Submission to

Inquiry into services and treatment options
for
persons with cancer

from

Cancer Information & Support Society
St Leonards (Sydney)

Don Benjamin

Convenor/Research Officer

Australian Senate

March 2005

Introduction

We have difficulty in addressing the Terms of Reference, as they presuppose that the current paradigm about what cancer is, and how it should be treated, is essentially correct and the services need only some changes. There is therefore no provision in the terms of reference for any questioning of this paradigm.

An example of this assumption is that section (b) has the following wording: "how less conventional and complementary cancer treatments can be assessed and judged with particular reference to… the extent to which [they] are researched, or are supported by research". There is no equivalent term of reference in part (a) that deals essentially with current "delivery of services and options for treatment.."

The thrust of our submission is in fact that the current paradigm about what cancer is, is invalid. In other words, we submit that much of the conventional treatment is not supported by research. Following from this, the way in which cancer should be treated should be completely changed.

The only opportunity for questioning the current paradigm is in reference to (a) (v) which refers to barriers to implementing best practice. However this again raises difficulties because it assumes that best practice is based on good evidence and provides benefits to people with cancer. We also question this assumption because we believe that while "best practice" is based on an invalid paradigm it is unlikely to be of benefit to people with cancer.

Although instructions for making submissions do not impose restrictions on length or format, we have tried to present this submission within the structure of the Terms of Reference. We wish to point out that in so doing we are not accepting the underlying assumptions implied in these Terms of Reference.

The terminology in the terms of reference is also restrictive. The two terms used by the National Center for Complementary and Alternative Medicine, part of the National Institutes of Health in the United States, uses the terms ***complementary*** and ***alternative***.

In this context, complementary therapies are those designed to add to or complement conventional or orthodox treatment. Those who use them generally accept the current paradigm regarding the nature of health and disease.

In contrast with this, alternative therapies are those designed to be used instead of, or as an alternative to conventional treatments because they are based on a different paradigm of what constitutes health. Alternative health practitioners generally see the allopathic treatment of disease as essentially symptoms oriented, whereas they tend to treat disease systemically or wholistically. When they treat symptoms they do so as part of a systemic treatment.

Other terms such as ***integrative*** therapies suggest that both orthodox and alternative therapies can be used alongside each other but without any assumptions about one being superior to the other. For example cancer might be considered a systemic disease and therefore treated mainly with alternative therapies, while its symptoms might be treated using some conventional therapies as long as they did not undermine the body's natural healing methods. For example the best results achieved anywhere in the world with terminal cancer patients involved whole-body therapy, but surgery was commonly used to remove a source of toxins. Infected teeth and tonsils were routinely removed for the same reason. Radiotherapy and chemotherapy were rarely used because they were seen as undermining the body's natural healing mechanisms.

These concepts are explored in detail in the submission.

We therefore seek to address the terms of reference highlighted in **bold**:

(a) **The delivery of services and options for treatment for persons diagnosed with cancer, with particular reference to**:

(i) the efficacy of a multi-disciplinary approach to cancer treatment,

(ii) the role and desirability of a case manager/case co-ordinator to assist patients arid/or their primary care givers,

(iii) differing models and best practice for addressing psycho/social factors in patient care,

(iv) differing models and best practice in delivering services and treatment options to regional Australia and indigenous Australians, and

(v) current barriers to the implementation of best practice in the above fields; and

(b) **How less conventional and complementary cancer treatments can be assessed and judged, with particular reference to:**

(i) the extent to which less conventional and complementary treatments are researched, or are supported by research,

(ii) the efficacy of common but less conventional approaches either as primary treatments or as adjuvant/complementary therapies, and

(iii) the legitimate role of government in the field of less conventional cancer treatment.

Summary relating to

(a) The delivery of services and options for treatment for persons diagnosed with cancer, with particular reference to:

(iii) differing models and best practice for addressing psycho/social factors in patient care

(v) current barriers to the implementation of best practice in the above fields.

We submit that the main reason that delivery of cancer services and options for treatment are unsatisfactory, and provide little in terms of survival benefits, is that the current paradigm about what cancer is, is invalid. As a result there is a *barrier to the implementation of best practice.*

The following information, given in more detail in **Part 1**, explains why we believe this is the case:

- There is little or no evidence from properly run randomised controlled trials that surgery, radiotherapy or chemotherapy have a significant effect on mortality or survival – suggesting the current paradigm is invalid
- This conclusion is supported by eminent leading cancer researchers such as John Bailar, former US Presidential Advisor and leading epidemiologists
- Evidence showing that current assumptions about the efficacy of conventional cancer therapies are invalid is dismissed as being flawed by those with vested interest in the status quo. As a result there is little improvement

The following information, relating to terms **(b) (i), (ii)** and **(iii)** is given in more detail in **Part 2**. It supports the validity of an alternative paradigm. In particular it suggests that a particular form of structured psychotherapy should be transferred from the area of palliative care into the area of primary treatment because results from its use are now far superior to any of those using conventional therapies. It should become the basis for *addressing psycho/social factors in patient care*:

- There is evidence from seven properly run randomised trials that a particular type of structured psychotherapy has a significant effect on survival for many types of cancer – suggesting that cancer is a systemic disease
- Any therapy that questions the current paradigm will not be accepted. For example two recent reviews (meta-analyses) of randomised trials showed no significant benefit from psychotherapy. This is because, of the seven well-run randomised trials showing significant increases in survival, two were not accepted because the results were "too good to be true". The remaining five were added to three trials that used ineffective psychotherapy that produced no psychological benefits and therefore no survival benefits. As a result the benefits of the five trials were swamped by the lack of benefits from the badly run trials – thus delaying acceptance for many more years.
- In effect, new therapies are required to satisfy far more stringent requirements for their acceptance than do any of the current conventional treatments.

Summary relating to

(b) How less conventional and complementary cancer treatments can be assessed and judged, with particular reference to:

(i) the extent to which less conventional and complementary treatments are researched, or are supported by research

The following information, given in more detail in **Part 3**, explains why there is little likelihood, without government intervention, of the situation changing so that people with cancer can gain real benefits in terms of survival:

It is implied in this term of reference that less conventional therapies have not been assessed in the past. This is not true. There is ample evidence from the world literature that many of such therapies have been well researched. Many have had their results published. Details of this research and the results are given in **Part 2**. Many more have had their results suppressed for the reasons given above. Details of this suppression are given in **Part 3**.

- The best survival results anywhere in the world from treating cancer come from systemic-based therapies such as those designed to restore natural body systems such as the immune system – supporting an alternative paradigm
- The reason such alternative cancer therapies are not being accepted is due to several factors, mainly political and financial, including the fact that the cancer industry world-wide is worth over $500 billion a year ($110 billion in the US, $2.7 billion in Australia) with strong vested interests, so that therapies that question the paradigm on which this industry is based are therefore unlikely to be considered, let alone accepted.
- Such therapies have been suppressed for many years throughout the world mainly for these reasons. A good example of this was exposed in a US Congressional inquiry into the closure of a cancer clinic in the Bahamas in the 1980s. The Congressional report revealed the political pressures that continue to operate behind the scenes.
- Examples of similar pressures operating in many countries (including Australia) are outlined
- The example of non-acceptance of psychotherapy is given above. Similarly the most effective *physical* alternative cancer therapies have been actively suppressed despite the very good results from these therapies published in mainstream medical literature.
- Such pressures are not confined to the area of cancer. The American Medical Association was found guilty of conspiracy to eliminate one of its competitors, chiropractors, and was helped by US government agencies such as the Post Office in this task. Governments in Australia, as in many other western countries, have legally conferred a monopoly status on the allopathic school of medicine for the treatment of cancer, and provide active support for elimination of its competitors from this area.

(ii) the efficacy of common but less conventional approaches either as primary treatments or as adjuvant/complementary therapies

Details of efficacy of many alternative cancer therapies are given in **Part 2**. As a result of their suppression:

- none of the most effective alternative cancer therapies are being used as primary treatments. When used at all they are usually started only after ineffective conventional therapies have been used and have weakened the body's natural ability to heal itself, so the person with cancer is less able to recover.

(iii) the legitimate role of government in the field of less conventional cancer treatment.

- Governments have provided the allopathic school of medicine with a virtual monopoly over the treatment of cancer. Doctors are therefore locked into an invalid paradigm for the treatment of cancer.
- Practitioners who wish to use therapies based on the more effective alternative paradigm are harassed and deregistered by medical bodies with the support of state governments.
- People who wish to avoid undergoing conventional therapies are harassed. Last year a 11-year old girl in NSW was forcibly removed from her parents and subjected to harmful and inappropriate chemotherapy that had never been shown in a randomised trial to provide survival benefits in her type of cancer. A general practitioner who tried to support the girl and her parents was subsequently deregistered. No reasons for his suspension were ever given, in breach of all basic human rights.
- Complaints made to government bodies such as the ACCC that the public is being misled by false statements about the efficacy of conventional medicine, are being ignored
- Health practitioners who provide evidence based testing services for doctors using alternative therapies are being prosecuted by the ACCC based on false information provided by state health authorities acting on behalf of the medical profession.

The legitimate role of government, if it wishes to provide cancer patients with freedom of choice in cancer therapies and the best available evidence-based therapies, is to

- stop supporting only one of the schools of medicine, the allopathic school that is locked into an invalid paradigm, and stop allowing its agencies such as the ACCC and the TGA to continue to suppress useful therapies under the guise of "protecting the consumer"; and
- set up an objective assessment body, similar to that set up by the US Congress (the National Center for Complementary and Alternative Medicine) not dominated by the allopathic school of medicine that has a vested interest in the status quo in cancer therapy.
- protect the rights of the Australian public. On the issue of public health, we have shown that conventional (orthodox or allopathic) medicine has not only suppressed and maligned complementary and alternative therapies but has also mislead the public as to the efficacy of conventional therapies.
- accept its legitimate role and put in place a fail safe review mechanism to ensure that all medical procedures, both conventional and complementary, are thoroughly scrutinised to assess the degree to which they are Evidence Based before being subsidised through Medicare and the Pharmaceutical Benefits Scheme. By "fail safe" we mean to ensure that the review mechanism cannot be influenced by vested interests such as big and powerful Pharmaceutical Companies.
- implement a phasing in of financial support for those medical interventions that are evidence based, according to the Cochrane Collaboration, over a period of say 10 years; and a similar phasing out of financial support for the 85% of medical interventions that are not evidence based.

Detailed Submission

Part 1 – The inefficacy of conventional treatments for cancer

The medical profession has a good track record in trauma intervention and in dealing with infectious diseases.

It does not have such a good record in the treatment of degenerative diseases such as cancer, coronary heart disease and arthritis.

This part of the submission covers:

- The lack of evidence for efficacy of orthodox therapies
- What this means in terms of paradigms for cancer

Lack of evidence for medical intervention:

"Only about 15% of medical interventions are supported by solid evidence... This is partly because only 1% of the articles in medical journals are scientifically sound."

*Richard Smith, Editorial "Where is the wisdom...? The poverty of medical evidence." BMJ (October 5) 1991; **303**: 198-99.*

Recently the peer-review system (that decides what to publish) has also come into disrepute:

"If peer review were a new medicine it would never get a licence…We had great difficulty in finding any real hard evidence of the system's effectiveness, which is disappointing, as peer review is the cornerstone of editorial policies worldwide"

Tom Jefferson, from the Cochrane Collaboration Methods Group interviewed by The Guardian (London) Sydney Morning Herald Jan 18-19, 2003.

The above figure of 15% applies to medicine as a whole. The figure for medical interventions for cancer is closer to 6%. Reasons for this figure are provided below.

What has led to this situation?

First let us look at what the consensus of medical opinion was up to 200 years ago before the development of what is now known as modern Western medicine.

In ~400 BC Hippocrates, the founder of Western Medicine believed that cancer was caused by an accumulation of toxins arising in the body in the form of "black bile".

In ~150 AD Galen, the founder of experimental physiology and pathology continued Hippocrates' ideas on cancer causation (black bile toxins) and treated the condition with medicines, diet and some surgery.

In 1520 AD Paracelsus believed that "it is not the physician who heals, but nature". Identify the cause. Treatment should then be designed to strengthen the body's own defences.

Paracelsus also said: "It should be forbidden and severely punished to remove cancer by cutting, burning, cautery, and other fiendish tortures. It is from nature that the disease arises and from nature comes the cure, not the physician."

His system of treatment included not only remedies but also a form of psychotherapy, because the causes of every disease are "to be found in the soul and spirit as well as in the body". He was thus the founder of the psychosomatic approach.

Josef Issels, Cancer: A Second Opinion. Hodder and Stoughton, London, 1975.

From about 1800, with the development of the achromatic microscope, individual cancer cells could be seen. How they differed from surrounding healthy tissue could also be seen.

All of the past thousands of years of knowledge and experience in the treatment of cancer was thrown out and it became the accepted dogma that the tumour was the disease, not a local symptom of a disease of the whole body. So its removal was assumed to be a cure. No evidence for offered for this change.

Surgery and anaesthetics became more sophisticated and became the only mode of treatment until radiotherapy was developed in the early part of the 20th century and chemotherapy was added from the 1950s.

In throwing out this old accepted paradigm of cancer being a systemic disease 200 years ago Western medicine has been travelling along a dead end street. As a result fewer than 6% of medical interventions for cancer have been shown to be effective in terms of extending life.

What reliable evidence is there for this claim?

The following summarises reliability of claims for efficacy in decreasing order of reliability:

- Properly run randomised controlled trials supported by epidemiological evidence - BEST
- Properly run randomised controlled trials - GOOD
- Comparison of incidence and mortality over time - FAIR
- Epidemiological evidence - FAIR
- Increasing percentage 5-year survival supported by epidemiological evidence - FAIR
- Increasing percentage 5-year survival - POOR
- Anecdotal/Clinical evidence - POOR

Epidemiological evidence looks at how a particular intervention, such as a new treatment, change in treatment, or new screening technique affects mortality after its intervention.

For cancer fewer than 6% of interventions are supported by reliable evidence such as at least properly run randomised trials, the top two levels of reliability.

The types of cancer with some evidence for efficacy are:

- ❑ Tamoxifen for breast cancer (properly run randomised trials)
- ❑ Chemotherapy for some rare types of cancer (properly run randomised trials)
- ❑ Chemotherapy for some sub-groups of women with breast cancer (poorly run randomised trials)
- ❑ Chemotherapy for acute childhood lymphoblastic leukemia (ALL) (increasing survival rates)
- ❑ Chemotherapy for some lymphomas (increasing survival rates)
- ❑ Short-term increase in survival from cutting out or shrinking tumours obstructing or pressing on vital organs using surgery, radiotherapy or chemotherapy (anecdotal/clinical evidence)

These will be discussed in more detail below.

In none of these cases is there any evidence for Cure. What is Cure?

Cure means that ***a group of people treated for a particular type of cancer have the same mortality rate as a comparable group of healthy people in the community***.

*Haybittle JL. Curability of breast cancer. Br Med Bull. (Apr) 1991; **47** (2):319-23*

An example of an unsuccessful attempt to identify such a group is given below.

As no such group of people exists among treated cancer patients it is misleading to use the word cure. Instead this submission uses ***control*** or ***eliminate***.

Control means the ability to live a long and good quality life, ultimately not dying of the cancer but with it.

For example many people die of natural causes but still have breast, prostate or other slow growing cancers present in their body. At Graz in Austria where all deaths were subjected to autopsies it was found that 40% of people who had died from all causes had undiagnosed cancer.

Eliminate means that all traces or symptoms of the cancer have gone. This does not necessarily mean that the person will not die of cancer later if the causes of the cancer have not been removed.

Most treatments for cancer are apparently based on an invalid paradigm, explaining why they have little proven effect on survival.

The term *cure* has been modified by the medical profession to *survival for 5 years without evidence of the disease* (ie tumours). This covers up the lack of cure for any type of cancer. As a result many cancer patients are both cured and dead.

The term *effective* has also been modified by the medical profession. In the context of orthodox therapy, effective means the ability to remove a tumour or shrink it to at least 50% of its original size.

If the tumour is only a symptom of a systemic disease, the presence or absence of a tumour, or the ability to remove or shrink it, is not a meaningful measure of efficacy if the cause of the disease is not affected and there is no increased survival.

A term *disease-free survival* has also been introduced to imply that treatment has been effective. Again if tumours are only symptoms of a disease, it is not a meaningful measure of the presence or absence of a disease. The disease could be progressing but the symptoms (tumours) are not yet apparent.

As will be shown below, in the absence of a properly run randomized controlled trial there is no way of knowing if the percentage five-year survival for a particular type of cancer is the result of medical intervention or is the natural history of the disease that would have occurred without intervention.

There is little evidence for improved survival from properly run randomised controlled trials.

The Inefficacy of Orthodox Cancer Treatments

The following information refers mainly to scientific evidence based on results from properly run randomised controlled trials.

It is not meant to imply that particular treatments don't provide survival benefits to some people. If results show no overall benefits, this could mean that some people benefit and live longer, but there must also be a comparable number who are harmed and live for a shorter time. However it is not normally possible to ascertain directly whether this is as a result of the treatment.

Similarly, early detection of cancer is of little use unless a therapy based on a valid paradigm is then used and real increased survival or reduced mortality occurs as a result of treatment.

The following relates mainly to cancer surgery but the same conclusion applies generally to radiotherapy and chemotherapy.

Evaluating Surgery for cancer

In 1993 Don Benjamin published a paper in which he presented evidence that showed that surgery had not been proven in any properly run randomised trial to be an effective treatment for any type of cancer, ie had not been shown to extend life or reduce mortality by comparing a group treated with surgery with an untreated group.

He therefore had to use other methods of evaluating the efficacy of surgery.

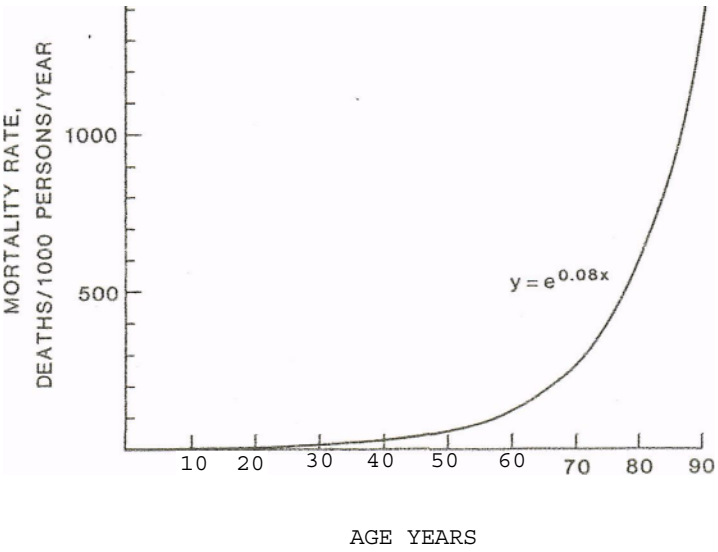
*Benjamin, D. The Efficacy of Surgical Treatment of Cancer. Medical Hypotheses 1993; **40**: 129-138.*

He used six different methods to evaluate the efficacy surgery:

- ❑ the graphical method
- ❑ comparative studies or dose response analysis
- ❑ comparison of incidence and mortality
- ❑ comparison of survival over time
- ❑ epidemiological method

Graphical method

In 1825 B.Gompertz established that, as a person ages from birth to death, the age-specific mortality rate doubles about every 8½ years. The same process applies for all living organisms but the time for doubling of mortality varies. A typical curve for humans is one with a formula such as $y = e^{0.08x}$ where x is the chronological age in years (fig.1). When plotted on semi-logarithmic graph paper (ie age along a linear scale and mortality along a logarithmic scale) this gives a straight line sloping up to the right (fig.2). Such a curve is sometimes referred to as representing a 'constant' mortality rate.



Fig, 1 The variation in Mortality Rate with Age for humans. Gompertz in 1825 described this relationship as a uniform logarithmic worsening of the tendency to die with increasing age. The formula $y = e^{0.08x}$ is only approximate. When plotted on semi-logarithmic graph paper this becomes a straight line sloping up to the right and is sometimes referred to as representing a 'constant' mortality rate.

In this context there are fundamentally three types of mortality curves: concave upwards, representing mortality increasing with the duration of the disease; a straight line, representing constant mortality, unaffected by the duration of the disease; and concave downwards, representing decreasing mortality with duration of the disease , (See Fig.3).

Gompertz B. On the nature of the function expressive of the law of human mortality, and on a new mode of determining value of life contingencies. Phil. Trans. Roy. Soc. 1825; ***115****: 513.*

It is conventional wisdom among medical workers that people with disseminated cancer have an increasing mortality rate and people with a heart attack get over their disease and recover. Both of these assumptions are incorrect as found by Hardin B Jones, Professor of Medical Physics at the University of California at Berkeley in the 1950s.

He analysed statistics on mortality rates for different diseases from studies throughout the world and found that for chronic diseases, including both cancer and heart disease, people with these diseases lie on a constant slope mortality curve. Their mortality continues to double every 8½ years. Each disease has a different age-specific mortality rate line, but all the lines had the same slope. The line for cancer is higher than for healthy people. Alternatively it can be considered to be displaced to the left by about 15 years. In other words they behave as if they had aged by 15 years. (See Figure 2)

Jones HB. DemographicConsiderations of the Cancer Problem. Trans. NY Acad Sci 1956; ***18*** *(4): 298.*

His findings were confirmed 10 years later by Zumoff and others.

Zumoff B, Hart H, Helman L. Considerations of Mortality in Certain Chronic Diseases. Annals Intern Med 1966; ***64****: 595.*

The graphical method is sensitive to the effects of any therapy that can affect mortality because groups of patients whose mortality is reduced by intervention fall onto a lower, healthier mortality rate line. Jones was unable to find any intervention for cancer that produced mortality or survival benefits.

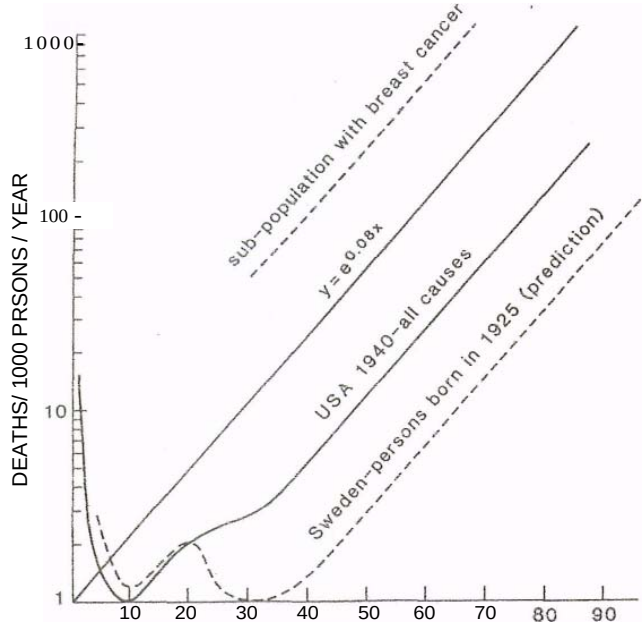


Fig.2 Sub-populations of people with specific degenerative disease have a constant-slope mortality rate curve, their mortality doubling about every 8.5 years (the same as healthy people). Those with a particular type of cancer have a characteristically high mortality rate. The line is displaced in time as if they had aged by 10-15 years,

A more common use of this graphical method involves plotting *relative* or *percentage survival* on a logarithmic scale against years from diagnosis. This produces a straight line sloping down from left to right. However in this case higher mortality rates produce a steeper slope.

Confirmation of this phenomenon has come from Maurice Fox who applied the graphical method to breast cancer. He used data on the survival of untreated breast cancer patients at Middlesex Hospital at the turn of the 19th century. This group had received no surgery, radiotherapy or chemotherapy. Their death rate was 25% per year with few survivors after 7-8 years. Fox then took the survival data of patients treated by surgery, radiotherapy and chemotherapy during the period 1950-1973 and plotted it in the same way as before.

This is shown as the black dots in Figure 4. The total treated group could be broken down into two sub-populations with a completely different prognosis. One group (40% of the total) had a poor prognosis and, like the untreated Middlesex

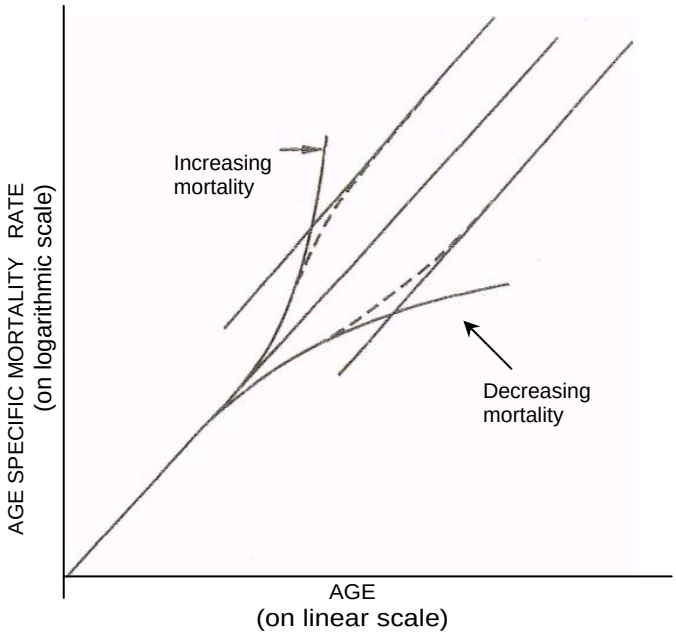


Fig. 3 There are fundamentally three types of mortality curves. 'Conventional wisdom' says that cancer shows increasing mortality and heart disease patients get over their disease after a heart attack. Both these suppositions are incorrect. Both diseases are associated with a constant slope mortality rate.

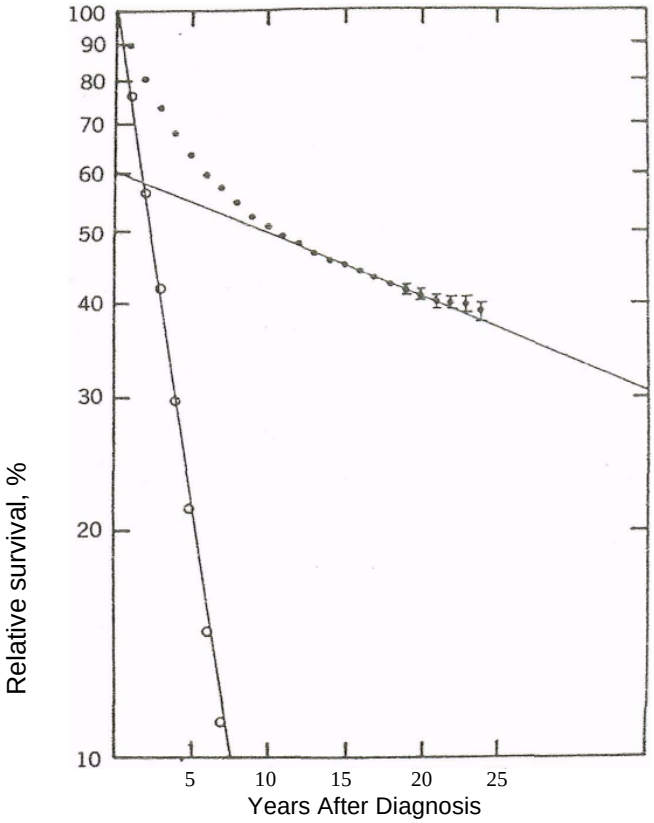


Fig.4 Survival data of breast cancer patients treated by surgery, radiation and chemotherapy from 1950-1973. It consists of two sub-populations: one (lower left) identical to that of untreated patients with advanced cancer, and the other (upper right) with survival only slightly less than that of healthy women of similar ages.

