A Word to My Profession: Converting to a Starch-based Diet Medical Practice

On the day of my graduation from my Internal Medicine Residency at the University of Hawaii in 1978 I had a memorable conversation with my boss, Irwin Schatz, MD, the medical director of my residency program. He said, "John, I like you and your family. But, I am concerned that you will starve to death with your crazy ideas about food. All you will collect for patients is a bunch of bums and hippies." My response was, "So be it. Then I will starve, because I cannot prescribe drugs and surgeries that I know will do my patients more harm than good." More importantly, I think that what Dr. Schatz was really trying to tell me was that I was going to fail financially because I was not playing by the traditional rules set by years of economic pressures for a successful medical practice.

The way general doctors make a secure living is to collect a bunch (herd, flock, school, etc.) of patients and get them hooked on medications for blood pressure, diabetes, cholesterol, pain, etc., which require that they return for a refill every one to three months. By keeping the customer coming back again and again, each visit results in an office charge of $80 to $170. Making people healthy and free from medications would appear to be economic suicide for any medical doctor.

I departed Dr. Schatz's office with these stinging words for him: "I believe you are wrong. My practice will be made up of successful people who have made great sacrifices to get an education, build businesses, and develop successful family and community relationships. These people will say to themselves, 'Look at me, and all that I have achieved. Why then, if I am such a big success, am I so fat and sick? Why have I failed in my health, without which I have nothing?'" I continued with Dr. Schatz (who himself carried a prospering belly), "When these people ask this question, I will be there with a new set of rules that will allow them to be winners in their health, too." History shows that I was right and he was wrong. I am the luckiest doctor in the world. Not only do I make an adequate income (like most doctors do), but I also have the satisfaction of seeing my patients heal and stay healthy (like most doctors don't).

In order to spread the fun around, I am happy to share with my colleagues how to set up a successful general practice based on a starch-based diet. This practice has two major distinctions from the usual practice: doctors must now do a whole lot of un-prescribing of medications and a lot more of patient education.

Medication Facts (United States)

- Percent of persons using at least one prescription drug in the past month: 48%
- Percent of persons using three or more prescription drugs in the past month: 31%
- Percent of persons using five or more prescription drugs in the past month: 11%
- Percent of physician's office visits involving drug therapy: 74%
- Among children (under age 12), less than 10% used two or more prescription drugs in the past month.
- Among older Americans (aged 60 and over), more than 76% used two or more prescription drugs and 37% used five or more.
- Women were more likely to use prescription drugs than men.
- People with regular healthcare, medical insurance, and prescription benefits take more prescriptions.
- In the United States, spending for prescription drugs was $234.1 billion in 2008.
- Number of drugs ordered or provided during physician's office visits: 2.3 billion annually

Sick People Take Medications—Healthy People Do Not

Medical doctors have no trouble adding more drugs to our medicine cabinet or changing brands. Our formal education teaches us that drugs are the solution to most ailments; un-prescribing medications is unheard of. Doctors fear being criticized by their colleagues, and even more, they fear a malpractice lawsuit if something were to go wrong while making important adjustments toward fewer medications. Dying with a large bagful of drugs at the bedside is one accepted sign of a diligent and caring doctor, even when those efforts ultimately killed the patient.

My experience has been that most of the medications prescribed, even for fat, sick people, do no good, result in significant harms, and are overpriced. The scientific research that supports my observations is freely available to curious professionals and the general public at the National Library of Medicine (www.pubmed.gov). To avoid inappropriate conclusions, it also is important to recognize that there are some good, and a few "miracle," drugs, especially when they are used for acute conditions, such as when antibiotics are used for infections.

Overprescribing is universally seen in chronic conditions, such as elevated cholesterol, hypertension, type-2 diabetes, gastrointestinal distress, and arthritis. By great fortune these are the same chronic conditions that are most amenable to a healthy diet. Thus adding diet therapy to a doctor's practice substantially increases the likelihood that medications can and should be stopped. The healing effects of a starch-based diet enhance the potency of many medications by relieving their original purposes (high blood pressure, sugar, and cholesterol are all reduced by the diet). Without timely reductions in medications, serious harm can be done. A precipitous fall in blood pressure will cause hypotension with fainting and falling. Blood sugars forced down by too much insulin results in mind-numbing hypoglycemia. Once off the medication the body will quickly regulate itself. Any real needs for medication will be determined by observing the patient carefully during this adjustment period.

