Sympathy for the Devils

The Stones left out one category of people synonymous with the devil—doctors, not all, just most. Twelve alleged followers of the Hippocratic Oath sent me on a cruise of horror crossing the river Styx. Hopefully, things will improve once I reach the other side.

For a handful of years, I was having difficulty breathing at night while trying to sleep. My primary care physician ("PCP"), Mark Gorny at Mt. Sinai West, referred me to an Ear, Nose and Throat ("ENT") specialist. The specialist diagnosed a deviated septum, probably from numerous hits to the nose while playing rugby decades earlier. The doctor was pushy to do an operation. He said, "You should get it done before you get any older, or I get older and my hands start shaking," as he demonstrated shaking his hand with a grin. I declined.

Gorny then prescribed a steroid nasal spray called fluticasone propionate and over-the-counter decongestants. Both provided enough relief for a decent night's sleep, which is crucial for any attorney. Gorny also referred me to another Mt. Sinai ENT doctor. This one had a CT sinus scan done, but he couldn't find anything in the scan that might be causing my difficulty breathing while trying to sleep, so he referred me for allergy tests. The allergy tests were negative. That's when I started doing my own medical research. This wasn't exactly rocket science, but three Mt. Sinai doctors couldn't figure out the problem. It took me about three hours to accurately diagnose the condition—turbinate hypertrophy, or so I thought.

Turbinates are parts of the nasal passages. They warm, moisturize and filter the air before it reaches the lungs. But when they become enlarged (hypertrophy) as a result of too much blood flowing into them, they block the nasal passages causing difficulty breathing. In my situation, standing was not a problem because gravity apparently prevented too much blood flowing into the turbinates. Lying down was a different story because blood then accumulated in the turbinates. The cause was simple—old age. As my former boxing trainer from Gleason's and Wall Street Boxing said, "Once you hit 70, nothing works anymore."

Armed with my diagnosis, Gorny referred me to another ENT doctor who confirmed the problem and operated to reduce the size of the turbinates in October 2016. After the operation, the difficulty breathing while sleeping or just lying down was gone, so I thought it a success, for a while. Clinical studies showed that my respite might last a couple of years or only months—it was impossible to predict. Over time, downsized turbinates tend to start enlarging again and might even grow back. If the condition returned, nasal sprays and decongestants could be effective in relieving breathing difficulties, but ultimately another operation would be needed.

Around April 2017, some difficulty in breathing returned at night while trying to sleep. So in June, I visited Gorny. It often takes weeks to see Gorny unless it's an emergency. Gorny told me to resume using the fluticasone spray. Saw Gorny three more times over 2017 and into 2018, in part, concerning the difficulty breathing that fluctuated in intensity and frequency. He continued to advise using fluticasone and decongestants, which sometimes helped and sometimes didn't.

By August 2018, the difficulty breathing had reached a point that for three hours or more a night, I could barely breathe at all through my nose and was unable to sleep during that time. I called for an appointment with Gorny, but the earliest available was October 10, 2018. I told the appointment person, "That's nearly two months off! Doctor Gorny is usually able to fit me in when it's important and this is important." Sorry he said, "That's the earliest we have." Sounded as though Gorny's office was turning into the VA.

At the October appointment with Gorny, he told me to continue using the fluticasone spray every day. As far as examining the anatomy of my breathing, he would leave that to my ENT whom I was visiting later that day. This was the ENT who had performed the turbinate surgery.

At the ENT's office, while examining my right nasal cavity, he said in surprise, "What's that brown mass?" Oh great, I thought. On further examination, he concluded, "It's a polyp growing in your nasal cavity that's blocking your breathing. It wasn't there when I did the turbinate operation." My thought was "polyp" is a nice word for tumor. I knew then I was dead, sooner than planned. He sent me for a CT sinus scan and did a biopsy. Cancer, but not just any form of cancer, the most virulent and fast spreading one—melanoma. In six weeks, it can doom a patient.

Melanoma usually attacks the skin because of ultra violet rays from the sun. My melanoma, however, never saw the sun. It was known as mucosal melanoma because it grew in the mucous membranes inside the body. It was rare, usually attacked older persons like me, an additional benefit of the "Golden Years," and its cause was unknown.

Mother Nature, as females usually do, tricked me. After the turbinate surgery restored my breathing, she apparently started a melanoma tumor growing in my nasal cavity that mimicked the same symptoms as turbinate hypertrophy. Naturally, like any male-fool, I assumed that the old problem was back and dealt with it the way Gorny suggested.

My ENT referred my to a couple of oncology surgeons who also took my medical insurance—AARP Medicare Complete Mosaic by UnitedHealthcare (more on that later). I also contacted Gorny's office requesting a referral to a specialist in mucosal melanoma, but never heard back from him. All of this was a nice stressful addition since it occurred in the middle of preparing for oral argument in a federal case before a lazy and incompetent Latina judge appointed by Obama. But what really annoyed me was the time consumed to deal with this doom. I had things to do to balance the accounts, but time was now rapidly running out.

I saw the two oncology surgeon's recommended by my ENT, but like an idiot, I didn't go with the one my instinct told me to because he wasn't a Mt. Sinai doctor. That alone should have made me choose him. I stupidly thought it would be more convenient to stick with Mt. Sinai doctors since all my doctors were with Mt. Sinai. In addition, because a couple of them were really good, I thought the odds were that the oncologists would also be good. Boy was that a mistake.

On November 6, 2018, the Mt. Sinai oncology surgeon, Alfred Iloreta, advised a treatment plan where he would do a full operation to try and take out all the cancer providing it had not spread to other parts of my body. If it had spread, then a more limited operation to temporarily restore breathing to allow me to sleep so as to maintain my "quality of life" for a period of time. In every meeting with every doctor or nurse, I told them, "I'm <u>not</u> looking for survivability but functionality so that I can get done what I have to do. Longevity has its place, but not for me at this point in life. A year maybe two will do just fine, providing I can still function as a lawyer, do wind-sprints and attend my boxing class." Boxing had become a gift from the gods I didn't want to give up.

Iloreta's treatment plan also included radiation therapy after the operation. His plan made sense, so we agreed to an MRI of the sinus area, which would specify the location of the tumor for an operation, and a full-body PET scan, which would look for cancer in other parts of my body. Iloreta's office scheduled the tests with the earliest possible operation for November 15th or at the latest December 6th. Iloreta stressed the importance of having an operation sooner rather then later because melanoma was an aggressive form of cancer that usually spread quickly. Because of my age, Iloreta needed a pre-screening physical exam by a doctor to determine the odds of my body reacting negatively to the surgery. Gorny did the pre-screening on November 7th and concluded my body healthy enough for the operation. The MRI and PET scans were completed on November 8th.

Iloreta also referred me to a medical oncologist, Dr. Philip Friedlander, and a radiation oncologist, Dr. Sonam Sharma. When a patient has a cancerous tumor, hospitals often require these three kinds of specialists to agree on treatment along with a tumor board.

