WEALTH CREATION STRATEGIES

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"Talent is not character. Expertise is not wisdom. And credentials are not a guarantee of sound judgment."
— ChatGPT, interpreting my ideas

"The 'common good' of a collective—a race, a class, a state—was the claim and justification of every tyranny ever established over men."
— Howard Roark, The Fountainhead, by Ayn Rand

Your Health May Be Your Most Valuable Financial Asset

Why Questioning Medical Authorities, Experimenting, and Thinking Outside the Box Can Preserve Both Health and Wealth

I've spent more than four decades helping people create and preserve wealth. We discuss investments, real tax rates, retirement accounts, inflation, estate planning, and the enormous power of compounding.

But there's another factor that may be more important than any of these: your health.

What good is a $5 million retirement portfolio if you're too sick to enjoy it? And how much less wealth might you leave behind if chronic pain or disability forces you to stop working ten or twenty years before you otherwise would?

Medical expenses are only part of the cost of poor health. Lost income, lost productivity, lost investment opportunities, and diminished enjoyment of life can be far more expensive.

I have some rather unusual personal experiences that illustrate why I believe people should take far greater responsibility for their own health. They should question the advice of even the most respected medical authorities and be willing to investigate possibilities that conventional medicine and its practitioners may never contemplate.

I'm not suggesting that you abandon your doctors. Some of mine are extraordinary. I'm proposing that you stop treating them as gods.

The Eyes Have It—Despite the Experts

I was born with—or possibly developed following an early medical intervention, such as an early vaccine—strabismus, initially manifesting as crossed eyes.

Two surgeries around age two overcorrected the problem, leaving my eyes diverging rather than converging. The problem gradually worsened. By my early twenties, my eyes diverged markedly.

Imagine a nerd like me trying to get a date.

In my mid-twenties, I visited one of the world's premier ophthalmology centers, UCLA's Jules Stein Eye Institute. After extensive examinations, the ophthalmologist delivered the verdict: nothing could be done.

She tried to console me by suggesting that my unusual condition might improve my driving: I could watch the road with one eye while simultaneously checking the rearview mirror with the other.

LOL.

Nearly two decades passed. I married, divorced, and eventually returned to the dating world. A girlfriend who had undergone LASIK surgery wondered whether lasers might correct my strabismus.

Why not ask?

I visited her surgeon, Dr. David Callister in Glendale. He examined my eyes and, when I asked whether laser surgery could correct the problem, responded with a curt, "No."

Oh, well. At least I asked.

But he kept examining me. Eventually, he stepped back, fingers against his chin, deep in thought.

"I don't think we can make it perfect," he said, "but I think a 70–80% improvement is quite doable."

"Wait a minute. You just told me laser surgery couldn't help. Huh?"

"Not with lasers. But a variation on conventional eye-muscle surgery is another matter."

I asked whether he was telling me that Jules Stein had been wrong—and that this operation could have been performed twenty years earlier.

His response was unforgettable:

"I just don't understand Jules Stein. They get a lot of things right. Yet there are some things they just. Don't. Get."

Wow.

He operated, creating the most psychedelic experience of my life. I was awake, albeit somewhat sedated, while he worked on the muscles controlling my eyes.

The result was remarkable. My eye alignment improved dramatically, and most people wouldn't notice anything unusual during ordinary conversation.

Unfortunately, the improvement didn't last. Over the next couple of decades, my eyes gradually returned to something resembling their previous positions.

Scar Wars: A New Hope

A couple of decades later, I called Dr. Callister's office, expecting to learn that he had retired.

He had. His successor referred me to Dr. Mark Borchert, a highly experienced ophthalmologist at Children's Hospital Los Angeles. (They do adults, too.)

Dr. Borchert had performed nearly 6,000 similar procedures. He knew and respected Dr. Callister, under whom he had studied. He believed he could achieve an even better correction.

He did.

Following approximately ninety minutes of conventional eye-muscle surgery, only a slight divergence remained.

But there was a problem.

At my first postoperative visit, Dr. Borchert admitted that the moment he began operating, the extraordinary scar tissue he encountered prompted an uncharacteristic, "Oh, f**k!"

He removed as much scar tissue as possible but expected it to return, completely undoing his work within five months.

He expected another operation would be necessary, approaching the problem from a different direction, through different eye muscles.

Those who know me can probably guess my next question:

"What prevents internal scarring?"

"Nothing," he replied. He was blunt and certain.

Now, Dr. Borchert is a wonderful physician and an exceptionally skilled surgeon. But I have never believed that expertise confers omniscience.

You know what I did next. I began researching.

I found online anecdotes suggesting that vitamin C might decrease internal scar formation during healing. I immediately began taking six to eight grams daily, spread throughout the day.

Five months later, Dr. Borchert examined my eyes. Incredibly, the same slight divergence remained.

His jaw dropped.

Was vitamin C responsible? I can't prove it; perhaps the correction would have persisted without it. But the result was strikingly different from what Dr. Borchert anticipated.

A single observation doesn't prove a hypothesis, but it does create a hypothesis worth investigating.