Hospital group, few had survived after 7-8 years. These are shown as open circles in Figure 4. The remaining 60% had a survival characteristic only slightly lower than that of women of similar age without evidence of cancer. These are shown by the other line in Figure 4.

*Fox MS. On the Diagnosis and Treatment of Breast Cancer. JAMA (Feb 2) 1979; **241** (5): 489-494.*

The normal conclusion drawn from this data is that breast cancer can be cured if detected early. However a second possible conclusion is that there are two groups of patients with breast cancer: 40% with a suppressed immune system for whom the cancer grows and spreads rapidly (the Middlesex Hospital group would have consisted mainly of advanced cases and therefore in this category); and 60% whose immune defences are still capable of keeping cancer under control. If the latter conclusion is valid it is possible that treatment had no effect in either of the groups.

The following analysis helps clarify this ambiguity by analysing survival for a complete group of breast cancer patients

It was at first thought that a sub-group of 704 women first seen with breast cancer in the Cambridge area from 1947 to 1950 and with long-term survival with breast cancer had been identified as 'cured' after 26 years using the correct definition of cure, viz *a group of people treated for a particular type of cancer have the same mortality rate as a comparable group of healthy people in the community.*

However further follow up after 35 years showed that the ratio of observed to expected deaths reached a minimum of about 2. (See Figure 5.) A 'cure' would require the curve to reach 1.

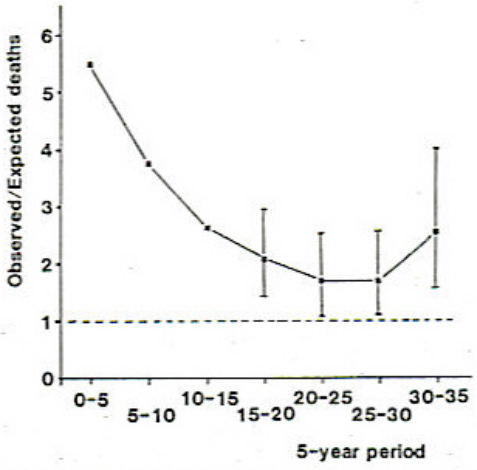


Fig..5 Ratios of observed to expected deaths in five-year intervals.
Error bars on last four points are 95% confidence limits.
Taken from Brinkley & Haybittle, Lancet 1984; **i**: 1118.

*Brinkley D and Haybittle JL. Long-term survival of women with breast cancer. Lancet (19 May) 1984; **i**: 1118.*

So the graphical method questions the claim that early surgery can cure or affect cancer.

Comparative studies or dose response analysis

Another useful source of evidence for evaluating the efficacy of cancer surgery is the group of randomised controlled trials that compared survival after different *degrees* of surgery: radical mastectomy, simple mastectomy, quadrantectomy, lumpectomy, or excisional biopsy. This is analogous to the dose response approach to determine the optimum dose of a relatively toxic medicine. A normal dose response curve is shaped like a bell. Too low a dose has no beneficial effect. The positive effect increases with dosage and reaches a maximum (optimal dose) after which the toxicity causes the response to fall back down again to reach zero. According to the current paradigm it is important to detect cancer early before cancer cells can spread. So the more healthy tissue around the tumour that is removed, the less likely it is for malignant cells to be left behind to spread. Excessively traumatic surgery could adversely affect the body. So there should be an optimum degree of excision to maximise survival. If this paradigm is invalid and cancer is a systemic disease with the tumour only a late-state symptom, it would make no difference how extensive the surgery was. The same survival would also apply without any surgical intervention.

Several such comparative studies have been carried out to measure the importance of radical surgery. All of these studies showed there was no difference in survival between women who underwent different degrees of surgery ranging from radical mastectomy to lumpectomy.

Fisher B et al. Ten-year results of a randomised clinical trial comparing radical mastectomy and total mastectomy with or

*without radiation. N Engl J Med 1985; **312** (11): 674.*

*Fisher B et al. Five-year results of a randomised clinical trial comparing Total Mastectomy and Segmental Mastectomy with or without radiation in the treatment of breast cancer. N Engl J Med 1985; **312** (11): 665.*

*Fisher B et al. Eight-year results of a randomised clinical trial comparing total mastectomy and lumpectomy with or without irradiation in the treatment of breast cancer. N Engl J Med 1989; **320**: 822-828.*

*Fisher B et al. Twenty-year follow-up of a randomized trial comparing total mastectomy, lumpectomy, and lumpectomy plus irradiation for the treatment of invasive breast cancer. N Engl J Med. 2002 Oct 17; **347** (16): 1233-41.*

*Veronesi U et al. Comparing Radical Mastectomy with Quadrantectomy, Axillary Dissection and Radiotherapy in patients with small cancers of the breast. N Engl J Med. 1981; **305** (1): 6.*

*Sarrazin L et al. Conservative Treatment versus Mastectomy in Breast Tumors with Macroscopic Diameter of 20 Millimeters or Less. Cancer 1984; **53** (5): 1209-1213.*

These results show the relevance of the comment made in 1963 by eminent cancer researcher Michael Shimkin that 'when many forms of treatment appear to yield the same results or lack thereof suspicion should arise that none is really effective and a no-treatment group in subsequent comparisons may be acceptable'

*Shimkin MB. The Numerical Method in Therapeutic Medicine, Public Health Reports 1964; **79** (1): 1-12.*

Despite what Shimkin said, still no randomised trials have been held to compare surgery with no treatment. Such a trial would be considered unethical today because it would involve withholding a "proven" treatment to demonstrate its efficacy. Such is the tortured logic of the medical profession. So the profession has locked itself in to an unproven method.

Comparison of incidence and survival

A third and fairly reliable measure of progress in cancer treatment comes from comparing the change of incidence of a particular type of cancer with the change in mortality over time. According to Enstrom & Austin progress in cancer control requires that the mortality rate decline more rapidly or rise more slowly than the incidence. There have been large changes in incidence and mortality over time for many cancers but in most cases the two graphs have changed by the same amount. In the few cases where incidence has risen faster than mortality, such as prostate and breast cancers, this can be explained by the fact that for prostate cancer there was an increasing rate of autopsies and operative procedures for other causes leading to an increasing recorded incidence of occult tumours most of which would not have caused serious symptoms during the man's lifetime. For breast cancer the increased incidence resulted from the introduction of breast cancer screening.

*Enstrom, JE & Austin, DF. Interpreting cancer survival rates. Science 1977; **195**: 847-851.*

As eminent Harvard cancer researcher John Cairns pointed out the incidence discovered by autopsies on 70-year old men who had died of other causes was up to 100 times as great as the incidence based on diagnosis of such patients presenting with symptoms. For this reason incidence figures are not a reliable measure for comparing with mortality trends for assessing progress in cancer control.

*Cairns, J. The Cancer Problem. Sci Am. 1975; **233 (5)**: 64-78.*

Similarly with breast cancer, the rising use of mammographic screening has identified many ductal carcinomas in situ, most of which would not have produced symptoms nor have been life-threatening.

Maurice Fox, mentioned above, plotted the change in incidence of breast cancer from the 1930s to the mid 1970s and compared this curve with that of breast cancer mortality over the same period. He found that both lines remained essentially flat and parallel until the mid 1960s when the introduction of mammographic screening resulted in an apparent increase in the incidence of breast cancer. This continued to rise as breast cancer screening became more widespread. Many more early breast cancers were detected and treated but the mortality rate curve remained unaffected. Figure 6 below (from the Fox paper) shows the divergence of the two lines from the 1960s as measure by Fox.

So comparison of incidence and mortality is only a valid measure of effectiveness if screening is not introduced. For this purpose incidence must be based on patients presenting with symptoms.

Baum has explained this phenomenon by pointing out that most of the tumours detected using mammo-grams are ductal carcinomas in situ, most of which are non-malignant in their nature.

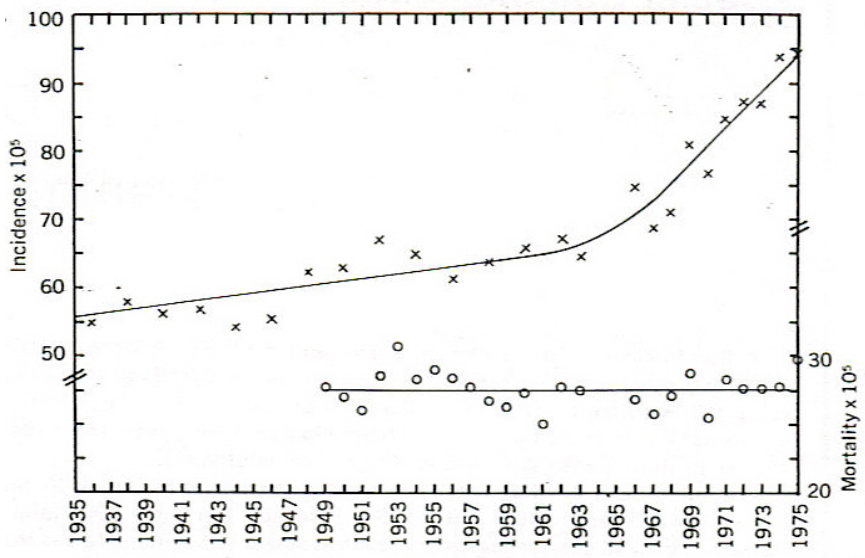


Fig.6 —Annual breast cancer incidence (x) and mortality (o) for Connecticut, age-adjusted for 1950 standard population (unpublished data, Connecticut Tumor Registry 1973, 1974, 1975).[20-27]

*Fox MS. On the Diagnosis and Treatment of Breast Cancer. JAMA (Feb 2) 1979; **241** (5): 489-494.*

*Baum M. False premises, false promises and false positives--the case against mammographic screening for breast cancer. Int J Epidemiol. 2004 Feb;**33** (1):66-7; Commentary, discussion 69-73.*

(The *in situ* status refers to the fact that the tumour has not invaded surrounding tissue, a basic requirement for malignancy.) These tumours are however described as cancer and are included in the breast cancer incidence statistics. Non-melanoma skin cancers are equivalent to *in situ* 'cancers' but, unlike *in situ* breast cancers are excluded from cancer statistics as these cancers do not invade surrounding tissue so do not satisfy the definition of malignant.

So there are no clear cases where survival could have improved as a result of surgery.

Increasing survival studies

A fourth and less reliable method of evaluating the efficacy of surgery is to compare percentage 5-year survival figures over time for the different types of cancer. For example there was an increase in percentage 5-year survival for all cancer sites between 1960 and 1975. According to Enstrom & Austin these figures are unreliable as a measure of progress in cancer control for several reasons including:

- increased 5-year survival can result from death happening later (real progress) or from making an earlier diagnosis. There is no progress here. Death still occurs at the same time but the existence of cancer has been known for a longer time leading to an 'apparent' increase in survival.
- Earlier detection affects the stage of a cancer when detected. For example stage III in 1990 is not the same thing as Stage III in 1970, and has a better prognosis irrespective of the effects of therapy.
- The 'Will Rogers phenomenon' shows that early detection results in an improved survival for **all** stages of a cancer, even if there is no overall increase in survival, because cases move into later stages boosting the apparent survival of those already in the later stage, similar to the previous point.
- Comparison between different years results in comparison of unmatched groups.

*Enstrom, JE & Austin, DF. Interpreting cancer survival rates. Science 1977; **195**: 847-851.*

According to Greenberg, another factor that can distort the survival figures is that

- Earlier figures with lower survival applied when more aggressive, and therefore more harmful treatments were reducing survival. An improved survival might simply reflect less harm done.

Greenberg, DS. A critical look at cancer coverage. Columbia Journalism Review. Jan/Feb 1975:40-44.

*Greenberg, DS . Medicine and public affairs. "Progress" in cancer research--don't say it isn't so. N Engl J Med. (Mar 27) 1975; **292** (13):707-8.*

The US General Accounting Office has confirmed that claims of increased survival have been overstated.

U.S. Congress General Accounting Office. Cancer Patients Survival; What progress has been made? PEMD-87-13, (3/31/87).

Recent evidence for the unreliability of an increasing percentage 5-year survival as a measure of cancer progress comes from a study headed by Gilbert Welch from the Dept of Veterans Affairs Medical Center in White River Junction, Vermont. In this study they calculated the change in 5-year survival from 1950 to 1995 for the 20 most common solid tumour types and correlated these changes in survival with changes in incidence and mortality for each tumour type. They found that from 1950-1995 there was an increase in 5-year survival for each of the 20 tumour types. The absolute increase ranged from 3% for pancreatic cancer to 50% for prostate cancer. During the same period mortality rates declined for 12 types of cancer and increased for the remaining 8 types. There was little correlation between changes in 5-year survival for a specific tumour and the change in tumour-related mortality. On the other hand the change in 5-year survival was positively correlated with the change in the tumour incidence rate. They concluded that 5-year survival is a valid measure for comparing therapies in a randomised trial but changes in 5-year survival bear little relationship to changes in mortality. Instead they appear related to changing patterns of diagnosis.

Welch HG et al. Are increasing 5-year survival rates evidence of success against cancer?. JAMA (14 June) 2000; ***283*** *(22): 2975-8.*

Epidemiological studies

A fifth method of evaluating a medical intervention is to observe mortality figures over time before and after the introduction of a new therapy or procedure. If the therapy or procedure is effective in reducing mortality the curve should show a significant drop in the mortality rate after its introduction.

One procedure widely claimed to have reduced cancer mortality is the Pap smear (named after its inventor George Papanicolaou). It is claimed that after its widespread introduction in the early to mid 1950s the mortality rate for cancer of the uterus, which includes cervical cancer, fell and has been falling since as a result of the test's continuous use.

Figure 7 suggests that this claim is also questionable. The death rate figures come from the American Cancer Society publication: Cancer Fact and Figures, 1984. The arrow has been added to show the time of introduction of the Pap test. It is clear from the slope of the graph in Figure 7 that the mortality had already peaked in the 1930s and had started its sharp decline before 1950. There was no change in slope of the graph after the widespread introduction of the Pap test. A similar lack of effect can be shown in relation to the introduction of mammographic breast cancer screening.

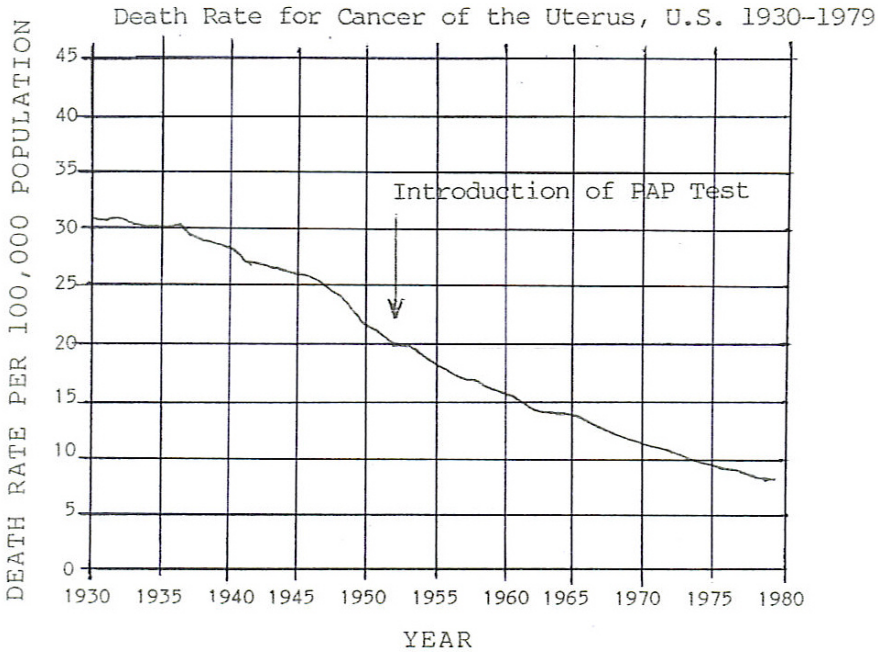


Fig.7. The declining mortality of uterine cancer in the United States. This death rate includes death from cervical cancer. The falling rate was not affected by the introduction of the Pap test.

None of these five methods have shown that surgery had affected survival or mortality for any type of cancer.

As stated above surgery has never been evaluated in a *properly run* randomized controlled trial comparing it with an untreated group. However, a recent paper reported on the result of a randomised trial comparing Radical Prostatectomy with Watchful Waiting for prostate cancer. This is probably the first randomised trial to evaluate the effects of surgery by comparing survival or mortality with an *untreated* group. However it contained serious flaws. For example

- it used an ambiguous definition of "*death from prostate cancer*" and claimed a 50% reduction in mortality using surgery as compared with watchful waiting.
- an analysis of the deaths from other causes showed that most of the apparent reduction in deaths from prostate cancer could be explained by
  - wrong attribution of deaths from prostate cancer to deaths from other causes in the treated group; or
  - deaths from other causes attributed to prostate cancer deaths in the watchful waiting group.

The reduction in overall mortality was not significant.

Holmberg L et al. A randomized trial comparing radical prostatectomy with watchful waiting in early prostate cancer. N Engl J Med (Sep 12) 2002; ***347*** *(11): 781-9* and *Comment by Scott D Stern in NEJM of (January 9) 2003;* ***348*** *(2): 171.*

There are also widespread claims that early surgical intervention following early detection of breast cancer saves lives. If this is the case, why hasn't this shown up in the above studies?

In 1996 Don Benjamin presented evidence that, contrary to widespread claims, mammograms don't save any lives and that:

- Claims for efficacy of earlier surgical intervention are based on flawed randomised trials that ignored the effects of five other variables, including the harm done by radiotherapy. There should be only one variable in a properly run randomised trial.
- If any of these variables were used differently in the study group as compared with the control group, the conclusions from the trials were invalid.

The variables in the two arms of all of the six trials evaluating mammography screening were:

- use of mammograms (the main independent variable)
- time of surgical intervention (how early – logically linked to the first variable)
- extent or degree of surgical intervention – 2nd variable (mastectomy vs lumpectomy)
- use of radiotherapy – 3rd variable
- use of chemotherapy – 4th variable
- use of hormone therapy – 5th variable

Benjamin, DJ. The Efficacy of Surgical Treatment of Breast Cancer. Medical Hypotheses 1996; ***47****: 389-397.*

All of these four other variables were used differently in the study group when compared with the control group. This was because the trial protocols stipulated differing treatment depending on the stage of the cancer when detected. He therefore concluded that the trials were seriously flawed and that the conclusions from these trials were invalid.

He therefore tried to identify which of these other variables could have affected mortality, and how their different use in the two groups might have produced this apparent reduction in breast cancer mortality, claimed to be up to 30%.

He found that most of the apparent reduction in deaths from breast cancer could be explained by women who would have died from breast cancer instead dying from other causes, due to the harmful effects of radiotherapy damaging the heart and respiratory systems.

All trials were flawed because their authors had not considered the fact that the reduced deaths from breast cancer were accompanied by a similar increase in deaths from other causes in the screened group, giving no significant overall benefit from screening. For example in the trial showing a reduction of 30% from breast cancer there was a 62% increase in deaths from other causes.

His 1996 findings were later confirmed by members of the Nordic Cochrane Group in Denmark who concluded that because of this and other flaws in all of the trials, screening for breast cancer with mammography is unjustified. There is no evidence from such trials that mammograms save lives or even extend survival.

*Olsen, O and Gøtzsche, P. Cochrane review of screening for breast cancer with mammography Lancet 2001; **358**: 1340-42.*

As mentioned above in relation to *Comparing Incidence and Survival*, Professor Michael Baum, a former proponent of Mammogram Screening in the UK now opposes the continuation of the breast cancer screening program as it not only produces no proven benefits, but has increased the number of unnecessary mastectomies carried out on non-fatal ductal carcinomas in situ.

*Baum M. False premises, false promises and false positives--the case against mammographic screening for breast cancer. Int J Epidemiol. 2004 Feb;**33** (1):66-7; Commentary, discussion 69-73.*

The actual effect Don Benjamin identified, harm from radiotherapy, has also been confirmed as follows:

1. A review of 36 randomised trials compared mortality after surgery and radiotherapy with surgery alone. The observed 6% reduction in deaths from breast cancer was accompanied by a 24% increase in deaths from other causes, which the reviewers attributed to damaging effects of radiotherapy on the heart. There was no overall benefit observed from the radiotherapy

Early Breast Cancer Trialists' Collaborative Group. Effects of Radiotherapy and Surgery on Early Breast Cancer – An Overview of the Randomised Trials. NEJM 1995; **333** *(22): 1444-1455.*

2. An analysis in Sweden of this effect found that patients who received the highest dose of radiotherapy had a
   - ❑ 30% increase in heart failure
   - ❑ 100% increase in deaths due to cardiovascular disease
   - ❑ 150% increase in death due to ischemic heart disease

   The difference became clear after 4-5 years and continued to increase up to 10-12 years.

Geynes G et al. Long-term cardiac morbidity and mortality in a randomized trial of pre- and postoperative radiation therapy versus surgery alone in primary breast cancer. Radiother Oncol (Aug) 1998; **48** *(2): 185-190.*

Other researchers have identified the actual mechanism of the damage to the heart:

The excess observed was confined to the sub-set of patients treated with tangential cobalt-60 fields for left-sided tumours, where the dose to the myocardium was greatest.

They observed that for left-sided tumours the dose to the left anterior descending coronary artery remained high even with newer techniques with lower doses.

*Cuzick J et al. Cause–Specific Mortality in Long-Term Survivors of Breast Cancer Who Participated in Trials of Radiotherapy. J Clin Oncol (March) 1994; **12** (3) 447-453.*

Another form of screening for breast cancer, breast self-examination (BSE) has also recently been found to produce no benefits in survival.

*Baxter, N. Preventive health care, 2001 update: Should women be routinely taught breast self-examination to screen for breast cancer? CMAJ (June 26) 2001; **164** (13): 1837-46.*

*Thomas DB et al. Randomized trial of breast self-examination in Shanghai: final results. J Natl Cancer Inst 2002; **94** (19): 1445-57.*

So early detection of breast cancer has no proven benefit if only orthodox treatments are then used.

What then is the basis for the continued claim by cancer authorities throughout the world that mammograms **do** save lives? They usually cite two sources of evidence:

- Expert opinion; and
- Falling breast cancer mortality rates.

Expert Opinion*:* Following the findings by Olsen & Gøtzsche in 2001 that mammograms could not be justified, a Working Group was convened of the International Agency for Research on Cancer (IARC) (part of the World Health Organization). 24 experts from 11 countries (representing vested interests in cancer from these countries) took part. Their press release No. 139 on 19 March 2002 dismissed the findings of the Cochrane Group and claimed that "many of the earlier criticisms were unsubstantiated and the remaining deficiencies were judged not to invalidate the trials' findings". They concluded that there was a reduction of mortality of 35% among women aged 50-69 who chose to participate in screening. No peer-reviewed paper was published to substantiate this claim so from a scientific viewpoint this statement has no scientific status.

Falling breast cancer mortality rates*:* Australian experts were quoted as saying that the recent fall in breast cancer mortality rates was due to the breast cancer mammographic screening program. Again no peer-reviewed paper was published to substantiate this claim. What are these recent falling statistics? The following two graphs provide a recent analysis of these rates both in the US and in Australia.

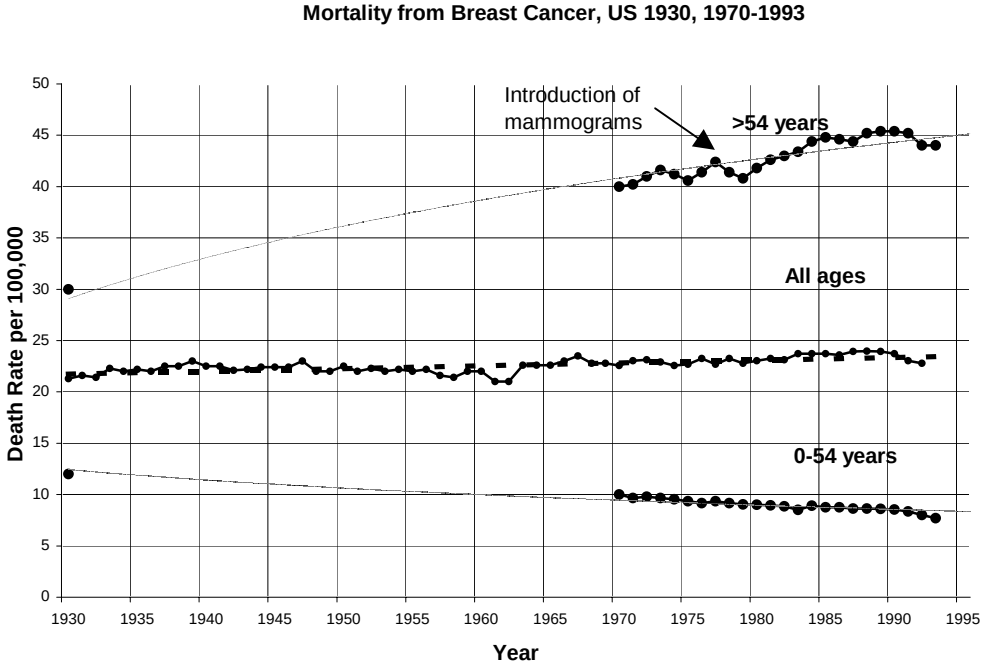


Figure 8. Changes in Mortality from breast cancer between 1930 and 1993. The arrow shows the introduction of mammography screening in the late 1970s.

Figure 8 shows that the *all ages mortality* has remained relatively constant at about 22-23 deaths per 100,000 of population for this entire period (~45 per 100,000 females). The claimed "reduction of mortality of 35% among women aged 50-69 who chose to participate in screening" would reduce their mortality from about 40 to 26. As a significant number of women in the US have chosen mammography screening and there had been no reduction in mortality by 1990 this claim must be invalid. The mortality among women >54 years appears to have peaked in about 1991. If the *all ages mortality* starts to fall it will be partly because of the under 55 aged women. Their mortality has been falling for many years (for reasons unrelated to mammographic screening) and this will no longer be counteracted by a rising mortality in older women. (1970-93 mortality data from a paper by John Bailar)

Bailar JC & Gornik HL. Cancer Undefeated. N Engl J Med 1997; ***336*** *(22): 1569-1574.*

If the mortality of women >54 also falls this will be partly because breast cancer incidence among this age group has also started to fall. Other reasons for this changing mortality are as follows:

Chu et al have published age-specific breast cancer mortality rates by decade beginning with women 30-39 years of age. They have argued that "statistical modeling indicates that the recent drop in breast cancer mortality [ie after 1995] is too rapid to be explained only by the increased use of mammography; likewise, there has been no equivalent dramatic increase in survival rates that would implicate therapy alone".

