Joe Mercola: Heart disease, one of the most common problems in the United States, and we're wasting tens of billion dollars on ineffective procedures. Why? Hi. This is Dr. Mercola helping you take control of your health, and today, we are joined by Dr. Thomas Cowan, who is a founding board member of the Weston Price Foundation. He's been on the broadcast here a few times previously, but we've got some exciting information now that was just published and released, showing the ineffectiveness of stents, which is a surgical procedure used to remediate the damages from coronary artery disease at the cost of tens of billions of dollars a year in the United States alone, and they don't work.

Welcome, and thank you for joining us.

Thomas Cowan: Thank you, Joe. Thank you for having me again.

Joe Mercola: Why don't we elaborate on some of the new findings and then expand on some of the better alternatives, because you are still practicing and regularly implement many of them.

Thomas Cowan: Yeah. Well, if I could, because I actually did my homework a little bit this time ...

Joe Mercola: Yeah. Oh, great.

Thomas Cowan: Right. It might be good to put this recent Lancet stent study in context.

Joe Mercola: Sure. That's always a good start. Why don't we begin there.

Thomas Cowan: The context is when you're talking about heart disease, there's a number of different parameters or ways of evaluating it that are crucial. For instance, if you have somebody with heart disease, and you do some sort of intervention, it's nice to know if the person will live longer because of your intervention. That's certainly one way of assessing. There's another way, which is to say, "Will this person be more or less likely to have a heart attack because of this intervention?" That's also an important thing to know. Then, there's another way, which is, "Is this person, who presumably, their main complaint in the first place was they were having chest pain, sometimes shortness of breath, sometimes other symptoms like ... but does it alleviate the, particularly the chest pain, otherwise known as angina that they're having?"

There's probably more, but those are the three biggies. The important thing to note about this study was that what's called PCI, or percutaneous interventions, which is another word for saying inserting a catheter into somebody's coronary arteries and doing something to unblock these arteries. This has been studied for many years, because it's been going on for many years. I would actually like to read something from a New England Journal of Medicine 2004 study, which was called The COURAGE Study, and this is a direct quote from that article, which says, "In summary, our trial compared optimal medical therapy alone or in combination with PCI," which means stents, "as an additional management strategy in patients with stable coronary artery disease. Although the addition
of PCI to optimal medical therapy reduced the prevalence of angina, it did not reduce long-term rates of death, nonfatal myocardial infarction, nor hospitalization for acute coronary syndrome."

That's, of course, a mouthful, but what it means is the state of the literature before this current Lancet study was that doing stents or other interventions, which actually includes bypasses, has never been shown to help people live longer or to prevent further heart attacks. They have been shown to be of aid in people who are having an acute MI, but in anything but that indication, the state of the art, or the state of the science was that they don't help people live longer, and they don't prevent further heart attacks. But as this study says, they say that the indication was for relieving angina. That was the state of where we were at 13 years ago. It was actually not appropriate and possibly even not allowed to tell somebody we were doing a bypass or stent so that you would live longer or not have a heart attack. You could tell them that you could do it because you're having chest pain, and this will relieve your chest pain.

But the interesting thing about it, as you know, is there was never a double blind study assessing whether, in fact, it did relieve angina, because this was always considered to be unethical, but somehow, and I don't know the history of how this came about, but this group of interventional cardiologists in England somehow got it through their review board that they could actually take these patients and do stents on them, who are having stable angina, which is where at least 90% of the stents are done, for exactly these kind of people, but that in half of the group, and as matched as they could, they did a control, which meant they put the catheter in, took the catheter out without doing a stent, told the patients they fixed their blockage, and then saw what happened as far as chest pain and exercise tolerance. In a way, to a lot of people's surprise, but not mine and probably not yours, what they found was there was no different in the chest pain, the angina, in the people who had the stent procedure versus those who didn't have the stent procedure, which means that the final indication for doing a stent, which is to relieve angina, is no longer valid. It's hard to come up with what the indication is at this point, except in the rare instance of an acute MI.

Joe Mercola: Just to put an additional perspective on this, this is a very common surgical procedure, to the point that it's done a million times every year in the United States alone.