Dr. Friedlander was apparently a world renowned big-shot to whom other doctors at Mt. Sinai deferred. Friedlander's Mt. Sinai biography states his

> clinical interests include the development of targeted therapies and immunotherapies for patients with melanoma. As a member of the Division of Hematology/Medical Oncology and as the Director of the Melanoma Medical Oncology Program at Mt. Sinai, he handles patients with cutaneous malignancies and works to develop collaborative translational and basic science projects and treatments for patients with cutaneous malignancies.

Entering Friedlander's office on November 12th, there was no indication it was a bait and switch operation.

"Bait 'n' switch" is when a merchant represents he has one item or service for sale, but when you show up, that item or service magically disappears and is replaced by one you don't want or costs too much. Friedlander made his money and furthered his medical career by treating patients with melanoma using immunotherapy. It's the modern-day horror of chemotherapy all over again. Chemotherapy targets and tries to kill oncogenes, which are mutated normal genes that cause cells to multiply rapidly and haphazardly—cancer. Immunotherapy, however, targets a person's immune system by putting it in high gear so it will attack and destroy the cancer cells. The problem is that the immune system on "speed" may also go after the lungs, heart, liver, eyes and so on with a litany of horrors. Immunotherapy had a success rate of 30% to 50% for melanoma—skin melanoma, not mucosal melanoma. The statistics for its side effects, regardless of what it was used for, were nowhere to be found, at least by me. The drug companies clearly kept such statistics on side-effects, but probably locked them away in their vaults. Not unlike the cigarette companies of old.

Another problem was that as with chemotherapy, immunotherapy is just a hit and miss approach. The drug companies find or invent expensive drugs but can't tell whether they will work unless the doctors sucker patients into being guinea pigs. If the drug doesn't work—meaning the patient dies or suffers to the end—then they move on to another drug and another patient. As of this writing, the drug companies had around 600 different immunotherapy poisons to test.

The chemicals of choice for Friedlander's snake-oil remedy were Opdivo and Yervoy manufactured by Bristol-Myers Squibb for metastatic melanoma. A month's treatment would gross Bristol-Myers $45,000 to $75,000. Friedlander made laudatory statements to the press about these alleged wonder-drugs, conducted clinical trials and published articles while his patients went through misery. In turn, Friedlander benefited financially—he owned stock in Bristol-Myers and other major drug companies pushing immunotherapy. He undoubtedly also received hefty speaker fees in the tradition of Bill Clinton to tout their effectiveness and sucker patients into taking these poisons. The drug companies most likely also paid for business trips complete with hotel, bar and perhaps carnal knowledge.

At first, Friedlander outwardly agreed with my surgeon's plan to do a full operation providing the cancer had not spread, and, if it had, a limited operation to restore breathing followed by radiation. Friedlander also added immunotherapy after the radiation if the cancer had spread. Friedlander reviewed the PET scan and said it showed “lesions” in my sternum and lower back that may indicate cancer. A “lesion” can be almost any abnormal change involving any tissue or organ due to disease or injury.

I responded, “Those lesions are most likely old or even recent sports injuries. I’ve cracked ribs a few times playing rugby, took more than a few hits to the sternum from martial arts and boxing. As for the lower back, one rugby game pushed the vertebrae you’re talking about out of alignment. Currently, I’m being treated for it at Mt. Sinai’s Spinal Center, which gives me steroid injections to mitigate the pain. Before I went there, I had to use crutches when I got up in the morning to get to the bathroom. Once the blood started flowing, I could make it to the law library or court.”

Friedlander replied, “It is unlikely that the melanoma has spread that far from the nasal cavity, but let’s be sure with two focused MRIs, one on the sternum and one on the lower back.” He scheduled the two additional MRIs for November 15th, which meant the earliest possible operation by Iloreta went out the window. That didn’t seem to be a problem at the time, since the later date of December 6th was still set for the operation, and the pre-screening done by Gorny was still good because December 6th was within 30 days of the pre-screening. Pre-screening for an operation has a shelf-life of only 30 days. Additionally, the oral argument in the federal court was set for December 4th, so a December 6th operation fit Iloreta’s and my schedules.

The following day at my appointment with Sharma, the radiation oncologist, she repeated Iloreta’s advice that an operation soon was crucial and that December 6th should be soon enough. She said that radiation treatment after the operation would last about three weeks. She clearly believed that either a full-blown or limited surgery would occur by December 6th. She listed the side effects of radiation, and, as with other doctors, I emphasized that my interest was not to maximize my existence but maintain my functionality for one, maybe two years, since I had things to do.

The second appointment with Friedlander was on November 19th. Friedlander said both the sternum and lower back MRIs also showed lesions as did the PET scan but a conclusion could not be made that they were cancerous. Once again, I told him they were probably old or even recent sports injuries and about the treatment provided by the Mt. Sinai Spinal Center to my lower back. To which Friedlander sharply responded, “I want you to stay away from steroids.” Oh yeah, as my lawyer state of mind took hold. Was this doctor telling me to go back to using crutches when I awoke in the morning to get to the bathroom?

Friedlander then advised doing a biopsy of the sternum and lower back to confirm whether the lesions were cancerous. If they were, he said “full-body” immunotherapy would be needed without any surgery or radiation. That wasn’t part of the original treatment plan.

Friedlander continued, “Even if the biopsies are negative for cancer, full-body treatment is still necessary. The biopsies that are done use a needle and take only a small section of each area, so they might miss the cancer.” For emphasis, he made a downward motion with his right hand holding an imaginary needle. So, heads he wins and tails he wins. That made no sense.

When doing biopsies, a doctor takes samples from different areas to decrease the chance of missing any cancer. Also, earlier Friedlander said the lesions on the sternum were the size of a finger nail. When I was a kid, I could hit that at 20 paces with my .22 rifle. Further, why do biopsies at all if the results didn’t matter. Something stunk here, but I did agreed to a brain MRI for the following day. As for the biopsies and immunotherapy, I tentatively agreed to them until I had time to analyze Friedlander’s actions and figure out his game.

At home I researched the side effects of these two drugs, Opdivo and Yervoy, used in combination. My research made clear that after spending over 50 years keeping my body in shape, I was not about to allow some doctor to pump poisons into it. My primary objective was not survival but to stay functional long enough to wrap-up my affairs. As a former weight-lifting champion in Florida once said, “Cancer knocks you down, but chemo [now immuno] finishes you off.” I wasn’t going that route. It was my car and I was the one holding the keys.

At about 5:45 pm November 20th, a couple of hours after the brain MRI, Friedlander calls to say that it showed a mild stroke in the occipital lobe (extreme back of the head). He had compared this MRI with the November 8th MRI of the face and neck ordered by Iloreta and saw the difference. The November 8th MRI did not show a problem in the occipital lobe but the new MRI did. He added that the new MRI did not show any melanoma, but the stroke was dangerous. Friedlander claimed he had shown the MRI to a female neurologist who feared that this stroke might be the beginnings of a major problem—a “cascade” of strokes. According to Friedlander, she had advised that I immediately go to Mt. Sinai’s emergency room and see its Stroke Intervention Team. Friedlander went over a list of symptoms, asking me whether I had experienced any—to which I replied no for all of them. The urgency in his voice started me thinking that Friedlander has been running a con all along. He wraps his voice in the emotion of urgency to push you into doing what he wants in order to serve his interests.