Chu KC et al. Recent trends in U.S. breast cancer incidence, survival and mortality rates. J Natl Cancer Inst 1996; ***88****: 1571-9.*

Gray et al have published the changes in *age at first birth* for women born over the period 1890 to 1960 showing some dramatic changes during this period. For example for women born after 1903 it had risen from 24 to 25.5 eight years later (1911). It had then fallen to 21.7 in women born in 1940 after which it had again risen to 24 ten years later (1950).

Gray GE et al. Changing ratio of breast cancer incidence rates with age of black females compared with white females in the United States. J Natl Cancer Inst 1980; 64: 461-3.

Feigelson et al, linking the data from Chu et al and Gray et al had noted that changes in age-specific breast cancer mortality rates can be correlated with corresponding changes in age at the birth of their first child. Factors associated with the earlier age of first birth apparently confer some protection from death from breast cancer. Or to put it another way, there is an increase in mortality that corresponds to an increased risk associated with the rise in the mean age at first pregnancy.

They observed that the ups and downs of breast cancer mortality by age group were consistent with these changes in *age at first birth*. For example those women in the age group 50-59 born between 1908 and 1938 experienced a consistent drop in mortality over the period 1973 to 1993. This fall in mortality also extended to women aged 40-49 born between 1928 and 1938. However for women born from the 1940s the *age at first birth* again increased until it had reach 24 around 1950 – the so-called 'baby boomers'. Mortality rates also increased for this group during the period 1980-99. This suggests the mortality rates for women >54 peaked because of the peaking of *age at first birth* of baby boomers.

The only change inconsistent with these factors were in the women under 49 born after 1940s whose mortality rates continued to fall.

Feigelson HS et al J Natl Cancer Inst (3 Dec) 1997; ***89*** *(23): 1810.*

Claims that the recent fall in mortality over most age groups cannot therefore be attributed to the use of mammogram screening or medical intervention, either with tamoxifen or adjuvant chemotherapy. Rather it would appear to be a combination of factors including:

- harm from post operative procedures, such a radiotherapy and chemotherapy, transferring breast cancer deaths to deaths from other causes, as happened in the screening trials;
- a natural falling incidence of breast cancer due to factors such as those mentioned by Feigelson et al above, masked to some extent by a continued artificially increased incidence resulting from mammography screening; and
- falling incidence of breast cancer after rising artificially in the 1980s and peaking in 1990. As with prostate cancer, mortality rates rose artificially along with incidence as a result of screening in the 1980s. Women diagnosed with breast cancer as a result of screening are more likely to have their deaths attributed to breast cancer than those not so diagnosed.

Feuer EJ et al. Cancer surveillance series: interpreting trends in prostate cancer – part II: cause of death misclassification and the recent rise and fall in prostate cancer mortality. J Natl Cancer Inst 1999; ***91****: 1025-1032.*

In Australia there are no comparable curves for the recent period. Figure 9 shows a graph compiled from NSW breast cancer mortality statistics. As can be seen from the upper graph for women over 54

years of age, the annual rates shown as black dots exhibit large variations from year to year due to the inaccuracy of statistical measurements.

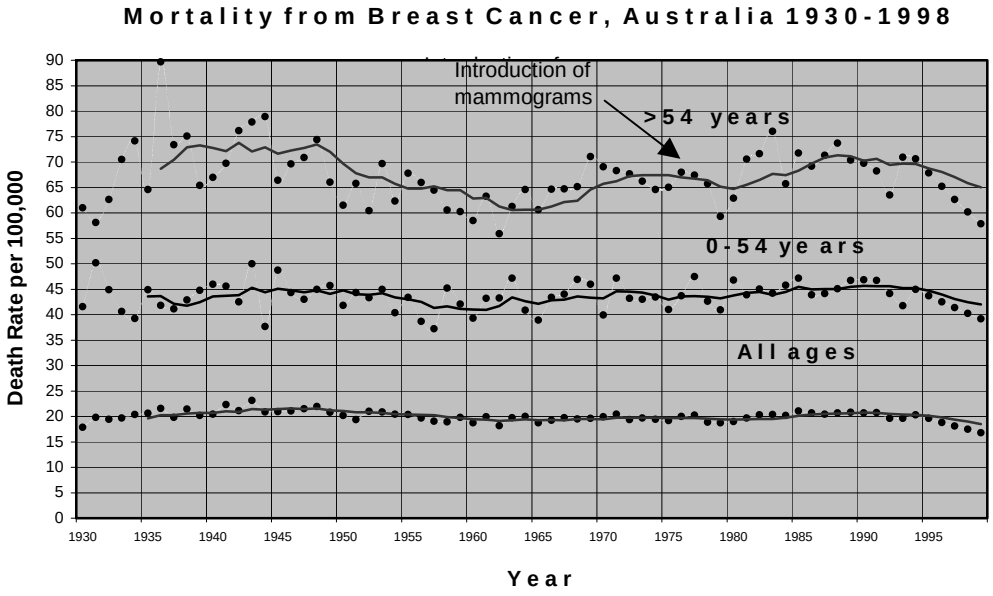


Figure 9. Mortality from Breast Cancer in Australia since 1930. The white line joining the black dots represents the year to year fluctuations. The black line shows the longer-term trend.

Since 1930 there have been several periods when there was an apparent short or long downward change in mortality (eg 1955-62 and 1969-75) followed by a comparable upward change. The more recent downward change from 1994-99 should be viewed in this light since the current low rate is comparable with that in 1962 well before the introduction of mammographic screening.

It is also possible that, as in the mammographic screening trials, any reduction in deaths from breast cancer could be accompanied by increased deaths from other causes resulting from harm from treatment that would appear in other mortality statistics.

The significant increase in mortality after the introduction of mammographic screening would suggest that the same artificially increased incidence observed in the United States statistics also occurred in Australia as a result of the increased likelihood of death being attributed to breast cancer..

So the claims of continued benefits from mammographic screening rely on “expert opinion”, which is contrary to all published evidence, and questionable mortality statistics. It is worth remembering that the reason the Scandinavian Cochrane Group chose to assess the methodology of the mammogram screening trials was that a 1999 epidemiological study found no decrease in breast cancer mortality in Sweden after 15 years, despite the fact that mammography screening had been recommended since 1985.

The same lack of evidence applies for other forms of cancer screening.

A paper reporting on results of a randomised trial comparing mortality after PSA screening with an unscreened control group also contained serious flaws.

- Although its authors claimed a 69% reduction of deaths as a result of screening they arrived at this figure by
  - comparing only 23% of those invited for screening in the Invited group (who were actually

screened) with 93.5% of those in the Uninvited group (who were actually unscreened), a meaningless comparison in randomised trials because they were unmatched groups;

or, in a second analysis by

– combining part of the Invited group with part of the Uninvited group (those actually screened in each group) and compared their mortality with that of a different group made up from combining part of the Invited group with a part of the Uninvited group (those actually unscreened in each group) , another meaningless comparison because they were unmatched.

An even more serious flaw was that

- the authors completely ignored the deaths from other causes in their calculations.

When the whole Invited group was compared with the whole Uninvited group the difference in mortality was not significant – the only meaningful comparison.

*Labrie F et al. Screening decreases prostate cancer death: first analysis of the 1988 Quebec Prospective Randomized Controlled Trial. Prostate 1999; **38**: 83-91.*

*Comment by Rob Boer and F Schröder. Quebec Randomized Controlled Trial on Prostate Cancer Screening Shows No Evidence for Mortality Reduction. The Prostate 1999; **40**: 130-131; and Freda Alexander and Robin Prescott. Reply to Labrie et al. The Prostate 1999; **40**: 135-136.*

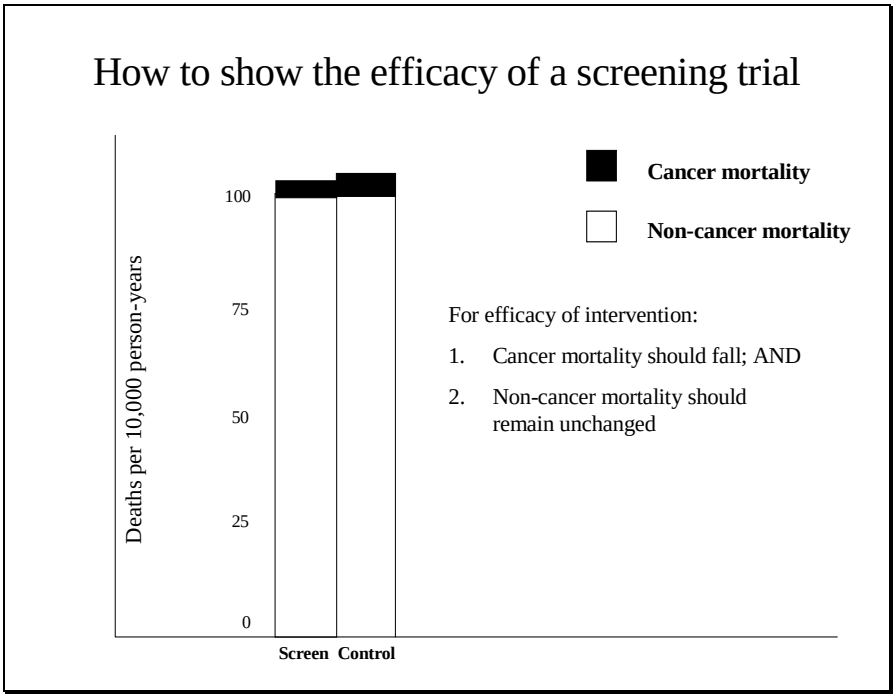
The same lack of scientific rigour applies to other forms of cancer screening.

In addition to those already mentioned, prostate, breast and cervical cancer, screening is currently being used for cancer of the cervix (Pap smear) based on flawed assumptions, and is being proposed for other types of cancer: colon cancer (fecal occult blood test) and lung cancer (X-rays).

A recent review of randomised trials evaluating screening for cancer has also cast doubt on the benefits of these forms of screening for the same reasons that have been identified in relation to mammogram and PSA screening trials, viz failure to take into account deaths from other causes. Authors had looked only at reduced deaths from the particular cancer and ignored comparable increases in deaths from other causes resulting from harm caused by the screening or subsequent treatment.

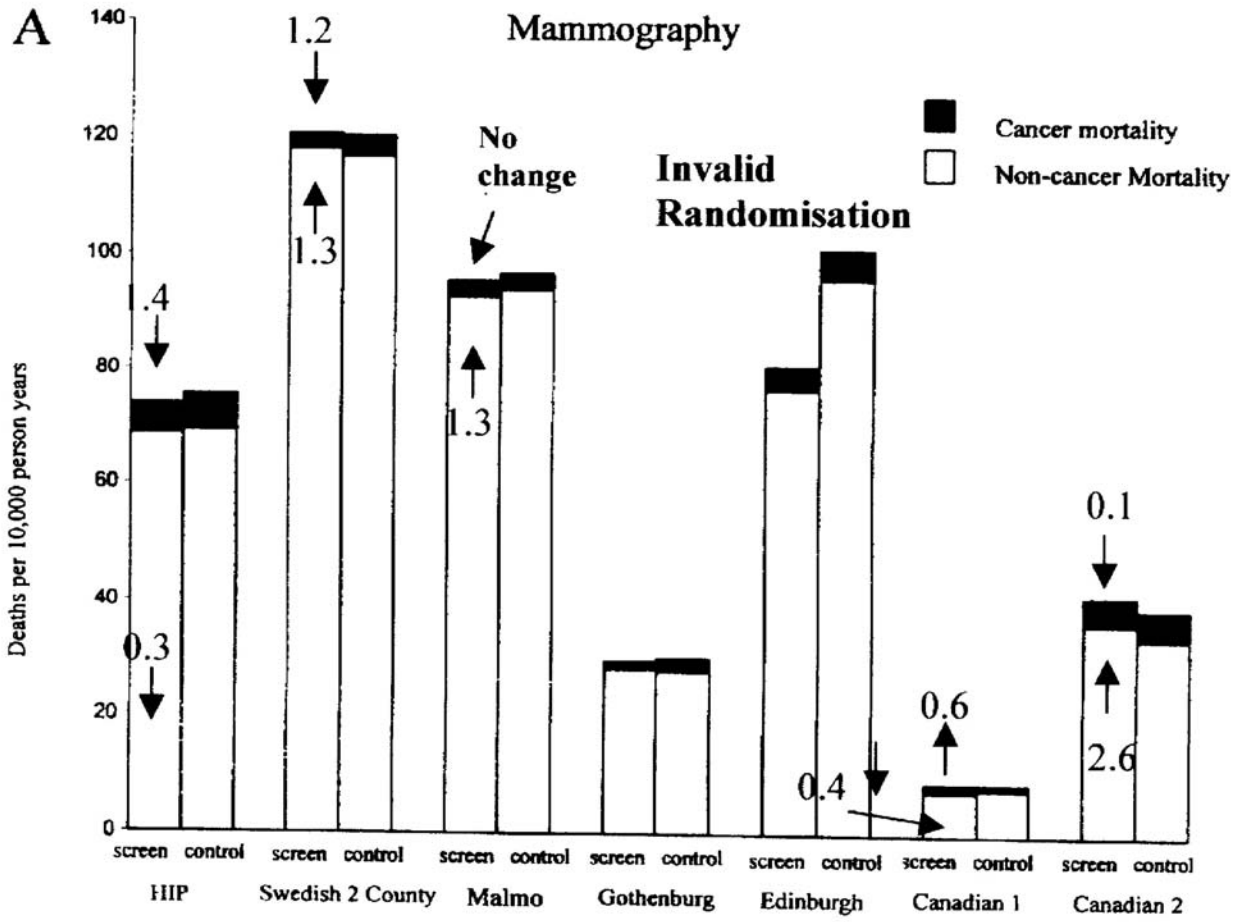
The following shows some of this evidence for breast, colon and lung cancer screening.

The first figure below shows the evidence necessary to show that a particular type of cancer screening is effective in reducing the cancer mortality rate using a properly run randomised controlled trial.



- In the two columns their height represents the total number of deaths from all causes in the two arms of the trial: the screened group and the unscreened (control) group.
- In the top section of each column is a black area representing how many of these overall deaths were due to the particular type of cancer.
- For the screening to be effective in saving lives the black section at the top of the left column must be smaller than the black section in the right column; AND, IN ADDITION
- The height of the white section in each column must remain the same.
- If the black section in the left column decreases and the white section increases by about the same amount, there is no proven benefit from screening.

The second Figure (A) shows the cancer and non-cancer mortality for the 7 randomised trials evaluating breast cancer screening using mammography discussed above.



Most of the trials were found to have serious flaws. The one with the fewest flaws Malmö showed no reduction in deaths from breast cancer and a reduction in deaths from other causes.

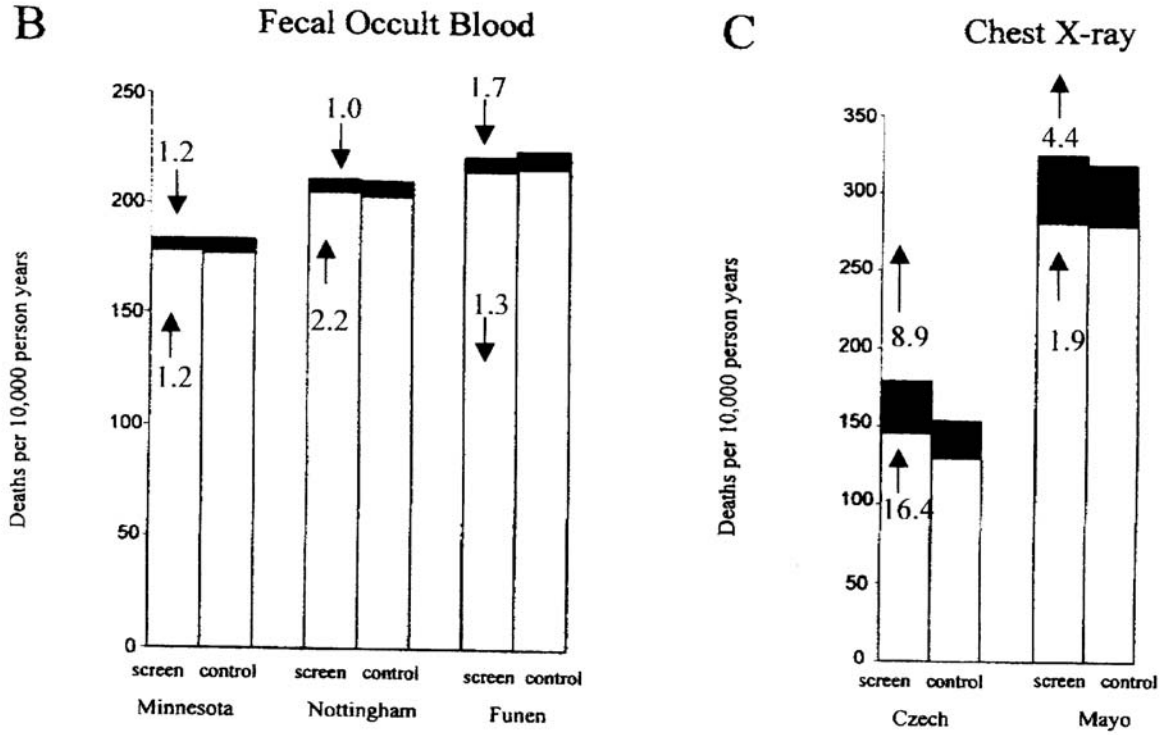
Although the Health Insurance Plan of New York (HIP) Trial appears to satisfy the above requirements, it was found to be flawed for several reasons. For example many more high risk women were excluded from the treatment group than from the control group *after* randomization. The Gothenburg Trial showed a small benefit that was not significant. The Edinburgh Trial was flawed due to poor randomisation, which was based on screening centres, not individuals. The Canadian Trial 1 (women aged 40-49) showed slight harm from screening but this was not significant. The Canadian Trial 2 (women 50-59) also showed greater harm but this was also not significant.

Cancer authorities usually quote the results of one of the flawed trials called the Swedish 2 County trial. There was a reduction in deaths from breast cancer (~30%) shown as a fall of 1.2 on the left column, accompanied by a comparable increase in deaths from other causes, shown as an increase of 1.3. The net result was no overall benefit. This result suggests that treatment harmed many of the women and they died as a result of the treatment, thus reducing the apparent deaths from breast cancer.

Death resulting from treatment should be included among deaths from the cancer for which they were being treated. This did not happen, mainly because many of the women who died had several problems: the breast cancer had produced some symptoms but these were accompanied by heart problems caused by damage from the radiotherapy, and respiratory problems caused by chemotherapy.

Unless the determination of cause of death is "blinded" the real cause of death can be missed. Another serious flaw was that, like the New York Trial, many more high risk women were excluded from the treatment group than from the control group *after* randomization. This is invalid in randomised trials because it results in the comparison of unmatched groups.

The third Figure (B) shows the results of the three trials evaluating colon cancer screening using the Fecal Occult Blood Test (FOBT).



In the first two trials (Minnesota and Nottingham) there was a fall in deaths from colorectal cancer but in each case this was accompanied by a similar increase in deaths from other causes, showing the effect of harm from the treatment.

In the third (Funen) trial, although there was an apparent fall in deaths from colorectal cancer, the accompanying larger fall in deaths from other causes throws some doubt on the validity of the trial. In any case the fall in overall deaths was not significant.

When a result is *not significant* this means the confidence interval in the result is wide enough to include zero, ie no benefit. This suggests the result is likely to be due to chance, not treatment.

The fourth Figure (C) shows the results of the two trials evaluating X-ray screening for lung cancer.

Both trials showed an apparent increase in deaths from lung cancer after screening.

In the Czechoslovakian Trial the difference in all-cause mortality between the two groups was much greater than the lung cancer mortality in the control group despite the fact that the two groups were well matched after randomisation. This suggests an under-reporting of deaths from other causes (and therefore also from all causes) in the control group biasing the results against screening.

*Black W, Haggerstrom D and Welch HG. All-cause Mortality in Randomized Trials of Cancer Screening. J Natl Cancer Inst, 6 Feb 2002; **94**(3):167-73; Author's response to discussion:5 June 2002; 94(11):865-6.*

So like prostate cancer screening, none of the other screening trials showed any benefit from earlier intervention following screening. Despite this clear evidence, cancer authorities are arguing for retaining breast cancer screening, extending it down to women aged 40-49 and introducing widespread colon cancer screening.

There has been some recent debate about the benefits of early detection, particularly with prostate cancer. It shows a serious misunderstanding of the nature of evidence by some "experts". The following are some quotes from the two sides of the debate:

Alan Coates, CEO State Cancer Council –

> "In the absence of symptoms there is no point in having a PSA test. The test turns healthy old men into cancer patients or cancer suspects without any proof that it helps stop them dying from the disease".

Australian Financial Review, 13 February 2003.

Phillip Stricker, Director of urological oncology, St Vincents Hospital –

> "We have treatment that can cure prostate cancer. And you can't find cancer of the prostate if you don't look for it".

Sydney Morning Herald, 18 April 2003.

Michael Schildberger, former Executive Producer and host of Channel Nine's "A Current Affair" –

> "If I'd listened to Professor Coates' advice I'd probably be dead by now."

Anthony Costello, professor and director of urology at Royal Melbourne Hospital –

> "Coates is preaching a very old dogma and the debate has moved on…Coates is relying on epidemiology, which isn't an exact science and there is now enough clinical evidence to show that diagnosing prostate cancer early through PSA testing does save lives".

Ralph Hunt, former federal Health Minister also believes he is alive today only because of testing and early treatment.

Alan Coates replies:

> "Their position is based on an untested assertion and as such is a matter of faith, not science. While it would be nice to think we had moved on, it would be even nicer to have evidence rather than dogma to support this assertion".

Australian Financial Review, 10 and 13 February 2003

Yet Alan Coates supports the continued use of mammographic screening.

What is the evidence behind these opposing assertions? Their relative reliability in relation to prostate cancer is as follows:

● Properly run randomised controlled trials supported by epidemiological evidence –	BEST	No good trials done
● Properly run randomised controlled trials –	GOOD	No good trials done
● Comparison of incidence and mortality over time –	FAIR	No evidence
● Epidemiological evidence	FAIR	No evidence
● Increasing percentage 5-year survival supported by epidemiological evidence –	FAIR	No evidence

- Increasing percentage 5-year survival – POOR No evidence
- Anecdotal/Clinical evidence – POOR Some evidence

So it would appear that Alan Coates is right: The only randomized trial evaluating PSA screening for prostate cancer was poorly run. Those claiming benefits from intervention following early detection are making an untested assertion that is a matter of faith, not science because it is based on anecdotal/clinical evidence.

So, like surgery itself, early surgical intervention following early detection has not been shown to extend survival for any type of cancer.

Surgery can of course extend a life by removing an obstruction to a vital organ such as the bowel, but this does not necessarily affect the cancer process, if, as seems to be the case, the tumour is only a symptom or element of that process. Removal of a benign lump in such a case can also save a life.

This lack of efficacy of surgery has been known for many years. The following is a selection of comments by eminent experts:

Hardin B Jones, Professor of Medical Physics at the University of California at Berkeley:

> "... no studies have established the much talked about relationship between early detection and favourable survival after treatment"… "The apparent life expectancy of untreated cases of cancer ... seems to be greater than that of treated cases"..."Neither the timing nor the extent of treatment of the true malignancies has appreciably altered the average course of the disease."

Delivering a "Report on Cancer" at the American Cancer Society's Science Writers' Conference in New Orleans, 7 March 1969.

Herbert Green, from New Zealand's Auckland Hospital (referring to the findings of H.B. Jones that treatment has little influence on the overall outcome):

> "...it appears that duration of symptoms makes no difference to ultimate outcome in cervical cancer - regardless of the stage or type of treatment."..."It is possible that the same holds for cervical and, if anatomic staging and duration of symptoms are important in prognosis, that the type of treatment is of less importance than is thought?"

Green, G. H. Duration of Symptoms and Survival Rates for Invasive Cervical Cancer. Aust. & NZ Journal of Obstet. and Gynec. 10, 1970, 238.

Richard Taylor (later Associate Professor at Sydney University) published a damning critique of his profession in 1980 attacking the excessive use of unproven and unsafe tests, treatment and technologies. He concluded that

> "… 'medical science' would be better labelled 'science-fiction medicine'. This... is particularly apt for a supposedly scientific discipline which pays more attention to promoting its technology than evaluating it, and spends more time stridently announcing victories than carefully analysing failures".

Taylor, Richard. Medicine Out of Control, Sun Books, Melbourne 1979.

James E. Devitt, MD PhD, FRCSC, a retired Canadian cancer surgeon who was the keynote speaker at the Lancet's Conference "The Challenge of Breast Cancer" in Brügge, Belgium on 21 April 1994 (where Don Benjamin presented his preliminary findings of his 1996 paper questioning the efficacy of mammograms), said

> "...Amputating, irradiating, or ignoring involved regional lymph-nodes does not affect survival. Preventing local recurrence after mastectomy by radiotherapy does not affect survival. The reappearance of cancer in the breast after conservative surgery does not worsen survival. The outcomes of screening studies, though controversy continues, suggest that failing to find some breast cancers and finding others later does not prejudice outcome"…..

"…Have we missed the forest by focusing on the tree? Perhaps the breast lesion is not the cause of the disease but merely the local expression resulting from a combination of changes in both local organ-tissue and systemic growth-restraining factors."

*Devitt, JE, Breast Cancer: have we missed the forest because of the tree? Lancet 1994**; 344**: 734-5.*

E. F. Lewison, (in relation to breast cancer surgery)

"In recording our surgical triumphs are we merely measuring the natural history of this malignancy?"

Lewison, E. F. An Appraisal of Long-Term Results in Surgical Treatment of Breast Cancer. JAMA 186 (11), 1963, 975-978.

Thomas L Dao, of the Roswell Park Memorial Institute's Department of Breast Surgery wrote (in a collection of essays in 1973 celebrating the 75th anniversary of Institute):

"Despite improved surgical techniques, advanced methods on radiotherapies, and widespread use of chemotherapies, breast cancer mortality has not changed in the last 70 years."

*Dao, Thomas L. Quoted by Greenberg, DS, in "Progress" in Cancer Research - Don't Say It Isn't So. N Engl J Med 1975; **292** (13): 707-708.*

A study in Germany compared the survival of treated and untreated elderly women with breast cancer. **Gregl** found that untreated women lived longer and recommended that such cancers not be treated.

Gregl, A., *Die Lebenserwartung des unbehandelten Mammarkarzinoms. Klin. Wschr 1963; **41**: 676.*

Miles Little, Emeritus Professor of Surgery, addressing a cancer conference at Sydney University in 1974 concluded:

"Despite refinements in surgical technique and management, and increasingly radical surgery, there is considerable doubt about the impact of surgery on the natural history of most malignancies. The apparently logical hypothesis that earlier diagnosis and more radical excision would lead to more cures, has not been borne out in practice. Surgery brings a mechanical approach to a biological problem".

