Submission No 12

THE PROMOTION OF FALSE OR MISLEADING HEALTH-RELATED INFORMATION OR PRACTICES

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PURPOSE OF SUBMISSION AND SCALE OF INQUIRY

In response to the invitation by the Committee for submissions to the inquiry into the *'promotion of false or misleading health-related information or practices'* we thank you for the opportunity for making this submission.

INTRODUCTION

We note that the inquiry terms of reference include:

(1) inquiring into and reporting upon measures to address the promotion of 'unscientific' health-related information or practices that depart from 'accepted medical practice' which may be detrimental to individual or public health, with focus on individuals and organisations that are not 'recognised' health practitioners *(Terms of Reference (a), (b) and (c)).*

(2) the adequacy of the powers of the Health Care Complaints Commission (HCCC) to investigate such individuals or organisations; and

(3) the capacity, appropriateness and effectiveness of the HCCC to take enforcement action against such individuals or organisations.

We will address the inquiry terms of reference regarding (2) and (3) together below. Before we do so, we address point (1) in the section immediately following.

We understand that the expression 'unrecognised' health practitioner (as used in the inquiry terms) refers to a health practitioner who is not subject to the registration scheme under the Health Practitioner Regulation National Law for the reason that the Law does not specifically extend to the services that the practitioner offers.

A central theme of our submission in relation to the terms of reference points (2) and (3) is that health practitioners who are not currently subject to the national scheme are nonetheless already accountable under the existing HCCC complaints regime and that vesting the HCCC with additional powers specifically directed at complementary health practices and information is neither necessary nor desirable.

WHO WE ARE

We are making a submission since each one of us have in our own lives, or in the lives of family or friends, witnessed great benefits from modalities that possibly do not, or have not as yet, fulfilled so called 'scientific' criteria but have support by way of other modes of substantiation known in medical circles as 'experience-based practice'.

This submission is made by a group of individuals that includes:

- Medical professionals who advocate that certain complementary health care principles and modalities can enhance medical practice, even if that complementary care is not in the strictest terms "scientific"; that said, there are scientific understandings that lend support to these specific complementary principles and modalities.
- Practitioners who offer complementary modalities that have not yet fulfilled scientific based evaluation, but have ample experience based practice and personal observations to indicate that they have a public benefit; and
- Individuals who have found enormous benefit from those complementary treatments

We do not write as advocates for complementary medicines of every kind. Indeed we understand that there have been cases in the field of complementary medicine of excessive claims that have posed risks to, and harmed, patients. We observe however that neither is western medicine free from such incidents.

What we advocate for is a regulatory system that upholds a commitment to true health and well-being in the community, based upon an open inquiry that reflects what we hold are the core values of science and medicine, and on the freedom of people to choose their medical care. This can never be a single-dimensional approach that insists that there is only one way by which advancements in understanding in science and medicine are achieved or that health and well-being are exclusively the property of science-based medical practice. For neither is the truth. The reality is that health and well-being is infinitely complex.

'Unscientific' and 'accepted medical practice' are unreliable standards by which to evaluate unrecognised health service providers.

In the MEDIA RELEASE the Committee's Chair has stated that the 'inquiry is not focused on ... alternative health care remedies' used as 'supplementary health care' (by which we understand the Chair to mean 'complementary health care') and that it is not intended to inquire into 'legitimate discussions and studies ... about appropriate treatments, along with the diversity of health options'.

Even if there is no intention to examine 'complementary health care', the terms of reference are sufficiently broad to cover complementary health care practices, since the Committee is asked to consider the 'promotion of unscientific health-related information' and there are corners of medical science that hold the view that all complementary medical practices and information (universally) are unscientific.

We are concerned that there are special interest groups who are relying upon the influence of their membership to lobby government to exclude complementary medicine from university education and primary health care. These groups are driving an agenda to ensure that complementary health providers are unable to promote their activities on the ground and that the theoretical and practical underpinning of such information and practices is 'unscientific'. They are in effect promoting that we should 'abandon all alternative and complementary medicines' and are seeking to restrict competition under the guise of 'scientific concern' in patient care.

Such an agenda is at odds with the widespread use of complementary medicine across the community. A study in 2007 showed that 68.9% of Australians use complementary medicines and nearly 45% of Australian adults and 24% of people with chronic disease use complementary medicine practitioners and products *(Xue et al, 2007)*. A recent national health survey, conducted by the Australian Bureau of Statistics, found about a quarter of Australian adults affected by one or more of five conditions – diabetes, asthma, arthritis, osteoporosis, heart or circulatory problems – regularly used a complementary or alternative therapy *(Armstrong et al, 2011).* A survey in 2008 of more than 4000 GPs by the National Prescribing Service indicated about 90% of GPs had recommended at least one complementary medicine in the past 12 months *(National Prescribing Service, 2008).*

The Committee's terms of reference are broad enough to serve this agenda, for instance, the Committee is asked to consider 'the promotion of health-related activities and/or provision of treatment that departs from accepted medical practice which may be harmful…'. This begs the question as to the criteria to be applied to assess harm – will it be the same as that applied to accepted medical practice where it appears that for a majority of treatments a balance is struck between benefits and harms? *(BMJ, 2007).*

We would like the Committee to reflect upon the possibility that any recommendations that have the aim of restricting the promotion of so-called 'unscientific health-related information' will:

(1) Inevitably lead to litigation over the nature and meaning of science and the question whether particular information or a particular practice is 'unscientific';

(2) Restrict the rights of consumers to choose their own health care services;

(3) Hinder the positive development of health-care practices and potentially restrict the expansion of medicine and science in general;

(4) Restrict new models of medical care based upon an integrative approach between evidence-based practice and experience-based practice; and

(5) Unintentionally include spiritual care-providers (ministers, priests, chaplains, spiritual counsellors etc) as spiritual care is an integral part of health care and their advice and counselling also influences health and well-being in ways that can be beneficial or detrimental. Their advice may also be deemed 'unscientific', deviating from 'accepted medical practice' and providing 'unscientific health related information'.

Thus we are asking that the Committee consider the nature of 'accepted medical practice' and also the notion of 'unscientific health-related information'. 'Accepted practice' is an unreliable standard. It begs the questions, 'accepted by whom and on what grounds?' It also risks concealing the reality that within medicine today there is an emerging recognition of the close and ultimately inseparable role played by traditional and complementary medicine. As the call for a more integrative approach to healthcare expands, the combination of complementary medicine and medicine is gaining pace as evidenced by the high uptake of complementary modalities by patients *(Xue et al 2007).* Furthermore, within medicine itself there can be variations in clinical practice, such that even within the profession there can be disagreement regarding what is 'accepted' and what is not. Given the ever expanding and evolving nature of science and medicine, it is clear that to restrict practices to that which is currently 'accepted' by one body of opinion will impede progress in these fields. Medicine would not be where it is today, if this logic had been applied through the ages.