Thomas Cowan: Right.

Joe Mercola: You might have a better idea on the cost of it, but my guess is it's at least 10,000, probably even closer to $50,000 to put one of those puppies in, or multiple of them.

Thomas Cowan: Yeah. I don't know what the cost is, but I don't think it's anywhere near 10,000, at least not in San Francisco. You can't even walk into the emergency room for less than a few thousand.
Basic ally, if it was $1,000, that would be a billion dollars in cost, and you know it's more than that. It's probably over ... It could be, potentially, hundreds of billions of dollars a year, ...

... and that's just the cost. The real tragedy from my perspective is that, you know, this is one of the most common causes of diseases in the United States, and the conventional medical approach is to use these stents or angioplasties, which, probably, are just as equally insignificantly effective, and that's their primary issue. But no, their primary component is [inaudible 00:07:49], which is a whole other discussion that we're not really going to go into ... [inaudible 00:07:53] we could touch on it, but they're giving ineffective therapies, and there's so many simple ones that really do work and that basically pose no risk or harm to the patient.

Right, and you know what ... To me, what was so interesting about this, because obviously, there's the Lancet study, which stands on its own, but then The New York Times ran, I don't know if it was the front page article, but a prominent article with the headline that stents are useless. Then, it was picked up by The Atlantic magazine, which did a whole piece on this. In The Atlantic, what was one of the most interesting and I would say provocative quotes that I've literally ever heard from a standard cardiologist, and this was from a woman, Dr. Mandrola, ... I think she was from UCSF. She lives in my backyard. Again, I wonder if you could permit me to read her quote, because ...

... I think it summarizes exactly what you're talking about. This is a quote, I found it in The Atlantic magazine, of a cardiologist who was interviewed by The Atlantic to comment on this study. The quote is, quote, "This study will begin to change the mindset of cardiologists and patients that focal blockages need to be fixed." Focal blockages are these blocked arteries that they put the stents in. Quote, "Instead, these findings help doctors and patients understand that coronary artery disease is a diffuse systemic disease. A focal blockage is just one manifestation of a larger disease." End quote.

Now, the thing that was so shocking to me about that is ... Like you, Joe, I've been in medicine for three and a half decades, or I'm not sure how long you have, and I've obviously written about heart disease and have had a lot of patients with heart disease and have talked on the phone with a lot of cardiologists and have a lot of patients who have a cardiologist. This is literally the first time I've ever heard a cardiologist admit that there is a diffuse focal disease here of which blocked arteries is only one of the manifestations of. That is such a heretical position. I've never heard a cardiologist say that. They say, "You have blocked arteries. That's your problem. We're going to unblock your arteries." To suggest that what they have is a systemic disease changes
everything. I can't emphasize that enough. This is not a blocked artery disease. A blocked artery is a, may or not be significant symptom in this disease.

The question that I would actually ask every listener of this ... I don't know what day it's run, but if it's run on Sunday, and you listen on Sunday, on Monday morning, I would actually hope that people call their cardiologist or go to their cardiologist and say, "I wonder what diffuse systemic disease that this is a manifestation of." I mean, that's the question. "I've heard that there's a cardiologist who's saying that this blocked artery is only one manifestation," which then, of course, is a perfect explanation of why stents don't work. They're not the disease. They're just one of the symptoms of the disease. "If that's the case, then what's my disease?"

Now, I would be very interested to hear the answer. I think what the answer is going to be is, "You have high cholesterol. That's your disease."

Joe Mercola: Yeah.

Thomas Cowan: Now-

Joe Mercola: Or SDS. SDS, statin deficiency syndrome.

Thomas Cowan: Right. Right, but what you're ... The systemic disease that they're referring to is apparently high cholesterol. Now, I don't want to bore your audience or you, but I actually looked up four papers in JAMA, three were in Lancet, showing that life expectancy tends to increase as cholesterol goes up, and that there is no relationship between high cholesterol and death, or from coronary artery disease or all cause mortality. There is none. This has been studied over and over again. The answer to what their diffuse systemic disease is not high cholesterol, in which case, I don't know what their answer is. In a sense, that's why I wrote the book, because ... I know that you and I are largely in agreement to what diffuse systemic disease we're actually talking about here.