Jacka J. Statistics relating to cancer, p.1 in Cancer - A Physical and psychic profile. Currency, Melbourne, 1977.

Michael Baum;

"…In the light of these results it is surely complacent to continue our current practice of subjecting at least 70% of women with primary disease to a futile mutilating procedure without further questioning."..

"Most cases of breast cancer seen in practice must be considered incurable. Our failure to improve survival rates has been due to clinicians rigidly maintaining obsolete concepts of the nature of the disease. If the current generation is to reduce mortality clinicians must first reject the simplistic mechanistic view of the disease that has led to more and more aggressive local treatment."

"Breast cancer is a systemic disease until proved otherwise. We must abandon the assumption that dissemination has not occurred until it is proved... "

*Baum, M., The Curability of Breast Cancer, Br Med J 1976;**, 1**; 439-442.*

L Cunningham:

"There is no evidence that early mastectomy affects survival. If women knew that they would probably refuse surgery".

Cunningham, L., Mastectomy for so-called lobular carcinoma in-situ, Lancet, 1980,1,306:

Peter Skrabanek:

"The evidence that breast cancer is incurable is overwhelming. The philosophy of breast cancer screening is based on wishful thinking that early cancer is curable cancer, though no-one knows what is "early"..."Adherence to these myths and avoidance of reality undermines the credibility of the medical profession with the public"..."If breast cancer is incurable, as many surgeons believe, then screening only adds years of anxiety and fear"..."It

is unacceptable to remove breasts on the basis of theoretical speculation. ”

Skrabanek, P., False premises and false promises of breast cancer screening, Lancet 1985,2,316-319.

Alan Langlands

“...It is perhaps time to stop and think. Some realism, if not fatalism, is creeping into the discussion. In spite of the hype which surrounds many of the publications and "breakthroughs", the fact remains that breast cancer is an incurable disease. So much so that a recent editorial in The Lancet was entitled "Breast cancer: have we lost our way?". It challenged clinicians and basic researchers to meet and try to find novel ways to approach this disease... ”

*Langlands, AO, Battling breast cancer with dollars and sense, Medical Journal of Australia (18 July) 1994; **161** (Editorial)*

Evaluating Radiotherapy for Cancer

As mentioned above a review of randomised trials of radiotherapy following surgery for breast cancer showed that overall survival was not affected, with the reduction in deaths from breast cancer being accompanied by an equal increase in death from other causes due to the radiotherapy.

*Early Breast Cancer Trialists’ Collaborative Group. Effects of Radiotherapy and Surgery in Early Breast Cancer – An Overview of the Randomised Trials. NEJM 1995; **333 (22)**: 1444-1455.*

A similar situation exists for colorectal cancer. The Colorectal Cancer Collaborative Group published results of a review of 22 randomised trials in 2001.

*Colorectal Cancer Collaborative Group. Adjuvant radiotherapy for rectal cancer: a systematic overview of 8507 patients from 22 randomised trials. Lancet 2001; **358:** 1291-304.*

Commenting on their results Ralph Moss stated that they “show that neither preoperative nor postoperative radiation therapy has an appreciable effect on overall survival in patients with this disease. Patients who received postoperative radiation therapy did have a 9% lower risk of death from rectal cancer than controls. But this survival advantage was all but wiped out by the more frequent deaths from other causes in the radiation therapy group. Overall, the risk of death from causes other than rectal cancer was 15% higher in those who received radiation therapy than in those who did not, a significant difference.

Moss, RW. Preoperative and Postoperative radiotherapy and survival in colorectal cancer. *Lancet (March 23) 2002; **359**: 1068-69.*

To counter this negative evidence, another review of these randomised trials re-analysed the results and by selecting three of the trials and ignoring the other 35 the authors claimed that “surgical adjuvant radiotherapy significantly improves overall survival of breast cancer patients [by 12.4%] provided that current techniques are used and treatment is given with standard fractionation. For the best sub-groups we observed an odds of death reduction of more than 20%. The results of this study stress the importance of reducing cardiovascular and other late toxicity in adjuvant radiotherapy for breast cancer.”

Van de Steene J, Soete G, Storme G. Adjuvant radiotherapy for breast cancer significantly improves overall survival: the missing link. Radiother Oncol 2000 Jun;55(3):263-72.

The National Strategic Plan for Radiation Oncology makes the simple statement that "radiation treatment is a proven, cost effective treatment for cancer".

National Strategic Plan for Radiation Oncology, August 2001. Royal Australian and New Zealand College of Radiologists 51 Druitt St, Sydney

To substantiate this claim it cites Swedish reports that state that "radiotherapy is effective as a curative treatment of many cancers".

Swedish Council on Technology Assessment in Health Care – Radiotherapy for Cancer, 1996.

The Swedish reports in turn do not cite results from randomised trials. Instead they admit that the claims of efficacy of radiotherapy are not based on results from randomised trials but on *clinical experience*.

For example in one of the Swedish reports called Critical Issues in Radiotherapy, in the section called "What is Radiotherapy and Does it Work, it states that "there is no question that radiotherapy works, in the sense that it kills cancer cells…It can cure many different types of cancer…"

Swedish Council on Technology Assessment in Health Care – Critical Issues in Radiotherapy, 1996.

It does not define "curative" but it is clear from the context of the Report that the word cure refers to the ability of radiotherapy to eliminate all cancer cells in small tumours and radiosensitive tumours. This assumes that the tumour is the disease, an unproven hypothesis. It does not refer to increased survival and there is no evidence presented in that Swedish Report than any such treatment is curative in the sense of affecting the disease by increasing survival. The meaning of "cure" in this context can be gauged from the statement that "of all patients cured of cancer, the majority is cured by surgery alone (around 60%). For this statement it refers to a study by Tobias and Tattersal.

Tobias J. Clinical practice of radiotherapy. Lancet 1992; 339: 159-164.

*Tobias J, Tattersall M. Doing the best for the cancer patient. Lancet 1985; **1**: 35-38*

Yet, as shown above, there is no evidence from any randomised trials that surgery has any effect on survival for any type of cancer. So this definition of cure is based on the ability to remove the tumour and the patient surviving a minimum of 5 years. This does not mean any reduction in mortality has been achieved. The Swedish Report also states that Radiotherapy plays a curative role in the treatment of about 30-40% of patients, either as a sole agent, or as part of combined therapy. The reference for this claim is given as [van der Schueren, 1991] yet no such author is listed in the References section of the Report and no paper on this subject by the author is listed in the medical literature for this year.

To justify why effectiveness has not been proven, the Swedish Report states that "in all of medicine including radiotherapy, however, it is quite difficult and often impossible to organize randomized trials. One problem is that many techniques used in radiotherapy are considered clinically effective based on clinical experience, so withholding them from a patient to evaluate their scientific merit may be considered unethical…. For these and other reasons, other types of controlled prospective studies are more common than randomized trials…. Although the results of these types of studies are considered less valid and reliable than the results of randomized clinical trials, they may still provide valuable information on effectiveness."

It is therefore clear that evidence of benefit from radiotherapy can only be found by selecting results from a small number of trials, rejecting all other evidence, ignoring all evidence of harm and using an invalid definition of the term cure. This then leads to the same justification for not carrying out properly run randomised trials as has consistently been used in the area of cancer surgery.

Although the negative evidence mentioned above applies mainly to breast cancer, similar evidence could also be cited showing a lack of efficacy for radiotherapy for other types of cancer.

The only likely survival benefits relate to the fewer than 5% of cancer patients who are likely to have their life extended temporarily by shrinking a tumour that is threatening a vital organ such as the bowel or brain. Although this evidence does not come from results of randomised trials but is anecdotal, applying it to life-critical situations is valid. In fact shrinking a benign tumour using radiotherapy can also save a life for the same reason.

It is not however justified to extend the use of radiotherapy beyond this group of selected cancer patients to 50% of cancer patients as is currently proposed in most countries including Australia.

Not only is radiotherapy an unproven treatment for cancer; there is clear evidence that it does harm.

Harm from Radiotherapy

A review of randomised trials of radiotherapy for breast cancer by Stjernwärd showed that it increased mortality, mainly from damage to the heart and respiratory system. It also suppressed the immune system for over a year.

*Stjernswärd, J. Decreased survival in early operable breast cancer. Lancet 1974; **ii**: 1285-1286.*

*Cuzick J, Stewart H, Rutqvist L et al. Cause-Specific Mortality in Long-term Survivors of Breast Cancer Who Participated in Trials of Radiotherapy. J. Clin Oncol 1994; **12 (3)**: 447-453.*

A review of data on 2,128 patients from nine randomised trials of post-operative radio-therapy (PORT) for non-small cell lung cancer comparing post-operative radiotherapy plus surgery with surgery alone showed that after a median follow-up of 3.9 years there was a significant adverse effect of postoperative radiotherapy on survival (hazard ratio 1.21). This 21% relative increase in the risk of death is equivalent to an absolute detriment of 7% at 2 years, reducing overall survival from 55% to 48%

*PORT Meta-analysis Trialists Group. Post-operative radiotherapy in non-small-cell lung cancer: systematic review and meta-analysis of individual patient data from nine randomised controlled trials. Lancet 1998; **352**: 257-263.*

In the 1970s writing in the Colombia Journalism Review Daniel S Greenberg reported on interviews he had had with several top researchers in the US. He asked them why doctors continue to recommend radiotherapy. One of the senior researchers was quoted as having said

> "Look, when you've got ten thousand radiologists and millions of dollars worth of equipment, you give radiation treatment, even if study after study shows that a lot of it does more harm than good. What else are they going to do? They're doing what they've been trained to do. Like the surgeons. They're trained to cut so they cut".

Greenberg, Daniel S. A critical look at cancer coverage, Columbia Journalism Review, Jan/Feb 1975, 40-44.

His article was updated and republished in the New England Journal of Medicine. In response to the question of why this situation persists, the senior researcher said

> "The problem is the closed mind of medicine… Orthodoxy prevails everywhere, and its hard to get them to listen to a new idea...I'm convinced that for some cancers, the survival rates were better decades ago, but don't tell anyone I said that. The official line is that we're making progress".

*Greenberg, Daniel S. "Progress" in Cancer Research - Don't Say It Isn't So". New Engl. J Med., (27 March) 1975; **292** (13): 707-8.*

Evaluating Chemotherapy for Cancer

Dr. Allen Roses, worldwide vice-president of genetics at GlaxoSmithKline reported at a scientific meeting in London in December 2003 that chemotherapy drugs induce a "response" (ie tumour shrinkage) in only 25% of people treated. He was arguing for a genotyping approach to enable predicting the drug response of an individual, to increase the success of therapies and reduce the incidence of adverse side effects. In this way, identifying the 75% of people whose genes would suggest they are likely to be non-responders to a particular drug, a different treatment would be used for them. The particular drug would then be restricted to the 25% identified a likely responders.

Roses, Allen. Glaxo chief: Our drugs do not work on most patients. Independent (UK) 7 December 2003.

Dr Roses was quoting from a 2001 paper published by Brian Spear that included a table that had been reproduced from The Physician's Desk Reference 54th Edition 2000.

*Spear, BB. Clinical application of pharmacogenetics. Trends Mol Med (7 May) 2001; **7** (5):201-4.*

What Dr Roses was talking about was "response" rates, not increased survival. As Ralph Moss has discovered, there is no correlation between response and increased survival.

Moss, RW. Questioning Chemotherapy. Equinox Press, New York 1995.

Thomas Moore describes the process whereby drugs get approval from the US FDA. Because drug development, evaluation and appproval is so expensive (over $200 million per drug), and it takes a long time to complete a proper randomized controlled trial to measure efficacy in terms of increased survival, the FDA has been persuaded to accept "surrogate endpoint" trials. This means that a factor is measured that is *assumed* to be correlated with increased survival. For cancer drugs this is "tumour shrinkage". The definition of efficacy is the ability to shrink tumours by 50%. If the current paradigm is invalid and tumors are only symptoms of an underlying systemic disease, tumour shrinkage might be irrelevant to increased survival. In fact the chemotherapy's toxicity might cause serious harm to the body and treatment might shorten survival. This is not considered when a chemotherapy drug is approved. Moore identified this problem when investigating how Tambocor and Encaid, widely prescribed for arrhythmia, had caused over 100,000 deaths in the United States before it was withdrawn from widespread use. Its approval had been based on the surrogate endpoint of its ability to reduce or eliminate arrythmia, on the invalid assumption that producing a more regular heart beat would reduce the risk of heart attack.

Moore, Thomas. Deadly Medicine, Simon & Schuster, New York, 1995.

So the use of chemotherapy is based on the false assumption that tumour shrinkage must automatically lead to increased survival. Chemotherapy has never been proven in a ***properly run*** randomised controlled trial to produce a *significant* increase in survival.

One set of randomised trials often cited as providing evidence for the efficacy of **adjuvant chemo-therapy for breast cancer** is the group making up the National Surgical Adjuvant Breast and Bowel Project led by Bernard Fisher.

There were 11,041 women in these trials who were randomised to long-term polychemotherapy vs. no chemotherapy. This was the chemotherapy with the best results. Looked at ten years after their participation in a randomised controlled trial, these women seemed to show a 6.3% survival advantage (51.3 % vs. 45.0%). For node-negative women the advantage was just 4% (67.2% vs. 63.2%). For node-positive women it was less than 7% (46.6% vs. 39.8%). This small difference led two researchers from Manitoba to write in the Lancet that "no overall survival advantage has been seen so far".

Before these figures can be relied on the original trials need to be analysed to see if they were methodologically sound. It is likely that they contain results from trials that have since been found to be flawed. The history of randomised trials of adjuvant therapy for breast cancer is dotted with examples of fraud and poor methodology.

For example in Italy, where the first positive survival effect was seen using the combination chemo-therapy of cyclophosphamide + metho-trexate + fluorouracil (CMF), later analyses revealed that many patients had been excluded because they could not complete the rather arduous treatment. So randomised comparisons were of healthier treated women against all controls, rendering the trial results invalid.

In the United States randomised trials of chemotherapy were begun in earnest in 1957 under the auspices of the National Institutes of Health (NIH). This program eventually became the National Surgical Adjuvant Project for Breast and Bowel Cancer (NSABP), headed by Bernard Fisher. In 1994 Fisher was sacked from the program because he had failed to notify the National Cancer Institute (NCI) of enrolment of inappropriate patients, a fact that had been known for three years. Further irregularities were then discovered in data from 12 other treatment centres. Some of the earlier NSABP trials had also involved exclusions that would have affected results, as in the Italian trial.

So the best results available for chemotherapy from randomised trials are not particularly good, and even these include results from centres in Italy, Canada and the United States that were later found to have breached trial protocols.

Yet adjuvant treatment of breast cancer with cytotoxic drugs is one of the lynch pins of chemotherapy and the NSABP was the key element within that program for more than 40 years. According to Irwin D. Bross, writing in the New England Journal of Medicine in 1994 "...the statistical quality control was grossly inadequate in the NSABP studies. Hence, whether or not some fraudulent cases are eliminated *post hoc*, any findings lack scientific validity".

Bross, ID. The NSABP trials. N Engl J Med. (Sep 22) 1994; **331**(12): 809.

Ulrich Abel, PhD, a biostatistician at the Institute for Epidemiology and Biometry, University of Heidelberg, Germany carried out a comprehensive analysis of the effect of chemotherapy on all types of epithelial cancer, that account for most cancers. He makes the following points about claims of efficacy in adjuvant breast cancer therapy:

- Good and consistent evidence of beneficial effects of adjuvant systemic chemotherapy on survival exists only for breast cancer, and more specifically, for patients with at most three positive nodes;
- So far no positive results seem to have been published for definitely postmenopausal patients;
- The restriction of beneficial effects to this small group appears somewhat strange;
- It is probable therefore that the effect is not due to the direct cytotoxic effects on the tumour but rather to treatment-related suppression of the ovarian function.

*Abel, U. Chemotherapy of advanced epithelial cancer: a critical review. Biomedicine & Pharmacotherapy 1992; **46**: 439-452*

Apart from adjuvant chemotherapy for breast cancer he found that there were very few randomised trials that had shown any benefit in terms of survival. These were confined to very rare cancer types and the increased survival was generally in terms of weeks or months, not a great benefit considering the often serious side effects experienced. He summarised the situation as follows:

> "Success of most chemotherapies is no less than appalling". … "There is no scientific evidence for its ability to extend in any appreciable way the lives of patients suffering from the most common organic cancers"… "Chemotherapy for malignancies too advanced for surgery, which accounts for 80% of all cancers, is a scientific wasteland".

Abel, U. Chemotherapy of Advanced Epithelial Cancer, Hippocrates Verlag GmbH, Stuttgart, 1990.

Claims have also been made in relation to **chemotherapy for invasive cervical cancer**. In fact the US National Cancer Institute claimed a breakthrough in the treatment of late stage invasive cervical cancer according to a news item in the Sydney Morning Herald of 24 February 1999. They claimed this was the first breakthrough in the treatment of this type of cancer in more than 40 years. However this new evidence warrants closer consideration because this new one is based on the results of randomised trials. The evidence found from 5 randomised trials is that adding chemotherapy in the form of cisplatin at the same time as radiotherapy, following hysterectomy, increased the percentage 3-year survival by about 10-12%.

Thus for women with Stage IIB, III and IVA cancer survival increased from 63% to 75%. For women with earlier invasive cancer, Stage IA2, IB and IIA, survival increased from 77% to 87%. It suggests that chemotherapy and radiotherapy have a synergistic effect when used together and possibly that chemotherapy stops cancer cells from repairing the damage caused by radiation.

Unfortunately trials comparing these types of treatment with no treatment have never be carried out so it is also possible that percentage survival is increasing towards what it would be without treatment. Radiotherapy has been found to increase deaths in many types of cancer so it is possible that the same result could have been achieved simply by eliminating the radiotherapy.

There is indirect evidence from *comparison of survival over time* that chemotherapy is beneficial for childhood **acute lymphoblastic leukemia** (ALL) and some lymphomas. Although, as mentioned above, statistics on increasing survival are notoriously unreliable, the improvement observed in treating childhood ALL has been quite large, with percentage 10-year survival increasing from around 10% in 1960 to 60% in 1985.

Lilleyman JS. Childhood leukemia THE FACTS. Oxford University Press, Oxford 1994.

This increase is large enough not to be readily explained by the confounding factors mentioned above in relation to cancer surgery, viz. earlier diagnosis extending the survival starting time; the increasing incidence of less-fatal forms; and the reduced use of more harmful therapies.

For other forms of leukemia the evidence is questionable. An analysis of 3-year survival rates between the 1950s and 1960s showed increased percentage 3-year survival over this period for all forms of leukemia, yet for all forms combined the survival remained unchanged. Unlike the case of ALL above, all of this increase can be attributed to the effects of earlier diagnosis extending the survival starting time and the changing proportion of the more fatal forms in the total cases.

Enstrom, JE & Austin, DF. Interpreting cancer survival rates. Science 1977; ***195****: 847-851.*

A less dramatic improvement in survival has been observed for some lymphomas.

Moss, RW. Questioning Chemotherapy. Equinox Press, New York 1995.

However much of this increase can be attributed to poor methodology.

Based on evidence from Ulrich Abel and the above sources, it would appear that benefits from chemo-therapy are limited to a few types of cancer:

From randomised trials:	adjuvant therapy for breast cancer (~6% increased survival after 10 years) small cell lung cancer (median survival increase - 3 months)
From increasing survival:	childhood acute lymphoblastic leukemia (50% increase in 10-year survival) Hodgkin's lymphoma some non-Hodgkin's lymphomas non-small cell lung cancer (median survival increase - a few weeks) ovarian cancer: invasive cervical cancer: (~11% increased survival after 3 years) testicular cancer Burkitt's lymphoma choriocarcinoma lymphosarcoma

There have been claims that chemotherapy has produced increased percentage 5-year survival for other cancers, such as cancer of the large bowel.

Moss, RW. Questioning Chemotherapy. Equinox Press, New York 1995.

However these apparent improvements must be attributed to poor methodology because none of these cancers exhibited a divergence between incidence and mortality rate curves over time.

Benjamin, DJ. The efficacy of surgical treatment of cancer. Medical Hypotheses 1993; ***40 (2)****: 129-138*

So, with a few exceptions such as childhood ALL and the small number of rare tumours mentioned above, the efficacy of chemotherapy would appear to be quite dismal. The overall percentage of cancer patients experiencing a significant increase in survival from chemotherapy is therefore likely to be about 3%.

Epidemiologists Peto and Easton state that

> "for most cancers in adults, and particularly for epithelial cancers, there has been so little progress that it is difficult to distinguish any real improvement in survival rates from artefacts due to improvements in diagnosis and cancer registration"..(survival is also slightly prolonged using tamoxifen for breast cancer; oestrogens for prostatic cancer; cytotoxic chemotherapy for small cell lung cancer and ovarian cancer; adjuvant therapy for resected breast cancer and possibly colorectal cancer.)

> "The efficacy of most other treatments is not established, however, and a small proportion of patients are certainly killed by the short or long-term effects of cytotoxic treatment…."
>
> "There have been considerable advances in avoiding disfigurement by radical surgery, limiting tissue damage by radiotherapy and controlling chemotherapeutic toxicity, but for the majority of adult epithelial cancers it is not clear whether the withdrawal of all cytotoxic therapy would measurably alter the annual number of cancer deaths..... "
>
> "In the many situations where it is not known whether treatment is effective, many clinicians respond by developing a set of firmly held but unsupported beliefs in the merits of particular regimens. The primary treatment of advanced non-metastatic laryngeal cancer, for example, will usually be by surgery at certain treatment centres and by radiotherapy at others. Whether chemotherapy is given as well and, if so, what form it will take, are also determined more by the idiosyncrasies and outpatient arrangements of the particular treatment centre than by objective evidence of long-term efficacy. Similar examples could be taken from most areas of cancer therapy".

*Peto, J. and Easton, D., Cancer treatment trials - past failures, current progress and future prospects, Cancer Surveys 1989; **8**: 513-533.*

According to the website of the Burzynski Research Institute:

> "…The failure of chemotherapy to control cancer has become apparent even to the oncology establishment. Scientific American featured a recent cover story entitled: "The War on Cancer -- It's Being Lost." In it, eminent epidemiologist John C. Bailar III, MD, PhD, Chairman of the Department of Epidemiology and Biostatistics at McGill University cited the relentless increase in cancer deaths in the face of growing use of toxic chemotherapy". He concluded that scientists must look in new directions if they are ever to make progress against this unremitting killer."

Chemotherapy Report, Do we need a new approach to cancer? Burzynski Research Institute Home Page, http://www.cancermed.com/chemo.htm.

John Bailar, now professor emeritus in the Department of Health Studies at the University of Chicago. has also stated that

> "The US death rate from all cancers other than lung, stomach and cervix (sites which have shown marked changes in incidence in recent decades) has not altered appreciably since 1950, when chemotherapy was virtually non-existent and other forms of treatment were primitive by modern standards".

He concluded that

> "...35 years of intensive effort focussed largely on improving treatment must be judged a qualified failure".

*Bailar J. Progress against cancer, N Engl J Med (May 8) 1986; **314** (19): 1226-1232.*

In a 1997 reassessment of the situation Bailar's view had not changed.

*Bailar JC & Gornik HL. Cancer Undefeated. N Engl J Med 1997; **336** (22): 1569-1574.*

Supporters of the status quo criticise these comments by making misleading claims about curing cancers. For example Robert J. Mayer and Lowell E. Schnipper

> "The Bailar article discounts the influence of treatment on the reduction in cancer mortality for individuals under age 55 ….. Seventy-five percent of all children with cancer can be cured -- largely because of advances in treatment. We have learned how to cure previously fatal conditions such as testicular cancer and Hodgkin disease in most patients; non-Hodgkin lymphomas can be cured in up to 50 percent of affected people. Systematic clinical studies have shown that post-operative treatment reduces death rates from breast cancer and colorectal cancer by 25-30 percent …."

John Cairns, professor of microbiology at Harvard University, published a devastating 1985 critique in Scientific American in which he said; "Aside from certain rare cancers, it is not possible to detect any sudden changes in the death rates for any of the major cancers that could be credited to chemotherapy. Whether any of the common cancers can be cured by chemotherapy has yet to be established".

Chemotherapy Report, Do we need a new approach to cancer? Burzynski Research Institute Home Page, http://www.cancermed.com/chemo.htm

The following are more extracts from the Home Page of the Burzynski Research Institute on the World Wide Web:

"…In an article entitled "Chemotherapy: Snake-Oil Remedy?" that appeared in the Los Angeles Times of 1/9/87, Dr. Martin F. Shapiro explained that while "some oncologists inform their patients of the lack of evidence that treatments work...others may well be misled by scientific papers that express unwarranted optimism about chemotherapy. Still others respond to an economic incentive. Physicians can earn much more money running active chemotherapy practices than they can providing solace and relief… to dying patients and their families."

"Dr. Shapiro is hardly alone. Alan C. Nixon, PhD, Past President of the American Chemical Society wrote that 'As a chemist trained to interpret data, it is incomprehensible to me that physicians can ignore the clear evidence that chemotherapy does much, much more harm than good'…. "

"In 1986, McGill Cancer Center scientists sent a questionnaire to 118 doctors who treated non-small-cell lung cancer. More than 3/4 of them recruited patients and carried out trials of toxic drugs for lung cancer. They were asked to imagine that they themselves had cancer, and were asked which of six current trials they themselves would choose. 64 of the 79 respondents would not consent to be in a trial containing cisplatin, a common chemotherapy drug. Fifty eight found all the trials unacceptable. Their reason? The ineffectiveness of chemotherapy and its unacceptable degree of toxicity."

*McKillop, WJ, et al. The use of expert surrogates to evaluate clinical trials in non-small cell lung cancer. Br J Cancer 1986; **54**: 661-667.*

The more familiar these doctors were with the treatment the less likely they were to accept it for themselves.

Similar findings came from two other studies published in 1987.

*Hansen, HH. Advanced non-small-cell lung cancer: To treat or not to treat? J Clin Oncol 1987; **5**: 1711-12.*

*Anonym. Ein gnadenloses Zuviel an Therapie. Teil I. Zweifel an den chemischen Waffen. Der Spiegel, 1987; **26**, 128-47.*

A study of how expert physicians would wish to be treated for genito-urinary cancer found a similar situation in 1988.

*Moore, MJ, Tannock, IF. How expert physicians would wish to be treated if they developed genito-urinary cancer. Abstract No. 455. Proc. Amer. Soc. Clin. Oncol. 1988; **7**: 118.*

In relation to the treatment of 252 advanced breast cancer patients one author observed that the "risk" of being treated by cytotoxic therapy was three times as high in the terminal stage as in the remainder of the patients.

*Holli, K, Hakama, M. Treatment of the terminal stages of breast cancer. BMJ. (Jan 7) 1989); **298** (6665):13-14.*

Abel also surveyed oncologists throughout the world and found that most of them would not undergo chemotherapy if they were diagnosed with cancer. The two main reasons given were that it was "not effective" and "too toxic".

As Abel points out, this does not point to the use of a therapy that is particularly geared to patients' wellbeing.