And if we never question the experts, how many such hypotheses will never be investigated?

A Specialist with Built-In Repeat Business

When I was perhaps 10 or 12, my mother took me to an ear, nose, and throat specialist because of a sinus infection. He drained my sinuses. A few weeks later, the infection returned—or had never completely disappeared—so he drained them again. And again. And again. For nine flipping months!

Even as a kid, I asked: If the treatment wasn't working, why did this doctor keep repeating it? This wasn't the scientific method at work. It seemed more like sinus-draining worship. Pure faith.

In my late 20s, I mentioned my continuing sinus problems to a friend. “You ought to see my chiropractor,” she suggested.

“A chiropractor? For my sinuses?”

“Trust me.”

I did. But this wasn't faith. I was willing to experiment, and if the treatment didn't help, I'd stop. The chiropractor inserted small balloons through my nostrils, inflated them, and repeated the procedure over approximately six visits, using lidocaine for pain relief. The result? Virtually no sinus problems for the next 15 years!

When my sinus problems returned, I mentioned the recurrence to my then-chiropractor. He told me he could accomplish the same thing using his pinky instead of balloons—with no anesthetic. I opted to try it. I bet you could hear my agonizing screams two blocks away! But after a half-dozen treatments, my sinuses were clear again.

Years later, when the problems returned yet again, I couldn't locate anyone offering the same treatment. I finally underwent a 90-minute procedure under general anesthesia at a major hospital in Century City. Despite the considerably greater medical sophistication—and much greater costs—I don't believe the results were nearly as good as those from either chiropractor.

The lesson? When a treatment repeatedly fails, reconsider the approach. And don't assume that the most expensive treatment, performed by the most credentialed practitioner, will necessarily produce the best result.

Can a Vitamin Improve a Ski Trip?

My experiments with supplements also began early in life.

In my twenties, I frequently stayed at Mammoth Mountain Inn, sleeping at an elevation of 9,000 feet.

I awoke two or three times every night gasping for breath. I didn't know what caused it, but I lived with it.

Then I encountered an intriguing observation in a health book, possibly one by Adelle Davis. The author suggested that vitamin E helped the lungs assimilate oxygen.

I put two and two together and began experimenting with vitamin E, taking 800 or 1,200 IU daily.

The nighttime episodes disappeared.

I slept normally at altitude until, about a decade later, I ran out of vitamin E the day before heading to Winter Park, Colorado, also at 9,000 feet.

I said to myself, “I’ll be fine.” But no. I woke up three times that night gasping for air.

The following morning, I found vitamin E at the Winter Park Safeway, took it, and slept normally that night.

Coincidence? I doubt it.

I've continued taking vitamin E ever since, gradually increasing my daily intake to 1,600 IU and sometimes 2,000–2,400 IU when heading to higher elevations or anticipating strenuous exercise. I've noticed substantially easier breathing while water skiing when taking the higher doses.

Now, don’t duplicate my regimen without researching the risks—high doses of vitamin E have been associated with increased bleeding. However, it worked for me, and my experience made me wonder: might it have applications elsewhere?

For years, I had wondered whether vitamin E might help people with chronic obstructive pulmonary disease—COPD. I mentioned the possibility to several friends with breathing problems. Nobody, to my knowledge, tried it.

One day, the woman who cleaned my office for years arrived carrying supplemental oxygen. "Crap," I said. She admitted she'd been a two-pack-a-day smoker.

I explained my experiences with vitamin E and offered to buy her some if she wanted to investigate the possibility. After several college-educated people declined my suggestion, my dear housekeeper—with not even a high school diploma—enthusiastically agreed to try it.

I gave her a bottle and explained the amount I'd been taking. I compared our weights. She knew what to do.

On a later visit, I asked what had happened. She'd reduced her oxygen use from four hours daily to two.

Was vitamin E responsible? The fact that she'd halved her oxygen use was not “proof” that vitamin E improved her lung function or that people with COPD can safely reduce prescribed oxygen. But it was evidence.

It would be wonderful to study whether vitamin E could help people with altitude-related breathing disturbances, including altitude sickness—and certain chronic respiratory conditions. But who would finance such research? Vitamin E is inexpensive, readily available, and cannot be patented. Competitors can sell vitamin E without contributing a dime toward the research. This is a fundamental economic principle: incentives matter. Here, the incentives do not align.

Of course, government agencies, universities, and nonprofit organizations also finance medical research. But are they necessarily immune to commercial influence? Hardly. The same financial interests that influence pharmaceutical research can also shape institutional priorities, research grants, and the questions researchers are encouraged—or discouraged—to investigate. Regulatory and institutional capture comprise the history of government regulation. The existence of supposedly independent research institutions doesn't guarantee that potentially valuable hypotheses receive fair hearings.

Getting a Grip

Here's a more recent experience, and one that may have saved my ability to continue working.

I began waking up with my fingers curled tightly into my palms. Opening my fingers was agonizing. It took time, effort, and considerable pain. The problem developed relatively suddenly, over at most a few weeks.