Joe Mercola: Mm-hmm (affirmative).

Thomas Cowan: If you want, I can go over the components of that, of which there are many.

Joe Mercola: No. Why don't you mention the book first?

Thomas Cowan: I wrote a book called Human Heart, Cosmic Heart, and it's basically about exploring, amongst other things, it's exploring why people have heart attacks and why people die of heart disease, because the biggest study that I've ever seen on the incidence is only 41% of the people who have a heart attack have a blocked artery to that part of their heart, and of those, 50% of the blockages come after the heart attack, not before, which means that at least 80% of heart attacks are actually not associated with blocked arteries. In other words, like this cardiologist says, there is some reason why people are dying of heart
attacks. I'm, of course, not saying they're not dying of heart attacks, but the blocked artery is only one symptom, one aspect of that disease. It's not a disease, as she points out.

Joe Mercola: Absolutely. Why don't you expand on your perception of what the underlying true foundational cause that's leading to this epidemic of heart disease that we have?

Thomas Cowan: It's obviously complicated or complex, and there's a number of manifestations, but the three most important things that I point out in my book is ... Number one, and this was the conclusion of the pathologist Baraldi, is that at least 90% of the people who have a heart attack have an autonomic nervous system imbalance. Specifically, they have a suppressed parasympathetic nervous system tone, which is caused by a number of things, including chronic stress, poor sleep, high blood pressure, diabetes, i.e. high sugar, low fat type of diet, smoking. Lots of things cause decreased parasympathetic tone. This has been identified mostly because of heart rate variability testing, which interestingly shows specifically low parasympathetic tone, not necessarily high sympathetic tone. One would think those are the same, but actually, they're not.

Now, conventional cardiologist is certainly aware of the role of the autonomic nervous system, which is why standard cardiology care includes beta blockers, which are blocking the sympathetic nervous system, but again, the actual research on this does not show high sympathetic activity, chronically. It shows low parasympathetic activity chronically. I would admit they're similar, but they're not the same. What's dangerous to people's health is this chronic stress, chronic sleep deprivation, high carbohydrate diet, low mitochondrial function. All the things that you talk about in your book, that leads to low sympathetic tone. Then, in the face of a sympathetic stressor, then you have a heart attack. It's not the same to say it's a sympathetic overactivity, which is why I think we could do a lot better than blocking the sympathetic nervous system.

That's one reason. A second reason, and for this, people who are interested in this should go to a website called heartattacknew.com, and under the frequently asked questions, there's a section called Riddle's Solution. You'll see what the actual blood flow to the myocardium, to the heart muscle looks like. We're sort of told, not directly, but implicitly that all the blood flow to the heart muscle comes through these three coronary arteries, although interesting, some people say there's two, and some people say there's four. I'm not sure exactly how many there are. It depends which ones you call the main ones or branches, but whatever. There's two to four major coronary arteries. All the blood comes through that. If you get a blockage in one of those, you die of a heart attack. That's the standard line.

The reality is, as I like to put it, nature is not so stupid to put all its eggs in two, three, or four baskets. Instead of just these two or three big rivers, so to speak, it puts multitude of tributaries so that the blood supply to the heart is a network of capillaries, not just these central rivers. Essentially, if you have a blockage in
one of the major arteries, your body does its own bypass. It sprouts new blood vessels. It perfectly capable of bringing the blood to the other, to whatever area of the heart it needs, and as long as your capillary network is intact, you will be protected from having a heart attack.

Now, that brings the question, why does somebody not have a healthy, robust microcirculation or capillary network? The answer to that is pretty straightforward. I mean, obviously, there's many answers. Like, we know that cigarette smoking or nicotine poisoning, if you would, has a corrosive effect on the microcirculation, so that's obviously one answer. Another answer, which I think is dear to your heart, is people who eat a high sugar, low fat diet, who end up with prediabetes or diabetes, who have chronic inflammation, that is a well-known influence, negative influence on your microcirculation. We know that overt diabetes actually corrodes and destroys your microcirculation, your capillary network. That's a predominant reason. We have millions and millions of people living on high carbohydrate diets, low fat diets, which has a inflammatory effect on their microcirculation. There are other reasons, too, but those are probably the big ones.