“If I had a stroke it’s because of those unnecessarily, inconclusive tests you put me through,” I angrily replied. Apparently the intentional infliction of emotional distress and dissembling were drivers of his con to manipulate patients into submitting to immunotherapy.

At the ER, the neurologists’ team extensively questioned me and did physical ability, strength and sensitivity touching tests. One of the neurologist’s first name was Helen, Asian, young and pretty—she could touch me anywhere she wanted. ER did blood work, took an EKG and did a head CT scan. The neurologists wanted me to undergo an echocardiogram, but to do that, I would have to spend the night in the ER. Four hours in that zoo was enough. I chose to walk out. Before reaching the door, however, one female neurologist did her best to scare the bejesus out me by listing all the horrors that might occur at home. It was then that I realized some doctors rely on two tactics to manipulate their patients into serving the doctors' interests rather than the patients'—false hopes and fear.

After escaping the ER Cabinet of Dr. Caligari, I was sure Friedlander was running a scam. He had initially agreed with the plan of doing a full operation to remove the tumor or a limited one to restore breathing followed by radiation treatment—the bait. All the while, he intended to drag out the search for more cancer, which meant delay that increased the emotional stress so as to pressure me into becoming one of his experiments with immunotherapy. That was the switch. As a friend said, "He's trying to use you as a guinea pig."

Friedlander was not pursuing my interests but his interests. My cancer was a rare form, so there weren't that many human guinea pigs around on which to experiment. The immunotherapy would make him money, provide another test case for an academic journal article, use me to develop science projects and bogus treatments that furthered his career, and, most importantly, curry favor with Bristol-Myers to reward him for suckering another patient into taking its costly drugs. Since my functionality was on the line—I ran. Canceled the biopsies, the immuno and went looking elsewhere for treatment.

My search took me to an old buddy, an oncology doctor. We used to chase girls at NYC nightclubs. He said the traditional treatment for this type of cancer was to do surgery first than radiation and maybe immunotherapy. Even if the cancer had spread, an operation on the tumor often lessens the ongoing spread of the disease. He suggested Memorial Sloan Kettering, New York University's Perimutter Cancer Center and Manhattan Eye, Ear and Throat Hospital.

Gorny also suggested Sloan or NYU and questioned whether the November 8th face MRI actually showed the same part of the brain as the November 20th MRI. A neurologist subsequently confirmed that the November 8th scan could not be compared to the November 20th one. The reason was that the scans were like cameras that used different f-stops depending of what area they were trying to record. The minuscule stroke was in the back of the brain while the November 8th MRI focused on the face and neck. So Friedlander lied about the stroke occurring after the November 8th MRI. He knew that a stroke subsequent to my pre-screening on November 7th would prevent an operation on December 6th, and used that lie and his political clout to convince Iloreta and Sharma to defer treatment to him. At the very least, it would cause more delay—read emotional distress—because pre-screening would have to be done again. Had the operation occurred on December 6th, Friedlander would have lost a pristine, untouched subject on which to experiment. Friedlander even had his own facility for such experiments in Paramus, New Jersey. At least it wasn't located in Ingolstadt, Germany.

Sharma and Iloreta had parroted Friedlander's position. Sharma advised doing biopsies on the sternum and lower back but cautioned that biopsies only access a tiny area via the biopsy needle. So if the results came back negative, there was still the possibility of cancer being in those areas. Did Friedlander write this script for her? She suggested that after doing the biopsies to then discuss future treatment. Of course, that would occur after December 6th, the last possible day for an operation due to the pre-screening time limit. This young lady could talk water out of the desert.

Later that day, Friedlander's office contacted me by telephone. Sharma had obviously told Friedlander about our telephone call. He was now trying to see whether I was dumb enough to follow her suggestion, which would increase the stress of delay and give him another shot of making good on his con. The young lady from Friedlander's office wanted to know what I was going to do about treatment. My response was that I wanted another opinion. She said, "Our invitation is always open." Right, to be a poisoned guinea pig serving Friedlander's interests and Bristol-Myers' profits.

Iloreta had a somewhat different interpretation from Sharma on the tests. He said that the PET scan showed a chance the cancer had spread. He also looked at the MRIs of the lower back and sternum that showed indications of lesions but saw nothing conclusive that the melanoma had spread. He suggested doing a biopsy and if negative then do a second biopsy. With two biopsies both negative, he was willing to do an operation attacking just the nasal cavity. But if either was positive, there would be no operation even to restore breathing as we had originally agreed. Friedlander had gotten to him.

Even with both biopsies negative, any operation had to be approved by the Mt. Sinai Tumor Board. Friedlander appeared to have sufficient political pull to veto any operation backed-up by his lie about a post-November 8th stroke, which indicated an increased risk of any operation. My time was running out. I didn't like those odds, so Sloan became my next place to request help.

At Sloan, a pleasant young lady answered the "New Patients" number. Gorny had never gotten back to me with a specific doctor's name. She asked a number of questions and I gave her my insurance information. She said they would need the written reports of all the tests Mt. Sinai had performed—two Cat scans, one PET scan and four MRIs. That's where another of

Friedlander's tricks on imprisoning his patients occurred. This guy was really turning into my number one enemy.

Mt. Sinai has its own intranet system that allows patients to view the written test results and a separate system that allows doctors to view both the written and imagining results. Friedlander delayed in putting on the patient system the test results for the three MRIs that he had ordered: sternum, back and brain. The doctor's system had them but to access that, I needed to be in a Mt. Sinai doctor's office. So why the delay? Friedlander knew that any other hospital or cancer center would first want all the written reports of the tests before referring me to any of its physicians. Any delay in obtaining the reports would increase the stress of my condition worsening, which it most definitely would and did given melanoma's virulent nature. Friedlander was still playing a delay game. He knew my stress would escalate knowing that the longer without treatment decreased the chances of any possible cure or temporary cure and would continue condemning me to a few hours of sleep a night due to the breathing blockage. He was still hoping such would drive me to the desperation of immunotherapy.

Since Friedlander's written test reports were on the doctor's system, I made a long put-off appointment with my orthopedist. At his office, his assistant printed out the missing reports. Armed with all the reports, I dropped them off at Sloan's office. At first the Sloan lady wanted me to fax them because Sloan did not have an office. That seemed strange. It surely was not a fly-by-night operation. She relented, however, and gave me an address on First Avenue to drop them off. She warned that there was no sign to indicate Sloan had a presence there and instructed me to push the doorbell for the seventh floor, someone would buzz me in. I was to go to the eighth floor desk of a particular female who would put me in a room and get the Sloan lady to whom I would give the documents in that room. Must be a CIA operation.