I visited Dr. Kamran Rabbani, one of those rare physicians who combine considerable knowledge with extraordinary integrity, intellectual curiosity, and humility.

He examined me and ruled out arthritis but couldn't identify the cause. Rather than pretend to know something he didn't, he admitted he was mystified. But he suggested trying astaxanthin, a supplement I'd never heard of. I don't recall whether he explained why it might help, but he mentioned that Costco carried it.

I bought a bottle. Within days, the pain disappeared.

Not diminished. Disappeared.

Several months later, however, the pain returned as suddenly as it had disappeared. What changed?

That's one of the most useful questions I've learned to ask, whether investigating medical symptoms, human behavior, or financial problems.

What did I add? What did I subtract? What happened shortly before the problem appeared?

I realized that I'd run out of Lifetones Uric Acid Support, a liquid supplement I'd been taking for reasons I could no longer remember (I do not have gout!). I'd stopped taking it about a week earlier.

Could it be that the two supplements worked synergistically? I reordered Lifetones immediately.

Within days, the pain disappeared again. Completely.

I don't know why this combination works. But here's what I do know: I use my hands constantly in my profession. Had the condition persisted or worsened, my ability to work would likely have ended.

Think about the financial consequences. The potential loss of earning capacity could have dwarfed the cost of supplements.

The best physicians aren't those who claim to have all the answers, but those willing to admit when they don't.

More Medical Mysteries—and Amazingly Inexpensive Solutions

I have experienced many other medical issues that required curiosity, research, a willingness to experiment, and outside-the-box thinking to resolve. Here are a few.

My Achilles Heel

I developed excruciating pain in my left Achilles tendon during a skiing trip. It was so bad that after a morning of skiing I had to limp off the slopes. The pain was a solid 6 or 7 on a scale of 10. I figured my skiing was over.

That evening, while recounting my predicament in a Jacuzzi filled with other skiers, someone suggested an NSAID. I didn't even know what an NSAID was (think Advil/ibuprofen or Aleve/naproxen sodium). I asked my wife Marty whether we had anything like that. She handed me one Bextra.

The relief was so profound and long-lasting that I skied the next day—and the rest of the week!

Unfortunately, I continued needing Bextra occasionally for recurring pain. It was withdrawn in 2005 amid the fallout from the Vioxx debacle and concerns about Bextra's own cardiovascular and serious skin risks. Vioxx, another FDA-approved COX-2 inhibitor (a type of NSAID), had been linked to tens of thousands of excess serious coronary events before its withdrawal. Interestingly, an FDA advisory committee had voted that Bextra's benefits justified keeping it on the market. The FDA nevertheless requested its withdrawal. Other NSAIDs didn't provide comparable relief.

Of course, I did some research. I found that a combination of glucosamine, chondroitin, hyaluronic acid, and MSM—ingredients found in various over-the-counter supplements—might alleviate the pain. I experimented with perhaps a dozen different combinations and eventually found one liquid combination—originally Wellesse Joint Movement, now sold by Nature's Way—that controlled the problem when numerous similar products did not.

Years later, I learned that fluoroquinolone antibiotics, including Levaquin and Cipro, can cause serious and sometimes lasting tendon injuries, particularly involving the Achilles tendon. Marty remembered that I took Levaquin in the early 2000s. I suspect Levaquin contributed to or caused the problem.

I continue taking half a capful of what I call "joint juice" daily, and my tendon is good. When I miss a couple of days, I feel it.

Facial Fatigue

Then there's pantothenic acid, which is Vitamin B5.

Following a bout with mononucleosis in my teens, I experienced unusual fatigue that I can only describe as extreme facial tiredness, almost as though my facial muscles were partially paralyzed, especially after heavy exercise.

I found a suggestion that pantothenic acid might help and began taking 500 mg daily. The symptoms disappeared.

Years later, after gradually increasing the dosage to 1,500 mg daily, I had an especially intense water-ski weekend. The fatigue returned, but instead of subsiding within a few days as in previous episodes, it persisted for weeks. I finally saw Dr. Rabbani, who evaluated me for Bell's palsy. He concluded that wasn't the problem, and admitted—remember, he's a doctor with humility!—that he couldn't explain the symptoms.

After thinking about it for a few days, I asked myself: can I safely double the dose? I found no serious concerns in the sources I consulted and doubled my daily pantothenic acid intake to 3,000 mg. The symptoms disappeared several days later.

An Acid Test

I've also experimented extensively with digestive enzymes.

I began suffering from indigestion that was, at times, quite serious. After trying at least a dozen non-pharmaceutical digestion formulations, I found two that seemed to work well for me—one costing approximately $50 and another costing less than $10, each for sixty capsules.

Same apparent benefit. Vastly different cost.

More recently, I discontinued Nexium, which I'd taken for acid reflux, after encountering an intriguing hypothesis: that some digestive complaints attributed to excessive stomach acid might actually involve insufficient acid or inadequate digestion. I began experimenting with supplemental hydrochloric acid alongside my digestive enzymes.