*Abel U . Chemotherapy of Advanced Epithelial Cancer, Hippocrates Verlag GmbH, Stuttgart, 1990. Biomed & Pharmacother 1992; **46**: 439-52.*

According to Dr Robert Willix, MD, "as many as 75% of cancer patients undergo chemotherapy…a treatment that only cures about 3% of patients and has no proven influence on the length and quality of life."

Robert Willix, Jr. M.D. Health & Longevity, February, 1998.

According to the website of the Callahan Regional Cancer Center in Great Plains west central Nebraska approximately 85% of cancer patients receive some form of chemotherapy and about 60% of cancer patients receive radiation therapy.

http://www.gprmc.com/support/cancer/callahan/

Thus 75%-85% of cancer patients receive chemotherapy, and (according to Dr Allen Roses from Glaxo-Smith-Kline) 75% of these people treated with chemotherapy experience harm without any benefit (ie 60% of cancer patients) and 25% experience a "response" (20% of cancer patients) mostly without any improved survival. Survival benefits exist for only about 3% of cancer patients.

Harm from chemotherapy

There are four main areas of harm:

- Weakening the body's natural defences such as the immune system
- Disrupting other body processes such as the metabolic, endocrine and lymphatic systems
- Increasing mortality through direct toxicity
- Decreasing the quality of life through all of the above reactions

Weakening the immune system can occur through either reduction of the number of natural killer cells or by reducing their activity. Chemotherapy has been found to reduce the activity of natural killer cells by 96%.

Beitsch, P et al. Natural immunity in breast cancer patients during neoadjuvant chemotherapy and after surgery. Surgical Oncology 1994; ***3 (4)****: 211-219.*

So if there are tumours growing elsewhere in the body and the immune system helps to control tumour growth, then chemotherapy could make things worse by allowing more rapid growth of other tumours present.

The increased mortality from the use of chemotherapy is not easy to estimate because about a third of cancer patients in their last few months receive chemotherapy, much of it being inappropriate. As they are not expected to live much longer it is not easy to attribute their death to the chemotherapy.

According to the website of the American Society of Clinical Oncology (ASCO) one-third of cancer patients receive chemotherapy in the last six months of life, even if the cancer is known to be unresponsive to treatment. This is based on an examination of medicare patient billing records and 7,919 cancer deaths in Massachusetts conducted by researchers at the National Institutes of Health, Boston University School of Medicine and Stanford University School of Medicine. It was reported on May 12, 2001 by Ezekiel J Emanuel MD from the National Institutes of Health, Bethesda, Maryland.

http://www.asco.org/ac/

Researchers concluded that responsive and unresponsive cancers were treated equally often with chemotherapy at the end of life. In the last six months of life, 33 percent of pancreatic cancer, 30 percent of melanoma, 30 percent of breast cancer, and 32 percent of colon cancer patients received chemotherapy. In the last month of life the figures were 8 percent, 10 percent, 8 percent and 7 percent, respectively. Breast, colon and ovarian cancers are chemotherapy-responsive, but melanoma, pancreatic, renal cell, hepatocellular and gallbladder cancers are not chemotherapy-responsive cancers.

However there is indirect evidence that post-operative chemotherapy (and radiotherapy) **increase** mortality in all forms of cancer where these therapies have been evaluated.

Harm from Radiotherapy and Chemotherapy

Analysis of records of 1.2 million cancer cases in the US SEER (Surveillance Evaluation & End Results) database showed that non-cancer deaths accounted for 21% of all deaths. These deaths were in excess of the rate expected for such patients. This excess was observed in all types of cancer with an overall figure of 37%. The excess ranged from 9% for breast cancer to 173% for lung cancer. During the year following diagnosis this excess was about 5 times higher, so it ranged from about 50% for breast cancer to about 800% for lung cancer. Major causes of these excess deaths were heart and respiratory failure, the types of deaths expected from chemotherapy and radiotherapy. The authors attributed this effect to the damage caused by cancer treatment.

Brown, Barry W et al. Non-cancer deaths in White Adult Cancer Patients. JNCI 1993; ***85 (12)****: 979-987.*

Evaluating Hormone Therapy for Cancer

We do not question the benefits that occur from the use of hormone therapy for some cancers, notably breast cancer. However this therapy is consistent with the alternative paradigm: it is not designed to kill tumours but prevent the breast cancer cells from receiving stimulation from endogenous estrogen via the endocrine system.

Summary

It is therefore clear that

- Surgery has not been shown in any properly run randomized trials to extend survival for any type of cancer;
- Earlier surgical intervention made possible by screening has not been shown in any properly run randomized trials improved survival;
- Screening for cancer has not been shown to provided survival benefits for any type of cancer and has been shown to cause harm, both from unnecessary intervention and from the effects of screening itself;
- Radiotherapy has not been shown in any properly run randomized trials to extend survival;
- Chemotherapy has been shown to extend survival in a small number of types of cancer, such as childhood acute lymphoblastic leukemia and some other rare cancers;
- Both radiotherapy and chemotherapy have been shown to cause serious harm with few benefits;
- There is no evidence for cure in any type of cancer;
- The only significant survival benefits from orthodox intervention relate to situations that are life-critical where surgical removal, or shrinking of a tumour with radiotherapy or chemotherapy are used where the tumour is of immediate threat to a vital organ such a the brain or bowel.
- Survival benefits can be therefore be shown to amount to less than 6% of cancer cases;
- For about 94% of cases, orthodox intervention must be classified as *experimental*.
- "Expert" opinion to the contrary is based not on evidence but faith and vested interests.

This shows the importance of applying the principles of **Evidence Based Medicine** to the treatment of cancer, whether orthodox (or alternative) therapies are used.

Evidence Based Medicine

It was stated at the beginning of Part 1 that most medical interventions and clinical practice in relation to cancer are not based on solid scientific evidence. Reference was also made to the growth of evidence based medicine as a world-wide attempt by a group of dedicated medical scientists to correct this situation. The following is a brief outline of its development and what it involves.

Archie Cochrane was a Scottish-born doctor who believed that medicine was supposed to be a science - yet, from the early 1970s wherever he looked for a scientific basis for what he was doing he found evidence lacking. He was so appalled by what he found that he wrote a book on the subject listing the dozens of medical interventions that were not scientifically based.

Cochrane, Archie. Effectiveness and Efficiency, Random Reflections on Health Service. The Nuffield Provincial Hospitals Trust and Cambridge University Press. Republished by BMJ Publishing Group, London 1989.

At a conference in Manchester in the UK in September 1991 mathematicians, statisticians, epidemiologists and specialists in health management pooled their knowledge on the efficacy of medical interventions. It was concluded that only about 15% of medical interventions were based on solid evidence.

Other evidence presented at the conference came from analysing scientific papers to see if their methodology satisfied particular criteria for scientific studies. About 1% were found to do so.

Richard Smith, Editorial "Where is the wisdom...? The poverty of medical evidence." BMJ (October 5) 1991; ***303****: 198-99.*

This conference gave rise to a world-wide evidence based medicine movement called the Cochrane Collaboration after Archie Cochrane. Much of the impetus started with a group at Oxford University.

In the United States one of its main proponents is David Eddy, Ph D, Professor of Health Policy & Management at Duke University, North Carolina.

Dr Eddy has followed up on Archie Cochrane's work in the US by evaluating medical practices there. He runs workshops on methods for evaluating medical practices. Participants review evidence that supports various treatments that are important in their specialties. For each of the medical problems the participants are asked to classify the existing evidence as "excellent, "good", "fair", "poor" or "none'.

For example at one workshop, for only one problem was there "excellent" evidence that compared the effectiveness of the treatment on an important criterion for a successful outcome. For 18 of the problems the evidence was "poor" or "none". For two problems there was "good" evidence. Unfortunately, for those problems the evidence contradicted current practices. For the remainder the evidence was only "fair".

He has compiled the results of evaluations for hundreds of medical interventions and concluded that:

> "Hundreds of diagnostic tests, devices, procedures and services are currently used and paid for without any evidence of effectiveness…if modern standards of evidence were applied to all medical practices, a huge proportion would be thrown into limbo, hundreds of 'standard and accepted' practices would be disrupted, and medical practice would be in chaos".

*Eddy, DM Clinical decision making: from theory to practice. Three battles to watch in the 1990s. JAMA (Jul 28) 1993;****270*** *(4): 520-26.*

Practising EBM involves five distinct steps:

1. Converting the need for information into an answerable question. The question can be a "background" question involving general knowledge about a particular disease or disorder (such as "what host resistance factors protect asbestos-exposed workers from contracting mesothelioma?") and a "foreground" question involving information about managing patients with this specific disorder (such as "in older patients with pulmonary mesothelioma from crocidolite exposure does adding radiotherapy yield enough reduction in morbidity to be worth its adverse effects?");
2. Tracking down the best evidence with which to answer that question;
3. Critically appraising the evidence for its validity, size of effect and usefulness in clinical practice;
4. Integrating the clinical appraisal with clinical expertise and the patient's unique biology, values and circumstances;
5. Evaluating one's effectiveness and efficiency in carrying out steps 1-4 and seeking ways to improve them both for next time.

In other words it involves evaluating the latest evidence, preferably based on results of properly run randomised trials, and seeing how it can best be applied to the patient's particular needs and values.

The Cochrane Collaboration is devoted to increasing the proportion of medical interventions that are based on good evidence rather than on the "opinion of experts".

If one were to look at the Cochrane Library you wouldn't find much in there supporting current interventions for cancer, either orthodox or alternative.

Part 2 – The efficacy of alternative treatments for cancer

The Alternative Paradigm

What is this alternative paradigm? How does it differ from the orthodox or conventional paradigm? And what evidence is there of benefit to people with cancer who have used alternative cancer therapies?

The *orthodox paradigm* sees the tumour as the disease that starts locally then spreads throughout the body. By cutting it out with surgery, or killing it or shrinking it by burning it with radiotherapy, or poisoning it with chemotherapy, the disease should be eliminated.

The *alternative paradigm* sees the tumour as a late stage symptom of an underlying chronic, degenerative disease. At a later stage tumours appear elsewhere, not as a result of spreading, but in the next most susceptible tissue. Clearly removing or destroying symptoms would not be expected to affect the underlying disease as the causes have not been removed.

The following evidence supports the second, alternative, paradigm.

The Role of the Mind/Emotions in Degenerative Disease

Behaviour therapy is the only method proven in several randomised trials to prevent cancer (and coronary heart disease - CHD) and produce a significant reduction in mortality in those who already have these degenerative diseases. What is behaviour therapy?

According to this evidence, because of their learnt behaviour/temperament, people either

- are susceptible to getting cancer (**cancer prone**) – sometimes called a Type C personality, or
- are susceptible to getting CHD (**CHD prone**) – sometimes called a Type A personality, or
- have emotional problems but don't get cancer or CHD, or
- are **emotionally healthy** and don't get cancer or CHD – the so called ***healthy autonomous*** type

According to Ronald Grossarth-Maticek,
3235 people diagnosed with stress were given questionnaires to determine their personality profiles

901 were categorised as ***cancer prone***
818 were categorised as coronary heart disease ***(CHD) prone***
570 were categorised as having a mixture of psychological tendencies but not likely to develop either
946 were categorised as the ***healthy autonomous*** type

After 13 years follow-up

Of the 901 cancer prone, 39% had died of cancer	(7% of CHD)	61% were still alive
Of the 818 CHD prone, 25% had died of CHD	(4% of cancer)	75% were still alive
Of the 570 not likely to develop cancer or CHD		81% were still alive
Of the 946 healthy autonomous type		95% were still alive

This strongly supports the hypothesis that degenerative diseases such as cancer and CHD have an emotional basis. How can this knowledge be used for prevention and treatment?

(a) Prevention
When this type of person was treated with a particular type of individual behaviour therapy, results were dramatic. For example

Cancer **incidence** treated dropped from **42%** to **26%**
Cancer **mortality** dropped from **32%** to **0%**

Using group therapy results were still good but not as dramatic (incidence down from 56% to 32%, mortality down from 47% to 7.5%.

Eysenck, HJ & Grossarth-Maticek, R. Creative Novation Behaviour Therapy as a Prophylactic Treatment for Cancer and Coronary Heart Disease – Part II Effects of Treatment. Behav Research and Therapy 1991; ***29*** *(1): 17-31.*

It is therefore clear that behaviour therapy can be used to affect a person's learnt behaviour and thereby significantly reduce their risk of getting cancer and other degenerative disease.

But what is its effect on people who have already got cancer? Let us look at the results of eight well-run randomised trials:

(b) Treatment

1. Effect of Behaviour Therapy on Terminal Cancer Patients

This study involved 24 pairs of cancer patients with six different types of inoperable cancer, including scrotal (1), stomach (2), bronchiolar (7), corpus uteri (4), cervical (5) and colorectal (5).

Survival times of the group treated with behaviour therapy averaged **5.07 years** (ranging from 1.7 yrs for bronchiolar to 9.5 yrs for colorectal). For the control group survival averaged **3.09 years** (ranging from 1.0 yrs for bronchiolar to 4.9 yrs for colorectal). This is an increase in survival of **64%.**

2. Effect of adding Behaviour Therapy to chemotherapy for women with metastasised breast cancer

50 women with metastasised breast cancer for whom chemotherapy had been proposed were divided into pairs matched for age, social background, extent of cancer and medical treatment. One of each pair was then randomised to receive psychotherapy in addition to chemotherapy. 30 hrs of psychotherapy was given to this group of 25 women. The other group of 25 received only chemotherapy.

Mean survival times for the 25 patients who received chemotherapy plus psychotherapy was **22.4 months** compared with **14.08 months** for the 25 who received chemotherapy alone, an increase of **59%**.

3. Effect of adding psychotherapy to no treatment for women with metastasised breast cancer

50 of those who refused chemotherapy in the trial above were matched, then one of each pair was randomised to receive psychotherapy.

Mean survival for the 25 patients who received psychotherapy was **14.9 months** compared with **11.28 months** for the 25 who received no treatment, an increase in **32%**.

It was also observed that the lymphocyte count of those receiving psychotherapy continued to rise over time whereas those not receiving psychotherapy fell, suggesting that the psychotherapeutic intervention may have had its effect through the involvement of the immune system.

Eysenck, HJ & Grossarth-Maticek, R. Creative Novation Behaviour Therapy as a Prophylactic Treatment for Cancer and Coronary Heart Disease - Results. Behav Research and Therapy 1991; ***29*** *(1): 17-31.*

4. Effect of structured psychotherapy on women with metastasised breast cancer

A randomised trials measured survival after structured psychotherapy for late stage breast cancer patients:

86 patients with metastatic breast cancer were randomised into two groups, a study group of 50 and a control group of 36. Both groups had routine oncological care, but the study group was offered a 1½ hr weekly supportive group therapy and self-hypnosis for pain for 1 year.

Average survival for the study group was **36.6 months** compared with **18.9 months** for the control group, a **94%** increase in survival.

Spiegel, D. et al. Effect of psychosocial treatment on survival of patients with metastatic breast cancer, The Lancet, October 14, 1989.

5. Effect of structured group psychotherapy on people with malignant melanoma

28 men and 33 women with melanoma were randomised into two groups, a study group of 35 and a control group of 26. The study group was given a structured psychotherapy group intervention which lasted about 1½ hours per week for 6 weeks.

After 6 years there were only 3 deaths out of 34 (9%) in the treated group compared with 10 out of 34 (29%) in the control group (corrected for smaller size) - a **69%** reduction in mortality.

Fawzy FI et al. Malignant melanoma. Effects of an early structured psychiatric intervention, coping, and affective state on recurrence and survival 6 years later. Arch gen Psychiatry Sep 1993; 50 (9): 681-9.

6. Effect of individual structured psychotherapy on people with different types of cancer

375 people were randomised into two groups, a treatment group of 190 and a control group of 185. After 3 years and 8 months follow up there was a reduction in deaths among those treated with psychotherapy of 51%.

*McCorkle et al. A specialized home care intervention improves survival among older post-surgical cancer patients. J Am Geriatr Soc. 2000; **48**:1707-13.*

7. Effect of individual structured psychotherapy on people with different types of cancer

271 people were randomised into two groups, a treatment group of 136 and a control group of 135. After 2 years follow up there was a reduction in deaths among those treated with psychotherapy of 39%.

*Kuchler T et al. Impact of psychotherapeutic support on gastro-intestinal cancer patients undergoing surgery; survival results of a trial. Hepato-Gasteroenterol 1999; **46**: 322-35.*

8. Effect of structured group psychotherapy on women with breast cancer

66 women were randomised into two groups, a treatment group of 30 and a control group of 36. After 5 years follow up there was a reduction in deaths among those treated with group psychotherapy of 24%.

*Cunningham A et al. A randomised controlled trial of the effects of group psychological therapy on survival in women with metastatic breast cancer. Psycho-oncology 1998; **7**: 508-17.*

So clearly particular forms of structured psychotherapy such as behaviour therapy have a dramatic effect on survival or mortality, far greater than that observed with any orthodox therapy.

Two recent reviews have concluded that psychotherapy has not been shown to provided benefits to people with cancer. However the authors of both meta-analyses reached that conclusion either by

- omitting several of the above trials with good results on the basis of "expert" opinion that their results were "too good to be true"; or
- including several other trials that used an ineffective form of psychotherapy that, unlike those listed above, produced no psychosocial benefits to patients in the trials.

*Chow E et al. Does psychosocial intervention improve survival in cancer? A meta-analysis. Palliative Medicine 2004; **18**: 25-31.*

*Smedslund G and Ringdal GI. Meta-analysis of the effects of psychosocial interventions and survival times in cancer patients. Journal of Psychosomatic Research (August) 2004; **57** (2): 123-131.*

The reason for this continued non-acceptance of psychotherapy as a treatment for cancer is discussed in Part 3 of this submission (Item 16. Hans Eysenck & Ronald Grossarth-Maticek)

The mechanism of this connection between the mind/emotions and the body's health is now becoming more widely understood, eg

- ❑ unexpressed or inappropriately expressed emotions give rise to circulating protein peptides
- ❑ cell receptors on the brain or other organs respond to these peptides and they enter the cells of the organ
- ❑ cell metabolism is disrupted
- ❑ the immune system becomes weakened

- ❑ health deteriorates

Candace Pert, PhD. Molecules of Emotion, Touchstone, NY, 1999.

Eight factors have identified that lead to disease in general:

- ❑ physiological factors such as poor nutrition, lack of exercise, environmental pollutants
- ❑ unresolved emotional stress factors
- ❑ lack of control, power or dominion over one's life
- ❑ loss of sense of humour, inability to differentiate between the serious and the trivial
- ❑ the effect of one's negative belief system
- ❑ loss of the ability to give and receive love
- ❑ being in a spiritual vacuum – lack of awareness of one's self identity; despair
- ❑ denial of one's problems – inability to accept one's situation, blocking change

Caroline Myss, C Norman Shealy. The Creation of Health, Bantam, Sydney 1999.

So what is this cancer profile that is claimed to lead to cancer?

According to Grossarth-Maticek & Eysenck the essence of this type of temperament is the **absence of autonomy**, ie **emotional dependence, which prevents such people from making independent decisions in the light of their own best interests.**

So what is this behaviour therapy and how does it change a cancer prone person's behaviour profile?

The aim of behaviour therapy is to

- increase the person's autonomy, ie his/her independence and ability to make rational decisions that lead to long-term positive consequences, even though this might involve some short-term negative consequences;
- teach the person to avoid behaviours that lead to long-term negative consequences, even where these may be associated with short-term positive consequences.

*Grossarth-Maticek R & Eysenck, HJ,. Creative Novation Behaviour Therapy as a Prophylactic Treatment for Cancer and Coronary Heart Disease – Part I -- Description of Treatment. Behav Research and Therapy 1991; **29** (1): 1-16.*

Michael Marmot has identified *lack of control* as the main cause of coronary hear disease in workers.

*Marmot MG et al. Contribution of job control and other risk factors to social variations in coronary heart disease incidence. Lancet (Jul 26) 1997; **350** (9073)**:** 235-9*

Evidence therefore supports the alternative paradigm that attributes much disease to emotional factors.

Dr Ian Gawler, who himself recovered from a terminal stage osteosarcoma with widespread secondaries throughout his body, believes meditation is also an important part of psychotherapy. An evaluation of the type of psychotherapy he uses at his 10-day live-in workshops for people with cancer and other life-threatening illnesses confirmed positive outcomes from a psycho-social viewpoint – a basic requirement if a therapy is to provide benefits in terms of survival (as shown above).

Other therapies

While looking for evidence of effective therapies for cancer we have discovered many other therapies based on different theories (and sometimes different paradigms) whose efficacy, unlike that of behaviour therapy, have mostly not yet been proven effective in randomized trials.

Even those that are not yet proven to be effective are relatively safe and cause less harm than most orthodox therapies. Many show good evidence for a significant improved survival compared with orthodox therapies. In fact the physical therapy with the best published percentage five-year survival for terminal cancer patients is that of the Wholebody Therapy developed by Dr Josef Issels, shown first below.

Here are some of the theories with the best scientific basis and the therapies based on them:

Therapies designed to boost the natural immune systems such as

- **Whole Body Therapy** of **Dr Josef Issels**
  - 85% 5-year survival with non-metastasised cancer patients
  - 16.6% 5-year survival with late-stage cancer patients
  - 15% 15-year survival with late-stage cancer patients

In 1970 these were the best survival figures for late-stage cancer patients ever published. The percentage five-year survival figures are about 8 times those achieved using the conventional therapies of surgery, radiotherapy and chemotherapy, typically 2% for terminally-ill cancer patients.

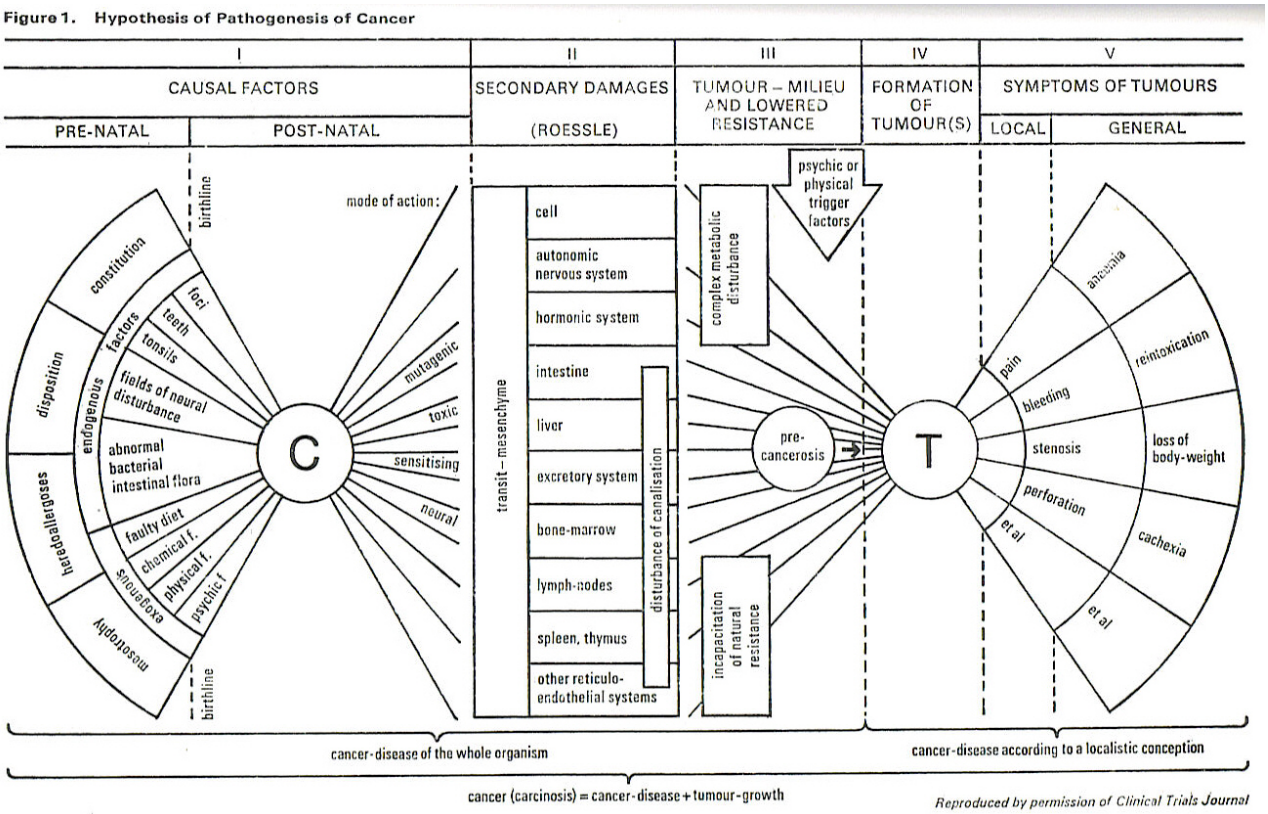
Issels, J. Immunotherapy in Progressive Metastatic Cancer - A Fifteen-Year Follow-up. Clinical Trials Journal, August 1970: 357-365 - editorial by Phillips S. Dr Joseph Issels and the Ringberg Klinik. Clinical Trials Journal. August 1970: 355-56.

This therapy sees the tumour as occurring in the last of five phases of cancer development. The diagram below shows the many causative factors leading to tumour growth that have to be dealt with to stop and reverse the cancer process.

Issels listed seven pre- and post-natal factors that are present during the first of a five-stage process. These are:

· head foci: teeth, tonsils, sinuses, etc;
· fields of neural disturbance;
· abnormal bacterial intestinal flora;
· faulty diet;
· chemical factors from the environment;
· physical factors from the environment (such as sunburn or other forms of radiation); and
· psychic stress.

Figure 1. Hypothesis of Pathogenesis of Cancer



Reproduced by permission of Clinical Trials Journal

According to Issels psychic factors are only one of the seven main causal factors for cancer.

He says these seven factors present during the first stage affect the constitution and damage the cells of the respective organs via mutagenic, toxic, sensitizing and neural effects via the cells' transit mesenchyme, producing secondary damage in cells, in control mechanisms (nervous and hormonic systems) and in detoxifying, excretory and defence systems.

The organ damage becomes apparent in the second stage. This in turn leads to the development of the tumour milieu and lowered resistance that allows to tumour to develop unchecked in the fourth stage.

Tumours reach a size sufficient to cause symptoms in the fifth stage, by which the whole body is affected by the cancer process.