It is well recognised within the medical field by both clinicians and epidemiologists that the reality of clinical practice is infinitely more complex than the linear application of epidemiological and clinical trial studies *(Feinstein and Horwitz, 1997).* The forms of knowledge (or knowing) that clinical practice draws upon includes the practitioner's understanding of the patient and involves forms of judgment that are qualitatively different from scientific method. We urge the Committee to consider the inadequacy of judging the validity of a treatment merely upon the satisfaction of 'scientific method'.

CURRENT LEGISLATIVE CONTROLS ARE MORE THAN ADEQUATE

The provisions of the *Health Care Complaints Act 1993* (HCC Act) in our judgment already afford an adequate and sufficiently high level of protection of public health and safety and available evidence to date has not shown otherwise.

The pivotal expressions in the Act are 'health services' and 'health service providers'. The expression 'health services' is widely defined: s 4. In addition to a list of identified services and modalities, including Chinese medicine, chiropractic, and acupuncture, the expression includes 'services in other alternative health care fields': (k). This is a catch-all expression, which in its generality is perfectly comprehensive and includes both 'recognised' and 'unrecognised' complementary health care services.

The definition of 'health service provider' is equally comprehensive. It includes individuals ('health practitioners') and bodies ('health organisations'), whether they are qualified (or not) or registered under a health practitioner national law (or not). Accordingly, the existing HCCC complaint system already fully responds to complaints concerning (and holds to account) registered and unregistered and qualified and unqualified health service providers offering 'recognised' and unrecognised' complementary health care services.

Moreover the proper subjects of a complaint under the existing system are also comprehensive and have not been shown to be inadequate by a proper case falling outside its scope and thereby escaping investigation.

Complaints can already be made under the HCC Act concerning:

(a) The 'professional conduct' of an individual health practitioner: s 7(1)(a);

(b) An alleged breach of s 99 of the *Public Health Act 2010* which, importantly for this inquiry, proscribes advertising or otherwise promoting complementary health care services ('recognised' or 'unrecognised') in a manner that is false, misleading or deceptive or is likely to mislead or deceive, or, even more significantly for this inquiry, in a manner that creates or is likely to create an 'unjustified expectation' of beneficial treatment outcomes: s 7(1)(a);

(c) An alleged breach of the Code of Conduct for Unregistered Health Practitioners ('Code'), being a code of conduct prescribed under s 100 of the *Public Health Act*; and

(d) A health service (including a service that is not a 'recognised' health service) which 'affects, or is likely to affect' the clinical management or care of an individual client: [s 7(1)(b)].

We will briefly address each ground of complaint below:

a) 'Professional conduct' of a health practitioner: s 7(1)(a)

The ground of complaint is extremely broad. It is not limited to complaints concerning conduct that, for instance, amounts to 'unsatisfactory' professional conduct as is the case under legislation regulating other professions.

The ground extends to matters concerning the knowledge and skill to offer 'recognised' and 'unrecognised' complementary health care services: cf *Gorman v Health Care Complaints Commission* [2012] NSWCA 251 (14 August 2012). It also encompasses matters of physical and mental capacity.

What the ground does not encompass is a complaint concerning the validity or otherwise of a practitioner's medical philosophy: *Gorman v HCCC.* However it would be a different matter were the practitioner to seek to rely upon his or her medical philosophy to justify his or her management or care of a patient where that philosophy had not been independently validated: *Gorman v HCCC.* In such a situation the practitioner's professional conduct would be a proper subject of complaint.

Accordingly, there is no need to expand the HCCC's powers.

b) False or misleading advertising: s 7(1)(a)

The HCCC's existing power to respond to complaints about misleading advertising by 'unrecognised' health practitioners is sufficiently broad already.

The HCCC's power is relevantly the same as the power of the Therapeutic Goods Association under s 4 of the Therapeutic Advertising Code 2007 under s 42BAA of the *Therapeutic Goods Act 1989.* It is the same as the power vested in the Australian Competition and Consumer Commission to respond to consumer complaints under s 18 of

the *Australian Consumer Law* (ACL) and its progenitor (s 52 of the *Trade Practices Act 1974*). And it is the same as the power vested in the National Health Practitioner Regulation Agency under s133 of the *Health Practitioner Regulation National Law* which, as well as proscribing misleading and deceptive advertising (s 133(1)(a)), also proscribes advertising that creates an 'unreasonable expectation of beneficial treatment' (s 133(1)(d)).

In short, the power that the HCCC currently has to control offending advertising and promotional activities is equivalent to that of national regulators. An extension of the HCCC's powers on account that its powers are deficient is not indicated.

The decisional law on the controls under the ACL, s 18 and its progenitor on false, misleading or deceptive advertising in medical and related matters broadly establishes that statements of fact will generally not be misleading or deceptive if such statements are not objectively verifiable as long as there is no scientific or medical evidence to the contrary. Further that a statement of fact is not necessarily misleading or deceptive if it cannot be demonstrated to be correct beyond any doubt: *Glorie v WA Chio & Pulp Co Pty Ltd* (1981) 39 ALR 67, 82.

We do not believe that the controls under the HCCC Act would be construed or applied differently from the corresponding provision of the ACL.

Public health and well-being deserve the deepest commitment as it is, in our view, the single most important indicator of who we are as a community and how we are living. The regulatory controls that protect the public in this area rightly should reflect the importance of this matter. However, the requirements of certainty in the conduct of affairs and coherency in the surrounding legal order mean that a regime for health-related advertising that is materially different from advertising in other fields is ultimately undesirable. The undesirability of such a development is even more evident where the demarcation between activity that is caught by the control and activity that is not, revolves around philosophical differences over the nature of science and medicine and what is health care.

Lastly, the existing controls have not been shown to be incapable of dealing appropriately with matters of consumer protection and patient rights in the cases that have come before the courts and tribunals to date and there is therefore no evidence for the need for an expansion in the HCCC's powers.

Accordingly, we do not support the introduction of a regime that applies a different standard in the control of health-related advertising.

There are ways in which the HCCC's existing regulatory functions can be supported. Initiatives for enhanced labelling of complementary medicines and The Quality Use of Complementary Medicines program set up by Paul Komesaroff, director of the Monash Centre for the Study of Ethics in Medicine and Society, in default of an adequate labelling regime are examples of such ways.

c) Breach of the Code for 'unrecognised' practitioners: s 7(1)(a)

The existing HCCC complaint process extends to the practices of 'unrecognised' complementary health-care practitioners in important ways already.