My symptoms improved markedly. This experience reinforced something I've learned repeatedly: don't assume that the usual treatment is the only treatment, and don't assume a pharmaceutical drug is safer and more effective than a non-pharmaceutical alternative.

An Aversion to Incisions

In August 2020, when it was supposedly "too dangerous" to go to the gym, I exercised at home. While working out with mere 20-pound weights, I did something awful to my left shoulder.

A decade earlier, I'd found an orthopedic surgeon who advised against surgery for a torn meniscus, telling me the pain would likely subside on its own. Here was a surgeon who didn't like performing unnecessary surgery. Naturally, I returned to him.

An MRI revealed a full-thickness tear of my supraspinatus tendon, a key component of the rotator cuff (the area baseball pitchers frequently injure). The tear initially measured approximately 1.5 centimeters.

(Years after Levaquin may have injured my Achilles tendon, I suffered a torn supraspinatus tendon and, not long after, an iliolumbar ligament injury. Coincidence? Perhaps. But knowing what fluoroquinolone antibiotics can do to connective tissue, I can't help wondering whether there's a connection—pun unintended—even decades later.)

The surgeon told me, “You MUST have surgery. This will not heal itself!” I told him I didn’t mind the surgery but did object to the six-month recovery period afterward. I delayed.

A month or two later, I saw Dr. Bryce Matthews, who had been my chiropractor for the past decade. I told him about the injury and asked him to be careful when adjusting me. Although my resting pain had largely subsided, I still couldn’t lift my arm even an inch without assistance. Around this time, I was also learning to exercise with resistance bands, keeping my elbows close to my body. He said, “Oh, we’ve got an osteopath who might be able to help with this.” I said, “Osteopath? That’s a back doctor!” He said, “Trust me.”

Having been an aficionado of chiropractors for decades, I trusted him. And remember I’m curious and open-minded. I met the osteopath, Dr. Adam Silver, a few weeks later and began a series of prolotherapy treatments.

Prolotherapy typically involves injecting a dextrose solution into targeted tissues—ligaments, tendons, and joints—with the aim of causing inflammation, which stimulates a healing response. Search engines generally describe the treatment as “unproven.” But my experience was considerably more encouraging. (And ChatGPT, while acknowledging the limitations of the “research,” was reassuring about the treatment.)

After six or seven sessions over the following half year, I recovered full function. I could even throw a baseball overhand without pain—although I wasn't particularly eager to test my luck!

The tear hadn't healed anatomically. Indeed, later imaging showed that it had enlarged to 2.5 centimeters. Yet my shoulder worked. I'd gone from being unable to lift my arm without using my other hand to lifting it freely without pain. Six years later, I still haven't needed surgery.

I continued exercising, quickly progressing from light to extra-heavy resistance bands, and gradually but dramatically increasing the number of repetitions, avoiding movements that might aggravate the injury.

That taught me an important distinction: anatomical abnormalities and functional disability aren't always synonymous.

My Neck Takes a Turn for the Better

During a cross-country trip in 2025, I realized I could turn my head only about 25 degrees in either direction. I have no idea when the restriction began. It must have developed so gradually that I hadn't noticed how much mobility I'd lost.

On the third or fourth day of our stay at an Airbnb in northeastern Tennessee, I was walking Sasha, our Great Pyrenees, when I met another dog lover. We struck up a long conversation about dogs, travel, philosophy, and health. When I mentioned my neck, she enthusiastically recommended Dr. Monica Knowles, a chiropractor about an hour away, convincing me that this wasn't an ordinary chiropractic practice. Curiosity, a desire to fix the problem, and a willingness to try different approaches, as always, won out. I made an appointment.

After just three sessions in four days, I could turn my head approximately 45 degrees in either direction—nearly twice my previous range.

Dr. Knowles practices the Blair upper-cervical method, a relatively uncommon chiropractic technique. Wanting to continue, I found another Blair practitioner, Dr. Thomas Polucki, conveniently located about 20 minutes from my office. Since seeing Dr. Polucki, my range of rotation has increased to approximately 60–65 degrees in either direction, which is about the maximum range we can expect given my neck structure (and apparent damage from my level of maturity).

Dr. Polucki later became part of another medical adventure, this one involving my hip area and lower back.

In 2023, I experienced an injury involving the right iliolumbar ligament, which connects the lower spine to the pelvis. The pain was excruciating—a solid 6—when attempting to stand up, even when pushing up on both chair arms or on my upper legs. Yet sitting down was easy. I wondered if Dr. Silver might be able to solve this problem. The unusual contrast led him to diagnose an iliolumbar ligament injury, which he treated with prolotherapy.

After my third and final treatment, Dr. Silver said something like, “See you next year.” He explained that compensating for the injury could eventually cause trouble on the opposite side. Sure enough, the left side went out—although not until three years later, in late April 2026. (Yes, I know how lucky I was on the timing!)

Dr. Silver again treated me with prolotherapy, while Dr. Polucki provided shockwave therapy for related lower back pain. Neither doctor knows the other, although I've told each how the other's treatment contributed to my recovery.

My experiences have convinced me of the considerable benefits of exploring alternatives outside the mainstream.

