in millimeters of mercury. 9. Uric acid is measured in milligrams per deciliter. 10. BUN is blood urea nitrogen, and is measured in milligrams per deciliter. 11. Magnesium is measured in milligrams per deciliter. 12. Potassium is measured in milliequivalents per deciliter. 13. 25 hydroxy (OH) vitamin D3 is measured in nanograms per milliliter. 14. PSA is prostate specific antigen and is measured in nanograms per deciliter. 15. TSH is thyroid stimulating hormone and is measured in milli international units per deciliter. 16. Hemoglobin is measured in grams per deciliter. 17. CLOD/D is defined as clear lines of definition and demarcation. It is when abdominal muscles can be seen to meet the abdominal muscles because of the absence of fat beneath the skin. 18. G-V-B means grains-vegetables-beans. 19. Aerobic Interval Training is very aggressive and high intensity, shorter duration exercise training of which two examples are Al Sears, MD's PACE (Progressively Accelerating Cardiopulmonary Exercise) program and the Blitz Power Workout exercise program of which there are several varieties found in a Google search.

The patient is advised of these goals, and a lifestyle program is promptly begun at the first office visit, based on the tenets outlined in Table 2. It is stated at this point to the patient that this is what we believe is biologically correct for the human body, regardless of where our current civilization has brought us to. People have developed the ability to choose counterproductive, more enjoyable choices, which become disease and cost-generating. The "why, how to, and why most don't" is explained in further detail from the education packet, at the

PMC's extensive website,²¹ and in the author's (HRS) book²² and cooking DVD²³.

Patients with significant elevations of these values may promptly be prescribed medications to reduce risk, especially with regard to significantly elevated cholesterol, blood pressure, or blood glucose. Relevant medications may also be prescribed if patients have ceased taking medications that had been previously prescribed by other physicians. Whatever the case, it is made clear what the ultimate goals are, and that achieving these goals offers a reasonable probability of freeing the patient from the risk of disease, the need to take medications, and have procedures or frequent follow-up visits. This is the foundation of "Abolitionist Medicine," in which the patient is educated and urged to participate as an equal partner.

Sometimes patients quickly or partially begin to follow these recommendations, but often medications are required to reach these disease-preventing goal numbers. Weight loss medicines are virtually never used.

Dietary Recommendations:

Various diets have been recommended to the public for disease mitigation: Mediterranean, DASH (Dietary Approaches to Stop Hypertension)²⁴, low carbohydrate with high protein, and low fat with high carbohydrate, and high fruit and vegetable intake. Amid all the confusion, the first proper question is "what is the proper diet for this human body/biology, which has no fangs or claws cannot safely digest carrion and has a carbohydrate (vegetarian- and fiber-containing foods) digesting enzyme in the salivary glands? Is the human body, to be biologically true to its makeup, designed to consume an (ideally) organic, fresh, whole, and unprocessed, perhaps low-heat cooked, predominantly carbohydrate and therefore vegetarian diet? Or should humans eat a somewhat higher protein diet, a much more flesh-inclusive one (made up of fish/fowl/meat/dairy/eggs) and/or refined and processed foods?"

Anatomists state that the human biology is vastly and predominantly herbivore (vegetarian), likely at the 90+% level (NB: we do not imply or believe that being 100% vegetarian is essential for freedom from diet-induced disease, although that is a fine goal for many reasons). "Vegetarian" is defined as consuming only "plant-originated, fiber-containing" foods. Thus, humans should consume a diet, or as referred to and recommended by the PMC, a Liv-it of unprocessed grains-vegetables-beans (termed GVB) with fruits-nuts-seeds and fermented foods. While it is a scientifically limited personal testimonial (HRS), the PMC's healthiest patients are vegan vegetarian, who also tend to be thinner, exercise more, do not drink much alcohol, and do not smoke.

All patients are advised to have more whole and unprocessed fiber, especially cooked vegetables (in our experience, raw foods stimulate appetite), along with less animal protein and processed foods. It is explained that this approach is a grain-vegetable-bean (GVB) dominance of about 19 out of 21 meals per week, and that this is correct for the human biology, as well as for relieving risk and diseases, in the vast majority.