Thus, the provisions of the Code establish standards of conduct specifically for 'unrecognised' practitioners. These include standards for the provision of health services in a 'safe and ethical manner' (cl 3), and not making 'claims' to cure certain serious illnesses (cancer or terminal illnesses), though practitioners are permitted to make a claim in relation to the alleviation of symptoms of such illness if that claim can be 'substantiated' (cl 5). The Code's adoption of a criterion of 'substantiability' as opposed to a narrowly rigid 'scientific evidence-based' criterion is significant. (As to this, see below).

Most significantly for purposes of this inquiry, the Code already:

(a) proscribes attempting to dissuade clients from seeking or continuing with treatment by a registered medical practitioner: cl 7(1);

(b) mandates that a health practitioner who has 'serious concerns' about the treatment provided to any of his or her patients by another health practitioner must refer the matter to the HCCC: cl 7(4);

(c) proscribes financially exploiting clients, among other ways, by providing services that are not designed to maintain or improve the clients' health or wellbeing: cl 10.

Accordingly, we do not identify a need for expansion of the existing regulatory regime for 'unrecognised' complementary health-care practitioners.

d) Services affecting, or likely to affect, clinical management or care: s 7(1)(b)

The power to act on a complaint about a practice affecting the 'clinical management or care' of a client is extremely broad, more especially since the ground of complaint was expanded by amendments commencing on 14 May 2013 in light of the decision in *Australian Vaccination Network Inc v Health Care Complaints Commission* [2012] NSWSC 110 (24 February 2012).

Following the introduction of amendments to s 7(1)(b), the ground of complaint now extends to a conduct directed at the general public that has a tendency ('is likely') to affect the management or care of a particular patient, without proof that such conduct in fact has affected the management or care of that patient.

Further expansion of the ground of complaint is not needed, and certainly not before the operation of the only recently expanded ground of complaint can be assessed.

The standard of 'substantiability'

The existing complaints regime, under the Code, adopts a standard of 'substantiability' in relation to claims concerning outcomes with particular 'unrecognised' health care practices.

The existing standard ('substantiability') was adopted after careful reflection on the nature of science and medicine. It is a significantly more open-textured and ultimately more widely

encompassing approach than the rigidly narrow experimental, evidence-based approach advocated by the vocal minority mentioned above. The existing standard of 'sustainability' acknowledges that "there are many ways of defining what characterises science, but reliance on evidence is not one of them", because science is hardly unique in that all systems of knowledge and belief claim to be based on evidence *(Komesaroff, 2012, See **APPENDIX 1**).*

The standard of 'substantiability' more nearly accommodates this understanding of the nature of science and medicine than the doctrinaire slogan of 'scientific' or 'accepted' medical practice advocated by a minority.

We are not saying there is not a need for regulation – there is a need to prevent unscrupulous practices – but the current legislative framework provides adequate protection. Also, there is a danger that an extension of the already existing regulatory regime will be used proscriptively and inflexibly and thus prevent developments in therapeutic practice.

SCIENTIFIC MODEL

The inquiry seeks to develop 'measures to address the promotion of unscientific health-related information or practices which may be detrimental to individual or public health'. It's important to note that something is not 'unscientific' because there is 'no evidence' and nor is it harmful or potentially harmful because there is 'no evidence'.

The process of science is open inquiry; this entails not holding to received wisdom just because it is the current view, but constantly probing all questions to arrive at their truth. This is a never-ending process because truth is always evolving and hence we need to be constantly open to revising our understandings of the world.

If we judge things within our current paradigm, then wisdom and knowledge does not expand: for example, without the courage of Copernicus to think outside the box of accepted wisdom then we would still have the false belief of a geocentric view of the solar system and without Harvey withstanding the vehement arguments of the medical fraternity in the 1800's we would not now accept as a foundation of medicine that there is a circulatory system.

EVIDENCE ITSELF IS POORLY DEFINED – WHAT CONSTITUTES EVIDENCE AND WHO DEFINES IT?

Evidence only has meaning when interpreted within a system by which it makes sense – for example the geocentric universe was accepted for 1500 years in spite of continually mounting evidence against this view. The evidence did not count as evidence since there was no framework or system of belief within which this counter evidence had meaning and furthermore the institutional powers of that period were strongly committed to the geocentric universe and did everything within their power to suppress this evidence against their world view. Another example is Galileo and the moons of Jupiter seen through his telescope

where the church representatives said they could not see them. In essence as human beings we see what we want to believe, not what we actually see. Therefore, evidence per se does not stand alone but has to be recognised and interpreted and that interpretation is done within a system that determines its meaning and relevance. We are by nature interpretative beings and thus there is in fact no pure and absolute objectivity that has not undergone interpretation. It requires humility to recognise that there is often more than one way of recognising, interpreting and categorising evidence be it for an academic paper or a parliamentary inquiry and mandates judicious use of discernment.

There are many different methodologies within science and randomised controlled trials are not infallible.

We need to understand that the methodologies of research in science are not all of science and that there are many different methodologies within science. There are lobbyists who advocate that medical research should only be conducted in terms of their view of double blind randomised clinical controlled trials and if research does not strictly adhere to this standard then it is 'unscientific'. This is fallacious. There are other disciplines and ways of knowing that could be applied using different methodologies. The lack of research or research conducted with other methodologies does not necessarily mean something is 'unscientific' or that it therefore has no benefit or is harming. Although the double blind randomised clinical controlled trials are considered the 'gold standard' of evidence-based medicine it is also recognised that there can be significant issues with these methodologies. Often they are difficult to replicate. In an extensive review of such trials 46 to 50% of attempts to replicate results were found to contradict previous findings (Prasad, Cifu and Ioannidis, 2012). Furthermore, in a review of randomised trials it was found that 40.2% of findings reversed findings that had been established as accepted medical practice (Prasad et al, 2013). All of this brings into question the validity of the accepted 'gold standard' label.

The point here is that whilst they are the accepted best practice, there are flaws in current scientific methodologies and that there are other ways of performing research, gathering evidence and ways of knowing if something is beneficial or not. Rawlins (2008) and Cartwright (2007) have elucidated some of these issues concerning evidence based medicine and randomised controlled trials -- specifically that the absence of randomised double blinded clinical controlled trials, does not indicate a lack of evidence for a modality or a technique.

The charge that complementary medicines are 'unscientific' is flawed.

Complementary medicines have been attacked as 'unscientific' by those who wish to discredit their use. To determine that a practice is 'unscientific' without conducting a full evaluation, and to dismiss its use with limited understanding, is entirely 'unscientific' in and of itself. Medical history in particular is littered with examples of treatments and practices that were once deemed 'harmful', 'quackery', 'no evidence' and which today are fully incorporated within medical understanding.

The lobbyists who advocate medical research should only be conducted in terms of the double blind randomised clinical controlled trials also make certain assumptions that are

themselves ‘unscientific’. For instance, without established ‘evidence’ they assume practices are harmful until proven otherwise and this is supported by only permitting certain forms of evidence and excluding others. However, the absence of evidence does not mean that a paradigm is harmful. Of course, on due reflection, it is obvious that absence of evidence of a benefit and evidence of actual harm are different inquiries.