Thinking Outside the Prescription Box

Why do so many patients receive treatments that follow a relatively narrow set of protocols?

Medical guidelines are intended to incorporate scientific studies, reduce preventable errors, and discourage treatments that lack adequate supporting evidence.

That can be valuable.

But they can become obstacles when treated as unquestionable rules rather than guides informed by evidence, including anecdotes. Scientific discoveries rarely begin with large clinical trials. Those trials are designed to test hypotheses, which usually arise from simple observations, sometimes a single unexpected result. After all, the search for truth—which is what science is—must begin somewhere.

Physicians work within systems shaped by hospital policies, insurers, reimbursement rules, licensing expectations, professional organizations, and malpractice litigation.

It’s much harder to be successfully sued when following “protocols.” A doctor who follows accepted practice may be better positioned to defend a treatment decision if something goes wrong. A doctor who departs from accepted practice may face greater scrutiny, even when the departure is thoughtful and well documented. That creates an incentive to conform.

Not every physician feels compelled to follow a single protocol, and guidelines are not universally binding. But the practical pressures are substantial.

Consider the economic incentives, too.

A physician may have little time to investigate an unusual case. Insurance may reimburse a standard procedure while providing little compensation for extended investigation, nutritional counseling, or consideration of less familiar alternatives.

None of this proves that conventional medicine is fundamentally corrupt, although I believe significant parts of the system have been compromised by institutional and financial malincentives.

I've spent a lifetime studying incentives in economics, taxation, and human behavior. Why would medicine be exempt from the pressure of malincentives?

What Does Wealth Creation Have to Do With This?

Everything.

Suppose a $500 treatment restores someone's ability to function *and* avoids $10,000 in out-of-pocket medical expenses.

That's a $9,500 savings.

Invested at 8% annually for thirty years, that amount could grow to approximately $95,600 before taxes.

But direct savings may be the least important part.

What if the treatment also allows someone to work another five years? That's five more years of earnings, five fewer years of drawing down retirement savings, and five more years for those savings to grow. Or what if it preserves decades of earning capacity that might otherwise have been diminished? What if it allows someone to continue exercising, traveling, or enjoying retirement?

Health is an asset that doesn't appear on your financial statements. Yet its value may exceed that of your investment portfolio.

Advocate for Your Own Health

I have spent decades investigating the behavioral manifestations of alcoholism, often beginning with observations that suggested hypotheses others hadn't considered.

Not every hypothesis proves correct. But I've found that careful observation, curiosity, and a willingness to challenge assumptions can be extraordinarily productive in the search for truth.

The same approach has influenced my medical decisions.

I pay attention to changes. I ask what preceded them. I research possibilities. I seek practitioners willing to consider explanations outside the norm.

And when something appears to work, I try to understand why. We don't always find an answer; even with something as familiar as aspirin, scientists are still investigating aspects of how and why it works. If something repeatedly helps me, I may continue using it without fully understanding the mechanics or chemistry. I accept that experimentation entails risks and requires its own separate cost-benefit analysis.

Again, I don't suggest that readers duplicate my supplement dosages or experiment with potentially hazardous treatments without investigating the risks. And now, the obligatory disclaimer, which I detest: “This is not medical advice. Consult your physician before changing medications or trying a treatment.” High-dose vitamins aren't automatically safe merely because they're vitamins. (However, if I suspected I was having a heart attack, I'd immediately call 911 and then take some cayenne pepper even though conventional medicine finds no convincing evidence for its efficacy.) On the other hand, I've taken doses far above the recommended daily allowances for certain vitamins for decades without apparent harm.

Ask more questions. Why this diagnosis? What else might explain the symptoms? What evidence—including anecdotes, which are real-life stories—supports the proposed treatment? What are the alternatives? What would happen if we did nothing? Then, to borrow again from economics, weigh the costs and benefits of each approach, because as Thomas Sowell puts it, everything is a trade-off.

And perhaps most importantly: what do we still not know?

Sometimes the answer will be that conventional treatment is the best choice. Sometimes a second opinion will uncover an overlooked possibility. At other times, an observation may generate a hypothesis worthy of experimentation.

You don't have to be a physician to notice that something changed. You don't have to be a scientist to ask why or to do your own research (which used to be called “reading”). And you don't have to accept that the absence of an established answer means there is no answer worth pursuing.

Your financial future depends partly on the decisions you make about your money.

It may depend more on the decisions you make about your health.

After all, creating wealth is only half the challenge. You want to be healthy enough to enjoy it.

Scientific “Authority” Must Be Challenged

“The science is settled.”

Sometimes that means the evidence is exceptionally strong. More often it means someone would prefer that we stop asking questions. The difference matters, especially when our health, earning capacity, and savings are at stake.

I have no objection to expertise. I rely on it. I object when credentials become a substitute for evidence, when dissent is treated as misconduct, and when institutions protect conclusions that should be tested.

History supplies numerous examples.

Discoveries Move. Institutions Don’t.