The Issels "wholebody" therapy therefore consists of two distinct approaches:

- treating the cancer milieu and its causes by dealing with each of the causative factors in turn and the damage caused to the different organs (from the first three stages). :
  - removal of toxic foci in head – teeth, tonsils etc. The presence of diseased teeth or tonsils cause circulating toxins that weaken or interrupt other bodily processes, so these are removed before the other therapies are started
  - desensitisation – autovaccines prepared from teeth extract
  - neural therapy – injections into scar tissue
  - oxygen-ozone therapy and Haematogenic Oxydation Therapy (HOT)
  - detoxification – inhaled hot ether
  - Immunotherapy - Coley's Toxins, BCG and autologous vaccines
  - Auto-Hormone Therapy – ultra-short waves through the brain
  - induced fever therapy – cancer cells, unlike healthy cells, cannot survive above 42ºC
  - regeneration of stressed organs – using organ specific drugs
  - normalising metabolic malfunctions – proteolytic enzymes, vitamins and minerals
  - improved diet
- treating the tumours and its effects (from the final two stages)
  - surgical removal of tumour to reduce toxic load on the body

Issels, Josef. Cancer: A Second Opinion. Hodder and Stoughton, London, 1975

A second therapy designed to boost the natural immune system is:

- **Immuno-Augmentative Therapy** of Dr Lawrence Burton at the IAT Clinic in the Bahamas
  This therapy involves taking samples of blood from the patient daily, measuring the relative level of four immune components (tumour antibody – to kill the tumour; tumour complement; blocking component – to slow down the tumour kill rate; de-blocking component – to accelerate the tumour kill rate) and giving injections of blood with these ratios optimised, using missing components obtained from the healthy blood of the patient's companion.
  Survival among more than 1,000 terminal cancer patients:
  - 15-18% 5-year survival with late stage cancer patients
  - 50% 5-year survival with mesothelioma patients

  Survival among 277 terminally ill patients treated in 1977:
  - more than 18% in good health 5 years later

*Clement, RJ. Peritoneal Mesothelioma. Quantum Medicine 1988; **1**: 68-73.*

A book about the IAT Clinic lists 125 late stage cancer patients with 18 different types of cancer who by March 1984 had responded favourably to the therapy and exceeded their prognosis.

Wright, Jane Riddle. Diagnosis Cancer - Prognosis: Life, Albright and Co., Hunstville, AL 1985.

A third therapy designed to boost the natural immune system is:

- **Iscador** based on an extract of mistletoe. Developed by Rudolph Steiner as part of Anthroposophical Medicine.

  10,226 cancer patients were involved in a prospective long-term epidemiological cohort study, including 1,668 patients treated with Iscador and a control group of 8,475 who had taken neither Iscador nor any other mistletoe product.

  In the non-randomized matched-pair study, survival time of patients treated with Iscador was longer for all types of cancer studied. In the pool of 396 matched pairs, mean survival time in the Iscador groups (4.23 years) was roughly 40% longer than in the control groups (3.05 years) .

  Results of the 2 randomized matched-pair studies largely confirmed the results of the non-randomized studies.

A fourth approach to restoring the immune system involves the use of attenuated toxins to stimulate the body's weakened immune system. Dr William Coley developed his toxins.

- **Coleys Toxins**

  Survival among 896 advanced cancer patients, 523 inoperable, 373 operable:
  46% 5-year survival with inoperable tumours
  50% 5-year survival for operable, including:
  - giant cell bone tumours - 79% (87% operable) 5 year survival
  - breast cancer - 65% (100% operable) 5 year survival
  - Hodgkin's disease - 67% five year survival
  - ovarian cancer - 67% " " "
  - melanoma - 60% " " "

All of these survival figures were well above those achieved with conventional treatments at the time.

*Nauts H. Bacteria and cancer - antagonisms and benefits. Cancer Surv. 1989; **8**: 713-23.*

A fifth approach to stimulating the immune system was developed by **Bjorn Nordenström** from the Swedish Karolinska Institute in Stockholm:

- **Biologically closed electric circuits**. Nordenström discovered that the body uses slowly cycling polarity changes as part of the healing process. He simulated this process using electrical probes inserted into tumours and cycling the polarity. He subsequently married his approach with that of doctors in China using acupuncture and adapted his therapy to take account of acupuncture points.

Bjorn Nordenström, Biologically Closed Electric Circuits. (self published)

It therefore appears that the most effective therapies for treating cancer involve
- some aspects of psychotherapy; and
- boosting the immune system.

This should therefore become the main focus of research in alternative cancer therapies

Other promising therapies with many anecdotal reports of success include those designed to restore other bodily systems; such as

Therapies designed to restore the body's damaged metabolic system:

- Gilbert Ling's Association-Induction hypothesis involving structured water (confirmed by NMR) and its implications for cell metabolism as developed by Freeman Cope (many cancer case histories presented by Max Gerson);

  According to this hypothesis cells become damaged by mineral imbalances but they can be restored if the damage has not lasted too long. For cancer the cells' potassium/sodium balance needs to be restored. This approach is used in the Gerson Diet:

The Gerson Diet

- This diet, high in potassium and low in sodium, can restore energy to the cells
- The diet also includes methods of detoxifying the cells using coffee enemas.

*Cope, Freeman. A medical application of the Ling association-induction hypothesis: the high potassium low sodium diet of the Gerson cancer therapy. Physiology Chemistry and Physics 1978; **10 (5)**: 465-468.*

Max Gerson wrote up his therapy in a book in which he also described the recovery of 50 terminal cancer cases who had recovered using his therapy. He died in 1959, eulogized by Dr. Albert Schweitzer, who wrote:

> "I see in him one of the most eminent geniuses in the history of medicine. Many of his basic ideas have been adopted without having his name connected with them. Yet, he has achieved more than seemed possible under adverse conditions. He leaves a legacy which commands attention and which will assure him his due place. Those whom he has cured will now attest to the truth of his ideas."

Gerson, Max. A Cancer Therapy – Results of Fifty Cases. 1958(Now in 6th Edition)

Gerson, Max. A Cancer Therapy – Results of Fifty Cases and the Cure of Advanced Cancer by Diet Therapy- A summary of Thirty Years of Clinical Experimentation. Station Hill Press 1997.

Thus there are additional systems in the body, not recognised by the medical profession, that are involved in healing mechanisms, as has been shown by Josef Issels and Max Gerson. Candace Pert had discovered receptors on the brain for endorphins and later discovered receptors on other organs for circulating protein peptides caused by emotions. She developed the concept of Molecules of Emotion. These chemicals of unexpressed emotions become stored in cells that then have to be detoxified.

Another theory is that there is a cancer microbe involved in the development of cancer. Therapy is therefore designed to kill or modify this microbe to make it harmless:

- Virginia Livingstone-Wheeler, Gaston Naessens and Dr Royal Rife claimed that a cancer microbe is involved so that, when the conditions are right, it proliferates and overwhelms the body.
  - Livingstone-Wheeler uses an autologous vaccine to kill the microbe along with a special diet.
  - Rife used electromagnetic radiation tuned to the microbe's natural frequency to destroy it
  - Naessens developed 714X to disrupt its growth cycle by flooding it with nitrogen.

The following are some of the other therapies based on alternative paradigms

- **Hydrazine sulphate** developed by **Joseph Gold** of the Syracuse **Cancer Research Institute.**

This is based on the theory that about 40% of all cancer deaths are due to cachexia, a wasting away process. Gold sought a substance to interfere with the enzyme that enables the liver to convert lactic acid from tumours into glucose, which is then commandeered by the tumour at the expense of the rest of the body – causing cachexia. Interrupting this process restores appetite resulting in weight gain, reduced nausea, improved quality of life and sometimes reduced tumour growth and extended survival.

Responses among 84 terminally ill cancer patients:

- **70% subjective improvement including:**
  - 86% appetite improvement (hydrazine alone)
  - 69% appetite improvement (hydrazine + chemotherapy)
- **17% objective improvement, including tumour regression**

*Gold, J. Use of hydrazine sulphate in terminal and preterminal cancer patients: results of investigational new drug (IND) study in 84 evaluable patients. Oncology 1975; **32**: 1-10.*

*Filov, V, et al. Results of clinical evaluation of hydrazine sulfate. Vopr Onkol 1990; **36**: 721-6.*

Therapies based on targeting cell energy such as using pulsating magnetic fields such as:

- using the QRS "mat"

- randomised trials show benefits with arthritis and rotator cuff tendinitis
- many anecdotal cases of improvement and increased quality of life with late-stage cancer patients
- Don Benjamin has carried out a small randomised crossover trial to measure benefits of this therapy after 8 weeks for cancer patients. Some small positive benefits were found.

❑ using **Phenergan** to selectively weaken the cells' mitochondria – causing cancer cell death – by the use of anti-histamines such as promethazine.

*Jones, GRN. Successful Cancer Therapy with Promethazine: The Rationale. Medical Hypotheses 1996; **46**: 25-29.*

Therapies based on controlling cell growth to enable other therapies to work such as:

❑ Cyto-luminescent therapy

❑ Vitamin and enzyme therapy, particularly vitamins A, C, E and selenium

❑ Microwave therapy – the Tronado machine
- available in Perth from Dr John Holt
- many anecdotal cases of tumour remission and increased quality of life with late-stage cancer patients

All of this evidence suggests that
- suppressed emotions play a major role in the onset of degenerative disease, including cancer
- an immune system impaired from different causes can be restored by several means
- cell metabolism is disrupted by injury or emotions
- cell energy is then inadequate to maintain cell membrane potential causing further deterioration
- cell damage can be repaired if not delayed too long
- toxins stored in the body from various sources, including emotions, disrupt bodily systems
- pulsating potentials are involved in the healing mechanism – so producing suitable fluctuations can simulate cell repair mechanisms
- other fluctuations affect brain frequencies and can stimulate hormone production
- microbes, including a cancer causing microbe, are susceptible to destruction using particular frequencies or products

Based on the randomised trials that show benefits of the alternative paradigm, the improved percentage 5-year survival and anecdotal evidence of benefits with others, it would appear that:

People with cancer should therefore select therapies from all four of the following areas:

❑ Body – Physical therapies to restore the body's systems including cell metabolism, immune system, detoxification

❑ Mind – Therapies to relax the mind and body: meditation, visualisation and imagery

❑ Emotions – Behaviour Therapy or other psychotherapy to eliminate emotional causes of cancer

❑ Spirit – Therapies to restore the spirit or psyche: hands-on healing, distance healing, prayer

Counselling should identify where each person is on their healing pathway and what therapies they are open to.

Orthodox therapies, such as minimal surgery, may be useful to complement alternative therapies where this reduces the amount of detoxification needed.

Treatment should therefore be based on either

❑ behaviour therapy or

❑ systemic therapies capable of reversing the metabolic changes brought about by the emotional factors, ie **healing** therapies

Attachment 1 summarises the relative efficacies of orthodox and alternative therapies.

Part 3 - The Suppression of Alternative cancer therapies

During the search of the literature in 1980 and through the international contacts developed through the Cancer Information & Support Society it was found that actions to suppress promising alternative cancer therapies had taken place in many countries, including Australia . Court cases charging doctors with manslaughter for using such therapies had occurred in Germany, the United States and Canada. In Australia doctors were threatened with deregistration if they continued to use such therapies (including Iscador).

The court cases all had a common thread involving the use of police powers to raid clinics and confiscate medical files, misrepresentation of facts, attributing false motives to the doctors charged and generally branding the doctors as "quacks" and "charlatans". In most cases the doctors were found not guilty, sometimes having to go to appeal. Often their careers were destroyed. Hundreds of their patients died unnecessarily.

There were two questions that came to mind:

1. What were their discoveries? - from a medical or scientific viewpoint
2. Why did the suppression happen, and why does it still happen? - from a political viewpoint
3. Is there a medical reason for keeping these discoveries from the general public that justifies the continued political intervention?

In order to answer these questions and understand how this could happen in a modern democratic society the many cases were analysed. It was concluded that suppression occurred as a result of four forces:

1. Their discoveries were generally of critical importance to the understanding of what cancer is and how it should be treated. In other words they challenged the prevailing **paradigm**.
2. Discoveries coming from within the medical profession, if accepted, would result in a challenge to the current **vested interests** of surgery, radiotherapy and chemotherapy.
3. For discoveries coming from outside the medical profession, there was an additional strong political pressure to resist a breaking down of the **monopoly** status of the allopathic school of medicine. Competition therefore threatens market share of the major provider – so money is a very relevant factor. Vested interests in the status quo are very strong protecting a $500 billion industry world-wide.
4. There are other subtle reasons helping to resist the acceptance of these discoveries
   - protection of **prestige and status**: discoveries from outside the mainstream of medicine would reflect badly on those at the head of their profession who claimed to be at the forefront of medical science; This becomes particularly threatening in view of:
   - the lack of **evidence** for real benefit from the treatments currently practised by the orthodox medical profession and growing evidence supporting the alternative paradigm. This is particularly relevant in the area of Psychotherapy.

In other words the driving force behind the suppression of alternative cancer therapies has been a combination of factors involving paradigms, vested interests, protection of monopolies, prestige and status, and lack of scientific evidence for current methods.

The main tragedy is that several of these doctors had discovered a different way of looking at cancer, AIDS and other degenerative diseases which enabled them to understand how to control them. And this information was being suppressed. They all had hundreds of terminal cancer patients whose cancer had been controlled using their methods yet this benefit was being denied to the wider society.

The examples come from many Western countries including Australia, France, Germany, Italy, New Zealand, the United Kingdom and the United States. The power of public opinion, acting through

consumer and government bodies is at last beginning to remove unscientific opposition to alternative therapies acting on behalf of vested interest groups. As nearly 50% of people now use alternative cancer therapies and increasing numbers are refusing orthodox therapies, the $500 billion a year cancer industry world wide is now under threat. This is resulting in an increased effort on the part of forces opposed to alternative cancer therapies to regain their customers by forcing their opposition out of business using the powers of the state.

As examples of how these forces play themselves out, the following summarises some of the examples of suppression of alternative cancer therapies as they show each of these four main forces in action.

1. Paradigms

As mentioned in Parts 1 and 2 there are essentially two main paradigms about what cancer is:

The **orthodox** paradigm states that cancer starts locally as a *"primary"* cancer, later spreads regionally into lymph nodes and in its final stages spreads to other organs in a process known as *metastasis*. Treatment focuses on cutting out, burning or poisoning the tumour (surgery, radiotherapy and chemotherapy).

The **alternative** paradigm states that cancer is a systemic, degenerative disease that starts as a result of a gradual break down of several body systems: the digestive, metabolic, the endocrine, the lymphatic and the immune systems. In its later stages a tumour starts to grow in the organ with the most susceptible tissue. Tumours are later found in other less susceptible organs but cancer cells have not necessarily spread. Treatment focuses on restoring the body's damaged systems to reverse the degenerative process – so that the tumour can eliminate itself.

These two paradigms conflict. For reasons given in Part 1, the term *complementary* therapies are not used**.** Rather the term ***alternative*** therapies is used instead.

A whole industry, currently worth about $500 billion world wide, has grown up on the basis of the orthodox paradigm.

2. Vested interests

In the United States where these forces were perhaps the strongest, the responsibility for protecting the status quo was assumed by the American Cancer Society (ACS), a private charity on whose board sits the wielders of power and influence such as oil companies and drug companies. Ralph Moss, in his book The Cancer Industry, and Samuel Epstein, in his book The Politics of Cancer - Revisited, describe in detail how the boards of the world's most influential cancer organizations, such as the ACS, represent the interests of the oil and drug companies, the manufacturers of mammography screening machines and radiotherapy machines. The ACS has a history of opposing alternative cancer therapies, when used either by qualified medical practitioners or those outside the medical profession.

Moss, RW. The Cancer Industry, Equinox Press, New York, 1989 (Previously published as the Cancer Syndrome).

According to Epstein "the American Cancer Society is fixated on damage control--diagnosis and treatment--and basic molecular biology, with indifference or even hostility to cancer prevention. This myopic mindset is compounded by interlocking conflicts of interest with the cancer drug, mammography, and other industries".

*Epstein, SS. American Cancer Society: the world's wealthiest "nonprofit" institution. Int J Health Serv. 1999;**29**(3):565-78.*

Epstein, SS. The Politics of Cancer - Revisited. East Ridge Press USA, 1998.

The ACS set up a *Committee on Quackery* whose job it was to compile a list of quacks and circulate it to all the medical associations through the Western world.

The Committee's name was changed in the 1950s to the *Committee on Unproven Methods of Cancer*

Management. The Committee published a book called "Unproven Methods of Cancer Management". The statements accompanying the list in the book stated that all these people either had no medical qualifications or had qualifications outside the cancer field. In fact, according to Ralph Moss, of the sixty advocates of unorthodox therapies listed in the Committee's book, 39 or almost two-thirds held bone fide medical degrees from universities such as Harvard, Illinois, North Western, Yale, Dublin, Oxford or Toronto. Eight others held PhDs in such fields as Chemistry, Physiology, bacteriology, parasitology or medical physics from universities such as Yale, Johns Hopkins, University of California at Berkeley, Columbia and New York University. Thus over 75 % of these "snake oil salesmen" as they were sometimes called, were medical doctors or doctors of philosophy in scientific areas. Of the other 25% three hold Doctorates of Science. Only five held no known degree.

Moss, RW. The Cancer Industry, Equinox Press, New York, 1989 (Previously published as the Cancer Syndrome).

In fact the list is a wonderful summary of the worlds most brilliant medical scientist from whom most of the progress in the treatment of cancer has come.

The American Medical Association also had its Committee on Quackery, formed in 1962 to focus on opposing chiropractors' efforts to become recognised as legitimate health care providers. That episode culminated in 1987 Supreme Court ruling against the AMA after an 11-year law suit brought by Chester Wilk and three other chiropractors. The court ruled that the AMA had conspired to boycott chiropractors, in other words force them out of business.

U.S. Congress Office of Technology Assessment, "Unconventional Cancer Treatments", OTA-H-405 Washington DC September 1990.

3. Monopoly

From the late 19th century most Western countries conferred on the allopathic school of medicine a monopoly status with regard to the treatment of cancer and several other diseases. There was no evidence that allopathic doctors had had any success with the treatment of cancer, but the medical profession was scared that their lack of success would leave the market open to unscrupulous people who might exploit the situation. Most Western governments have introduced legislation to prohibit the treatment of cancer, and certain other diseases, by anyone outside the allopathic school of medicine.

Since that time the medical profession has used the powers of the state to protect this monopoly. A good example of this is described in the case of *Wilk vs the AMA* mentioned above, where the US Government and its agencies were found to have conspired with the AMA to destroy the chiropractic profession.

The cancer industry world-wide is worth about $500 billion, employing hundreds of thousands of people in the fields of medical research, treatment, nursing, rehabilitation, sales, advertising, product promotion, medical reporting.

According to the US Department of Health and Human Services, National Institutes of Health Budget papers for year ending 2003, page 6, "medical care expenses for cancer patients and survivors add up to $60 billion annually, about 5 percent of all dollars spent on health care in the United States". This figure does not include the indirect costs to the country resulting from loss of productivity resulting from morbidity from cancer, which take the figure well over $110 billion per annum.

http://www3.cancer.gov/admin/fmb/2003cj.pdf

The figure for direct health costs for Australia is $2.7 billion.

www.cancer.org.au

In Australia, with the growing proportion of people tuning to alternative cancer therapies, there has been a concerted effort by Governments, both Commonwealth and State, to protect the allopathic school of medicine's monopoly over cancer treatment. At the Commonwealth level the ACCC launched a

campaign to restrict access to alternative cancer therapies as part of an internationally organised sweep of the internet to identify alternative cancer practitioners and their products. This was done ostensibly as a way of protecting consumers from misleading advertising. On 29 January 2002 the ACCC issued a media release stating:

ACCC leads international internet sweep for health scams

> Cyber health scams around the world are under the microscope this week as the Australian Competition and Consumer Commission and other consumer and health protection authorities from Australia and up to 30 other countries begin searching thousands of websites to uncover shonky health claims.
>
> The International Marketing Supervision Network Internet Sweep is targeting websites which offer 'miracle' health products and services, as well as sites promoting legitimate products as if they have properties they do not have.

One victim of the internet sweep was a Mr Desveaux who marketed the products on his Victoria-based website claiming that such products could "assist in treating and/or curing" such diseases and infections as AIDS, cancer, herpes, hepatitis, Epstein Barr , multiple sclerosis, chronic fatigue syndrome, discoid lupus, alcoholism and drug additions, bronchial asthma, dermatitis, and immune diseases.

Products sold include O2xyrich Liquid Oxygen, Colloidal Copper, Colloidal Gold, SleepAweigh, Noni Juice, White Powder Gold and Etherium Gold, Olive Leaf Extract, Stevia, Peruvian Maca, Unique Water, Biosun Hopi Candle, and Colloidal Silver makers.

Although his advertising did not claim to “cure” cancer it said it “could assist in treating and/or curing…cancer”.

Apparently it is OK for cancer authorities to claim they can cure cancer, when they can’t provide evidence for this; yet no one outside the allopathic school of medicine can even claim that a product could assist in curing cancer.

At the State level, on 31 October 2002 Minister for Health, Craig Knowles issued a press release stating:

> The NSW Government will crackdown on 'miracle cures', 'wonder drugs' and misleading health claims and advertisements to protect people who are sick and vulnerable…
>
> The Minister for Health, Mr Craig Knowles, today said that up to $2 billion is spent in Australia on alternative health products and procedures, many of which have not been scientifically tested or proved....
>
> To combat dodgy cures and health practices, the Government will:
> - Review the existing laws and regulations available to stop peddlers making false health claims, selling untested or unproven health products or conducting potentially unsafe procedures;
> - Strengthen the powers to investigate and prosecute quacks;
> - Bolster the powers of the health professional boards eg NSW Medical Board to deal with practitioners involved in dodgy practices;
> - Increase the penalties for marketing bogus health products;
> - Initiate a public education campaign.

The Government appointed Professor John Dwyer to head a Committee to carry out this task. Professor Dwyer’s only expertise in this area is an enthusiasm to stamp out all alternative cancer therapies.

Because of his extreme bias in this regard and his aim of protecting the allopathic school of medicine from any competition from natural health practitioners, the Committee quickly disintegrated when others on the Committee refused to work with him in such a biased fashion.

However the fact that a State Government issued such a biased press release and was prepared to allowed its offices to be used to eliminate competition in the health field, is a measure of how far the medical profession has taken control of government to protect its monopoly over the treatment of cancer at the expense of the 50% of the population who now choose to use alternative medicine.

As the Minister said in his press release, "$2 billion is spent in Australia on alternative health products and procedures" about the same as is spent on prescription drugs, revealing the motive behind the move.

He also stated that "many of these products and procedures have not been scientifically tested". No mention is made that very few of the product and procedures used to treat cancer by the allopathic school of medicine have been scientifically tested (as outlined in Part 1 of this submission).

On 11 November 2002 the Society lodged a formal complaint on behalf of our members with the ACCC citing many examples of public statements made by cancer experts that we believed to be inaccurate or misleading. This involved

- six on the subject of the benefits of early detection of breast cancer using mammograms;
- one on the subject of the benefits of early detection of cervical cancer using Pap testing;
- two on the subject of the benefits of early detection and intervention for prostate cancer using the PSA and other tests, including a claim that surgical intervention is "curative";
- one promoting preventive screening for other cancers that saves lives; and
- two promoting radiotherapy for inappropriate cancers.

In each of the 12 cases we provided detailed extracts from references that questioned the validity of the claims, such as has been done in Part 1 above.

The ACCC responded that they do not investigate misleading claims and that we should instead take the matter up with the individuals who had made the claims, or with the local State Department of Health. (At the time they were in fact investigating a complaint made to the ACCC by Professor John Dwyer that Jenny Burke had made misleading claims about the services she was providing, despite there not having been a single complaint from a client.)

They also stated that it was their belief that orthodox therapies for cancer were supported by a substantial weight of evidence.

They did not provide a single reference to back up this claim.

4. Evidence and Prestige

In the early 1990s the Evidence-Based-Medicine movement began to grow in the form of the Cochrane Collaboration, and this has added to a more scientific approach to the evaluation of medical interventions and further jeopardised the arguments of orthodox cancer authorities who claim that alternative cancer quacks are enticing people away from proven therapies. As outlined in Part 1, only about 15% of orthodox medical interventions are based on good scientific evidence. For cancer the figure is less than 6%.

Recently the Cochrane Group has also discovered that the peer review system on which medical science is based is flawed. What is published is therefore not an accurate or representative measure of the efficacy of therapies.

As the findings from the Cochrane Group have started to question some of the evidence on which cancer treatment is based (eg mammography), those in positions of prestige, the cancer "experts", have used the power of their positions to question these findings and support the status quo. (See Part 1)

Some insight into how and why orthodox medical authorities such as the American Medical Association and cancer authorities in particular such as the American Cancer Society have suppressed alternative cancer therapies can be gauged from the Chapter 8 in the US Congress publication "Unconventional Cancer Treatments" entitled 'Organized Efforts Related to Unconventional Cancer Treatment: Information, Advocacy, and Opposition'. This publication resulted from a Congressional Investigation headed by Guy Molinari into suppression of the IAT Therapy in the Bahamas. (See Item 9 below)

U.S. Congress Office of Technology Assessment, "Unconventional Cancer Treatments", OTA-H-405 Washington DC September 1990.

However the only way of seeing how these forces are played out in the local arena is to examine what has actually happened in the cases where qualified doctors had their work actively suppressed.

What are the suppressed therapies?

The following is a summary of some of the better known and researched therapies. Details of these and many other such therapies are given in Ralph Moss' book Cancer Therapy.

Moss,RW. Cancer Therapy, Equinox Press, New York, 1992.

1. Dr Royal Raymond Rife (not medically qualified, but one of the first suppressed last century)

In 1920 Royal Rife, an engineer, identified what he claimed was the human cancer virus using the world's most powerful microscope (which he had invented), cultured the virus and injected it into rats. These injections were claimed to have caused cancer in every one of the 400 rats. Later he was able to find a frequency of electro-magnetic energy that would cause the cancer virus to self-destruct when within that energy field. He created a device that emitted that energy field and was claimed to have been successful at destroying cancer viruses inside patients who were within 10 feet of the device.

In 1934, the University of Southern California appointed a Special Medical Research Committee to bring 16 terminal cancer patients from Pasadena County Hospital to Rife's San Diego Laboratory and clinic for treatment. The team included doctors and pathologists assigned to examine the patients, if still alive, in 90 days. After the 3 months of treatment, the Committee concluded that 14 of the 16 patients had been completely "cured". The treatment was then adjusted and the remaining 2 also were allegedly "cured" within the next 4 weeks. On November 20, 1931, forty-four of the nation's most respected medical authorities honoured Royal Rife with a banquet billed as "The End To All Diseases" at the Pasadena estate of Dr Milbank Johnson.

In the early 1930s the Smithsonian Institution investigated Rife's Universal Microscope and his earlier ones with the help of Dr Arthur Isaac Kendall, of the department of bacteriology of Northwestern University Medical School and Dr. Edward C. Rosenow, of the Mayo Foundation. They confirmed Rife's claims and that it had a resolution of 31,000 diameters and magnification of 60,000 diameters, about 10 times more powerful than conventional microscopes made by Carl Zeiss at the time.

Rife's Microscope, The Smithsonian Report. From the Annual Report of the Board of Regents of The Smithsonian Institution – 1944.

But by 1939, almost all of these distinguished doctors and scientists were denying that they had ever met Rife. This complete reversal was the result of pressure from the drug companies on them.

The editor of JAMA, Morris Fishbein, tried unsuccessfully to buy the rights to Rife's healing instrument for the drug industry. Later Rife's laboratory and those of several of his colleagues were destroyed by arson and sabotage.