We recommend that, optionally, two of the 21 meals per week can include palm-sized servings ("your palm for you, my palm for me") of wild game such as Alaskan (but not farm-raised Atlantic or Norwegian) salmon, grouper, flounder, or snapper, i.e., any wild-caught fish, but not farm-raised tilapia, catfish, or most trout. Also acceptable are free-range chicken, cage-free eggs, or bison, according to the needs and tolerance of the human biology. This optional animal protein consumption is acceptable if the patient wishes such and is trim; having abdominal clear lines of definition and demarcation (CLOD/D as described above). This appearance is essentially the absence of fat beneath the abdominal wall skin, which is 11-22% body fat for men and 15-25% body fat for women, and the patient is athletically conditioned.

Discussion:

Imagine what the effect on the frequency of diseases and costs for most stroke, dialysis, heart failure hospitalizations, the relevant pharmaceutical prescriptions, and office visits would be if hypertension due to overweight, alcohol consumption, and the currently high sodium/salt intake were brought into line with those of other cultures where these risk factors and/or behaviors that pathologically elevate blood pressure do not

occur. "In societies where no salt is eaten, or at least the salt intake is so low that it cannot (easily) be measured (e.g., the Tarahumara Indian tribe of northern Mexico), BP does not rise with age and remains about 90/60"²⁵ throughout life and into old age. Such a nationwide BP would abolish nearly, if not all, of the care and spending necessary for the treatment of hypertension and its related complications.

NOTHING is 100% prohibited, but the implications of the patient's choices are supportively made clear: this is "an invitation to consider..." and all are "free to choose." This program does not promise 100% success, but maturity leads us to find our successes where we can, and to assiduously continue to work on the need to improve the results, being guided by the numbers on Table 2 and the above insights. Aside from small random events, education precedes effective action and change. The path to achieving these goals naturally begins with education and continues with appropriate medication and surgery, if necessary. Such near abolition of disease and costs is a real possibility if readers take the application of these ideas and goals seriously.

How did hamburgers, pizza, steak, potato chips, ice cream, French fries, eating in restaurants, colas, macaroni and cheese, collard greens cooked with salt pork or ham hocks or smoked turkey wings, pecan and sweet potato pies, and fried (or even baked) chicken become so popular?

The answer is clear (to us): those foods activate or "turn on" (according to the phraseology of Timothy O'Leary, PhD., of LSD notoriety: "tune in, turn on, and drop out")²⁶ endocannabinoid, mu, dopamine and probably other pleasure-generating and repeat reward-seeking receptors. And these foods, in turn, end up raising human cholesterol, triglycerides, blood pressure, and so on, that cause weight gain and related risk factors, and ultimately generate the common diseases of concern. Giving the endocannabinoid (marijuana) blocker rimonabant, or the mu receptor antagonist naltrexone, causes people to lose interest in food and begin to lose weight.^{27,28} As a personal insight, the foods that are correct for this human biology do not "turn [us] on" and we are less drawn to repeatedly consuming these healthier foods.²¹

Before too many statistical arguments erupt concerning this article, readers are encouraged to see the online report, "Million Women Study

Wrong, Group Says,”²⁹ reviewing the remarkable thought processes of the University of Cape Town’s Samuel Shapiro, PhD, et al regarding the possible causal link of hormone therapy to the subsequent development of breast cancer in postmenopausal women so treated. That article states that the “generally accepted principles of causality: time order, information and detection bias, confounding, statistical stability, duration-response, internal and external consistency, and biologic plausibility [were] lacking in nearly all categories” in the Million Women study. Shapiro did NOT take a pro or con position about hormones being carcinogenic in that setting. He merely pointed out the incorrect data-gathering and interpretation in that study concerning that concept.

Such powerful criticism can and should undoubtedly be laid against much of what is now called “evidence-based medicine.”⁶ Our effort has been to sift through what seems to be the best information that can be garnered from the medical literature as well as what has proven effective for disease prevention⁷ in making our recommendations. This seems more reasonable than citing a litany of references, and is how we justify the recommended values as laid out in the “PMC Wellness Protecting and Disease Preventing Goal Numbers” of Table 2. The goal should be evidence-based medicine. Scientific anarchy is not acceptable, but there is far too much naïve data-gathering⁸ passed off as valid science, based on improperly performed studies that fail in Shapiro’s most cogent critique.