In 1847, Ignaz Semmelweis introduced chlorine hand disinfection in the doctors' obstetric clinic at Vienna's General Hospital. Many doctors walked from the autopsy room to the birthing room. Long before we understood bacteria, Semmelweis suspected they were carrying something deadly on their hands.

The clinic's annual maternal death rate fell from 11.4% in 1846 to 1.27% in 1848—a nearly 90% reduction in maternal mortality. Yet his experiment with disinfectants met extraordinary resistance. Accepting the idea that doctors should wash their hands meant admitting to transmitting disease.

Semmelweis died of sepsis after admission to an asylum in 1865; many argue the resistance to his work drove him insane. True or not, his story is a warning about the human cost of taking positions contrary to “established authority.”

Acceptance of Semmelweis’s discovery took decades. Other discoveries faced even longer delays.

In 1747, British naval surgeon James Lind demonstrated that citrus fruits were remarkably effective against scurvy. The Royal Navy took another 48 years to routinely provide sailors with lemon juice. Even Lind didn't fully appreciate the implications of his own findings. Sometimes the evidence is ahead of the experts—even the expert who discovered it.

Oftentimes great discoveries come from outside the field. Alfred Wegener was a meteorologist, not a geologist, when he proposed continental drift in 1912. Matching fossils, rocks, and evidence of ancient climates suggested that continents now separated had been connected. Many geologists treated him as an outsider trespassing on their territory and ridiculed him.

His proposed mechanism was inadequate. But that did not contradict evidence that continents were moving. Later discoveries involving the ocean floor, magnetic reversals, seafloor spreading, and earthquake patterns helped establish modern plate tectonics. While Wegener did not develop that entire theory, his central insight survived the ridicule.

Medicine can also embrace a particular treatment too readily. Egas Moniz shared the 1949 Nobel Prize in medicine for prefrontal leucotomy, commonly called lobotomy. The Nobel organization's own account acknowledges that the operation could cause serious personality changes. Medicine's highest honor did not make the treatment safe.

And consider John Lykoudis, a Greek general practitioner who began treating ulcers with antibiotics in 1958. He reportedly treated about 30,000 patients, struggled to obtain approval for his formulation, and was fined by a medical disciplinary committee in 1968. Lykoudis's treatment deserved investigation, not dismissal. Decades later, his central insight—and his use of antibiotics— were vindicated when Robin Warren and Barry Marshall established the role of Helicobacter pylori in many peptic ulcers, for which they—not Lykoudis—received the 2005 Nobel Prize in Medicine.

Nutrition Corrupted

Ancel Keys helped make saturated fat a central suspect in heart disease. His selective presentation of country-level data in the 1950s drew criticism from other researchers. I believe the popular message that evolved from his work—"carbs good, fats bad"—contributed to disastrous dietary choices for hundreds of millions.

Industry funding helped reinforce that message. The Sugar Research Foundation sponsored a 1967 review in the New England Journal of Medicine that emphasized reducing dietary fat and cholesterol while discounting evidence against sugar. The Foundation's sponsorship of the review was not disclosed.

Cholesterol, meanwhile, has been treated almost as an enemy, despite being essential to life—including brain function. I am deeply skeptical of the enthusiasm for prescribing drugs to lower it. One review of 21 statin trials found an absolute reduction in mortality of approximately eight-tenths of one percentage point over the studies' follow-up periods—a considerably less impressive figure than relative-risk advertising suggests. Statins also increase the risk of diabetes and can cause muscle pain and weakness. Before committing someone to years of medication, the profession owes that patient an explanation of the likely absolute benefit, the potential harms and side effects, and whose financial interests the prescription serves.

My own experience gives me substantial reason to question the familiar "carbs good, fats bad" message. I began restricting carbohydrates about thirteen years ago and adopted a ketogenic diet—high in healthy fats, moderate in protein, and very low in carbohydrates—nearly seven years ago.

I didn't change my diet to lose weight, nor did I deliberately limit how much I ate. Yet after going partly keto, my weight dropped from about 196 pounds to 186 and stayed there. After I went fully keto, it dropped again—to 175. I hadn't even realized how much more weight I'd lost until I stepped onto the scale. I was stunned. The weight loss was an unexpected benefit, not the objective.

Another consequential change involves my blood pressure. When I was younger and before starting any blood pressure medications, I often recorded readings around 160/110. I had fought going on meds for it, but my wife Marty and her late father, Dr. Bernard Baltes, finally convinced me. For years, I took 32 milligrams of candesartan (Atacand) daily, eventually divided between morning and evening doses, which stabilized my blood pressure at 120/60-70. A year or two ago, I inadvertently omitted the evening dose from my daily pill containers. When I discovered the mistake, my first question was: "How's my blood pressure?"

It was 120/70.

More recently, I began taking substantially less. Although I haven't kept a precise medication log, I estimate that I now average 16 milligrams once every three days. My readings commonly run around 120/60 to 130/60–70.

I cannot establish exactly when my medication requirement decreased, because I didn't test a lower dose systematically throughout those years. Nor can I prove that keto caused the improvement, or supplements that I've periodically added. But carbohydrate restriction was a major sustained change in my life, and I know of nothing else that would connect the dots. After decades of daily medication, maintaining comparable blood pressure readings while taking much less deserves an explanation.