That done, Sloan then needed the imaginings from the tests. Friedlander had no control over that, so it only took a day to obtain the CDs. Sloan, now having all the test results, a sincerely nice and competent nurse made appointments for me with two Sloan doctors, a surgeon and a medical oncologist.

At a little after 4 pm on the day before the appointments, this nasty sounding young lady from Sloan's Finance Department calls.

"We don't accept your insurance. If you want to go ahead with tomorrow's appointments it will cost you $1,000 for each."

"What are you talking about? I already went through the insurance approval."

"Who gave you the approval?" I told her the lady at the New Patients number.

"Hold on, I'll try to call her."

(Holding on)

"She's not in today."

Sounded convenient to which I responded, "So you waited until late afternoon on the day before the appointments to call and tell me this. Why didn't you call sooner?"

No answer, just more of $1,000 per appointment. Was this a shake down?

"I'm dying of cancer and you pull this stunt. Why don't you just send me a six shooter to blow my brains out?"

Her tone changed, and she actually tried to help. She explained that switching my insurance wouldn't work because the enrollment period had closed five days earlier—December 7th. Was there suppose to be irony in that? Friedlander's delaying con kept coming back to haunt me. The same insurance problem surfaced at NYU—AARP Medicare Complete, which wasn’t as complete as the name implies, was not accepted there either. I always knew there was a reason for not liking AARP besides its socialist propaganda.

The Sloan finance lady did help by getting out-of-network authorizations from my AARP Medicare insurance. But all that took time—more delay, and the authorizations came through too late to make appointments in 2018, thanks to Christmas. I knew there was a reason for not liking that holiday.

The AARP authorizations only covered one-time appointments. For ongoing coverage at Sloan, NYU or elsewhere a different insurance plan was needed. This threw me into the Medicare insurance morass. I’m a relatively bright guy with two graduate degrees with honors, but figuring out which insurance might still be available and which doctors it covered approximated the denseness of Leibniz’s modal metaphysics. How could those Federal and State bureaucratic idiots make something so complicated?

Since it was too late to change plans, another option was needed, but time kept ticking away as the most virulent form of cancer continued to march toward my brain. I felt like an infected earthling in the movie Alien.

A couple of friends helped steer my doomed existence to the only insurance possibility. Cancel my current insurance, which would throw me back into traditional Medicare A & B and buy a Medicare Supplement plan to pick up the remaining 20% of Part B along with the Part A deductible. The problem was that none of this coverage would take effect until January 1, 2019, and I would lose my prescription plan, but there was no choice.

Friedlander’s intentional manipulations at imprisoning his hoped for human guinea pig kept on ticking. Whenever a doctor sees a patient he writes up a “consultation report.” It summarizes the patient’s condition and treatment plan. My oncology buddy told me to request that the consultation notes from all three Mt. Sinai doctors be faxed to him. The surgeon and radiotherapist did so the next day because that is what N.Y. Public Health Law § 17 requires. As for Friedlander, he just ignored it.

Another of his tricks was that he and his staff never left any voicemail messages. Clearly out of fear that someone would use those party opponent statements against him in court to prove his pathological malfeasance and lying.

By now, any inkling of hope of a cure or temporary cure went out the window. Friedlander had boxed me into a corner from which there was no escape—do what he wanted or die sooner rather than later because of the delay he intentionally caused. Just before Christmas, I chose to die sooner—seemed a fitting present for that time of year.

Friedlander, cancer's ally and the drug companies' shill, had caused a delay in treatment for at least two months. Time was running out, but I started researching possible lawsuits such as medical malpractice, negligent misrepresentation, fraud and intentional infliction of emotional distress against Friedlander. After talking with a couple of lawyers who did malpractice work, both declined to take the case. That left me with bringing my own case. The problem was I wouldn't be around long enough. Such a case would take a few years just in the trial court, and, of course, Friedlander's lawyer would delay, delay and delay until I dropped dead. So instead, I filed a complaint with the Office of Professional Medical Conduct at the N.Y. State Department of Health and sent a copy to Mt. Sinai's CEO. Mt. Sinai did nothing, other than send me a PR letter from its "Director of Service Excellence." The Department of Health, however, started an investigation.

After going through numerous doctor appointments, medical tests pumping radioactivity and other drugs into me while being inundated with radiation, and the continuing lack of sleep, it became clear that my law practice was over. The problem is that you think about the illness all the time, trying to figure out your next move. For me, my mind had always been preoccupied with my cases, now they were just an afterthought.

On the medical side, since Mt. Sinai was the place were people go to suffer undo death, I started looking for any surgeon not connected with Mt. Sinai who would remove at least some of the tumor allowing me a near normal sleep that would enable me to wrap-up my affairs.

Looking for a little escape from these horrors, my oncology buddy and I planned to hit a nightclub in Queens on New Year's Eve 2018. That New Year's Eve turned out different from all the others over all the years. The tumor decided to start bleeding, sending blood flowing out my right nostril. Dripping blood like a vampire who had just supped wouldn't exactly go over well with the girls, so I canceled.

In 2019, my insurance apparently changed. Apparently because no one at UnitedHeathcare or Medicare were able to give consistent answers. The answers always changed with the person. A friend said he once went to a seminar addressed by the head of Medicare for New York who admitted that not even he knew all the ins and outs of the program.

My first appointment in January 2019 was with the surgeon that Sloan had assigned me. He wasn't the one I requested, but Sloan's administration, similar to Obamacare, assigns you a doctor. Take it or leave it. The surgeon was also a medical oncologist like Friedlander and had reviewed the records provided to Sloan.

After the introductions, I said, "Given my situation and the uncertainty of whether the cancer has spread, it's necessary for me to arrange my cases so that they can be handed-off to other attorneys. To do this, I need to be functional—meaning capable of acting as a lawyer until the cases are transferred. The tumor in the right nasal cavity is blocking any breathing through it. That inability to breathe now allows me only 3 to 4 hours of sleep a night because of my alternative breathing pattern. Such sleep deprivation is negatively impacting my functioning as a lawyer, putting my affairs in order, and maintaining a semblance of quality of life, such as physical activity. What I need first off is a palliative operation to restore at least temporarily my breathing." (My oncology pal told me to use that word, "palliative." In the law, we use mitigate.)

The Sloan surgeon said, "I understand your objective, but we as physicians also have an objective not to do something that does not cure the disease."

To which I thought, "It's my life not yours, so my objective takes precedence." This guy was looking like another Friedlander who just wanted a lab rat.

The surgeon continued, "Immunotherapy will treat the whole body for any other cancer that may have spread. It can shrink the tumor and offers the best chance of extending a patient's life." This was his "false promise" tactic that duplicitously left out "quality of life."

I countered, "There's no reliable statistics on immunotherapy shrinking a tumor. It may, it may not, and no studies show the time it might take even if it does actually shrink a tumor. All the evidence is anecdotal."