The other thing, I think, again, which is probably dear to your hear, is ... So to speak, dear to your heart. ... is the way you get a robust microcirculation is through exercise. If you never exercise, your body doesn't have to try to bring more blood flow to the myocardium, and your microcirculation will deteriorate. Human beings are not meant to not move their body ever in their whole life. That's just a, not a good strategy, so the more you-

Joe Mercola: Well, well. An expansion, though. Let me just interrupt for a moment. It's not just exercise, because that's the mistake I made, just, working out every day for an hour for, you know, 40, 50 years, and that's not it. I mean, you need some of that, but you need continuous movement throughout the day, non-exercise. The combination is what really provides optimum health in that area.

Thomas Cowan: Yes. Yeah, and you can get into the splitting ... Getting into the details, and that's obviously crucial as to how to move and when to move and all this, but my point is movement and staying strong is a strategy for improving the microcirculation. Again, conventional cardiology is aware of this issue. That's why they use Plavix and aspirin, essentially to keep the microcirculation intact, so that's another one.

The third area, which I highlight particularly in my book, which cardiology is not aware of, is, and again, it's something that I think you've written about a lot, is when you stop creating or making fuel in your mitochondria, and you do what's called a glycolytic shift, and you start fermenting fuel in the cytoplasm, you end up creating lactic acid as a product of this fermentative metabolism. Whenever lactic acid builds up in a tissue, say in your leg or in your heart, you get cramps and pain. In your leg, we call it cramps and pain. In your heart, we call it angina.
That's because of the lactic acid buildup in the tissue, which also restricts the blood flow and makes the tissue more toxic. In your leg, you then stop moving. Your heart can't stop moving, so this anaerobic or, like, glycolytic fermentation continues. The lactic acid continues to build up. That interferes with the ability of the calcium to get into the muscle, which then makes the muscle unable to contract, which is exactly what you see on a stress echo or a nuclear thallium scan. You see a dyskinetic or an akinetic muscle, which means it doesn't move, because the calcium can't get into the cells because the tissue has become too acidic. Eventually, the acidosis continues, and that becomes the cause of necrosis of the tissue, which is what we call a heart attack.

In my mind, it's very clear the sequence of events that has to lead to a heart attack. By the way, that explains this sort of dyskinetic area, or part of the heart that's not moving. That creates pressure and a sort of a sheer pressure in the artery embedded in that part of the heart, which causes clots to break off there, and that explains why you get clots forming after the heart attack, not before. This acid, lactic acidosis buildup is one of the key events, without which you won't have angina, and you won't have the progression to necrosis.

Those are the three, the autonomic nervous system, the microcirculation, and lactic acid buildup. Luckily, as you say, there are safe, nontoxic, effective ways to address each of those, either individually or together, and if we want, we can go over what some of those are.

Joe Mercola: No. I think we need to, and let's start with one of the ones that I've known about for over 20 years, maybe 25 years. When I initially encountered it, I was highly skeptical of it, and I thought, "It's crazy. Why are they doing this?" This is ECP, or external cardiac ... or ECCP, external cardiac counterpulsation, where you hook a patient up to a machine that essentially has these giant blood pressure cuffs that are around your pelvis and upper legs and lower legs. You're hooked up to an EKG monitor, and the leads will allow the machine to contract quite high, to quite high levels, when your heart is relaxing or in diastole.

It basically, it's a passive form of exercise, which is just extraordinary and probably one of the most profound ways to improve microcirculation that you mentioned. It's a way that you really can't do with regular exercise. It's just, it's sort of counterintuitive, but why don't you talk about that, because I think this is probably one of the most underutilized interventions for helping people recover from cardiac disease and could literally. I mean, every one of those people who had a stent, they needed ECP.

Thomas Cowan: Right.