Furthermore, an assumption that a treatment that has qualified as ‘scientific’ is therefore of benefit is also flawed since “accepted medical practice” often fails to pass this threshold. Evidence itself does not support the view that because a practice has been scientifically studied it will necessarily be of benefit. Instead it clearly shows that research is fallible. For example, we attach a copy of a paper that reports on a significant number of evidenced based medical practices that have subsequently been shown to be of harm or no benefit and raises questions about the validity of much of the ‘evidence’ currently used in ‘accepted medical practice’. The paper concludes that the reversal of established medical practice is common and occurs across all classes of medical practice (Prasad et al 2013, **APPENDIX 2**). A further study found that “slightly more than a third of medical practices are effective or likely to be effective; 15% are harmful, unlikely to be beneficial, or a trade-off between benefits and harms; and 50% are of unknown effectiveness” (BMJ, 2007).

Thus it is crucial that the Committee is aware that what is ‘accepted medical practice’ today is likely to be shown tomorrow to be of no benefit or even harmful as demonstrated in these papers. Furthermore, we have highlighted the fallacy of believing that current day ‘accepted medical practice’ is in fact always beneficial and the standard against which all other forms of care and healing should be measured. Thus we can see that the narrowly defined evidence base of scientific medicine is fallible.

To restrict models of health practice only to what has satisfied the currently ‘accepted’ scientific model unduly affects the development of new treatments that may be of great public benefit. It also does not allow for other ways of knowing and understanding the human condition, the human body and human experiences obtained through other disciplines that are also pertinent to health-care. The provision of ‘whole person’ healthcare requires knowledge of the different dimensions of the human being and how they interact including the physical, emotional, mental and spiritual. All of these contribute to health and wellbeing but not all aspects are subject to scientific study nor would that be appropriate. This also needs to be carefully considered before any change to current legislation is sought.

CLINICAL PERSPECTIVES OF PATIENT CARE AND ‘EVIDENCE-BASED PRACTICE

Modern medical practice is recognising that evidence-based medicine has its flaws and that there is much to be gained by learning from experiences obtained through the practice of medicine. In addition the value of the individual patient experience, previously dismissed as anecdotal, is in some arenas gaining favour (Feinstein and Horwitz, 1997). Feinstein recognised many years ago the importance of person-oriented medicine and criticised medicine for not recognising that ‘only [people] can suitably observe, evaluate and rate their

own health status' (Thorgaard and Jensen, 2011). It seems that despite other areas of progress in medicine, this consideration continues to elude the medical system where the experience of the person regarding what has impacted their health and wellbeing is not given due credence and the personal experience of the patient is all too often ignored.

It is perhaps key to the Committee's deliberations to reflect that a narrow view of scientific-based evidence cannot alone direct what is appropriate health care when consideration is given to the role of the individual patient in determining a course of treatment.

COMPLEMENTARY HEALTH CARE SHOULD BE JUST THAT, NOT AN ALTERNATIVE TO STANDARD MEDICAL PRACTICE

The Committee's terms of inquiry refer to the publication of information that 'encourages individuals or the public to unsafely refuse preventative health measures, medical treatments, or cures'.

We envisage that complementary health care should be just that - complementary to the current medical system and not alternative. There should be regulation of misleading information that suggests that treatments be adopted in preference to sound medical treatment. For instance, the regulation of organisations that operate under the guise of vaccination education but have an agenda to promote that vaccination is harmful should be regulated: *Australian Vaccination Network Inc v Health Care Complaints Commission* [2012] NSWSC 110 (24 February 2012). However, as we have outlined above, the current regulatory regime, as amended in May 2013, would more than cover such circumstances and there is no need for further change without evidence to show that it is inadequate.

However, the practice of complementary therapies should not be restricted simply because these treatments depart from a benchmark of 'accepted medical practice' that 'may' pose some risk. This imposes a higher standard than that of accepted evidence based practice.

As we have outlined above, what is 'accepted practice' is ever evolving. In 2008 Levine (2008) carried out a review of Esoteric Healing (a complementary modality taught by Serge Benhayon and Universal Medicine) in which he concluded that whilst it may seem strange or unconventional to some, that in some instances, today's Esoteric practices could be tomorrow's scientifically-accepted medicine. We support this view and there is scientific research that supports the principles of Esoteric healing, which has a significant focus on self-care and lifestyle.

Having lived and applied the principles of Esoteric philosophy and healing and undertaken its modalities, we have all experienced significant beneficial changes in our own lives, health and wellbeing and thus we know for ourselves the benefits of this particular form of complementary medicine without the personal need for scientific research, yet we appreciate the need for that within the scientific community. As such we are undertaking a number of research projects so that the community at large may become aware of the benefits of this form of complementary medicine. In a world where there are rising epidemics of obesity, diabetes, mental ill health and where cancer is 1 in 3, the students of

Universal Medicine who live the principles of Esoteric healing are going against those trends – something that in and of itself is worthy of research and discussion.

As those 'on the ground' we can all testify that Universal Medicine fully supports conventional medicine and has led to significant benefits in our own health and wellbeing.

We are intelligent, highly self-reflective people who have in one way or another all experienced health benefits as a result of receiving complementary health care alongside what is considered accepted medical treatment. By way of reflection upon the benefits of such care that certain groups would label as outside 'accepted medical practice' we have provided anecdotal case studies of individuals who combined traditional medicine and complementary care to great effect and suggest that this is a contribution that can add to mainstream science and medicine. See **APPENDIX 3**.

INFORMATION THAT ENCOURAGES REFUSAL OF MEDICAL TREATMENT

We note that the Committee is focused upon the promotion of "unscientific health-related information" and seeking to ensure that the regime to regulate misinformation is effective. However, equally there should be regulation of misleading claims made by respected scientists who have the authority of science behind them, and are able to make unsubstantiated claims about complementary therapies. We present by way of example an article by Emeritus Professor John Dwyer, 'When Healing Hands Start Grasping' *Australasian Science,* May 2013 (**APPENDIX 4**)

Dwyer is a well-known figure in the media – he is a long-time friend of the Australian Skeptics and founded the Friends of Science in Medicine (FSM). The latter group was formed as a lobby group with the purpose of applying pressure on government and educational institutions to prohibit funding of complementary medicines. It advocates for the eradication of "pseudoscience in medicine" and defines true science within the limited parameters of an "experimental, evidence-based approach" (See **APPENDIX 1** – Komesaroff et. Al., 2012; Flatt, 2013). Dwyer's views on any form of complementary healthcare are predictable and he has consistently provided the media with an assured and guaranteed belligerent criticism of anything that is not within the bounds of conventional medicine. He conveniently ignores that many of the results achieved in conventional medicine are poorly understood in the same way as complementary therapies. In this article he appears concerned with the very issue the Committee is considering – the requirement for increased regulation of "unscientific" practices that he considers a 'menace to public health'. Indeed he suggests that "adequate consumer protection from misleading and often fraudulent practices remains disappointingly inadequate, both at the state and national level." In this article he considers that there has been a failure of legislative control and takes umbrage with the fact that the HCCC had not seen fit to intervene to regulate the dissemination of information on Esoteric Breast Massage (EBM) (a therapy he describes with contempt).