This surgeon/medical oncologist then resorted to the other manipulation that many cancer doctors use to make a patient do what serves the doctor's interests as opposed to the patient's—fear.

"An operation could show that there is leakage from the brain, which will make it a major operation with siginifcant risks—possible loss of sight, impairment of the brain or injury to nerves."

"I'll take the risk," thinking he didn't go into the risks of immunotherapy because that was what he wanted to do.

I then asked two questions: "If I don't have medical treatment, how long will I live?" His face registered shock. Apparently, he's accustomed to patients so desperate to live that they accept his statements as gospel.

"I have no way of knowing."

My second question brought home the point that I was about to walk out. "How will I know I am near the end by not having any medical treatment?" He mentioned a few consequences of which I already knew.

Having undercut his smug arrogance by making him realize I was not about to blindly follow his dictates, I offered him a deal.

"Do the palliative operation to restore my quality of life, at least temporarily, and I will consent to any experimental procedure you want." Of course I had my fingers crossed behind my back. I might or might not go with the immunotherapy. It depended on whether I had accomplished the things I wanted to do before embarking for Dante's Eighth circle. Realizing he would lose this human guinea pig with a rare form of cancer, he steps out to call Sloan's medical oncologist to whom I had also been assigned. After the call, he agreed and arranged for me to see that medical oncologist right away. Apparently at Sloan as at Mt. Sinai, the medical oncologist is the boss.

The medical oncologist was considerate and agreed to the palliative operation. She also knew Friedlander and said my melanoma was at stage four. How did she know that without biopsies—more fear tactics.

The next day brought me to NYU's cancer center to meet with a very considerate nurse and doctor. The manipulation, however, consisted of anecdotal examples of miraculous recoveries from immunotherapy alone. "It reduced or eliminated patients' tumors while destroying cancer in other parts of their bodies." NYU's treatment plan for me was once again playing craps with immunotherapy to eliminate the tumor and destroy the cancer allegedly in other parts of my body. No one knew whether the cancer had spread, although thanks to Friedlander, by now, it probably had.

So far, three medical oncologists from three different reputable hospitals all pushed the same Bristol-Myers drugs. Could all three be on that company's payroll, either directly or indirectly? Friedlander was—he owned stock in Bristol-Myers and other major drug companies pushing immunotherapy drugs. Or was it just the trendy new miracle cure touted by a profession dependent on drug company grants.

Until now, I had always thought that doctors were supposed to relieve suffering, not prolong it to serve their material and research interests. Yet three reputable medical institutions, Mt. Sinai, Sloan Kettering and NYU Langone didn't give a damn about what suffering I was going through. All they cared about was conning another human being into being a lab-rat for the latest trendy unproven cancer treatment for my type of melanoma. The cancer profession was reminding me of used car salesmen.

There was one more oncology surgeon to try. The one my instinct told me to go with at the beginning but didn't. He was sharp, understood my position and agreed that a patient's quality of life was crucial. His nurse was competent, nice and an attractive blonde—too bad I wasn't younger. They functioned the way I remembered doctors and nurses used to—focusing on the patient's problems rather than viewing a patient as just another brick in the wall of their careers and bank accounts. So I went with their treatment plan and canceled the Sloan operation. Why have a surgeon operate on me who didn't want to do the operation. Also politely told NYU thanks but no thanks.

Before the operation, the surgeon referred me to a medical oncologist at Columbia Presbyterian. Just the title "medical oncologist" gave me trepidation after my prior experiences with these specialists, so I was once again ready to walk. This oncologist at least appeared to be the opposite of the other three. Friedlander was a con artist, and both Sloan and NYU wanted to do immunotherapy first and have me wait to see whether it actually shrunk the tumor regardless of the impact the side effects would have on my life. The Columbia doctor understood the need for me to get enough sleep to put my cases in shape for another attorney and maintain a semblance of whatever quality of life remained. He also said there were a number of different drugs used in immunotherapy, not just Bristol-Myers' Opdivo and Yervoy, which depended on the patient's condition, but we would talk about that after the operation.

The surgeon scheduled the operation. Then, just days before surgery, pre-screening demanded a doctor's note (sounded like grammar school) that my body was in good enough shape to undergo the operation after Friedlander's delaying con discovered a miniscule stroke from some unknown time. Gorny, my PCP, was the logical choice. He had been my doctor for 19 years, treated numerous injuries from old boys' rugby games, martial arts, hip-hop and a few fist fights. He clearly knew my physical condition better than anyone. In addition, he earlier told me that the stroke would not impact an operation on the tumor. So what does this Mt. Sinai doctor do? He refuses to provide clearance for the operation the day before surgery—unbelievable. As a result the operation is put off—more delay.

What's with these Mt. Sinai doctors? Freudian slips began sneaking into my conversations with medical personnel substituting Mount St. Helens for Mount Sinai. The actions of that con artist Friedlander just kept-on plaguing me.

Since that miniscule stroke may have been caused by a blood clot from the heart or an artery leading to the brain, the surgeon's nurse, not one to waste time, arranged an appointment with a cardiologist for the next day, the day the surgery would have occurred but for Gorny. The cardiologist was sharp and knew her stuff.

I explained Friedlander's delay of inconclusive tests that prevented an operation.

"He was basically just trying to use me as a . . . ," and simultaneously we both said "guinea pig." She knew the ways of doctors like Friedlander.

She also highly recommended my current surgeon as someone who had operated successfully on a couple of her relatives.

Armed with my echo cardiogram and other information, she used a program to estimate the chances that my physical shape couldn't handle the operation. It was 0.9% that there would be a problem. Gorny, who also had access to my echo cardiogram since he ordered it, should invest in such a program.

The January 22, 2019, operation was on again but almost off again due to a Lennox Hill Hospital latina employee in admissions who spoke an English I never heard before, and who didn't understand how things work in America. She refused to accept my NYS Court ID as proof that my last name was "Den Hollander" and not "Hollander" as the DMV had recorded. Latinas usually have four or five words in their names; she should have understood. Her immediate boss, however, was an American steeped in our ways and concluded that if they changed my name in their records to match my DMV license, then insurance would not pay. Ah, the power of the buck.

Everybody else was very competent and considerate, and the operation went off without a hitch. Afterwards, my surgeon said he couldn't understand why no one else would operate and added that he couldn't imagine the suffering I had gone through. Since my first appointment with Dr. Friedlander two months earlier, the tumor had grown 270%. Melanoma cancer cells still remained because a radical operation in my head at that time would have turned me into what my high school Spanish teacher used to call me—a vegetable. Radiation would be needed to deal with the remaining melanoma cells. The question of course is could it all have been removed back when Iloreta first wanted to operate, November 15, 2018?