From: www.excel.net/~jaguar/c-virus.html

In a letter of 6 September 1989, Rolf Wieland, senior microscopy expert for the world-known German optics firm Carl Zeiss, wrote from his company's Toronto office: "What I have seen is a remarkable advancement in light microscopy. ... It seems to be an avenue that should be pursued for the betterment of science".

http://www.luminet.net/~wenonah/new/somatid.htm

2. William Koch, MD, PhD

Dr William Koch's contribution to cancer control was a substance he called Glyoxylide. This substance together with a special diet was designed to stimulate cell oxidation and cleansing of the body. His work was judged and condemned as worthless by the Cancer Committee of the local Wayne County Medical Society in 1923. Yet in Belgium and Canada his treatment was judged successful, converting

many terminal cancer patients to a status of "cancer-free. Persecution forced him to work in Mexico and Brazil.

In 1942 and 1946 the US Food and Drug Administration (FDA) prosecuted him in two trials and a permanent injunction was granted against the Koch Laboratory in 1950. Several other physicians were expelled from their medical societies for using glyoxylide, which the FDA contended was indistinguishable from distilled water.

3. Robert Lincoln, MD

Dr Robert Lincoln developed the Lincoln bacteriophage method of treating cancer. He identified bacterial strains as contributing factors in hundreds of perplexing disease symptoms, including depression, the common cold and cancer. His success with cancer became known when US Senator Charles Tobey, whose son had been cured of cancer by Lincoln, intervened on Lincoln's behalf when he was expelled from the Medford (Massachusetts) Medical Society in 1952. However despite Senator Tobey's help Lincoln was hounded to his death in 1954.

4. Stanislau Burzynski. MD, Ph D

Dr Stanislau Burzynski found life in Communist Poland difficult and migrated to the United states in 1969 to pursue his research. He developed a theory that involved correction rather than destruction of cancer cells by giving them the missing information needed for them to develop into differentiated body-organ cells. He did this using protein peptides that he called antineoplastons that he extracted most easily from the urine. Working at his Houston Clinic in Texas he isolated four of these peptides that allegedly restrained up to 99% of the growth of three different types of cancer cell, with no inhibitory effect on surrounding normal tissue.

Despite achieving a very high success rate with terminal cancer patients he was investigated by the Harris County Medical Society which told him to stop lecturing to universities and avoid all publicity about his discoveries. His research funds were cut off. When a reporter inquired about the two year investigation, the Medical Society intimated that it would not be wise to have anything to do with him.

5. Andrew Ivy, MD, PhD

At the time Dr Andrew Ivy was the world's most cited scientist. He developed an immuno-therapeutic drug he called Krebiozen. He was investigated by the Chicago Medical Society and found to be "unethical". He was suspended in 1953 by this Society and from the AMA. He lost his job as head of the prestigious University of Illinois Medical School which he had held for many years and was never reinstated. Several members of the AMA had tried to acquire distribution rights to his new medicine or "wreck all those who were connected to it".

6. Joseph Gold, MD

From 1969 Dr Joseph Gold worked on a chemical called hydrazine sulphate that he had designed to stop cachexia. (see Part 2). He believed that cachexia was the actual cause of death in over 50% of cancer patients. His results were published in the October 1975 issue of Oncology. He had reported objective improvement in 17% of terminally ill cancer cases. 70% had showed subjective improvement including increased appetite, weight gain, strength and control of pain. Similar results were reported in the Soviet Union's Petrov Research Institute of Oncology in Leningrad.

The Sloan Kettering Research Institute, against Gold's advice, tested hydrazine sulphate as an anti-tumour drug using improper dosage levels, inadequate treatment times and incomplete presentation of results. The Institute found it did not reduce tumour size and placed hydrazine sulphate on the Unproven Methods list.

Dr Gold's research funds were cut off. The Soviet scientists continued their research on terminal cancer

patients and found that 12% of patients had reduction in tumour size, 32% had stabilised their cancer and 65% had experienced subjective improvement.

7. Max Gerson, MD

Dr Max Gerson discovered his treatment for cancer by mistake. He was trying to eliminate his severe migraines for which his colleagues said there was no effective treatment. He suspected something in the food he was eating, so he eliminated all food except apples and his migraines went away. He then gradually added other foods until they came back. Several of his patients tried his anti-migraine diet and some who also had lupus erythematosis found that their lupus cleared up. Several of his patients with lupus tried it and one who also had cancer found the cancer went into remission. He gradually modified it for cancer. He later observed that the diet he had developed was high in potassium and low in sodium so that it had restored energy to the potassium-sodium pump believed energised all cells. Max Gerson published his anti-lupus diet in JAMA. However when he tried to publish his anti-cancer diet it was suppressed by the editor of JAMA, Morris Fishbein because it prohibited smoking cigarettes. At the time the journal relied on funding from the tobacco industry for its advertisements promoting cigarette smoking.

In 1946, Gerson demonstrated recovered patients before the Pepper-Neely Congressional Subcommittee, during hearings on a Bill to fund research into cancer treatment. Senator Pepper was so impressed with Gerson's results that he proposed that the whole $150 million in the Bill be allocated to fund research and treatment using the Gerson method. The AMA lobbied strongly against this proposal, which would have meant the beginning of the end for the cancer establishment, and the Bill was defeated. Although only a few peer-reviewed journals were receptive to Gerson's then "radical" idea that diet could affect health, he continued to publish articles on his therapy and case histories of healed patients.

In 1958, after thirty years of clinical experimentation, Gerson published *A Cancer Therapy: Results of 50 Cases*. This medical monograph details the theories, treatment, and results achieved by a great physician. Gerson died in 1959, eulogized by long-time friend, Albert Schweitzer M.D.: "...I see in him one of the most eminent geniuses in the history of medicine".

From: *www.gerson.org/about/mg.asp*

8. Josef Issels, MD

Dr Josef Issels, a German doctor, was disillusioned with his results at treating his cancer patients so he analysed the world literature for new ideas and discovered that good ideas had wrongly been abandoned in the nineteenth century following the development of the microscope. He experimented with the alternative paradigm that had been accepted for thousands of years. Concentrating on boosting the immune system he obtained excellent results at his Ringberg clinic in Bavaria, which he had opened in 1951. Because of his successes he soon became well-known.

Issels was charged with manslaughter in June 1961 in a court case fabricated out of malice, denunciation and false accusations, engineered by President of the Bavarian Medical Council. The process made its way through the court system for 4 years and led to the closing of the clinic and hundreds of his patients died unnecessarily. He was found guilty based on fabricated evidence. He was later completely acquitted on appeal held in October 29, 1964 and the higher court judge found that the local medical society had conspired with government officials and a sympathetic judge to destroy him and his work.

During the late 1960s several British cancer patients recovered from cancer after going to his clinic in Germany. News spread of the many successes.

John Anderson, M.D., Professor of Medicine, Former Head and Chair of the Department of Medicine at

King's College Hospital Medical School, University of London, England and Former Consultant to the World Health Organization on Oncology visited the Clinic and reported:

> "He (Dr. Issels) is undoubtedly producing clinical remissions in patients who have been regarded as hopeless and left to fall back on their own resources".

The BBC also heard about some of these recoveries and tried to have a cancer expert from the United States flown in to Germany to report on the clinic in confidence to the BBC. He was a distinguished American professor of medicine at a major US University and an authority on clinical chemotherapy and cancer statistics. He expressed his enthusiasm and agreed to the offer subject to talking first to the American Cancer Society. After talking to the ACS he changed his mind.

The BBC sent a film crew to the clinic and made a film about Issels, called "Go and Climb a Mountain". Professor John Anderson, impressed by the statistics compiled by an independent assessor, provided some medical advice to the BBC.

Before its release the film was shown to a few British cancer experts, including Professor Sir David Smithers, who wrote to the BBC attacking the film and misrepresenting the film's message.

In contrast Denis Burkitt, discoverer of Burkitt's Lymphoma and a member of the government's Medical Research Council, found it to be exceedingly interesting and supported its release.

However the scheduled public screening on March 17, 1970 was cancelled. On October 18 *The Observer* published a front page story "Cancer Film Banned by BBC. This embarrassed the BBC and the head of BBC-1, Paul Fox, ordered that the film be shown at peak viewing time on November 3.

David Smithers and Dr Gordon Hamilton Fairley attacked the film in a joint letter to the BBC and criticized the BBC for showing it.

Denis Burkitt stated in a letter to the BBC on November 22:

> 'I would like to congratulate you on your courage in showing the Issels film. I am sure you did right. Claims like this deserve investigation. It is quite unscientific to say, "It can't happen: therefore, it didn't happen"'

After its showing the film was destroyed. Our Society was unable to obtain a copy of it and the BBC denied having any record of it.

As a result of the international publicity aroused by the film, pressure grew for the British medical authorities to evaluate the Issels Clinic. Britain's Co-ordinating Committee on Cancer Research was forced to agree to send a team to investigate. The investigating team consisted of five cancer experts, including three who had already attacked the film and Issels methods. The team was led by Sir David Smithers. Gordon Hamilton Fairley was also on the team. A third member Dr Robert J.C. Harris, when head of the Department of Environmental Carcinogeneis, Imperial Cancer Research fund, London, had told the BBC researchers in January 1970:

> "A great deal of what he does is quackery. I can judge this without going along to his clinic. There is no point in going along. If I went, if anybody went along who's an accepted cancer researcher, we would all be guilty by association with a quack".

It was never likely that this team would give an impartial report on the clinic. They visited the Ringberg Clinic for five days from January 25, 1971 to evaluate the Issels Therapy. Although other team members had expressed pleasant surprise at the apparently good state of health of the terminal cancer patients they saw at the Clinic, their final report was a whitewash full of mis-statements such as:

- many of the patients who had recovered did not have cancer in the first place (All had in fact been diagnosed as terminal cancer patients by reputable centers in Britain or Germany)
- many of those who had recovered did so as a result of delayed effect of orthodox therapies (All of the cases referred to had been written off as dying because orthodox therapies had not worked)

- the survival statistics calculated by independent assessors were no better than that achieved by orthodox therapies (Percentage 5-year survival for terminal patients was 16.6%, about eight times better than that achieved by orthodox therapies)

At that time Issels has the best published survival statistics in the world for late-stage cancer patients. (See Part 2) However in 1996 after these years of harassment and bad publicity Issels' health deteriorated. He retired to America with his wife Isa where they became senior medical consultant and co-principal medical investigator at a specialised cancer hospital in Tijuana, across the border from San Diego. They worked with other doctors and researchers who were well connected to the then Office of Alternative Medicine at the US Institutes of Health in Washington.

Issels died on February 11, 1998 in San Diego.

In June 2001 Issel's son Rolf opened the Issels Foundation in Munich by which time there were 200 hospitals, clinics and diagnostic centres using the Issels methods.

Also in June 2001 a clinic devoted to Issels' methods opened in Birmingham, England. Another had already opened in Southhampton.

From: *Gordon Thomas, Cancer Doctor: The Biography of Josef Issels, M.D., Who Brought Hope to the World with His Revolutionary Cancer Treatment*.

9. Lawrence Burton, Ph D

Dr Lawrence Burton developed a cancer treatment based on restoring the balance of four natural immune components in the blood: tumour killer/tumour antibody/tumour necrosis factor (TNF)- this accelerates tumour kill; tumor complement factor (TCF); and tumour blocking protein factor (BPF) – this slows down or stops the action of TNF; tumour de-blocking protein factor (DPF) – this neutralizes the action of BPF.

Attempts to have his therapies accepted in the 1960s were opposed by US health officials. One tried to buy the rights to his treatment but Burton refused to sell, suspecting it would be suppressed. That person organised continued harassment of Burton who left the US and set up a clinic in the Bahamas. When the official was diagnosed with a brain tumour he went to Burton for help. For years officials from the US National Cancer Institute, acting in collaboration with the American Cancer Society, sought to have his clinic closed down.

Under pressure form the US National Cancer Institute the Bahaman Health Dept closed the clinic in late 1985. Hundreds of Burton's cancer patients' lives were threatened by the closure and many petitioned their congressional representatives.

Suppression Exposed

An investigative journalist, Gary Null, discovered that a woman high up in the US Government bureaucracy (possibly Virginia Knauer) had contacted the Bahamian Department of Health and threatened to announce on the media that hundreds of patients had caught AIDS at a clinic in the Bahamas unless the Burton Clinic was closed down. Because the Bahamas rely on tourism for their survival, Burton's Clinic was closed down.

As a result of the threat to the cancer patient's lives Congressman Guy Molinari raised the issue in Congress and got approval to set up an inquiry in January 1986 into the Clinic's closure. He chaired the inquiry.

The hearing discovered that Dr Curt from the National Cancer Institute had provided Virginia Knauer, special adviser to President Reagan on Consumer Affairs, (through her assistant Feena McLaverty), with information alleging that Burton had caused hundreds of people to get AIDS at his clinic. Virginia Knauer then used this information on behalf of the American Cancer Society in a press kit for a coming

conference on health fraud. The American Cancer Society had listed Burton on their list of unproven methods (formerly the list compiled by their Committee on Quackery).

When confronted with this false information obtained from the NCI, Dr Curt denied he had given it. It then transpired that a Dr Katterhagan at the Center for Disease Control in Atlanta had claimed that he had identified the AIDS virus in blood samples that had come for the Burton Clinic in the Bahamas. Later Dr Katterhagan admitted that the information the Center had on the serum from the Burton Clinic was inconclusive. None of Burton's patients had died of AIDS.

U.S. Congress. Congressional Public Hearing. A Hearing on the Immuno-Augmentative Therapy of Dr. Lawrence Burton. Jan 15, 1986, 26 Federal Plaza, New York.

Congress ordered the NCI to back off and remove all disparaging comments about the IAT on their website. Once this suppression ceased the IAT Clinic reopened.

Congressman Guy Molinari requested the US Congress' Office of Technology Assessment to examine the IAT treatment with a view to designing a clinical trial protocol to permit valid evidence of efficacy and safety to be gathered. At the same time Congressmen John Dingell requested the OTA to review the issues surrounding unconventional cancer treatments. The OTA publication Unconventional Cancer Treatments came out of this investigation.

U.S. Congress Office of Technology Assessment, "Unconventional Cancer Treatments", OTA-H-405 Washington DC September 1990.

Congress also forced the establishment within the National Institutes of Health of a rival body to the NCI, the Office of Alternative Medicine to evaluated alternative therapies properly, including those for cancer, rather than try to suppress them. For years opponents of the OAM within the cancer establishment opposed its work. This was revealed in a further congressional hearing of the Committee on Government Reform and Oversight held on 4 February 1998 chaired by Congressman Representative Burton. However the OAM survived and on 21 October 1998 became the National Center for Complementary and Alternative Medicine with increased funding of $50 million.

As part of the clearing out of biased attitudes towards alternative therapies in the US, the medical journal JAMA featured several articles on alternative therapies during 1998 and devoted its 11 November issue entirely to alternative therapies - a far cry from the early days when the AMA had been found guilty in the US Supreme Court of conspiring to destroy the chiropractic profession, using the government offices of the health and postal departments. Issues raised included the role of the Cochrane Collaboration in evaluating complementary medicine.

*Ezzo J, Berman BM, Vickers AJ, Linde K. Complementary medicine and the Cochrane Collaboration. JAMA. (Nov 11) 1998; **280** (18):1628-30*

Similarly the Canadian Medical Association Journal reviewed several promising alternative cancer therapies in its pages over several issues from April to June 1998. This resulted from work of a Task Force on Alternative Therapies of the Canadian Breast Cancer Research Initiative led by Elizabeth Kaegi of the National Cancer Institute in Canada.

*Kaegi E. Unconventional therapies for cancer: 1. Essiac. The Task Force on Alternative Therapies of the Canadian Breast Cancer Research Initiative. CMAJ. (Apr 7) 1998;**158** (7):897-902.*

*Kaegi E. Unconventional therapies for cancer: 2. Green tea. The Task Force on Alternative Therapies of the Canadian Breast Cancer Research Initiative. CMAJ. (Apr 21) 1998;**158** (8):1033-5.*

*Kaegi E. Unconventional therapies for cancer: 3. Iscador. Task Force on Alternative Therapies of the Canadian Breast Cancer Research Initiative. CMAJ. (May 5) 1998;**158** (9):1157-9*

*Kaegi E. Unconventional therapies for cancer: 4. Hydrazine sulfate. Task Force on Alternative Therapies of the Canadian Breast Cancer Research Initiative. CMAJ. 1998 May 19;**158** (10):1327-30.*

*Kaegi E. Unconventional therapies for cancer: 5. Vitamins A, C and E. The Task Force on Alternative Therapies of the Canadian Breast Cancer Research Initiative. CMAJ. (Jun 2) 1998;**158** (11):1483-8.*

*Kaegi E. Unconventional therapies for cancer: 6. 714-X. Task Force on Alternative Therapeutic of the Canadian Breast Cancer Research Initiative. CMAJ. (Jun 16) 1998; **158** (12):1621-4.*

Likewise the Medical Journal of Australia devoted 14 pages of its December 1998 issue to alternative therapies and discussion of evidence based medicine.

*Hensley MJ, Gibson PG. Promoting evidence-based alternative medicine. Med J Aust.(Dec 7-21) 1998;**169** (11-12):573-4.*

Lawrence Burton died in 1993. The IAT Clinic still operates under the supervision of British doctor John Clement.

10. David Rubin, MD

When Dr David Rubin's mother was dying of cancer and nothing more could be done for her, he looked into alternative therapies. He had heard about Laetrile so he went to Mexico to investigate it himself. He was impressed by its effect on improving cancer patients' quality of life. He interviewed several of its proponents in the United States and took samples back home to Israel where he analysed it. He found it was not laetrile at all but amygdalin, an extract from apricot kernels. He knew that amygdalin could not shrink tumours because the enzyme necessary to release its cyanide, beta glucosidase, was not present in humans. Only the proper laetrile could do that because its cyanide was released safely only in tumours where there was a high concentration of the enzyme beta glucuronidase. Amygdalin could work only if it were converted into the proper laetrile in the body.

So David Rubin could not save his mother's life. But instead he spent the next few years working out how to make the real Laetrile. He finally succeeded by feeding almond leaves to goats and extracting the laetrile from their urine. He later worked out how to synthesis it more effectively. He tried it out on humans and it worked as predicted. Of 10 women with breast cancer, all went into remission, although one died from toxemia because the tumour was destroyed too rapidly for the body to excrete it safely. He hadn't heard of Max Gerson's detoxification using coffee enemas.

*Rubin DL, Rubin EJ. A minimal toxicity approach to cancer therapy: possible role of beta-glucuronidase. Med Hypotheses. 1980 Jan; **6**(1):85-92.*

When his local Israeli Medical Association found out about Rubin's work on "laetrile" he was immediately branded a "quack". None of his former colleagues would work with him and denied he had ever worked a Hadassah Hospital. He left Israel and migrated to the United States where he abandoned the "laetrile" issue.

11. John Richardson, MD

In the autumn of 1976, Dr John Richardson received a certified letter from the Medical Board of the State of Ohio requiring him to appear, two weeks hence, before that Board for a hearing because he was using Laetrile (Amygdalin) and nutritional therapies for his cancer patients. His lawyer George Kell defended him. Several months later the Enforcement Officer of the State Medical Board tried to talk him out of using these therapies saying that the State Medical Board was not happy with what he was doing. His response was "I was not placed on this earth to please the State Medical Board. I was placed on this earth to please God. I know that the nutritional program I am using adds far more to the quality and quantity of life of the cancer patient than anything offered by orthodox medicine. Therefore, I am obligated to God to do what I know to be right. Whether the State Medical Board agrees or disagrees is not important.

From: *Laetrile Case Histories; The Richardson Cancer Clinic Experience, by John A. Richardson, M.D., and Patricia Griffin, R.N., B.S. Bantam Books*

12. Emanuel Revici, MD

For several years the medical authorities of New York State tried to stop Dr Emanuel Revici from using alternative cancer therapies on his patients. He was finally taken to court. In a landmark U.S. Appeals

Court case of Schneider v. Revici (1987) the court affirmed a cancer patient's right to get not just Revici's treatment, but any alternative method. But state authorities have continued to ignore the court's finding. In November 1993 they again revoked his licence to practise medicine. They charged him with inadequate examinations and record keeping. No patients had filed a complaint. The cancer establishment has been out to get Revici for decades. He is a "heretic" who uses medicines of his own invention and claims some astonishing results. At the age of 96 the aged doctor had to occupy his days in a desperate struggle to restore his medical license.

From The Cancer Chronicles #19 © January 1994 by Ralph W. Moss, Ph.D

13. Gaston Naessens (a biologist, not a medical practitioner)

Gaston Naessens, while still in his twenties in France, invented a microscope more powerful than any other available through which he was able to observe the mechanisms of life from the pre-cancerous stages. He later migrated to Quebec. Unlike the electron microscope, which can only view inert matter, Like Royal Raymond Rife, mentioned above, Naessens' microscope is capable of viewing living and moving microbial life-forms at magnifications and resolution orders of magnitude greater than those attainable by current state-of-the-art instruments. Under this microscope he discovered an indestructible entity that he called a *somatid*.

He found that in healthy persons the somatid has a normal 3-stage cycle (somatid, spore, and double spore), but goes through a pleomorphic or form-changing 16-stage cycle in persons afflicted with cancer and other degenerative diseases. It is observable in the blood up to 18 months before any clinical signs of disease have appeared.

His therapy, based on his discoveries with his microscope, was a product (714-X) based on camphor that floods the cells with nitrogen, thus interrupting the 16-stage cycle and allowing it to revert to the normal 3-stage cycle.

With this treatment, Naessens claimed that in over 75% of 1,000 cases of cancer treated with 714-X, saw their afflictions arrested and reversed and came back to perfect health.

Like the earlier Rife microscope and the treatment developed from it, medical authorities refused to accept that people outside the optical and cancer fields could invent a better microscope and a more effective treatment than "the experts".

In letter, dated 12 October 1989, Dr. Thomas G. Tornabene, director of the School for Applied Biology at the Georgia Institute of Technology (Georgia Tech), who made a special trip to Naessens's laboratory, where he inspected the microscope, wrote:

> "Naessens's ability to directly view fresh biological samples was indeed impressive ... Most exciting were the differences one could immediately observe between blood samples drawn from infected and non-infected patients, particularly AIDS patients. Naessens's microscope and expertise should be immensely valuable to many researchers".

In 1989, Naessens was brought to trial at the instigation of the Quebec Corporation of Physicians on five counts, including "accessory to murder". He was acquitted on all counts by a jury of his peers. The Persecution and Trial of Gaston Naessens gives an in-depth account of the historic trial, the many notable witnesses for the defence, and the continuing vendetta of the cancer industry against a man working for the betterment of humankind. The author, Christopher Bird, attended the entire trial and continues in his unflagging support of Gaston Naessens.

From: *The Persecution and Trial of Gaston Naessens, by Christopher Bird. Published by H. J. Kramer, Inc. Tiburon, CA, 1991.*

14. Luigi Di Bella, MB BS.

Professor Luigi Di Bella, a retired physiologist who lived in Modena in Italy developed a cancer therapy based on a combination of somatostatin, vitamins, retinoids, melatonin, and bromocriptine. ACTH (adrenocorticotropic hormone) and low oral doses of the well-known chemotherapeutic agents cyclophosphamide and hydroxyurea were sometimes also included. Di Bella claimed that his treatment stimulates the body's self-healing properties without damaging healthy cells.

In December 1997 he made headlines after Carlo Madaro, a judge in the Southern Italy city of Maglie, ruled that the health authority should fund the treatment for a patient. The case involved a 2-year-old child with brain cancer who was being treated with Di Bella's regimen. The child's parents asked for free somatostatin, believed to be the regimen's key component. Under Italian law, somatostatin and its analogue octreotide can only be prescribed to manage the diarrhea and flushing associated with rare tumours called carcinoids. Despite this, most pharmacies in Italy had run out of these costly drugs because of the Di Bella regimen's popularity, and many patients were buying them abroad. After judges in several more Italian towns backed the requests of patients asking for somatostatin, oncologists were accused of conspiring to keep cancer patients away from a potentially curative therapy. Political leaders were criticized and rumours of a possible government crisis began to spread.

Then, following a televised debate with Di Bella in January 1998 -- watched by nine million Italians -- Minister of Health Rosy Bindi announced that clinical trials would be carried out in public hospitals. Di Bella was asked to collaborate with the leading Italian cancer specialists in writing the trial protocols.

According to a Ministry of Health spokesperson the decision was made to resolve a "problem of public order". However, some cancer specialists were critical and refused to participate in the research because they believed it was unethical and appeared to legitimise Di Bella's claims. Those who chose the Di Bella treatment were entered into nine phase II, open-label studies at several cancer centres. These studies included patients with cancers of the breast, lung, pancreas, colon, brain, head and neck, and non-Hodgkin lymphomas who were unresponsive to conventional treatments or who had refused proven treatments. Patients with more advanced cancers were eligible for another trial, another study intended to follow a total of 2,600 patients.

Although the public expected to learn within a few months whether the Di Bella's regimen was superior to conventional treatments, warnings came out that the trials lacked control groups and could not provide conclusive evidence. Meanwhile, Di Bella himself expressed fears that the results would be "sabotaged" by mainstream doctors. He also accused drug companies of conspiring against him and even claimed he had been the target of an assassination attempt. The drama increased when Di Bella, speaking to European Parliament members, announced that his regimen is also effective against retinitis pigmentosa, multiple sclerosis, amyotrophic lateral sclerosis, and Alzheimer's disease, all of which have no known medical cure.

The results of the Phase II clinical trials were published in the British Medical Journal 1999; **318**: 224-228. The trials were made up of 11 independent multicentre uncontrolled phase II trials relevant to 8 different types of cancer and were held in 26 Italian hospitals specialising in cancer treatment. There were 386 patients with advanced cancer enrolled in the trials between March and July 1998 and followed to 31 October 1998.
The treatment included melatonin, bromocriptine, either somatostatin or octreotide, and retinoid solution, the drugs that constitute Di Bella's multitherapy. These were given to patients daily. Cyclophosphamide and hydroxyurea were added in some trials. Responses were assessed every 1, 2, or 3 months, depending on the specific trial, and toxicity was evaluated using criteria developed by the World Health Organisation.

No patient showed complete remission. Three patients showed partial remission: 1 of the 32 patients with non-Hodgkin's lymphoma; 1 of the 33 patients with breast cancer; and 1 of the 29 patients with

pancreatic cancer. At the second examination, 12% (47) of the patients had stable disease; 52% (199) progressed; and 25% (97) died.

The authors concluded that the Di Bella multi-therapy did not show sufficient efficacy in patients with advanced cancer to warrant further clinical testing.

Professor Di Bella denied these results saying that the trials dis not use his protocols, referring to the quality and the quantity of the drugs used. The results of the second study were claimed to show more positive results.

Dr Di Bella died in July 2003, aged 91. The Isola Bella Clinic has been established in Toronto, Ontario, Canada, to provide patients with access to the Treatment Protocol designed by Dr. Luigi Di Bella.