As we have outlined above the current regulatory framework is entirely adequate to govern "misleading and often fraudulent practices" and what is obscured in the presentation is that

there was found to be no need for government intervention because there was no reported harm to any patient and that there was nothing for the regulatory bodies to be concerned with.

As noted above Dwyer aims to eliminate pseudo-science, yet there was no scientific rigour in his critique of Esoteric Breast Massage. He asserts (with no evidence to back up his claims) that the alleged benefits of Esoteric Breast Massage are “ludicrous” and is clear that this fits within his directive to attack any complementary therapies that do not satisfy the extremely limited paradigm of evidence-based medicine .

What Dwyer presents are no more than strongly held opinions about complementary therapies and there is a complete failure to utilise any of the methodologies of objective science. It is actually a paper containing merely conjecture passed off as science. As we have suggested, a complementary therapy is not ‘unscientific’ because it does not exist in the contemporary domain of mainstream medicine, nor is it appropriate to make that assumption without due rigour. The method of science involves detached observation and the steady collection of evidence over time. It does not involve the immediate dismissal of all that seems foreign or implausible to the investigator.

Dwyer had not investigated the Esoteric Breast Massage or applied scientific methodology to his theory. He specifically did not:

- interview women who had received Esoteric Breast Massages;
- develop a series of case studies on those women who have had Esoteric Breast Massage ;
- develop population studies on the hundreds of women who have had Esoteric Breast Massage;
- analyse the technique himself.

In short, Dwyer’s opinions were not based upon data that he had collected or analysed – there was no objective data in his article to be analysed or discussed. The very criticism that Dwyer makes, that the complementary therapy discussed is “unscientific”, was itself not substantiated by any scientific method.

There is a growing practice-based experience of the benefits of breast massage. It is currently taught at John Flynn Hospital, Tugun and the Mater Hospital, Brisbane with clinical tests showing improved lymphatic drainage and reduced mastitis (Clinch, Accessed 2013). Dwyer not only failed to investigate the modality he also failed to take into account early evidence of health benefits arising from breast massage:

‘Study of the body's lymphatic system shows that breast tissue contains an abundance of lymph vessels. Unlike other areas of the body, however, the breast lacks sources of external compression, such as muscles or strong overlying fascia that promote natural lymphatic drainage. As a result, fluid has a tendency to stagnate, which may lead to breast pathologies (mastopathy). This is where gentle, non-stimulating techniques can be applied to aid fluid recirculation.’ (Science Daily, 2012)

Personal opinion of Dwyer appeared in his article to be considered “science” whereas in fact it involved serious misinformation about a therapy that is considered beneficial according to a growing body of practice-based experience.

The article by Dwyer and its presentation highlight a number of false assumptions about which the Committee should be cognizant. First, scientific authority should not be misused; second, treatments that have been labelled as ‘unscientific’ may be part of practice-based experience that can serve public health and should not be dismissed for not fulfilling evidence based criteria.

Finally, there have been a number of papers critically reviewing the approach (and rhetoric) of FSM and Dwyer and we encourage the committee to consider these as highly relevant to this inquiry. For example, the attached paper by Komesaroff, Moore and Kerridge (2012) (see **APPENDIX 1**) illuminates the importance of science and medicine remaining open to contrary views and the dangers of any one theory or ideology dominating and forcefully opposing and squashing all others in the belief that their way is the only right way. The attached article by Flatt, 2013 (see **APPENDIX 1**) observes that FSM ridicules complementary medicine and asserts that complementary modalities should be abandoned because they are ‘underdeveloped, unsophisticated and absurd’. Furthermore, FSM portrays patients of complementary therapies as gullible victims who are ‘naive and susceptible to mythology’ and thus in need of greater protection. What appears to elude consideration by FSM is that 68.9% of Australians use complementary medicines (Xue et al, 2007) so that FSM would have us believe that 70% of the population are incapable of making informed choices about their own health care.

Flatt concludes that FSM ‘contradict the literature in their viewpoint on complementary medicine and its use’ and that they use a style of language to promote their own beliefs and suppress alternative views.

Of great importance for the Committee’s deliberations is Flatt’s conclusion that ‘[t]he statements that FSM use have no respect for complementary medicine or its patients, create no potential for the application of science to this healthcare field, and leave no room for equitable scholarly debate.’ What is more, “[i]f this type of ideological discourse is allowed to flourish unchallenged, the possible consequences for freedom of knowledge and unfettered access to healthcare are significant.” We share this view.

COMPLEMENTARY HEALTH CARE REQUIRES RIGOROUS STANDARDS OF ETHICS

‘First do no harm’ (*primum non nocere*) is the foundation of the Hippocratic oath. However, this does not just apply to patients but also to doctors and all healthcare professionals. By first doing no harm to ourselves by our way of living and being, it becomes automatic to do no harm to another. Evidence shows that doctors who look after themselves are better doctors and their advice is taken more seriously by their patients. Fraser, Leveritt and Ball found that “if a GP was perceived to be healthy, the advice they gave was considered more credible” (Fraser, Leveritt and Ball, 2013). The NHS Health and Wellbeing Review by Steve

Boorman (Boorman, 2009) also shows that when staff look after themselves there are better outcomes for patients.

Taking its rise from the foundational tenet of the Hippocratic oath we are all accredited with the Esoteric Practitioners Association (EPA), an association that holds the health and well-being of practitioners as paramount in the practice of complementary esoteric healing. The EPA takes this foundational principle even further, with an understanding that the way that we live affects our health and wellbeing and that by living in a way that is deeply caring for ourselves, we are then able to bring that same quality of care to another. Esoteric Practitioners are required to invest in their own ongoing personal development, and live in a fully self-caring and responsible way, applying care and attention in every aspect of their lives, from diet and nutrition, to sleep, and how they conduct their relationships and in society. This integrity in living is the foundation of harmlessness. The EPA code of ethics requires practitioners to live according to these principles as part of their accreditation. A practitioner living in a healthy and responsible way then knows, by their own quality of living, what are healthy lifestyle choices and can advise and inspire others accordingly.