The Columbia medical oncologist recommended a radiation doctor, Horia Vulpe, with whom he worked. On my first visit, Vulpe explained the procedure and the initial preparation for it. He was young, Romanian, and seemed to be a decent guy interested in helping his patients. He added that the radiation shouldn't start until a month after the operation. Meanwhile, he had to present my case to Columbia University's Tumor Board. The board meets monthly at the Columbia University Medical Center. It is made up of skull base tumor experts that determine the "optimal treatment" for individual patients. According to Columbia, "the tumor board is able to make patient-centered decisions that are less biased by a particular provider's personal experience or specialty." Terrific, now a committee was making decisions about my life.

On my second visit, a month after the operation and arranging my life for weeks of radiation, five days a week, and fully expecting to begin the medical preparation for it—everything changed. Vulpe was no longer gun-ho to get moving with the treatment, but said he wanted to do more testing to find out whether the melanoma had spread and tried to push me into doing—you guessed it—Opdivo and Yervoy. Here we go again, I thought—*déjà vu* Dr. Friedlander. Vulpe also seemed in a rush to get through the visit. Was something going on again behind the scenes to manipulate me into doing this immunotherapy? Was Columbia just another sell-out cancer institution acting as a front for drug company experiments and patient exploitation that transferred insurance dollars into drug company pockets, and, of course, Columbia's pockets by way of a *quid pro quo* arrangement? Then again, maybe Vulpe and Friedlander were in cahoots. Vulpe knew about Friedlander because he had asked about my Mt. Sinai experience, which I told him. But a conspiracy between these two—that seemed far-fetched.

The first test ordered by Vulpe was the proverbial PET scan. The MRIs were scheduled for two weeks later. The problem with the MRIs was that Vulpe's office scheduled them all for one session lasting three hours. At the MRI unit at Columbia Presbyterian, the technician said, "This is too much for one person at once. We're not going to do all these MRIs in one sitting. The body just can't take it." So they did an hour and a half for the face and neck MRIs and scheduled me for another session a week later. The face and neck MRIs were necessary for Vulpe to start radiation treatment while the next session would focus on whether the cancer had spread.

The following week, the MRI technician told me that only the back would be scanned.

"What about the sternum?" I asked.

She answered, "It's just going to be your back from below the neck to the bottom. There's no sternum or chest MRI ordered."

That was strange. Why didn't Vulpe also order an MRI of the sternum? Dr. Friedlander had emphasized that Mt. Sinai's PET scan showed "nail size lesions in the sternum." Then again, given his pathological conning, maybe not so strange. Friedlander had relied more on the fear tactic of cancer spreading to the sternum than my lower back because I had a great explanation with rugby for the lower back lesions not being cancer—at least four months ago. By now—who knew.

MRIs show whether there is a mass of tissue in the body where one does not belong. It may or may not be cancer. PET scans on the other hand claim to indicate the presence of cancer but are notoriously inaccurate. They use a measurement called "standardized uptake value" or SUV to indicate whether an area might, I repeat might, be cancerous. They should really call it SVU. They inject you with a radioactive substance, usually sugar from the Alamogordo Dessert. The PET measures how much radioactivity was absorbed in an area compared to the rest of the body. An SUV above 2.5 may indicate cancer. However, there are a lot of problems with this measurement, not the least of which are false-positives indicating cancer, but after the patient dies, an autopsy shows no cancer. Also, an SUV above 2.5 can result from infection, inflammation, autoimmune processes, sarcoidosis, benign tumors or injuries. In my case, Friedlander's Mt. Sinai PET reported 4.7 for the sternum, 4.6 for the lower back and 11 for the nasal cavity, which everyone already knew was cancer. The Columbia PET was 4.0 for the sternum and 4.6 for the lower back and the nasal cavity was 6.6 absent the tumor. Given the fast spreading, virulent nature of melanoma and the intervening four months, I would have expected higher readings from the Columbia PET than the Mt. Sinai PET, assuming both were actually measuring cancer. Unless, of course, Friedlander had falsified the Mt. Sinai findings at the time, but now—thanks to his intentional delays—the Columbia tests might accurately show melanoma.

Still, no matter what a PET or MRI shows, the only way to confirm cancer is with a biopsy.

Vulpe said he wanted biopsies of the sternum and lower back. The scheduling office for Columbia called me about the upcoming biopsies.

“You’re biopsies are scheduled for 8:30 am this coming Tuesday,” the young lady from the scheduling unit told me on the Friday morning, the weekend before the biopsies.

“How do you know I don’t have to be in court that day? Aren’t you supposed to work out your scheduling with the patient?”

“Well, it’s set for Tuesday, but before the biopsies you need to have blood tests done.”

“And where do I get the tests done before Tuesday?”

“You can do the tests here. Also you need an escort home after the biopsies because you’ll be given sedation.”

“Friday, before an operation for Tuesday morning, I’m supposed to find an escort. People I know work, they can’t just drop everything on a moment’s notice. What if I can’t come up with someone—do I try an escort service?”

“Then we’ll have to cut back on the sedation and it will be more uncomfortable.”

“You mean it will be more painful.”

“Yes.” These medical people always use “uncomfortable” to mean pain.

“Let me get back to you if I can find an escort.”

Needless to say, I couldn’t find an escort on such short notice; a friend was willing to do it later in the same week of the scheduled biopsies. So I called the scheduling office back but had a real hard time getting through. Someone picked up the phone a couple of times but didn't say anything. I waited and waited, "Hello, hello." Nothing. When I finally got a live but moronic person in scheduling on the phone, she immediately transferred me somewhere without even letting me explain the reason for my call. The person to whom I was transferred, who was naturally in the wrong department, transferred me back. Eventually I got through on the following Monday, but the incompetents in Columbia's scheduling office arranged for the blood tests on Tuesday, so the biopsies were off.

After the blood tests, I never heard back from Columbia's scheduling office, so I called Vulpe's office—twice. No one who was alive ever answered that phone. So my messages went to voicemail asking when the biopsies would be and when Vulpe would start my radiation treatment. After all, the reason for seeing him was radiation treatment—not another Mt. Sinai run-around.

Called Vulpe's office a third time, but still no living person answered, so I left another useless voicemail. None of these delays made any sense. Radiation treatment should have started February 22nd, now it was the end of March, and every minute melanoma was most likely spreading. So I went looking for another radiation oncologist by calling my surgeon's nurse navigator to complain about Vulpe's delays and asking for a recommendation for another radiation oncologist. My surgeon had previously been a power at Columbia before moving over to Manhattan Eye, Ear and Throat Hospital. A couple of days later, Vulpe called me to arrange for a CT scan needed as preparation to start the radiation treatment. Nothing like knowing influential people.

At my third visit with Vulpe for the CT scan, I made clear to him that my functionality was primary—not longevity, and that I was <u>not</u> doing immunotherapy.

"We'll deal with that later," he said. "Right now, you need to reschedule the biopsies."

I said, "After my experience with Columbia's scheduling office, I'm not doing it."

"Alright, try the front desk or one of the nurses to schedule it."

A nurse in the CT scan section decided to dare the gauntlet of idiots and the brain dead in scheduling to arrange for the biopsies. After much delay and her clear frustration over the telephone, she managed to set-up the biopsies.

