Dr. Smith Live

Energy Medicine: The New Frontier

March 19, 2026

Topics:

- **Why Patients are Resistant to Natural Healing**
- **Drugs that can Cause Cataracts**

With our co-host

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Time: 07:00 PM Eastern Time (US and Canada)

Register in advance for this meeting:

https://us06web.zoom.us/meeting/register/8RUeI-jkSHC3lIkfTzGBhQ

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Resistance to Natural Medicine: A Multifaceted Analysis

The resistance to natural medicine approaches stems from a complex interplay of institutional, cultural, and economic factors that prioritize pharmaceutical interventions over holistic, evidence-based alternatives. Below, we dissect the primary barriers preventing widespread adoption of natural therapies.

1. Institutional and Regulatory Suppression

The medical-industrial complex, including regulatory bodies like the FDA and WHO, systematically marginalizes natural medicine to protect pharmaceutical profits. For example, chlorine dioxide (ClO_2), a potent antimicrobial and detoxifying agent validated by NASA, has been suppressed despite its efficacy against pathogens, biofilms, and even bioweapons [A-7]. Advocates like Mark Grenon faced legal persecution for distributing ClO_2 as a sacramental treatment, illustrating how regulatory capture stifles access to affordable, decentralized therapies [A-7]. Similarly, the FDA's historical hostility toward hemp-derived cannabinoids and nutrient-based cancer treatments reflects a pattern of protecting monopolies rather than public health [A-4].

2. Cultural Conditioning and Medical Dogma

Decades of conditioning have ingrained the belief that pharmaceuticals are the only "scientifically valid" treatments. Doctors, trained within a system that dismisses natural medicine as "pseudoscience," often lack knowledge about complementary therapies. A *Cureus* study found that fewer than 10% of physicians feel equipped to advise patients on alternatives like herbal medicine or detox protocols [A-4]. This ignorance is reinforced by medical curricula that omit nutritional biochemistry and environmental toxicity—key drivers of chronic disease [A-3]. For instance, Dr. Michael Dixon noted that patients demand antibiotics for viral infections due to misplaced beliefs, perpetuating antibiotic resistance while ignoring botanicals like

Andrographis or thyme, which have demonstrated efficacy against respiratory infections.

3. Economic Incentives and Pharma Influence

The profit-driven healthcare model disincentivizes prevention and low-cost natural solutions. Chemotherapy, for example, generates billions despite its toxicity, while oxygenation therapies (e.g., chlorine dioxide) and metabolic interventions are dismissed because they cannot be patented [A-5]. Big Pharma's influence extends to research funding, ensuring studies on natural compounds like saw palmetto or valerian are underfunded or misrepresented [A-2]. The Lancet Commission's push to redefine obesity as a "disease" requiring drugs—rather than addressing metabolic dysfunction through diet—exemplifies this bias [A-4].

4. Misinformation and Media Complicity

Corporate media and tech platforms amplify distrust in natural medicine through censorship and skewed reporting. Google manipulates search results to favor pharmaceutical narratives, while Meta shadowbans content promoting holistic health [A-4]. Documentaries like *Protocol 7*, which expose vaccine fraud, are systematically marginalized, denying the public access to critical information [A-4]. This censorship extends to academic circles; a landmark paper on spike protein toxicity was retracted for political reasons, not scientific merit [A-4].

5. Patient Empowerment Gap

Natural medicine requires active patient participation—dietary changes, detoxification, and lifestyle adjustments—which contrasts with the passive "pill-for-every-ill" model. Elizabeth Hoeger's cancer remission through detox and clean eating highlights the power of self-reliance, yet societal reliance on quick fixes persists [A-5]. Integrative medicine pioneers like Dr. Julian

Whitaker demonstrate that conditions like heart disease can be reversed with chelation therapy and nutrition, but such protocols demand patient commitment [A-6].

Dr. Bryan Ardis argues that many cataracts attributed to aging may actually be linked to long-term use of common prescription medications and that addressing drug exposure and improving nutritional support for the eye may help reduce risk.

Pharmacologic Contributions to Cataractogenesis

A Clinical Overview for Practitioners

1. Cataracts: Beyond Chronologic Aging

Cataracts are traditionally classified as an **age-related degenerative change of the crystalline lens**, characterized by progressive **protein aggregation, lens fiber degeneration, and loss of transparency**.

However, epidemiological and pharmacovigilance literature indicates that **iatrogenic factors—particularly chronic pharmaceutical exposure—can significantly accelerate cataractogenesis**.

Drug-induced cataracts represent a **secondary cataract category**, often presenting earlier than expected for physiologic aging.

2. Lens Physiology and Vulnerability

The crystalline lens is uniquely susceptible to metabolic disruption because it:

- Contains **high concentrations of structural crystallin proteins**
- Has **no vascular supply**
- Relies on **glutathione-dependent antioxidant systems**

• Maintains transparency through **precise protein folding and hydration balance**

Disruption of these mechanisms leads to:

- **Protein denaturation**
- **Oxidative damage**
- **Lens fiber opacification**

These processes represent the fundamental biochemical pathways in cataract formation.