I have the luxury of closely observing the effects of any changes that I recommend. My interaction with patients begins with a history and physical examination. At that time most medications are stopped. Over the next seven days at my residential center in Santa Rosa, CA, blood pressures are taken, blood sugars are recorded if they are diabetic, and patients are weighed. With this constant overview, if I make an incorrect decision, then I can make new recommendations—daily or hourly when needed. Fortunately, only on rare occasions do I need to restart a medication or even start a new one.

Developing a Successful Practice

In 2006 I gave a lecture in Los Angeles to a group of scientists and medical doctors titled "How to Make as Much Money as a Bypass Surgeon and Still Feel Good about Yourself." I reason that rewards should come to honest doctors, too. Starting a live-in center like mine may not be a possibility for most physicians, but fortunately, in an office setting any doctor can make the transition to a starch-based diet practice with little sacrifice. I recommend that most physicians start out with a part time practice and gradually shift to seeing only patients interested in dietary change.

This is the model:

Step 1: The doctor continues his or her regular practice of seven-minute office visits. This keeps the cash flowing uninterrupted. These routine office visits will serve as the time and place to make the same kinds of medication adjustments that I make at my clinic. In this outpatient setting, patients will need to do their own monitoring at home (BP, sugars, weight, etc.). Timely reports will be made to the doctor (at the next office visit, or more frequently by phone or email). Based on this information, the doctor will recommend further adjustments in medications. New patients will begin with a full half-hour history and physical examination.

Step 2: Evening or weekend classes are set up for ongoing group education. During group meetings, patients learn the basic principals of the McDougall Diet. The McDougall website provides downloads, DVDs, and written materials for this education. Shopping trips to cookware stores, supermarkets, and health food stores, and restaurant excursions can be arranged. Cooking DVDs and/or live cooking demos are performed at meetings. Classes can be taught by the doctor, a dietitian, chefs, and by similarly talented instructors. I recommend that *The Starch Solution* book be used as the primary classroom textbook. *The McDougall Quick and Easy Cookbook* would be a helpful addition (at least offered as an option). The enthusiasm that develops among participants encourages everyone to adhere to the diet and improve their health.

Example Schedule for Out-patient Classes:

Meeting 1:
Main Talk: My Best Arguments for the Starch Solution
Cooking Demo: Segments from McDougall Made Easy DVD or live demo. Breakfast: Fantastic Overnight Oatmeal, Your Kids Will Love These Pancakes, and Fabulous French Toast

Meeting 2:
Main Talk: Science Behind the Maximum Weight Loss Program
Cooking Demo: Segments from McDougall Made Easy DVD or live demo. Sandwiches with Eggless Salad and Mexi Soup

Meeting 3:
Main Talk: Marketing Milk and Disease
Cooking Demo: Segments from McDougall Made Easy DVD or live demo. Dinner: Confetti Rice, Mashed Potatoes with Gravy, Bean Burritos, and Tofu Tacos.

Meeting 4:
Main Talk: When Friends Ask: Where Do You Get Your Protein?
Cooking Demo: Segments from McDougall Made Easy DVD or live demo. Desserts: Lemon and Chocolate Puddings.

Meeting 5:
Main Talk: Soy Is Food, Not A Poison or A Miracle Drug
Cooking Demo: Segments from McDougall Made Irresistible DVD or live demo. Breakfast: No Huevos Rancheros, Veggie Benedicts and Pumpkin Muffins

Meeting 6:
Main Talk: Save Money and Your Health – Don't Buy Vitamins (Except for One)
Cooking Demo: Segments from McDougall Made Irresistible DVD or live demo. Lunch: McVeggie Burgers, Falafels with Tahini and Hummus, Quinoa, Dal, Potato and Split Pea Soups

Meeting 7:
Main Talk: President Clinton—You Should Not Have Agreed to Heart Surgery
Cooking Demo: Segments from McDougall Made Irresistible DVD or live demo. Dinner: Baked Penne Florentine, Easy Mayan Black Beans, Creamy Pasta Primavera, Thai Green Curry Rice

Meeting 8:
Main Talk: Osteoporosis and the Broken Bone Businesses
Cooking Demo: Segments from McDougall Made Irresistible DVD or live demo. Dips and Sauces: Tofu Dips and Artichoke Spread, Walnut Sauce and Peanut Dressing. Desserts: Lemon and Chocolate Puddings

*All of these lectures are available free or at low cost in the McDougall online store as video downloads and DVDs. By including different lectures from my web site this schedule can be shortened, lengthened, changed, and/or improved.