Columbia's Interventional Radiology Division handled biopsies—a group of competent and considerate medical professionals.

The doctor said, "We're just going to biopsy your sternum."

"What about the lower back," I said after lying face down on the table.

He replied, "If we don't find what we're looking for in the sternum, then we'll try the lower back." So I turned over.

To which I thought, and if there's nothing in the lower back, what's next, my knees, then my feet—where does it end? Conspiracy theories whirled in my head thanks to the experience with Friedlander. Was all of this part of Columbia's Tumor Board and Vulpe's strategy of delay to stress me into relenting to immunotherapy that would make money for Columbia and the drug companies? Had I escaped one bait & switch to fall into another in which the bait was radiation therapy, which likely would eliminate some or all of the cancer in my head, and the switch was again immunotherapy? The tumor operation was January 22nd, so radiation should have started February 22nd. Vulpe's additional testing and his less than efficient office had delayed the treatment, which was now set to start on April 1—were the fates mocking me? The prospect of more biopsies and the accompanying delays made me decide that if radiation didn't start the first week in April, then I was walking. I'd try to find a radiation oncologist who would start treatment immediately, but if I couldn't, then I'd do without.

That contingency plan didn't happen. The biopsy found what Columbia and Vulpe wanted to find—melanoma in my sternum. Was the melanoma there five months ago when Mt. Sinai did its PET scan, or had it spread thanks to Friedlander's scam and Vulpe's delay? No way to know, but logic says it had spread. So, Friedlander essentially committed second degree murder on me out of greed and Vulpe's unnecessary delay made him an accomplice.

The biopsy report stated "Metastatic Melanoma," and later on in the report that I was a prime candidate—guinea pig—for immunotherapy using the same two chemicals Dr. Friedlander, Sloan Kettering, NYU Langone and Vulpe had pushed—Bristol-Meyers' Opdivo and Yervoy—the proverbial "bad penny." That was never going to happen, which I made clear to Vulpe.

What were the odds that four different institutions would push the same two chemicals to treat my mucosal melanoma? Especially, when there were no reliable statistics or dedicated clinical trials on the effectiveness of those chemicals for mucosal melanoma. The reason there were none is that those two chemicals were used to treat skin melanoma—that's not the melanoma I have, which is genetically different. The only logical conclusion is that each and every institution, except for the one where my surgeon was a boss, wanted to use me as a lab-rat to see if those two poisons worked on mucosal melanoma. Were all the delays meant to give melanoma time to spread so that the only treatment left was immunotherapy—you decide.

Now, if they had offered me 50% of what Bristol-Meyers would make by pumping those poisons into me, good chance I would have agreed. After all, by now my life was over. Why not use the money for hitting strip clubs, like the good old days in Russia. But no, they had to try conning me. So was delay the full-extent of Columbia's con? Vulpe kept bringing up combining radiation with immunotherapy to be administered by the Columbia medical oncologist, but I kept telling him no way. After radiation, I would find my own way into oblivion.

Three weeks of radiation was not exactly pleasant, although the technicians, nurses and the front desk were great. I couldn't see how they did it. Everyday, one doomed patient after another, but they kept a smile on their faces and a perkiness that lifted even my nihilistic attitude. I actually looked forward to seeing them, maybe because they laughed at my jokes. Amazing that going for radiation, which made the inside of my mouth feel like I had been chewing on a cactus, was something to anticipate. The world still produces, now and then, human beings.

Vulpe, on the other hand, was a different story. The worst part of radiation was Vulpe's failure to give me some instructions during it. As a result, seven days into the radiation, the right side of my tongue felt like it had been sliced and diced. I—not Vulpe—came up with the idea to mitigate further damage to my tongue, which had nothing to do with the cancer—keep it lying flat and off to the left assuring it was out of the way of the radiation. Worse, there were medical techniques to protect the tongue from radiation, such as a mouth piece with a tongue depressor or medications used to coat the tongue. Vulpe didn't use any of them on me, didn't tell me about any of them, and didn't warn me about what could happen to my tongue. Why?

When I visited my surgeon after the end of radiation and showed him the injury to my tongue, he got angry. Asked me for Vulpe's telephone number, which I gave him. I didn't witness the call, but I'm sure he bawled out Vulpe. The location of the injury made no sense. The cancer was in the right nasal cavity—not the mouth or the tongue.

So, was Vulpe an East European incompetent? At first, I thought yes—on three occasions he prescribed pain medicine to deal with the tongue, but when I showed at the pharmacy—no prescription. I had to remind him all three times to send the prescription to the pharmacy. Then, however, I looked more closely on what transpired when the tongue pain started. Vulpe initially prescribed a topical mouthwash that was useless beyond 15 minutes of using it. He then prescribed a bottle of morphine, which made me sick, and replaced that with a bottle of oxycodone.

Oxycodone was no stranger. After the turbinate operation, I took it in pill form—one in the morning and one in the evening. It relieves pain alright, but the real danger is that it makes reality look great. When I awoke in the middle of the night craving another pill—something that never occurred during my druggie days in college—I threw the remaining bottle of 40 pills in the garbage. No way, I'd ever try that stuff again.

My conclusion is that Vulpe intended to slice and dice my tongue so that I'd end up on either morphine or oxycodone, taken every four hours, which would turn me into a malleable patient lacking in critical thinking or a desire for the truth about what he and Columbia were scheming. His con didn't work. But ten weeks of near constant pain, much of it sever, from the tongue injury, which required eating only baby food, oatmeal, applesauce, yogurt and macaroni and cheese, made me curse this monster from the show Supernatural. Even talking was painful, which is what lawyers do a lot.

Vulpe was one smooth operator who would have sold a lot of used cars if he had chosen that profession. At our last meeting, most likely assuming I was stoned on oxycodone, he even tried to convince me to continue with radiation by him to the lower back, and, of course to start immunotherapy.

“How do you know my lower back even has a cancerous tumor?” I asked.

“It’s there,” he said in a voice of over-confidence of the con-artist.

Now it was clear why he didn’t have a lower back biopsy done. If a biopsy had been done and was negative, then there was no chance of getting me to agree to lower back radiation. Of course, if it was positive, then I’d have to do radiation, but since I was still clear headed—it wouldn’t be with him.

Thinking me stoned on oxycodone, Vulpe’s greed pushed for more radiation by resorting to one of the two psychological methods so often used by oncologists—the fear tactic. In response to my questions, he actually estimated how much life I had left without more radiation and by implication immunotherapy—six months. That was a surprise—not the six months, but that no other oncologist, other than my pal, would even make an estimate.

It was an obvious trick I had been expecting—low balling. But even if he was right, I didn’t care, since it gave time to do that which I intended. Vulpe, however, was trickier than that.

He emphasized that without the lower back radiation and immunotherapy, the cancer would likely paralyze me—making my legs useless. “The moment you feel any tingling in your legs, come see me immediately, so we can prevent any paralysis.”