CONCLUSION

Human beings are multidimensional beings and as such we require multi-dimensional approaches to healthcare that reflect and understand the different facets and dimensions that contribute to health and healing which are broader than the purely physical and psychological. This necessitates the willingness, the humility and openness of medicine and science to consider other disciplines and ways of knowing about the human body and human experience in addition to the scientific method. It is imperative that this openness and the right of autonomous human beings to have freedom of choice regarding their own healthcare is not restricted by pressure from interest groups and vocal minorities who take a fundamentalist approach to medicine and science.

We have the evidence from our own lived experience that living according to the principles of Esoteric philosophy as presented by Universal Medicine and undertaking Esoteric healing modalities, that our lives, health and wellbeing have significantly improved and can testify to the benefits of this form of complementary medicine. This is aligned with the views of Feinstein (Thorgaard et al 2011) that people themselves are ideally suited to observe, monitor and evaluate their own state of health and wellbeing.

We are dedicated to living with harmlessness and integrity and to deeply caring for ourselves and others in equal measure. Thus we support:

1) regulations to curtail unscrupulous practices eg advising against medical treatment and consider that current legislation is more than adequate in this regard;
2) conventional medicine in full;
3) the use of some forms of complementary therapy to work alongside conventional medicine in recognition that conventional medicine does not have all the answers to humanity's ills;

4) the understanding that there are more disciplines and ways of knowing and gaining evidence and interpreting that evidence than those contained within the narrow confines of the scientific method. As such we have detailed concerns regarding the reliance on evidence purely according to that accepted by science, its interpretation, what is considered and not considered to be 'accepted medical practice' and who is and is not 'unregistered health practitioners' (eg spiritual care advisors).

5) the right of autonomous human beings to make choices regarding their healthcare

In addition, we have brought to your attention independent academic works that expose the ideology and force being used by FSM to bring about an end to complementary medical practices and the lack of evidence to support their critique.

It is upon this basis that we are making this submission as we care about the health and wellbeing of our community and the ever unfolding understanding of the human body, medicine and what it means to live in true well-being.

We invite the committee to carefully consider our submission.

We would like to meet in person to discuss any aspects of interest to you.
In light of the importance of the issues that we have raised, we would also welcome the opportunity to give oral evidence before the Committee.

To contact us, please telephone or email:

Charles Wilson [redacted] or
Alison Greig [redacted]

THANK YOU FOR YOUR CONSIDERATION.

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APPENDIX 1

Medicine and science must oppose intolerance and censorship

Friends of Science in Medicine should avoid threatening their own values

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Science has always been — and should be — a battleground for contending views on what is true. Because of the close connection between knowledge and power, however, the risk is always present that those who command the dominant theories or ideologies will rely on their positions of influence to overcome those who oppose them. It is important that those who treasure tolerance and the value of open, unfettered discourse remain sensitive to these risks and — even when they personally disagree — to protect and foster the expression of contrary viewpoints.

When the nature of science and medicine is at stake, the importance of this task is especially pressing. We believe that the views promoted in a commissioned editorial in the Journal, by the Friends of Science in Medicine (FSM), exceed the boundaries of reasoned debate and risk compromising the values that FSM claims to support.[1]

In its own words, the key objective of FSM is "countering the growth of pseudoscience in medicine", where true science is defined as a set of practices characterised by "an experimental, evidence-based approach". The strategy of the group — which deliberately and forcefully relies on the unquestioned eminence of its members — is to apply pressure on governments and educational institutions to withdraw or prohibit funding for health practices referred to in a general sense as "complementary medicines". The organisation models itself on similar groups in the United States and the United Kingdom and proudly refers to the success of these groups in having had funding removed from certain alternative medicine courses.[2] It is clear that FSM aims to emulate this success in Australia through a campaign to influence public opinion and apply pressure on government and educational institutions.

We do not write to advocate complementary medicines. Indeed, two of us are physicians who practise exclusively in the field of Western medicine and are actively engaged in "conventional" laboratory and clinical research. Furthermore, we accept that there are serious and important issues to be considered regarding claims about, and risks posed by, many "complementary" health practices, and regarding the nature and status of evidence in medicine. As even the most vigorous supporters of complementary medicines accept, the field has been beset by excessive and fraudulent claims, which in many cases have misled — and, in some cases, posed direct risks to — vulnerable individuals.

We feel that the appropriate response to these problems is not to seek to suppress all approaches to health care which we cannot understand or with which we do not agree. Rather, it should be to establish a system of safeguards that minimise risk, while continuing to protect the rights of consumers to choose their own health care practices. Such safeguards should include legal, professional and conceptual criteria and target specific rogue practices while protecting and regulating others. We believe that any approach other than this would run the risk of threatening the core values and practices of science and medicine.

What are the core values and practices of science? FSM claims that what distinguishes the "scientific" nature of medicine is its reliance on evidence, and that all other approaches to health care are merely "pseudoscience". We believe that this is wrong because it is at variance with the key insights of much of twentieth-century philosophy of science, which largely sought to understand the nature and meaning of science. There are many ways of defining what characterises science, but reliance on evidence is not one of them, because all systems of knowledge and belief make claims to interpretation of the evidence.[3,4] Indeed, it is well known that, in Galileo's day, Aristotelian physics commanded a much stronger empirical basis than did the esoteric theoretical idealisations of the Galilean system, not to mention Einstein's theories of relativity in the years after they were proposed.[5] Nor indeed is science merely a method, as it incorporates — and promotes — a wide array of methods and approaches.

What characterises the practices of science and medicine — as we understand and value them — is an openness to contrary perspectives and points of view, a belief in the merits of critical inquiry, a commitment to open and free dialogue to settle disputes and disagreements, and a renunciation of the use of polemic and force to suppress contrary viewpoints. We do not disagree with trenchant critiques of bodies of thought that cannot be substantiated by argument or data. What concerns us is a politicised process to apply pressure on governments and educational institutions to act in accordance with the views or convictions of one particular group.

In addition to this ethical point is a philosophical one. A key premise of many scientists and practitioners is that Western medicine is evidence-based whereas complementary medicine is not. There are several problems with this premise. First, as discussed above, is that it is mistaken to identify science with evidence. Second, the claim is based neither on evidence nor on a clear differentiation of the variety of forms of complementary medicines. While there may be little, if any, data to support more marginal, or fringe, forms of complementary medicines, there is an extensive evidence base relating to other complementary therapies, including Western herbal products, nutritional supplements, traditional Chinese medicine, and certain non-drug practices, such as meditation.[6,7]

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The third problem is that the concept of evidence-based medicine, which was once so popular, is highly contested and debated within Western medicine itself.[8] This is because the kind of evidence that is available to clinicians is never more than limited and partial, and that the clinical art always requires different kinds of inputs that set it apart from formal scientific deliberation. As has become widely recognised, clinical judgement draws together a range of skills and theoretical considerations. These include rigorous history-taking and examination, respectful dialogue with patients and relatives to determine the goals of treatment, and assessment of special biological, psychological or cultural conditions, risks, costs and other factors.[9] Evidence from laboratory, epidemiological, clinical research and clinical trial studies cannot solely generate or determine the clinical decisions. These high-level data deal only with populations and probabilities and can, therefore, provide no more than hypotheses to be tested. It is the job of the clinician to convert these data into judgements relating to individual patients. This process of clinical decision making involves forms of judgement and kinds of knowledge that differ qualitatively from those which motivate and direct scientists.[10] Medicine is a complex craft, and a large part of its richness and success depends on its ability to draw on a wide array of practices and forms of knowledge. Despite the undoubted wealth of information that laboratory and population studies provide, from the point of view of the clinician, a great deal of uncertainty remains, at the conceptual and methodological levels. We cannot afford to be overconfident about our own approaches or dismissive of those of others.