Step 3: Developing a larger diet-oriented clientele may take a little effort. During office visits, by email communications, newspaper advertisements, or other promotions, patients learn about the opportunity of becoming well through better eating. As patients become trimmer, healthier and drug-free they will spread the word and others will join the medical practice of doctors who know how to make them well and medication-free.

Medication Changes I Usually Recommend:

How a patient feels about his/her medications is important: Many want off of them and others are afraid to stop them. The patient's expectations must be considered seriously when the physician makes a decision. If unsure of the need for continued use of a medication, it is generally better to stop or reduce it (maybe slowly) and to observe the response. Remember, sick people take medication and the goal of a starch-based diet medical practice it to have healthy patients who don't take medications, whenever

possible. The Hot Topics on my web site is filed with information on treating patients. See www.drmcdougall.com and use the "search" feature. Questions can also be emailed to me at drmcdougall@drmcdougall.com.

Hypertension:

Typically, I ask patients to stop all medications that are used to treat hypertension on the first day they start the diet. I may recommend a more gradual reduction if the patient's initial blood pressure in the office is very high (for example 170/110 mmHg or greater) or the patient is on several different brands of medications. Either finding suggests the patient is more severely ill. I also recommend gradual reduction for a class of medications called beta-blockers: I cut their dosage in half every three to five days. Beta-blockers "block" the effects of adrenaline on the heart, weakening this muscle (that's how they lower the pressure). Rapid withdrawal of this class of drugs can leave the heart very sensitive to the effects of adrenaline and rarely can result in a rapid heartbeat. This may be frightening, but seldom has important health consequences. If this symptom occurs (and it rarely does), then I ask the patient to take a small extra dose of their beta-blocker. This stops the fast heartbeat. Reductions in the beta-blocker are then resumed.

When medication is needed to lower BP, I like to use an inexpensive and time-honored medication called chlorthalidone. It is relatively safe and very effective at lowering numbers. A good blood pressure goal with medication is about 140/85 mmHg (and not lower). (Without medication the blood pressure ideally would be 110/70 mmHg or less.) I do not start or increase medications unless the blood pressure is 160/100 mmHg or greater, and expected to remain at those high levels for months. While making changes, blood pressure should be checked every morning at the patient's home and the results should be periodically relayed to the doctor. For more information see: http://www.drmcdougall.com/misc/2009nl/nov/bp.htm

Type-2 Diabetes:

Generally I stop all oral medications (pills) on the first day. If the patient is clearly type-2, I also stop all of his/her insulin on day one. Generally, the more overweight a person is, the more likely they have type-2 diabetes (a condition of insulin resistance, where generous amounts of insulin are produced by the body). Thin patients with elevated blood sugars are likely to be producing insufficient amounts of insulin and may need this hormone delivered as a medication at some point. If I am unsure about the patient's insulin needs (in other words, significant insulin insufficiency may exist), then I am more conservative and cut their insulin dosage by one-half to two-thirds the first day. Type-1 diabetics will always need to take insulin, however, I usually reduce their insulin dosage by one-third with the initiation of the diet.

A normal blood sugar level is 100 mg/dL or less, fasting in the morning without medications. In general, while on medication, my goal is to have the morning blood sugar for a diabetic at about 150 mg/dL. A lower goal will result in a greater likelihood of harmful hypoglycemia. Regardless of the blood sugar numbers, most people with type-2 diabetes lose weight faster and feel better without any medications. There are three reasons that I prescribe insulin for type-2 diabetes: If the patient loses too much body weight, develops symptoms of diabetes like excessive urination, or the patient worries about their blood sugar numbers.