Joe Mercola: That's what they needed. They did not need that stent.

Thomas Cowan: Right.
Thomas Cowan: The only thing I would correct you is it's actually called EECP, and that might help people, because if they want to find a provider of this technique, they should go to EECP.com, that's Eddie, Eddie, Cat, Paul.com. It stands for enhanced external counterpulsation. Of these three, the EECP works on the second one, which is the microcirculation, and it's very simple and straightforward. If you squeeze more blood up to the heart when the blood is relaxed, i.e. in diastole, you will force the heart to make more microcirculation or more ... It has a so-called angiogenesis effect, so you will make the heart sprout new blood vessels, and essentially, because of that, you will end up bringing more blood to the heart where it's needed, because the more microcirculation, the more robust it is, the better blood flow to the heart. It's really as simple as that.

Just like you said, it's like passive exercise. You squeeze really hard on your lower extremities and your pelvis, push the blood up to the heart. You time it so when the heart is relaxed. Sprouts new blood vessels. New blood vessels mean more blood flow, and the blockage becomes irrelevant. This has been shown to be curative, meaning it will stop people with angina for at least five to seven years with one course of treatment. You do one course of treatment, which is about seven weeks. It lasts for five to seven years, sometimes longer. No angina. It's Medicare approved. It's paid for by insurance. It's been studied in the literature. Again, at least 80% effective for getting rid of patients' angina, which, by the way, was the last refuge of the reason for stents, which is now no longer a refuge for, a reason for doing stents. But this, also ...

Joe Mercola: Yeah. A stent ...

Thomas Cowan: ... protects people from having heart attacks.

Joe Mercola: In addition to the mechanical effects that you mentioned, it also has hormonal benefits. I was at a presentation recently, a few weeks ago, from a cardiologist who was using this in his practice and reviewed some studies that show that people who are receiving the EECP would actually have decreased insulin resistance, and they would tend to lose weight, and their blood sugar would be under better control. I think that's an artifact of the fact that it is a type of exercise. Even though it's passive, it's still exercising your body.

Thomas Cowan: Yes. Right. I'm sure there is other reasons, and more blood flow is just overall better for your health so that everything will work better. It's-

Joe Mercola: It increases cardiac stem cells, too, which is intriguing.

Thomas Cowan: Yes. Yep. It's simple, interesting, and effective, and as far-

Joe Mercola: And relatively cheap.
And relatively ...

If you've had the ... It's cheaper than a stent, or certainly cheaper than a bypass.

It's cheaper than a stent by 10 times.

Yeah. Even if you had to pay for it yourself. I mean, if your life depends on it.

Even if you have to pay for ... Yeah.

It's crazy.

Yeah.

Anyway, I'm sorry for butting in there, but I just am such a passionate advocate for this technology. We'll discuss the others, but maybe here's a good time to jump into the, one of the potential side effects or results of this type of study, if it's embraced and believed by the vast majority of the population, and that is that most people or most physicians who are subspecialists and considering a specialty to choose may not choose cardiology, because these stents and these ... are an intervention that they get highly rewarded for. If there's not a financial incentive for the people that go into cardiology, the cardiologists might start dropping in significant numbers.

Right. Well-

You have some theories on that, so why don't you give us your view [crosstalk 00:29:44]

Well, I mean, I don't know. I think we'll see what happens with that. I mean, one would hope that it's just about the science and about what's good for patients. I would hope that this creates a sea change, not just in doing stents, but ... That's why I can't emphasize enough, we have to see this as a diffuse systemic disease. Unfortunately, again, as you know, the treatment with things like diet and exercise and stress reduction and EECP is not nearly as lucrative, at least in the short run, and I know that a lot of the hospitals, one of their main financial cash cows, so to speak, is doing interventional cardiology. If Medicare cuts them off or the insurances cut them off, that will create a huge change even in the nature of hospitalization and why people get hospitalized and what hospitals can actually afford to do, so this is a huge change in a whole lot of things that go into what's happening with medicine these days.