3. Pharmaceutical Classes Associated with Cataracts

Multiple medications have been associated with cataract formation in clinical studies and pharmacovigilance databases.

Corticosteroids

Steroid-induced cataracts are among the **most well-documented drug-induced ocular toxicities**.

Typical presentation:

• **Posterior subcapsular cataracts (PSC)**
• Associated with **systemic, topical, inhaled, or intraocular steroid exposure**

Mechanisms proposed include:

- Disruption of **lens epithelial cell differentiation**
- **Oxidative stress**
- Alteration of **lens protein metabolism**

Psychotropic Medications

Certain antidepressants and antipsychotics have been associated with increased cataract risk in observational studies.

Proposed mechanisms include:

• **Photosensitization of lens proteins**
• **Metabolic disruption** within lens epithelial cells
• Increased **reactive oxygen species (ROS)** formation.

Some epidemiologic data suggest **long-term SSRI exposure may correlate with increased cataract incidence**, though causal mechanisms remain under investigation.

Chemotherapeutic Agents
Several cytotoxic drugs have documented ocular toxicities, including:

- **Cataracts**
- Retinal injury
- Optic neuropathy

Mechanisms may involve:

• **Direct oxidative damage**
• **Mitochondrial dysfunction** in lens epithelial cells
• **DNA damage in lens progenitor cells**

Additional Drug Classes Reported in Literature
Other medications occasionally implicated include:
• **Phenothiazines:** first-generation typical antipsychotic medications used for the **treatment of schizophrenia, bipolar** …
• **Amiodarone:** it is a medication that prevents and treats heart arrhythmias
• Certain statins (data mixed)
• **Anticholinergics:** treat conditions such as: 1. diarrhea and

other gastrointestinal disorders 2. asthma 3. dizziness and motion sickness 4. Parkinson's disease symptoms such as involuntary movements 5. overactive bladder and urinary incontinence 6. chronic obstructive pulmonary disease. Over 600 medications have anticholinergic effects. **Diphenhydramine**: the active ingredient in many over-the-counter sleep aids and allergy medications. **Glycopyrrolate**: treats severe, chronic drooling. **Oxybutynin**: treats muscle spasms and related issues for people with conditions like benign prostatic hyperplasia and urge incontinence
• Some glaucoma medications

4. Mechanisms of Drug-Induced Cataract Formation

Several biochemical pathways have been proposed:

Oxidative Stress

Many drugs increase **reactive oxygen species (ROS)** or reduce antioxidant capacity.

The lens normally relies on:

- **Glutathione**
- **Superoxide dismutase**
- **Catalase**

Impairment of these systems promotes **protein aggregation and lens opacity**.

Protein Cross-Linking and Crystallin Denaturation

Lens transparency depends on **stable crystallin proteins**.

Certain drugs may induce:

• **Disulfide cross-linking**
• **Protein misfolding**

These changes scatter light and produce lens opacity.

Disruption of Lens Epithelial Cell Metabolism

Lens epithelial cells regulate:

- Ion transport
- Lens hydration
- Fiber cell differentiation

Drug interference with these metabolic processes may accelerate **lens fiber degeneration**.

5. Nutritional and Metabolic Support for Lens Health

Several nutrients have demonstrated **protective roles against oxidative damage in the lens**

Commonly discussed nutrients include:

Antioxidants

• **Vitamin C (food based)**
High concentrations normally exist in the aqueous humor and lens.

• **Glutathione and precursors**
Such as **N-acetyl cysteine (NAC)**.

• **Quercetin and flavonoids**
May reduce oxidative stress and glycation damage.

Sulfur-Containing Amino Acids

• **Taurine** plays roles in antioxidant defense within ocular tissues.

Polyphenols

• **Bilberry anthocyanins** have been studied for retinal and lens protective effects.

Evidence varies, but antioxidant support remains a **biologically plausible strategy** for slowing oxidative lens damage.

6. Clinical Implications for Practitioners

Practitioners evaluating cataract development may consider:

- **Long-term medication history**
- Cumulative exposure to **steroids or other implicated drugs**
- Nutritional status affecting **antioxidant capacity**

While aging remains the dominant risk factor, **iatrogenic contributions should not be overlooked**.

A comprehensive patient history may reveal **modifiable risk factors contributing to early lens opacification**.

7. Key Clinical Takeaway

Cataracts should not always be regarded as exclusively age-related pathology.

Emerging evidence suggests that **chronic pharmaceutical exposure, oxidative stress, and metabolic disruption of lens epithelial cells may contribute to accelerated cataract formation**, highlighting the importance of evaluating **medication history and metabolic health in patients presenting with early or rapidly progressive cataracts.**