My concerns also extend to the seed oils common in many packaged foods rich in refined carbohydrates. I avoid them because I have done, as they say, my own research and believe them to be a slow-acting poison. My blood pressure experience cannot tell us whether avoiding those oils contributed to the improvement, but it reinforces my interest in examining the ingredients and dietary advice we have been encouraged for decades to accept.

I learned that carbohydrate restriction is hardly a recent discovery. My study of regulatory capture leads me to suspect that industry influence over government helped marginalize this dietary approach. In 1863, a carpenter and undertaker—not a doctor—named William Banting published his experience losing weight on a low-carb diet prescribed by surgeon William Harvey. His booklet, which predates today's diet wars by generations, is one of the most influential diet and nutrition booklets of the late 1800s. The Weston A. Price Foundation calls him the "father of the low-carbohydrate diet" in the title of a terrific article about his life on its website. His booklet

became so influential that "to bant" entered the language as a term for dieting.

Meanwhile, measured obesity among Americans ages 20–74 rose from 13.4% in 1960–62 to 40.8% in 2021–23. Those figures give us ample reason to question whether the dietary advice promoted during those decades served us well. In my view, that advice not only failed to serve us well; it helped destroy the health of tens of millions of Americans.

Reviewed by Peers. Guaranteed by Nobody.

"Peer reviewed" sounds reassuring. It tells us a paper underwent a review process. It does not tell us that independent investigators, not bought and paid for, repeated the experiment, verified the underlying records, or obtained raw data.

Richard Smith, editor of the *British Medical Journal* for thirteen years, described conventional peer review in 2006 as "almost useless for detecting fraud." In BMJ experiments, papers were deliberately seeded with major errors. Most reviewers detected only about a quarter of them; none of the reviewers detected every error.

A process that misses substantial errors should not be sold to the public as a certificate of truth.

A revealing later investigation went beyond reading manuscripts. Anesthetist John Carlisle examined 526 randomized trials submitted to *Anaesthesia*. Among the 153 for which he obtained individual patient data, he identified false data in 67—44% of the 153—and classified 40 as fatally flawed "zombie" trials.

Correcting the Record—Eventually

Perhaps the most disturbing failure comes after someone identifies a problem.

Prestigious publication does not guarantee reliable evidence—or prompt correction. In 2006, Nature published a paper linking a particular amyloid-beta assembly to memory impairment in an animal model of Alzheimer's disease. A retraction notice eighteen years later described manipulated figures and underlying data that could not be verified. For nearly two decades, other researchers built on findings whose evidentiary foundation ultimately could not withstand scrutiny.

The failures can occur on an industrial scale. Hindawi, a publisher of peer-reviewed scientific journals, was purchased by John Wiley & Sons for nearly $300 million in December 2020. Retraction Watch reported more than 8,000 Hindawi retractions in 2023 amid evidence of paper mills and manipulated publication processes. Thousands of papers had passed through a system supposedly designed to screen scientific work for reliability before publication. Their subsequent withdrawal demonstrates how badly those safeguards had failed—and why "peer reviewed" should never be treated as an arbiter of truth.

Writing in 2021, Richard Smith of the BMJ was arguing that health research should no longer receive an automatic presumption of trustworthiness. He described incentives that reward producing and publishing papers while making exposure of fraud costly to the institutions involved.

Careers, grants, publication income, and institutional reputations can all depend on keeping the papers coming regardless of their veracity. Correcting a record that stood unchallenged for years can mean admitting that earlier safeguards failed.

I study incentives and malincentives in economics and taxation. Medicine and scientific publishing are not exempt from their influence.

Same Problem in My Profession

In tax practice, I frequently encounter the danger of treating authoritative shorthand as a complete answer when someone asks, "What's my marginal tax bracket?" When a retiree in the 22% bracket adds $1,000 of income that counts toward Social Security taxation, an additional $850 of Social Security can be added to adjusted gross income. With those dollars all taxed at 22%, the additional federal tax is (22% of $1,850 =) $407. That's a 40.7% real marginal rate.

For an itemizer fully affected by the SALT deduction phaseout, a 32% bracket can become a 41.6% marginal rate, not including other possible phase-outs of deductions. While these are consequences of rules, not scientific fraud, they illustrate why we must ask what lies behind a confident answer.

Always Ask

These cases involve different failures: resistance to observations, premature enthusiasm, undisclosed sponsorship, unreliable data, a failure to understand the data (or law), and delayed correction.

I would ask an unconventional practitioner for evidence, too. Being outside the establishment does not confer immunity from error, financial incentives, or an oversized ego. But neither does being inside it.

A patient's repeated experience can justify a question long before a controlled trial supplies an answer. A controlled trial deserves scrutiny even after a prestigious journal publishes it. As Darrell Huff illustrated in his incomparable 1954 book *How to Lie with Statistics*, numbers can mislead as readily as words. And an institution's confidence deserves serious scrutiny when it refuses to disclose the raw data, funding sources, and relevant conflicts of interest—including who stood to benefit from a particular result—or explain what evidence might change its conclusion.