All these things, how you live, how you sleep, who you love, how you love, who you express gratitude, these are the causes of heart disease, but we also have some aids if you get into some trouble and you need some help. It's good to have some aids, at least that's apparently why there's physicians in the first
place. Supposedly, we're supposed to help people who are already having some trouble, ...

Joe Mercola: That's right.

Thomas Cowan: ... but I totally agree. People need to look at how we live our lives.

Joe Mercola: Yeah, and I just want to emphasize one point, which I came to a relatively recent appreciation of in that we know, and conventional medicine admits to the fact that 50% of the population, that's 50%, which is extraordinary, have diabetes or prediabetes, but really, the fundamental cause of that is insulin resistance. If you look at a more sophisticated and sensitive way to determine that, which is insulin testing through a glucose tolerance test, and you measure the insulin levels a few, at certain times after the glucose challenge, then you'll find the area under the curve, and you'll determine and realize that upwards of 80% of the population in this country has insulin resistance.

Thomas Cowan: Yes.

Joe Mercola: 80%, which is just extraordinary. To me, there's a cure for this, and the cure is, I mean, a cure in the truest sense of the word, is ... Obviously, it has to do with diet, but it's not so much what you eat. It's when you eat. If you can work your way up to the point where you are not eating for five days or more, even ... If you go longer, you're going to need to be supervised, typically, but if you can longer, for five days, and do that regularly in cycles, that is the most powerful metabolic intervention I've ever encountered, and can really go a long way to addressing the insulin resistance, which not only contributes to heart disease, but cancer, of course diabetes, Alzheimer's, and virtually almost all the chronic diseases that we know of.

Thomas Cowan: Yes. I mean, I don't know as much as you do about this. I, personally, am a huge fan, personally and professionally, of what's called intermittent fasting of up to 18 hours, which I do, myself, three to six days a week.

Joe Mercola: But the next level, that's ...

Thomas Cowan: Yeah. There's-

Joe Mercola: You're going to get some benefit, because the real magic occurs at day three, after 72 hours. That's when you massively upregulate autophagy, which is your body's ability to digest and remove senescent cells, and a senescent cell is a derivative of the word senile, meaning aged, and it cannot reproduce anymore, essentially just taking up space, clogging up your system, doing you absolutely no good, just causing damage. Most people have lost the ability to effectively clean that up and take out the garbage. That's what fasting does, and in addition to that, it increases stem cells, just like EECP, but it does it systematically, not just in the heart.
Thomas Cowan: Yes. I'm all for it. I haven't used that and tested that enough. I personally have gotten to the point of intermittent fasting and regular use of saunas as a detoxification aid, and walking on sandy beaches and being out in the sun, and sleeping the right amount. I'm sure there's a next step, and I'm sure that's probably not the end of the steps for either one of us.

Joe Mercola: Yeah. I've just recently adopted ... I'm doing monthly five day fasts, and I'm just started my third one as we're recording this today.

Thomas Cowan: Oh.

Joe Mercola: I think it's a powerful discipline and just massively useful for if you're interested in optimizing your longevity, because these calorie. You know, there's studies that show calorie restriction is useful, but that's almost impossible to get compliance to. But essentially, you're receiving the same benefits, because you're not eating for a few days, and if you do it like you're doing, with this intermittent fasting, you do that maybe even up to 20 hour fasting, you do that for a month, then you can slide into a five day fast and have no hunger. I mean, it's not really even a challenge.

Thomas Cowan: Yeah. Again, I haven't looked into that, but I have no doubt that you're on to something here.

Joe Mercola: Yes, but it's all about treating the cause and then really addressing the insanity, the absolute ludicrousness that conventional medicine has chosen to determine how they're treating these common causes of disease like heart disease. This recent study in The Lancet with the stent study, I mean, I'm hoping it will catalyze the removal of this system. Are you aware of a process that insurance companies go through, because to me, it seems that's the key. If they can stop reimbursing for this procedure because there's good clinical evidence that it doesn't work, then that's going to, essentially, cut the legs out from under the cardiologists who want to continue doing this procedure.