The current rise in disease frequency, severity, related disabilities, and costs recall the prophetic

Shakespearean quote in Hamlet: “Diseases desperate grown by desperate means are relieved or not at all.”³⁰ If physicians widely comprehended a difficult truth – that virtually all of the diseases with which we are familiar, with few exceptions, are due to the choices that people or groups make – and if they conveyed this to patients with humility, it could catalyze a great opportunity. We would see a shift from expensive and invasive diagnosis and treatment toward disease- and cost-reducing medicine, as just defined.

Conclusion:

This article states that accepting and practicing these guidelines by individuals, groups, and even on a broader scale will largely free the public from developing diseases, along with the disabilities and costs associated with those diseases. This freedom from costs will extend beyond individual patients to taxpayers, governments, and the healthcare and health insurance industries. This is the best and most effective solution to the current and difficult healthcare and cost crisis. What is needed to make such an outcome a reality is a change in the thinking of both physicians and patients, which is the equivalent of recent political revolts and regime changes. As President Obama said on July 22, 2009, “Americans are going to have to give up things that don’t make them healthier.” He has repeatedly implied that to achieve important solutions to critical problems, one should use entirely original approaches ... such as this one of Real Preventive Medicine. This is not a sales pitch; it is information about what is offered to patients, the essentials and majority of which are provided free of charge. Perseverance is everything.

References

1. Tsao CW, Aday AW, Almarzooq ZI, et al. Heart Disease and Stroke Statistics-2022 Update: A Report From the American Heart Association. *Circulation*. Jan 26 2022;CIR0000000000001052. doi:10.1161/CIR.0000000000001052
2. Cheng A, Braunstein JB, Dennison C, Nass C, Blumenthal RS. Reducing global risk for cardiovascular disease: using lifestyle changes and pharmacotherapy. *Clin Cardiol*. May 2002;25(5):205-12. doi:10.1002/clc.4950250503
3. Andersson C, Naylor M, Tsao CW, Levy D, Vasan RS. Framingham Heart Study: JACC Focus Seminar, 1/8. *J Am Coll Cardiol*. Jun 1 2021;77(21):2680-2692. doi:10.1016/j.jacc.2021.01.059
4. Farhud DD. Impact of Lifestyle on Health. *Iran J Public Health*. Nov 2015;44(11):1442-4.
5. Nyberg ST, Singh-Manoux A, Pentti J, et al. Association of Healthy Lifestyle With Years Lived Without Major Chronic Diseases. *JAMA Intern Med*. May 1 2020;180(5):760-768. doi:10.1001/jamainternmed.2020.0618
6. Thomas JA, 2nd, Gerber L, Banez LL, et al. Prostate cancer risk in men with baseline history of coronary artery disease: results from the REDUCE Study. *Cancer Epidemiol Biomarkers Prev*. Apr 2012;21(4):576-81. doi:10.1158/1055-9965.EPI-11-1017
7. NHE Fact Sheet.
8. Musich S, Klemes A, Kubica MA, Wang S, Hawkins K. Personalized preventive care reduces healthcare expenditures among Medicare Advantage beneficiaries. *Am J Manag Care*. Aug 2014;20(8):613-20.
9. Steven B. Cohen P. The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2009-2010. 2012;
10. Charchar FJ, Bloomer LD, Barnes TA, et al. Inheritance of coronary artery disease in men: an analysis of the role of the Y chromosome. *Lancet*. Mar 10 2012;379(9819):915-922. doi:10.1016/S0140-6736(11)61453-0
11. Miller VM. Family matters: sexual dimorphism in cardiovascular disease. *Lancet*. Mar 10 2012;379(9819):873-875. doi:10.1016/S0140-6736(12)60200-1
12. West R. Tobacco smoking: Health impact, prevalence, correlates and interventions. *Psychol Health*. Aug 2017;32(8):1018-1036. doi:10.1080/08870446.2017.1325890
13. Baron JA. Beneficial effects of nicotine and cigarette smoking: the real, the possible and the spurious. *Br Med Bull*. Jan 1996;52(1):58-73. doi:10.1093/oxfordjournals.bmb.a011533
14. Burkitt DP. Some diseases characteristic of modern western civilization. A possible common causative factor. *Clin Radiol*. Jul 1973;24(3):271-80. doi:10.1016/s0009-9260(73)80037-6
15. Eaton SB, Konner M, Shostak M. Stone agers in the fast lane: chronic degenerative diseases in evolutionary perspective. *Am J Med*. Apr 1988;84(4):739-49. doi:10.1016/0002-9343(88)90113-1
16. Ornish D, Brown SE, Scherwitz LW, et al. Can lifestyle changes reverse coronary heart disease? The Lifestyle Heart Trial. *Lancet*. Jul 21 1990;336(8708):129-33. doi:10.1016/0140-6736(90)91656-u
17. Bernard SA, Gray TW, Buist MD, et al. Treatment of comatose survivors of out-of-hospital cardiac arrest with induced hypothermia. *N Engl J Med*. Feb 21 2002;346(8):557-63. doi:10.1056/NEJMoa003289
18. Atherosclerosis: its cause and its prevention. *Am J Cardiol*. Dec 1 2006;98(11):1550-5. doi:10.1016/j.amjcard.2006.10.005
19. Silverstein HR. Preventing heart disease. *The Lancet*. 1990;doi:10.1016/0140-6736(90)90319-Z
20. Berry JD, Dyer A, Cai X, et al. Lifetime risks of cardiovascular disease. *N Engl J Med*. Jan 26 2012;366(4):321-9. doi:10.1056/NEJMoa1012848
21. Preventive Medicine Center. Hartford.
22. HR S. Maximum Healing. Berkeley, CA; North Atlantic Books 2010.
23. Silverstein H. DVD: Putting it all together.
24. Filippou CD, Tsioufis CP, Thomopoulos CG, et al. Dietary Approaches to Stop Hypertension (DASH) Diet and Blood Pressure Reduction in Adults with and without Hypertension: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *Adv Nutr*. Sep 1 2020;11(5):1150-1160. doi:10.1093/advances/nmaa041
25. Roberts WC. Systemic hypertension: some observations. *Am J Cardiol*. Dec 1 2005;96(11):1610-1. doi:10.1016/j.amjcard.2005.09.004
26. Inside The Strange Journey Of Tim Leary, From Harvard Professor To 'The High Priest Of LSD'. 2022;
27. Isoldi KK, Aronne LJ. The challenge of treating obesity: the endocannabinoid system as a potential target. *J Am Diet Assoc*. May 2008;108(5):823-31. doi:10.1016/j.jada.2008.02.019