The people offering advice may know far more than we do about their specialties. They can still be wrong, and we are entitled to ask how they know, who benefits, and what they might have overlooked. We bear the consequences of following their advice—in our health, our ability to earn a living, and the savings we hope to enjoy.

That gives us every reason to keep asking questions, especially when someone tells us to stop. Science advances when we investigate those questions and test the answers—especially when the results threaten established beliefs or powerful interests.

Before December 31 Some Tax Decisions Cannot Wait

Several tax changes deserve attention before year-end. Some offer opportunities; others add complications. Please contact us quickly to review your situation and allow financial institutions time to process transactions.

Welcome Relief: Form 1099

For payments made during 2026, the general reporting threshold for nonemployee compensation and certain other business payments increased from $600 to $2,000. The change applies to covered payments reported on Forms 1099-NEC and 1099-MISC, including qualifying payments for services and rent. Inflation adjustments begin after 2026.

This long overdue change means fewer forms but does not change the need to keep complete records. Payees' Forms W-9 should be obtained with the first payment, because the threshold applies to the *total* paid to each recipient during the year, not each individual payment.

A Charitable Deduction Without Itemizing

Beginning in 2026, taxpayers who do not itemize can deduct up to $1,000 of qualifying cash contributions, or $2,000 on a joint return.

"Cash" includes checks and qualifying electronic payments made directly to qualifying charities. Donated clothing, furniture, and other property do *not* qualify.

For a married couple filing jointly and not itemizing in either year, there's a 'smoothing' angle: donating $4,000 in one year and nothing the next produces only one $2,000 deduction. Splitting the donations equally between two years produces a $2,000 deduction in each year. Halve those dollar amounts for non-joint filers. I often say "Smooth out the income!" Here I say, "Smooth out the charitable deductions!"

Giving From Your IRA May Still Be Better

If you are at least age 70½ and do not itemize, giving directly from your IRA to eligible charities through qualified charitable distributions, or QCDs, may still be the better option. Unlike the new charitable deduction, QCDs keep otherwise taxable IRA distributions out of your income and can, therefore, reduce the taxable portion of your Social Security benefits.

The Subsidy Giveth—and the Tax Return Taketh Away

Beginning in 2026, you must repay the full amount of any excess federal "health insurance" premium subsidies received during the year. The former repayment caps are gone—even for households below 400% of the federal poverty line. If your household income exceeds that threshold, you generally lose eligibility for the federal credit altogether and must repay all advance federal subsidies.

An increase in income—from any source—could trigger a substantial subsidy repayment in addition to any tax on that income. If you receive subsidies through Covered California or another "marketplace," contact us before year-end so we can review any opportunities to manage your income. As always, promptly update the "marketplace" whenever your expected income changes.

A California Warning About 529s

Our summer issue explained how 529 plans have become more versatile. For federal purposes, the annual limit for qualifying K–12 expenses increased to $20,000 per beneficiary in 2026, and certain postsecondary credentialing expenses also qualify.

California has not adopted those expansions. A withdrawal that qualifies for federal tax-free treatment may produce California income tax on the earnings portion and an additional 2.5% California tax on those earnings. Check in with us before using these expanded withdrawal provisions.

More Health Plans Allow HSA Contributions

Beginning in 2026, qualifying bronze and catastrophic individual-market health plans receive expanded HSA-compatible treatment. Certain direct primary care arrangements also no longer prevent otherwise eligible individuals from contributing, and qualifying membership fees can be paid from an HSA federally tax-free.

If you previously assumed your coverage ruled out an HSA, reconsider that assumption when reviewing your health plan.

Beneficial Ownership Reporting Mostly Gone

Thankfully, as I expected after the 2024 election, the Trump administration eliminated the requirement for *U.S.-created entities* to report "beneficial ownership" information to the Financial Crimes Enforcement Network (FinCEN) of the U.S. Treasury Department.

Business owners should remain wary, however. FinCEN warns that fraudulent filing notices are circulating, including demands for information or payment using fictitious government forms. If you receive such a notice, please do not respond without running it by us.

Roth Conversions and RMDs—Don't Wait

Roth conversions intended for 2026 must be completed by December 31. Required Minimum Distributions must also be taken by year-end, although special rules apply to first-year RMDs. Remember: converting more isn't necessarily better. The objective is to increase long-term after-tax wealth, not merely minimize this year's taxes. Contact us before initiating a conversion so we can evaluate the consequences, including Medicare Surcharges and the taxation of Social Security.

A 401(k) Surprise for Higher Earners

Beginning in 2026, employees who are 50 or over, whose 2025 wages from their employer exceeded $150,000, generally must make their 401(k) "catch-up" contributions as Roth contributions, rather than pre-tax contributions, if participating in a plan subject to the new rule. Pre-tax catch-up contributions made in error may require prompt correction to avoid plan compliance problems. Contact us if this is an issue, as the rules are absurdly complex.