This does not mean that there is not a need for a vigorous and forceful debate about systems of medicine and individual practices, and it in no way detracts from the urgent need to protect vulnerable members of the community from those who seek to exploit them. Nor does this mean that we should not continuously re-examine the cultural role that universities play in society and their function is fostering critical learning, creativity and the pursuit of knowledge. These are important questions as they reflect ideas about the degree to which universities should promote or restrict access to different epistemologies and about where, and how, different disciplines and techniques should be taught and learnt. From whatever side one speaks, however, whether from the point of view of medicine or its interlocutors, the institutions of science and health care are too important to be subject to political campaigns seeking to enforce their own preferences regarding what they consider to be true science or how they believe clinical practice should be conducted.

> “What concerns us is a politicised process to apply pressure on governments and educational institutions to act in accordance with the views or convictions of one particular group”

It is important that those who seek to be friends of science do not inadvertently become its enemies. We call on the members of FSM to revise their tactics and instead support open, respectful dialogue in the great spirit and tradition of science itself.

Competing interests: No relevant disclosu es.

Provenance: Not commissioned; externally peer eviewed.

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APPENDIX 1

CREATIVE APPROACHES TO RESEARCH

CRITICAL DISCOURSE ANALYSIS OF RHETORIC AGAINST COMPLEMENTARY MEDICINE

JEFF FLATT

Purpose

This paper aims to critically analyse a selection of the 'Friends of Science in Medicine' media to determine if power and ideology are linguistically structured and deployed in their representation of complementary medicine.

Design/methodology/approach

Thirteen separate media events are collated as a single case and analysed by critical discourse analysis. This research design interrogates discourse statements for their constitution and reproduction of power and ideology.

Findings

The Friends of Science in Medicine represent complementary medicine through a strategy of rhetoric and argumentation that contradicts the literature. Their discourse is symbolic and derives from a power-based ideological perspective that forms the basis for promoting exclusion of complementary medicine from university education and primary health care.

Keywords: Critical discourse analysis, rhetoric, complementary medicine, ideology, power, Friends of Science in Medicine, science, evidence-based medicine.

Flatt, Jeff. 2013. Critical Discourse Analysis of Rhetoric Against Complementary Medicine. *Creative Approaches to Research*, vol. 6. no.2, pp. 57–70.

This paper presents a critical study of events occurring in Australia in early 2012. These are the collective discourse of the 'Friends of Science in Medicine' (FSM), who are a special interest group originating from within biomedicine. They advocate the cessation of university complementary medicine education 'not based on scientific principles nor supported by scientific evidence' (Friends of Science in Medicine, 2011). FSM formed in late 2011 and as of February 2012 had a membership of '450 Australian biomedical scientists and clinical academics' (Token Skeptic, 2012). By April 2012 they had widened their focus from university education to the clinical practice, use and legitimacy of complementary medicine within Australian society. The six complementary medicine disciplines identified within their original criteria had also enlarged to an open-ended listing by this time (Friends of Science in Medicine, 2011; Friends of Science in Medicine, 2012).

A variety of responses emerged as this discourse progressed during the early part of 2012. Internet postings generated lengthy debates within comment forums and scholarly journals published articles that reinforced or disputed the FSM position (Norrie, 2012; Novella, 2012; Spedding, 2012). Complementary medicine professional associations also responded and expressed concern that FSM were using emotive reasoning based in anecdote, inaccurate definitions and misrepresentation (National Herbalists Association of Australia, 2012; Australian Traditional Medicine Society, 2012). In addition, some observers described the FSM depiction of complementary medicine as problematic due to political and ideological overtones and power-based rhetoric (Komesaroff, 2012; Komesaroff et al., 2012; Myers et al., 2012).

Because they are attempting to impact the education and practice of complementary medicine in Australia, it is essential FSM are accurate in their interpretation of the disciplines they are discussing. The responses described above indicate that their argument is contested, and it is suggested that their rendering of complementary medicine is neither accurate nor impartial because of their ideological and power-based interests. This paper will investigate this possibility.

RESEARCH DESIGN, DEFINITIONS, AIM AND LIMITATIONS

None of the publications cited above have systematically examined the FSM discourse. As a consequence, in-depth empirical analysis of the objectivity of FSM is lacking. This paper attempts to address this by applying critical discourse analysis (CDA) to statements used to portray complementary medicine. CDA is chosen for this task because it is able to scrutinise the concepts of power and ideology within discourse (Wodak, 2001). As Blackledge (2012) explains, CDA can analyse text for the constitution and reproduction of power because it is through language that agents establish unequal power relations and enact discriminatory

practices. Power and ideology are selected for review because various commentators cite their influence within the FSM interpretation of complementary medicine. Adams et al (2009) also identify these as strong socio-cultural features of the biomedicine - complementary medicine relationship, and as discursive repositories that characterise debate between these healthcare fields.

There are a variety of CDA approaches to the analysis of discourse. In Meyer's (2001) review of the theory and method of CDA, he identifies fourteen techniques that examine power and ideology. Four of these are relevant to this study: *coherence*, which explores statements that signify the immediately observable intention of the discourse; *lexical style*, which considers specific words used for more subtle intentional meaning; *rhetorical figurativeness*, which examines the use of symbolic language to generate persuasive meaning; and *propositional structures*, which investigates the use of statements that propose knowledge. In short, this choice of analytical techniques explores the meaning, intention, persuasiveness, and knowledge propositions within discourse.

In this paper, discourse is defined as 'meaning-making as an element of the social process' that arises from 'a way of construing aspects of the world associated with a particular social perspective' (Fairclough, 2012, p. 11). Definitions of power and ideology are sourced from the literature discussing biomedical and complementary medicine relations. In this context, the notion of power derives from medical sociology and is concerned with professional dominance of healthcare practice, patients, training, and regulation (Broom, 2006). According to Baronov (2008), biomedicine has a dominance in these areas that derives from an ideology consisting of science, privilege and positivism. He describes these features interacting in various forms to socially express biomedical power.