Research on type-2 diabetics consistently shows aggressive treatment with medications causes an increase in complications, death, hypoglycemia, and weight gain. Low blood sugar (hypoglycemia) causes confusion and has resulted in death due to accidents. Under suspicion of drinking while driving, the police have arrested many diabetics over-treated with medication. In addition to the physical dangers, diabetics commonly have their lives destroyed by the acts of testing and treating. A blood sugar monitor becomes the center of attention for the diabetic and all those nearby.

When insulin is needed I try to use a regime of one to two shots a day, using long-lasting insulin (like Lantus). I err on the side of under-treating in order to avoid hypoglycemia. Blood sugars will be self-monitored daily and reported to the doctor as needed. For more information see: http://www.drmcdougall.com/misc/2009nl/dec/diabetes.htm

Cholesterol:

Taking statins can result in greatly reduced cholesterol numbers. If these medications (statins) are stopped the first day when a patient starts the diet, then he/she will often be disappointed if their cholesterol goes up on the next test. For this reason I often leave them on their current dosage until after the second blood test. Then after the second blood test, they can see the extra cholesterol-lowering benefits of their new diet, and I will stop these medications (especially in otherwise healthy people). However, if they are not healthy—they have a history of serious heart disease, stroke, or other artery disease—I will continue the statins with a goal of lowering their cholesterol number below 150 mg/dl. For more information see: http://www.drmcdougall.com/misc/2007nl/may/statins.htm

Coumadin (Warfarin):

Coumadin is an antivitamin K drug helpful for preventing blood clots in a few medical conditions, including atrial fibrillation. Vegetables are loaded with vitamin K and as a result, patients on Coumadin are usually told to avoid vegetables. But, vegetables are healthy. There is no real contradiction with proper treatment. When changing to a starch-based diet, the Coumadin dosage is simply adjusted in order to accomplish the desired blood thinning effects (based on periodic blood tests). Taking a little more Coumadin when needed is not a health hazard. In most cases, however, I find the change to a starch-based diet (high in vitamin K vegetables) requires no adjustment in dosage of Coumadin.

I also try to get patients with atrial fibrillation off of Coumadin. As with most conditions, many patients are over-treated. With this drug, the benefits for reducing stroke are small and the side effects (mainly bleeding), drug costs, and inconvenience (frequent blood tests) are great. The CHADS score is a helpful tool for deciding who should not be on these powerful blood-thinning drugs. (I have too little experience with the new drug Pradaxa to comment.)

Indigestion:

I usually stop the regular use of antacids on day one. I ask patients to take an antacid only as needed, and then to switch to the milder over-the-counter brands like Zantac or TUMS. I also instruct patients to raise the head of their bed using four-inch blocks. Gravity keeps the stomach acids out of the esophagus at night. Raw vegetables (onions, green peppers, cucumbers, radishes), fruit juices and hot sauces are foods on the McDougall Diet that commonly cause GI distress. Emphasize starches.

Laxatives:

Generally these can be stopped and used only as needed. However, it is not unusual for patients to have hard stools from their previous eating habits when they begin their new diet. A glass of prune juice will help the bowels empty. I will occasionally order a dose of Milk of Magnesia (MOM) to force stubborn movements.

Thyroid:

Generally I leave patients on their supplement of thyroid and adjust the dosage based on their TSH level. However, many patients on medication have a perfectly functioning thyroid gland and no need for supplementation. If in question, the only way to tell those who need medication from those who do not is to stop the thyroid supplement and recheck the TSH level in three to four weeks. Treat based on the results.

Antidepressants:

Generally, I do not change these. When patients do stop them, they are almost always unhappy with their decision after a few days. Patients wanting off antidepressants should stop them slowly. Lithium is a very effective medication for manic-depressive disorders. A low-salt diet reduces lithium excretion and may cause toxicity. Adjustments are made by lithium blood tests.

Pain:

I try to get patients to minimize their use of pain medications. In most cases the patient self-regulates the dosage with the goal of taking as little as possible. Aspirin is a highly effective, but almost forgotten, medication.

Dr. McDougall's Health and Medical Center
P.O. Box 14039, Santa Rosa, CA 95402
http://www.drmcdougall.com