28. van Bronswijk H, Dubois EA, Pijl H, Cohen AF. [New drugs; rimonabant]. *Ned Tijdschr Geneeskd*. Nov 24 2007;151(47):2620-2. Nieuwe geneesmiddelen; rimonabant.

29. Million Women Study Wrong, Group Says. <https://www.medpagetoday.com/endocrinology/menopause/30698>.

30. Hamlet. SW. Act 4, Scene 3, lines 9-11.

¹ Silverstein HR. National Cholesterol Education Program Adult Treatment Panel III Guidelines and the Abolition of Symptomatic Coronary Artery Disease. *Am J Cardiol* 2003;91(5):654.

² Silverstein HR. Preventing Heart Disease. *Lancet* 1990;335(8683):227.

³ "We must prevent..." Sniderman AD. *JACC* 2008;52(4):300-301.

⁴ Boekholdt SM, et al., *JAMA* 2012: 1302-1309.

⁵ Matthijs Boekholdt S, Arsenault BJ, Mora S, et al. Association of LDL cholesterol, non-HDL cholesterol, and apolipoprotein B levels with risk of cardiovascular events among patients treated with statins: a meta-analysis. *JAMA* 2012;307(12):1302-1314.

⁶ Ghali J. – other references too, but only Silverstein can remember what they are. 😊

⁷ Silverstein HR. National Cholesterol Education Program Adult Treatment Panel III Guidelines and the Abolition of Symptomatic Coronary Artery Disease. *Am J Cardiol* 2003; 91(5): 654.

⁸ Personal communication from J.T. Guy, M.D., 2011 ...will the editors of the *Am J Cardiol* allow this?