This guy was as good as any girl I ever dated at manipulation. First he obtained the information on my life-style in the disguise of preserving my “quality of life.” He knew that nearly everyday I had to travel on my legs to the law library or court. He knew that once a week I ran wind sprints on my legs and attended boxing class on my legs. He also knew I was being treated by a spinal institute for age related problems and the old rugby injury that misaligned one of my lower vertebras and hurt nearly everyday. One of the symptoms the spinal institute told me to watch out for was "tingling in my legs," which Vulpe knew. So he mixed that all up into a fear tactic meant to manipulate me—assuming I was stoned on the oxycodone he prescribed—into doing what made him and Columbia money: more radiation and immunotherapy. None of the other oncologists I saw ever raised a paralysis issue.

To replace Vulpe as my radiation oncologist, I moved over to an excellent and pretty one at Sloan who was recommended by my friend. No way I'd ever see Vulpe again unless it was in court.

Vulpe's radiation had ended on a Friday and the following Monday the office of the Columbia medical oncologist who does immunotherapy called to make an appointment for me. Coincidence—I doubt it. More likely, these two hatched the con to get me on morphine or oxycodone so as to make me amendable to immunotherapy and more radiation.

Both Friedlander and Vulpe played with my life in order to make money and further their hospitals' *quid pro quo* relationships with the drug companies. They didn't give a damn about me.

This end of life experience taught me that a deadly conformity of belief has infected the cancer profession. Most doctors buy into the hype of immunotherapy as a cure-all. There is a systemic conspiracy among cancer institutions and the drug companies. Both make lots of money and gain fame pushing today's alleged magic bullet for cancer. It's always been the same old scam with most cancer doctors, institutions and medical companies. Create an illusion that medicine has finally discovered the cure for cancer, sell it to the public and everybody involved makes a lot of money while the patients die miserably—often from the new-improved bogus treatments. In the past, there were radical mastectomies, anti-viral drugs, chemotherapy and now immunotherapy. If you want to find out the truth about any alleged cancer miracle, ask the technicians—not the doctors—who work at these institutions.

The neurology profession didn’t appear to be much better—exploit the patients with multiple tests to meet the medical “test or perish” requirement (similar to academia’s publish or perish rule).

To deal with the non-symptom, miniscule stroke, I visited a neurologist at NYU’s stroke center before Vulpe’s “slice-n-dice” radiation started. The center had a good reputation and was just 20 blocks up First Avenue from my apartment. She was cute, always a plus, and Asian, so at the upper end of the bell curve. She showed me my brain MRI and pointed out the small area where a blood vessel had burst. Strokes happen when clots build up in a blood vessel that block the flow, so the vessel bursts. Twenty years ago, the technology wouldn’t even have found it because it was so small.

She asked about any symptoms.

“No, no head aches outside of the usual for lawyers, no numbness, no black outs—I haven’t drunk that much in years.” I answered.

“Are you physically active?”

“Once a week, I do wind-sprints, and once a week I take a boxing class. I don’t spare, just train the way boxers do—heavy bag, pads, double under bag, and exercises.” Looking back, I wish I had kept my mouth shut, but I thought she needed to know and would be impressed. Guys always spill the beans trying to impress good looking babes.

She replied, “The first thing we need to do is determine the cause of this stroke. There are two possibilities: cancer, because it causes the blood to thicken, which increases the chance of a clot in the brain . . .”

That made sense, since the cardiologist had told me the same thing.

“. . . or you’re doing too much physical activity for someone your age.”

That made no sense, and my suspicion antenna went off.

“When people around your age exercise too much, their hearts may become arrhythmic. Some beats come too quickly causing an increase in pressure that causes a blood clot to break off and travel to the brain causing a stroke. In order to determine whether you have arrhythmia, we need to monitor your heart for a month.”

“I’m not stopping the wind-sprints and definitely not stopping boxing.”

“You can continue with your usual activities, but you’ll be wearing a patch on your chest that sends a signal to a monitor that records the rate of your heart beats.”

I went along with this tentatively, and she referred me to another neurologist who handles patch monitoring—talk about specialization.

The second neurologist provided the patch and a cell phone that picked up the signals from the patch on my chest and sent them to—where else—a computer. The second neurologist also added that the cause of the stroke might be a hole in my heart, and that I should undergo a special test for such. I almost laughed in his face. I’ve been playing sports since I was kid—never did anything like a hole in my heart come up. One of my girl friends had been born with one, but that’s the closet I ever got. This neurologist was just another doctor pushing unnecessary tests to make more money or comply with the test or perish rule in the medical profession.

The following day, I put the patch on just above my heart. Next day, did my wind-sprints—guess who called? The monitoring company, which I ignored. Two days later the monitoring neurologist called.

“Sunday your heart rate went up well over 100, what was going on?”

“As I told you and the other NYU neurologist, I do wind-sprints. That’s what wind-sprints do.”

“Did you ever have a stress test?”

“Sure years ago.”

“You should come in for a stress test.”

“I’ll deal with that later.”

This guy was really pushing my patience. One of the purposes of wind-sprints and boxing is to keep your heart in shape. I do wind-sprints and because my heart rate goes up, he wants a stress test—no way. All this neurologist was doing was adding to my stress by implying something was wrong when it wasn’t. Like Friedlander, he hoped I’d relent just to relieve the anxiety he intentionally caused by doing whatever stupid thing he wanted because it would make him money and he’d look good to the hospital administrators. No way!

To prepare for the then upcoming radiation treatment, Vulpe needed a three dimensional map of my head to highlight the melanoma, which meant a specialized CT scan. That required taking the monitoring patch off. According to the NYU neurologists, it could be taken off and then put back on at any time. So off it went, did the CT prep scan and back on it went. Later that night the monitoring cell phone starts beating. It was not receiving signals from the patch. I called the monitoring company, twice—do this, it didn’t work, so now “we’ll trouble shoot.” Then I realized. Strokes are caused by stress, and this test involving a computer not doing what it was supposed to was causing plenty of stress. Not only was I fighting doctors using fear tactics to manipulate me into taking unnecessary, time consuming tests and unproven drugs, but I was also now fighting another computer. I had enough computers in my life to fight—I canceled the test, terminated the "test or perish" neurologist and kissed (unfortunately not literally) the Asian neurologist goodbye.

All of these medical shenanigans made me realize that often when an older patient visits a doctor, the doctor jumps for the Medicare money by exploiting the patient. Through false hopes and fear tactics, the doctor manipulates the patient into numerous useless tests, multiple visits and unproven treatments while suckering the patient into becoming the doctor's latest guinea-pig. The patient goes through hell, stupidly believing the doctor is trying to help him rather than con him.

No girl ever jerked me around as much as the medical profession. Shakespeare obviously mistakenly wrote in Henry VI, "The first thing we do, let's kill all the lawyers." He must have meant "doctors." Sure some lawyers will rob you, but plenty of doctors will torture, exploit and even kill you.