Thomas Cowan: Yeah. I mean, I have no insight, particularly, in to that whole world, but I do know that you're right, that this is very much tied to funding. It's also tied to funding of hospitals, though, so this is going to have to be ... I'm sure they're going to look at this very carefully to see what is sustainable and what's prudent, and maybe they'll try to repeat the study and do it in a way to get a different outcome, or ... I don't know what's going to happen, but again, I would like to just keep the focus on what this UCSF cardiologist said, no matter what about stents or bypasses, the blocked arteries is not the disease.

This is a diffuse systemic disease, and every patient, every person who goes to a cardiologist, I think, has the obligation and the right to know what, in your opinion, is this diffuse systemic disease that we're treating, because you have your wonderful opinion about it. I have my three step opinion about what's going, which is very similar. I'm sure the Chinese medicine people have deficient
kidney chi or something, and these are all ways of describing the diffuse systemic disease that's underlying this. The problem is I've never heard any cogent explanation in standard cardiology of what diffuse systemic disease they think they're treating besides high cholesterol, which turns out to be, like, a complete red herring, as they say. That's not the problem. People with higher cholesterol live longer, so that's not the problem.

Joe Mercola: There'll be hundreds of thousands of people that are watching this interview, and a significant number of them will have themselves personally challenged with a coronary blockage or heart disease or have relatives that have that issue, so I'm wondering what you would recommend to those individuals outside from making a phone call to their cardiologist's office and asking them that, because that, I mean, that's a provocative question, but still, they need some basic steps. What would your set of recommendations be?

Thomas Cowan: Well, my first one, even though I must admit it's a bit self-serving, is to read my book, because ...

Joe Mercola: Sure. That's a good start.

Thomas Cowan: ... that will give you a perspective on the history of coronary blockages and their relevance and another way of looking at it in a very simple, clearly defined program that you can follow with your health care practitioner's help and advice that I think will make a significant impact on your life or the life of your loved one suffering from heart disease. That includes looking into diet and includes looking into movement. It includes looking into, you know, I say intermittent fasting. They should look at your guidelines on five day fasting. It includes looking into EECP. It includes going an EECP.com website and finding out where the place is in your area, asking your cardiologist or your primary care physician for a referral so you don't even have to pay for it. It includes, if you have overt heart disease, I put people on strophanthus. I put people on emu oil because of the vitamin K content. I have people do earthing or walking on the beach. Preferably, I have them get out in the sun. I have them think about their relationships and their connection with love and gratitude, all the things that I think, in worst case scenario, will help your life. That's the worst thing that can happen if you do this. The best thing-

Joe Mercola: They won't kill you prematurely like statins.

Thomas Cowan: Well, yeah. I don't know anybody who's been killed by eating better quality food and walking on the beach. Almost everybody who does that says, "You know what? I feel better." Now, is that enough to fix their coronary artery disease or their angina? Maybe not, but it's a good start. If you throw in some beet powder or fermented beet powder like you have, that's another step. It is, I think, as effective as nitrates for treating chest pain and helping with lowering your blood pressure.
Joe Mercola: Probably. You know what's even better than beets, though, that's a higher density?

Thomas Cowan: Arugula.

Joe Mercola: Arugula. Yeah. You got it, so fermented arugula powder, which I think we're both coming out with.

Thomas Cowan: Actually, I was going to ask you if you wanted me to send you some arugula powder. I could send-

Joe Mercola: Oh, yeah. That is ... I don't know that ... We'll have to talk after the interviewer, but yeah, that is the best, is arugula.

Thomas Cowan: Yeah. We have a whole bed of it.

Joe Mercola: It's significantly higher than beets.

Thomas Cowan: Yeah, and it makes great powder, too.

Joe Mercola: Yeah.

Thomas Cowan: That's what I would do. Now, there are obviously other good writers on this. I don't want to say I'm the only person who's ever written anything of use. I'm not such a big fan of the sort of vegan raw food approach to this. There's certainly some popular books, and I know that sometimes they get some positive results, but I don't think the long-term benefits are where we want to go with this, so that's not my approach.

Joe Mercola: Well, it's certainly better than the standard American diet.