From: *www.quackwatch.org/01QuackeryRelatedTopics/Cancer/dibella.html* and *www.mednaturalia.net/dibella/home.html*

15. Eric Asher, MB BS

Dr Eric Asher was a GP on the North Shore of Sydney in the 1980s who was impressed by the benefits he observed using Iscador, an extract from the mistletoe plant, on the quality of life of some of his cancer patients. He was carpeted by the local medical board and told to stop using it. He persisted in using it on the grounds that as a doctor he felt obliged to do what he thought best for his patients. He was again threatened with having his licence to practice withdrawn if he persisted in using it.

Although it is not clear what happened after that, as CISS did not refer our members to him any more, we admired him for his persistence against authorities at the time.

16. Hans Eysenck, PhD, DSc and Ronald Grossarth-Maticek, PhD

Dr Hans Eysenck ruffled many feathers among the clinical psychology profession when he published a classic review of the efficacy of psychotherapy for the treatment of neurosis in 1952 called "The Effects of Psychotherapy: An Evaluation". He had been sent to the United States in 1949 to evaluate American clinical psychology practices in preparation for launching the first department to teach the subject in the UK.

He could find no good evidence that psychoanalysis in particular or psychotherapy in general produced any benefits for people with neurotic disorders when compared with no treatment at all. In other words many people with neuroses gradually improved, with or without therapy. He did however find some evidence for benefits for a particular type of behaviour therapy.

*Eysenck HJ. The effects of psychotherapy: an evaluation. J Consult Clin Psychol 1952; **16**: 319-24.*

As a result he was ostracised by his clinical fraternity, had efforts to establish alternative methods of treatment (behaviour therapy) blocked by psychiatrists, was refused research grants by embattled psychoanalysts on grant-giving bodies and was generally treated as an outcast and a parish.

Although later analyses confirmed his findings, denigrations and erroneous statements of the original arguments still appeared in textbooks and articles. Efforts were made to terminate his appointment.

He also put his reputation as one of the world's foremost psychologists on the line when he backed the work of a European researcher Ronald Grossarth-Maticek who had done research in the early 1960s in Yugoslavia, and later research into the effects of behaviour therapy among 10,000 elderly residents of Heidelberg in Germany in the early 1970s.

Eysenck had Grossarth-Maticek's work published in 1991.

*Grossarth-Maticek R & Eysenck, HJ,. Creative Novation Behaviour Therapy as a Prophylactic Treatment for Cancer and Coronary Heart Disease – Part I -- Description of Treatment. Behav Research and Therapy 1991; **29** (1): 1-16.*

*Eysenck, HJ & Grossarth-Maticek, R. Creative Novation Behaviour Therapy as a Prophylactic Treatment for Cancer and Coronary Heart Disease – Part II Effects of Treatment. Behav Research and Therapy 1991; **29** (1): 17-31.*

It caused such a furore that a complete issue of the journal Psychological Inquiry was devoted to a critique of Grossarth-Maticek's work.

The criticisms were focused on his *prediction* studies that used a questionnaire to identify a 'cancer-prone' or 'heart disease-prone' personality type and measure the incidence of cancer and heart disease in these patients many years later. The criticisms were essentially that Grossarth-Maticek's claims of prediction were "too good to be true" and that there were some errors in the data, implying that the results had been faked. Little of the criticism was levelled at the *treatment* studies, although the criticism of the Prediction studies was assumed to transfer across to the *treatment* studies. The results of the *treatment* studies were ignored despite the fact that other treatment studies (that used a similar type of psychotherapy) that showed a similar reduction in mortality among people with cancer, were accepted.

The medical profession has largely ignored this important work, partly because it has been published largely in psychological journals and partly because denial is a common response to paradigm-shattering new information.

From: *www.attitudefactor.com/grossarth.htm, Thomas R. Blakeslee, 1997*

17. Ryke Geerd Hamer MD

When his son was accidentally shot in 1978 Dr Hamer suffered a traumatic emotional shock. He later developed a testicular cancer. His research identified many other cancers preceded by emotional traumas and he developed "The New Medicine" based on a different paradigm of what cancer is.

According to his "Iron Rule of Cancer" all such emotional traumas affect the psyche, the brain and a particular organ at the same time. They lead to a tumour growth whose location can be accurately predicted depending on the type of trauma and how the person reacts to it. If the conflict is resolved the tumour goes away. If not the cancer grows and is later detected (as occurred in Hamer's case). He claimed to have amassed a large amount of evidence to support his theory, which he presented to the University in Tubingen in October, 1981 as a post-doctoral thesis for qualification as a university lecturer. The main objective of the thesis was to provide his results to the University so that they could be tested on the next available cases as quickly as possible and benefit patients. In May 1982 the University rejected the work on the interconnections between the psyche and cancer, without testing a single case for reproduction, something they later admitted to in court.

In 1986 the District of Koblenz initiated an action to stop Hamer from practicing medicine on the basis that he "failed to deny the Iron-Rule-of-Cancer and failed to convert to the tenets of official medicine". Since then Hamer has not been allowed to talk to any patients. A presiding judge of the District Court of Cologne advised him, by warrant, to find (at age 51) another calling, unrelated to medicine. By 1994, based on research of 20,000 cases, Hamer had expanded his system to the 5 biological laws that cover all diseases in the entire field of medicine.

In 1997 Dr Hamer was arrested and jailed in Germany for 18 months under an obscure natural therapy law introduced under Adolf Hitler to suppress Gypsies.

Since 1999 Dr Hamer has lived in Spain because courts in Germany, Austria, France and Switzerland want to try him for any cancer patient who died following his advice. Also doctors and natural therapists in Europe who practice according to the principles of the New Medicine face persecution. In Austria, Belgium, France, Germany and Spain authorities have started proceedings against such doctors to take away their right to practice. Court cases have been going on for years. Only courts in Spain adopted the enlightened position that it was not their role to decide between conflicting medical theories and therapies. This vicious response of the establishment is understandable because widespread knowledge and application of the New Medicine would mean the end of the medical-pharmaceutical complex.

However while he has been living in Spain, the "Tribunal de Grande Instance" in Chambéry, in France charged and sentenced him *in absentia* to a three-year prison term for *agitation against medical science and instigation of "the New Medicine, with the purpose of its practice"*. He had written a version of his book *The New Medicine* in French!

On 9 September 2004 Dr Hamer was arrested in Spain at the request of the French Government. He was be extradited to France to serve the 3-year sentence.

From*: users.mrbean.net.au/~wlast/hamer.html*

18. Dr Ernesto Contreras, MD

Just before the formation of our Society in 1981, Don Benjamin, who had chaired a sub-committee of the NSW Humanist Society evaluating alternative cancer therapies, was involved in organising a visit to Australia of Dr Ernesto Contreras, the head of a cancer clinic in Tijuana, Mexico. Dr Contreras was on the American Cancer Society's list of advocates of "Unproven Methods". His methods included amygdalin, an anti-cancer diet and prayer along with an excellent doctor-patient relationship. Two incidents during his visit are worth reporting:

(a) The Sub-Committee had organised several opportunities for Dr Contreras to explain his treatments to groups of nurses in NSW hospitals who had expressed an interest in meeting him. At the last minute they were told by the nurse organising the hospital meetings that she had been told to cancel the meetings, otherwise she could forget her nursing career.

(b) The Sub-Committee had also arranged for Dr Contreras to appear on ABC TV. The ABC rang to say that they would have to have a representative of the NSW Cancer Council on the same program to ensure "balance". On the night the "debate" was recorded, the Cancer Council spokesman, Dr Gordon Sarfaty slandered Dr Contreras, accusing him of being a quack out to make money out of gullible people dying of cancer. Needless to say the program could not go to air because the ABC feared litigation from Dr Contreras. Even though Dr Contreras assured the ABC that, as a practising Christian, he was not interested in legal action against those who criticised him, the ABC refused to broadcast the program, thus allowing Contreras' opponents to effectively censor his appearance.

19. Eckard Roehrich, MB BS

Dr Eckard Roehrich, a medical practitioner with a clinic on the NSW Central Coast was recently deregistered and given three days to close his clinic after he helped a couple in their attempts to protect their 11-year old daughter from receiving inappropriate chemotherapy. Despite Dr Roehrich's help in testifying on their behalf in the NSW Supreme Court, their daughter was taken from them and forced to undergo chemotherapy. Her parents were denied access to their daughter during this period by the NSW Department of Community Services (DoCS). The deregistration action against Dr Roehrich followed soon after he had showed resistance to health and other government authorities.

We understand that Eve Hillary is making a separate submission that includes this case.

20. Jennie Burke

Jennie Burke, a Sydney pathologist and Director of Australian Biologics, was recently prosecuted by the Australian Competition & Consumers Commission allegedly for misleading advertising and diagnosing cancer. This had followed a complaint from Professor John Dwyer, who is campaigning to eliminate practitioners of alternative cancer therapies in NSW.

Dr Burke was able to force the ACCC to mediation, which means they admitted they had insufficient evidence to support their case. The prosecutions have been dropped conditional upon Jennie notifying her clients that she does not diagnose disease. She states that she has never claimed to diagnose disease, only provide test results to enable practitioners to do the diagnosis or monitor their patients' progress.

We understand that Dr Burke is making a separate submission that describes this case.

The role of the media

Why haven't most people heard about these cases?

Media reports in Australia during 1998 included the Channel 7 coverage of the Di Bella treatment in Italy, the Channel 9 three-part series on the Politics of Cancer (which featured several members of the CISS Committee, including Don Benjamin), and the ABC three part series "Two Much Medicine", based on Ray Moynihan's book by the same name, which made only a passing reference to cancer. There has been hardly any other coverage of viewpoints questioning the current paradigm over the past 25 years. The reason for this quite simple

Most organs of the mass media rely for their news on retaining good contacts with experts in the various fields. Medicine is no exception. What happens when a reporter wants to write a story about a different point of view, or suppression of a new discovery? A good example comes from the HIV/AIDS controversy. Professor Peter Duesberg is a leading microbiologist and discoverer of the retrovirus. He questions the current paradigm about what AIDS is, or that it is caused by the HIV retrovirus. In his book "Inventing the AIDS Virus" he explains how media suppression happens:

"Aside from inviting docile journalists to meetings and conferences and funding AIDS activist groups, the CDC and NIH have one other powerful tool for maintaining media cooperation. Elinor Burkett, a courageous *Miami Herald* reporter who wrote a major article covering the HIV-AIDS debate, explained it best as a question of "access":

> 'If you have an AIDS beat, you're a beat reporter, your job is everyday to go out there, fill your newspaper with what's new about AIDS. You write a story that questions the truth of the central AIDS hypothesis and what happened to me will happen to you. Nobody's going to talk to you. Now if nobody will talk to you, if nobody at the CDC will ever return your phone call, you lose your competitive edge as an AIDS reporter. So it always keeps you in the mainstream, because you need those guys to be your buddies...'
>
> 'When you call the CDC on the phone, and I called them certainly on a regular basis when I was writing that piece, they say things to you like "You will be responsible for people in Miami stopping using condoms, if you write that article." Do I want people in Miami to stop using condoms? Of course not!... There's all kinds of blackmail, and I don't mean overt blackmail. It's emotional blackmail of that sort, and it's the fact that exactly what I knew was going to happen, happened, which is, I can't get a phone call returned by any of them.'

Duesberg, Peter H, Inventing the AIDS Virus, Regnery Publishing Inc., New York, 1996

Anthony Fauci, Director of National Institute of Allergy and Infectious Diseases, stated the point more bluntly in 1989, declaring in an editorial that Duesberg's ideas were nonsense and complaining that his views were receiving too much publicity.

> "Journalists who make too many mistakes, or who are sloppy", he warned, "are going to find that their access to scientists may diminish".

And in a 1993 letter to the journal *Nature*, two of the most powerful virologists in Italy bared their teeth:

> Your subtitle ends: "He should stop". Or, we submit, "should he be stopped?" For example, should he somehow be prevented from appearing on television to misinform individuals who are at risk from the disease? One approach would be to refuse television confrontations with Duesberg, as Tony Fauci and one of us managed to do at the opening day of the VIIth International Conference on AIDS in Florence. One can't spread misinformation without an audience.

The same process happens in much of the mainstream media. As a result, over the past 25 years that our Society has been operating, spokespersons for cancer authorities have been able to use the media as their public relations outlet for their products and services, with no one able to question their claims.

When Milan Brych was in the news in Australia and New Zealand in the 1970s most media reported stories about him mainly for their news interest, with a slight bias against him. In 1977 a woman was invited to appear on Channel Nine's *Open House* show to talk about the treatment Brych had given to a member of her family. A few days after the invitation was issued, a telegram was received signed by Channel Nine's Anne Wiley. It read:

> "Because of objection from the Australian Medical Association and a decision by management we regret we must withdrew our invitation for you to appear on Open House. Please accept our apology."

Quill, J. Milan Brych, The Cancer Man. The Publishers House, 1982.

This parallels our own personal experience. A few years ago Don Benjamin was invited to be interviewed by a regional television station NBN, based in Newcastle, on the subject of orthodox and alternative cancer therapies. The first interview, in which he spoke about the limited evidence for efficacy of orthodox therapies, was broadcast on 20 October 2000. In February 2002 he was invited back to record two more interviews that were broadcast on 15 February and 1 March. Just prior to recording this first interview the topics to be covered were discussed. Don raised the topic of mammography screening as one they had not covered so far. It was suggested that he not raise the issue of the lack of benefits of mammogram screening in view of the Channel's prior involvement in a television promotion of breast cancer screening. This he agreed to.

He mentioned the lack of proven benefits from earlier surgical intervention for other forms of cancer. However, during the interview the interviewer himself, Nat Jeffery, raised the subject of mammogram screening, suggesting that surely this early type of breast cancer detection must save lives or at least improve survival. To this Don refrained from stating an opinion (as agreed) and simply replied that the latest review of randomised trials evaluating mammography screening, published in October 2001, had found no proven benefits in terms of overall survival. The latest review of trials of breast self-examination had also found no benefits. The second interview was then recorded (which included references to the dramatic benefits of psychotherapy) and after the interview he was asked back for a third interview the following month to talk about alternative cancer therapies. Before the third interview took place he was notified that there would not be any more interviews. Apparently the TV station head had received a complaint from "a doctor with influence".

In August 1997 the Society lodged a complaint with the Australian Press Council about bias in the media. The Press Council suggested that CISS submit an article for the November issue of Press Council News, which we did. The Press Council published the article along with comments by Dr Sally Redman and Janet Pelly from the National Breast Cancer Centre.

This had no effect on the continued bias in the newspapers.

The Society has written letters regularly to newspapers in response to misleading claims by cancer experts about the benefits of surgery, radiotherapy, chemotherapy and cancer screening. About 5 of these letters have been published over as many years out of over 150 letters written with the view of correcting misleading statements.

For many years the Society had lodged written complaints to the ABC about bias in its programs such as the Health Report stating that it was only presenting one side of the debate: supporting surgery, radiotherapy and chemotherapy and mammography screening, and criticising the efficacy of alternative therapies. After several years of the ABC defending its programs, it stated in July 1999 that:

> "the [ABC Radio] program is constrained by medical orthodoxy - it would be irresponsible if it were not. The program's producers believe medical orthodoxy is clear that psychotherapy is not an effective treatment for cancer. Surgery, chemotherapy and radiotherapy can all be effective…."

The Society again complained to the ABC in October 2001 with no effect. We therefore took the complaint to the Independent Complaints Review Panel citing continued instances of bias from 1998 to 2002, particularly the ABC's continued refusal to air any opposing views on the subject of mammography screening, even after the Nordic Cochrane Group had reviewed all the randomised controlled trials and found that mammograms were not justified. The ICRP upheld the Society's complaint. This finding had no observable effect on the ABC's Health Report.

It is therefore clear that writing to the papers and radio has had little or no effect. Some interviews have been aired on television but these were then discontinued as a direct result of suppression.

It is therefore not surprising that an overwhelming majority of the public are unaware of any viewpoint questioning the current statements that orthodox cancer therapies are effective.

Summary of Part 3

So we believe it is clear that there are strong forces of vested interests acting to protect the monopoly conferred on the allopathic school of medicine from competition in Australia, as in most Western countries.

An increasing number of people are questioning orthodox cancer therapies when they see their friends and loved ones gaining no benefits and experiencing much harm from orthodox cancer therapies. They also see many appearing to do well when they reject orthodox therapies a try one of the many alternative cancer therapies around.

The growing use of the internet is giving an increasing number of people more information about alternative cancer therapies, including many self-help ones.

This in turn has spurred cancer authorities to try to limit people's access to this type of information on the internet, ostensibly to protect them from misleading claims; but in fact in an attempt to retain and hopefully increase their falling market share of the cancer industry.

Those questioning orthodox therapies rely on Societies like ours to help them sift through the often conflicting claims made by orthodox and alternative practitioners.

It is therefore important that orthodox and alternative practitioners be all required to abide by the same rules of evidence, and not make claims they cannot substantiate.

Most people are not fools. They are capable of seeing through propaganda when they can get access to views from each side. The Government should avoid taking sides in this competitive area and ensure that the ACCC abide by its charter of ensuring competition, not stifling competition with the misguided excuse of protecting the public.

Summary and Recommendations

Summary

1. For the past 3,000 years and until 200 years ago it was accepted practice that cancer is a **systemic** disease probably caused by metabolic imbalances (then called humours) and emotional factors (such as *melancholy).*
2. The decision to change the paradigm about 200 years ago to one that states cancer is a **localised** disease that later spreads was made without any solid evidence.
3. The decision to intervene with surgery for most types of cancer, based on this new paradigm, was also made without solid evidence.
4. The decision to add radiotherapy and chemotherapy was based on their ability to shrink tumours, not extend survival.
5. Over the past 50 years a cancer industry has been built up worth about $2.7 billion in Australia with many vested interests wanting the current situation to continue.
6. Only about 15 % of all medical interventions are now based on solid evidence, such as the results of randomised controlled trials, and the figure for cancer is closer to 6%.
7. Most medical interventions, including screening and treatment for cancer, are based on the results from flawed trials run by medical scientists who have an inadequate understanding of the requirements of randomised controlled trials.
8. This situation, and similar ones in other fields of medicine such as cardiology, gynaecology and obstetrics, has led to one where a new international group was formed in 1991 called the Cochrane Collaboration that has attempted to bring medicine back to a scientific basis using the principles of Evidence-Based Medicine (EBM).
9. There is strong opposition to EBM because it questions most (~85%) medical interventions, and confining medical interventions to proven therapies would destroy the medical profession overnight.
10. There is evidence from seven well-run randomised controlled trials and other survival trials that the old paradigm is more valid. Intervention using systemic therapies has been found to result in dramatic improvement in survival, even with late-stage cancer. These interventions include behaviour therapy (for the emotions), immunotherapy of various types, and nutritional methods to restore the body's immune, metabolic, endocrine and lymphatic systems.
11. There is strong opposition to these and other alternative methods by the cancer industry because acceptance that cancer is a systemic disease (a new paradigm), would undermine the cancer industry worth $500 billion world- wide.
12. Many such therapies continue to be suppressed. The Australian Government acting together with State Governments, is involved as part of an international campaign to opposed alternative medicine. The NSW Department of Health, the ACCC, the TGA and the NSW Dept of Fair Trading are part of this concerted campaign. This is part of an international effort being pursued through the World Trade Organisation (spearheaded by Germany though the WTO's Codex Alimentarius Committee) to stamp out alternative medicine by making vitamins and supplements at therapeutic levels only available on prescription.
13. The recent Pan Pharmaceuticals recall is only a small part of this campaign. Another example is that the ACCC prosecuted Jenny Burke, Director of Australian Biologics Testing Service in Sydney, based on false information supplied to it by Professor John Dwyer, who is leading this campaign on behalf of the NSW Department of Health. The prosecution was later dropped, despite Jennie Burke having to pay her own costs of over $700,000.
14. A third recent example is that the NSW Medical Board suspended the licence of Dr Eckard Roehrich after he tried to protect a 11-year old girl from being forced to undergo inappropriate chemotherapy against her wishes and those of her parents. With the help of DOCS she was taken from her parents and treated inappropriately.
15. Overseas the most recent example is Dr Ryke Geerd Hamer from Germany who was prohibited from practising medicine when he refused to denounce his new theories about the emotional cause of cancer. He migrated to Spain to enable him to continue to practice medicine. He was arrested in Spain in September 2004 to be extradited to France where he had been tried in absentia and sentenced to 3 years imprisonment for using a particular form of psychotherapy not sanctioned by his profession (with good results in Europe, mainly Germany and Austria) and refusing to renounce his new theory.

16. Our Society has been providing information about evidence based non-toxic therapies to our members since 1981. There are over 150 alternative cancer therapies mentioned in the literature. The most promising therapies include
    - Psychotherapy/behaviour therapy: (7 published randomized trials, 1 unpublished randomized trial and many anecdotal reports from people who have completely recovered from terminal cancer;
    - Immunotherapy as used by Dr Josef Issels in Germany: 16.6% 5-year survival and 15% 15-year survivals with terminal cancer patients; 85% 5-year survival with primary cancers;
    - Immunotherapy at the IAT Clinic in the Bahamas: 15-18% 5-years survival with terminal cancer patients;
    - Gerson Diet: Many anecdotal reports of complete recoveries from terminal stages;
    - Hydrazine sulphate: Many published papers reporting on improved survival of late stage patients;
    - Antineoplastons (Dr Stanislaw Burzynski): Many anecdotal reports of complete recoveries from terminal stages;
    - Curaderm: Effective non-surgical treatment of skin cancer (developed by Dr Bill Cham in Queensland but currently unavailable in Australia as a result of the TGA's intervention);
    - Phenergan: Cheap, non-toxic therapy for cancer developed by Dr Robert Jones in the UK: Many anecdotal reports of recovery.
17. Our Society complained for many years to the ABC about biased presentations by Dr Norman Swan on the Health Report. We finally lodged a formal complaint to the Independent Complaints Review Panel which upheld our complaint.
18. Our Society complained to the ACCC about misleading statements repeatedly being made by cancer "experts" about the efficacy of conventional intervention. We provided documented references showing that the claims were invalid. The ACCC dismissed out complaint without investigation, in contrast to their response to an undocumented complaint from Professor John Dwyer (see 12 above).
19. Our Society complained to the NSW Department of Health (via Frank Sartor) about the same issue and sought information about why Professor John Dwyer was being supported in his campaign against alternative medicine (citing the examples of Jennie Burke and Dr Roehrich). They would not intervene.

The Role of Government

20. Any political party that supports EBM should introduce a policy that would mean that after 10 years no subsidies would be provided to any treatment under Medicare (including for cancer) unless it were evaluated properly using EBM and found to be effective either in extending life or improving quality of life. This would exclude most interventions with surgery, radiotherapy and chemotherapy.
21. Introduction and implementation of EBM over a 10-year period would completely solve the problem of continued escalation of health costs in Australia.
22. The Australian public is on side in this issue because over 60% of people use alternative therapies because they are instinctively aware of the limitations of orthodox intervention so this issue would also be a vote winner. (As much is spent annually on alternative medicine paid for out of the person's own pocket as on prescription drugs under Medicare).
23. Any political party supporting such a policy would have to be prepared to take on the vested interests of the medical profession. Both the ALP under Carmen Lawrence and the Liberal Party under Michael Wooldridge as Federal Health Ministers claimed support for the principles of EBM but backed off from implementing an EBM policy because of vested interests from the medical profession.
24. Any party would also be subjected to strong opposition from international interests.
25. The only meaningful reform in the US in the last 30 years followed a congressional inquiry by Congressman Guy Molinari into the suppression of an effective alternative cancer therapy (immuno-therapy at the IAT Clinic in the Bahamas) by the US National Cancer Institute. This resulted in the setting up of the Office of Alternative Medicine (OAM) as part of the US National Institutes of Health. The OAM is now the National Center for Complementary and Alternative Medicine (NCCAM).

Recommendations

The legitimate role of government, if it wishes to provide cancer patients with freedom of choice in cancer therapies and the best available evidence-based therapies, is to

- stop supporting only one of the schools of medicine, the allopathic school that is locked into an invalid paradigm. **(a) (v)**;
- stop allowing its agencies such as the ACCC and the TGA to continue to suppress useful therapies under the guise of "protecting the consumer". Change in legislation governing the ACCC and TGA might be required **(a) (v)** and **(b (iii**);
- set up an objective assessment body, similar to that set up by the US Congress (the National Center for Complementary and Alternative Medicine - NCCAM) not dominated by the allopathic school of medicine that has a vested interest in the status quo in cancer therapy **(a) (iii)**, **(b) (i) , (ii)** and **(iii)**;
- upgrade the status of those alternative physical therapies described in Part 2 to form the basis of primary treatment for cancer, replacing surgery, radiotherapy and chemotherapy **(b) (ii)**;
- upgrade the status of psychotherapy so that the types shown effective in randomized trials are used as one of the primary therapies for cancer **(a) (iii)** and **(b) (ii)**;
- protect the rights of the Australian public to accurate information. On the issue of public health, we have shown that conventional (orthodox or allopathic) medicine has not only suppressed and maligned complementary and alternative therapies but has also misled the public as to the efficacy of conventional therapies **(a) (v)** and **(b) (iii) –** this could become one of the roles of the new body;
- accept its legitimate role and put in place a fail safe review mechanism to ensure that all medical procedures, both conventional and complementary, are thoroughly scrutinised to assess the degree to which they are Evidence Based before being subsidised through Medicare and the Pharmaceutical Benefits Scheme. By "fail safe" we mean to ensure that the review mechanism cannot be influenced by vested interests such as big and powerful Pharmaceutical Companies and implement a phasing in of financial support for those medical interventions that are evidence based, according to the Cochrane Collaboration, over a period of say 10 years; and a similar phasing out of financial support for the 85% of medical interventions that are not evidence based (96% in cancer). That is, ensure a level playing field so that consumers can decide what is best for themselves **(b) (iii)**.

As pointed out at the beginning, the terms of reference do not allow for the questioning of the current cancer paradigm. We believe this is essential if any significant benefits are to be achieved for cancer patients in Australia. We therefore recommend not only the setting up of a body similar to the NCCAM in the United States, but that its roles include assessment of the validity of the current paradigm as presented in this submission and provision of unbiased information to the Australian people.

A Vision for Australia

We see a Cancer Centre being set up in one of the main capital cities providing the best available cancer therapies to Australians and people from nearby countries. This will obviate the need for Australians to spend thousands of dollars traveling overseas to Mexico, Germany and the United Kingdom get access to these therapies.

We see a wholistic live-in Cancer Centre with a comprehensive program of treatment based on the best therapies from the Issels Clinic in Germany, the IAT Clinic in the Bahamas and some cancer centres in Mexico, supported by a professional team of psychologists trained in the type of psychotherapy that has provided the significant survival benefits in seven published randomised trials. The Centre would also make available the other therapies such as hydrazine sulphate, Coley's Toxins, Antineoplastons, Glyoxilide and Phenergan and provide a high quality nutritional progam based on the Gerson and similar diets.

Australia has some of the best wholistic medical practitioners in the world to provide these modalities. In addition, Dr Ian Gawler and Petrea King have pioneered the concept of the live-in psychotherapy centre for people with cancer. They have produced many long-term survivals with terminal cancer patients.

The Australian people deserve the best health and the best medical treatment in the world. They are not getting it in the area of cancer. This Senate Inquiry has within its powers to provide an environment where this Vision can be born and grow to a reality.