Thomas Cowan: Better than the standard ...

Joe Mercola: Yeah. That's not hard to beat, but yeah. It's probably less than optimal.

Thomas Cowan: Less than optimal.

Joe Mercola: But you don't need a lot of animal protein. That's for sure. I mean, you can easily overdo it, and most people do. We want to keep that high quality and relatively low amounts of animal protein.

Thomas Cowan: Yeah, but I would definitely encourage people to eat good quality fats, and I'm pretty sure that you share that sentiment. There's also a very interesting movie about that by a British cardiologist called thebigfatfix.com, and you can download the movie. It's really about how fat has never been the culprit, eating fat, in causing heart disease. It's always been sugar-related.
Joe Mercola: Yes, indeed, and it's similar with salt. I mean, salt gets a lot of bad raps, too, ...

Thomas Cowan: Yeah. You're right.

Joe Mercola: ... but it's actually the wrong white powder. The pernicious white powder is sugar.

Thomas Cowan: Correct. Right, oh, and refined salt isn't so good either, but Celtic sea salt or Himalayan salt is fine.

Joe Mercola: Sure. Yeah, absolutely. All right. Well, any other points you'd like to emphasize before we sign off?

Thomas Cowan: I don't think so. I think we got the gist of it.

Joe Mercola: Well, great.

Thomas Cowan: Yeah. I just want to emphasize the systemic disease, not your arteries.

Joe Mercola: Yeah. We will definitely put a link to your book in there that people can access if they're interested in more information, because there's a lot of valuable information in there.

Thomas Cowan: Great.

Joe Mercola: It also highlights an interesting concept that we didn't discuss this interview but did in a previous one with respect to how the heart is not really function as a pump. It doesn't work that way, ...

Thomas Cowan: Right.

Joe Mercola: ... which I think you explain really well in your book. It's an interesting concept that's not really well-articulated through even many of the natural medicine circles. It's a novel concept, so thank you for putting that out there.

Thomas Cowan: Yeah. Well, I could finish with a brief comment on that, because, again, on my Human Heart, Cosmic Heart website, there's a bunch of articles on the heart is not a pump, including an article by an anesthesiologist in Upstate New York. He wrote a book called The Heart and Circulation: An Integrative Approach. His book was endorsed by the head of cardiac anaesthesiology at Harvard Medical School, who said that, "Branko Furst," is his name, "is correct. There's no way the heart is a pump, and thinking the heart is a pump is the same as believing in Newtonian physics. It's an outdated concept."

There was another website that I recently ran into. I'm not sure of the name of it, but it had to do with ventricular muscular bands, and he said something very interesting, because he's a cardiac surgeon who dissected the heart and said,
just like the same conclusion that I came to, that the heart is a vortex creating machine. But he said something very interesting, which I had not thought of, which is when the heart gets sick, and it gets hypertrophied and dilated, in other words, stretched out, it actually does start pumping at that point, and as soon as the heart starts pumping, it's in a death spiral, because it's such an inefficient pump that it starts using all the energy to keep pumping.

It essentially robs your body of the energy, which is what you see with people in end stage congestive heart failure. They actually, they shrivel away. Their tissues die, because they need so much energy to, quote, "pump" the blood in this inefficient manner. That's like the deep backup plan. "We're going to die. We better start pumping, because that's our only option." Once you're in that, you're basically not got very long to live. It's very interesting that this fundamental concept, the heart is a pump, only happens when you're about to die, which was a very interesting comment on how we see medicine. We think it's normal for you to be in a state where you're basically in a terminal decline, ...

Joe Mercola: Yes, indeed.

Thomas Cowan: ... and there's nothing normal about that.

Joe Mercola: Yes. Sad to say, but that is the way it is now, and you and I are both committed to helping change that paradigm, because it certainly is in radical need of a revision to help focus on the natural underlying foundational causes of the disease. Thank you for all you're doing.

Thomas Cowan: Thanks again, Joe.

Joe Mercola: Again, your book is going to be great, and if you're interested in more details, then that's where to go. Great. Well, thank you again.

Thomas Cowan: Thank you, Joe.