Assessing whether this power and ideology are linguistically structured and deployed by FSM in their representation of complementary medicine is the aim of this paper. To achieve this, a concise paraphrased review of the FSM argument is presented, followed by a description of the main thematic areas of their discourse. Statements illustrating the FSM depiction of complementary medicine are extracted from these themes and CDA is applied. The findings from this process are aligned to the literature and the presence of power and ideology within the discourse is discussed.

Limitations

This paper does not explore the genre, history or intertextuality of the FSM discourse. This refers to the presence of similar arguments within different texts through time, and is the analysis of the common goals of a 'discourse community' (Wodak, 2008, p. 15). While highly relevant to this paper, this area contains a considerable amount of rich material that constitutes a separate publication.

THE FSM ARGUMENT AGAINST COMPLEMENTARY MEDICINE

The primary contention within the FSM argument is that the tertiary teaching of complementary medicine undermines the credibility of Australian universities. They state that the delivery of these courses represents an invasion of 'pseudoscience' into academia that sullies genuine scientific teaching and research (MacLennan and Morrison, 2012). They claim that complementary medicine university health science courses are unscientific due to their theoretical groundings, which that say are untestable. They are 'distressed' that these therapies are given scientific validity and state that healthcare should not be taught or practiced unless it has scientific evidence (ABC Brisbane, 2012; Science on Top, 2012; Token Skeptic, 2012; ABC Breakfast, 2012).

Shortly after their initial media penetration, the FSM discourse moves away from a purely university focus. Their discussion widens to include the clinical practice of complementary medicine within Australia, which they claim uses fabricated scientific credibility to deceive the public. The presence of these practitioners in the community, FSM argue, leads to dilution of the health dollar and wastes public money (ABC Brisbane, 2012; ABC Central Coast, 2012; The Skeptic Zone, 2012). Incredulity at the willingness of the public to engage with 'nonsensical' medicine is stated, and disbelief at the potential for intelligent people to suspend their normal judgment to pursue complementary medicine healthcare is present (2SER's Razors Edge, 2012; ABC Brisbane, 2012; The Skeptic Zone, 2012).

This indicates that the focus of the FSM argument is not only the cessation of university delivery of complementary medicine but also the rejection of the practice and use of these healthcare practices within Australian society. Their discursive position is summarised within their contentions that '... the whole idea here is that we should abandon all alternative and complementary medicines' and '…hopefully eventually getting rid of the whole concept of an alternative system …' (ABC Brisbane, 2012; ABC Breakfast, 2012).

COLLATING AND ANALYSING THE FSM DISCOURSE

FSM were active in the Australian media in the first four months of 2012 and promoted their argument through the *Sydney Morning Herald*, the *ABC*, the *Conversation*, the *Medical Journal of Australia*, the *Australian Doctor*, regional radio stations, and skeptic podcasts. By May of 2012 thirteen separate FSM discursive events were sourced from the public domain and collated as a single case. This fusion of multiple media is able to occur as the discourse creates a unified message with thematic saturation.

Three dominant themes emerge from FSM statements focusing on the representation of complementary medicine. These centre on practice, patients, and the demarcation of complementary medicine from scientific biomedicine. In the following section each of these themes is discussed through a literature-based description, a selection of relevant FSM statements, and an analysis of their content.

Practice – a Literature-based Description

The term complementary medicine describes a set of heterogeneous disciplines with a taxonomy and public healthcare delivery status that varies between different national and state regulatory systems. Most recognisable are those professions and occupations supported by technical literature, professional associations and recognised systems of education (Kaptchuk and Eisenberg, 2001). The practice of these disciplines is diverse, descriptions of different clinical methods are published, and in Australia practice variations are recognised (Nestler, 2002; Expert Committee on Complementary Medicines in the Health System, 2003; Dunne et al., 2005; Conway, 2011).

A cohesive practice method with theories of holism and vitalism is promoted within complementary medicine. This refers to the view that patients have an interconnected matter, life, and mind that is 'more than the sum of its parts', and treatments are prescribed with the aim of augmenting a 'vital principle distinct from physiochemical forces' (Smuts, 1936, p. 101-102; Morgan, 1998, p. 36). However, this proposed unity of method is not evident amongst all practitioners and these theories, their definition, and their application are contested in the complementary medicine literature (Fulder, 2005; Greco, 2009; Evans, 2012).

The FSM Representation of Practice

The FSM discourse does not clearly define complementary medicine, and states '… terms are very tricky. We ourselves have wondered how to use them' and '(t) here's a sort of, there's a word CAM which amalgamates complementary and alternative medicines, and it's probably not a very good bracket…' (Science on Top, 2012; World News Australia, 2012). They describe the historical origins of complementary medicine as 'spring(ing) fully born into the mind of some German peasant or sort of a backwoods bloke in America as a fully blown theory' (Science on Top, 2012). FSM comment on those who might follow these historical origins when they say 'God knows why you should think that people who believe the world was flat are wiser than people now' (Science on Top, 2012).

FSM describe complementary medicine practice using vitalistic theory. Reill (2005) outlines the original eighteenth century description of this as a non-physical force forming an indefinable energy. FSM apply this definition when they state '…they've gotta have a mysteries energy that no-one can define and no-one can locate and no-one can identify', '… there's always a mysterious energy

involved' and '…completely fanciful theory of mysterious energies …' (Token Skeptic, 2012; Science on Top, 2012). Practice is described as ineffective pseudoscience because '… when you try and test the theory …. you can't because it's not testable…' which means '… there's absolutely no evidence and could be no evidence to support them…' (ABC Brisbane, 2012; Token Skeptic, 2012). Consequently FSM describe complementary medicine as '… a faith, that's not a science, that's a faith' (Token Skeptic, 2012).

Because FSM believe these therapies are unfounded, practice efficacy is said to be due to non-specific treatment effects. Statements such as '(t)here's a huge placebo effect for many of these things' and '(h)omeopathy … it's a total placebo…' show that FSM do not believe complementary medicine therapies have effectiveness (Radio Adelaide, 2012; ABC Central Coast, 2012). This leads FSM to then describe practice as dangerous because patients, they say, are ineffectively treated. This creates '…delays in effective treatment, side effects, drug interactions, health misinformation and distrust of conventional medicine' (MacLennan and Morrison, 2012, p. 225). Statements accentuating this risk are applied, such as '... public harm being done to patients', '… there's a lot of harm being caused in women's and children's health', '… the threat is to society in general' and '(l)ives have been lost over this' (The Skeptic Zone, 2012; ABC Brisbane, 2012; 2SER's Razors Edge, 2012).

Analysis of the FSM Representation of Practice

FSM do not clearly define or delineate complementary medicine practice. Subsequently, they universalise a wide variety of distinct practices. This fictional grouping is then subjected to ongoing negative sentiment that has a demeaning intention. This is borne out in the lexical style, where copious derogatory statements occur. These statements act to ridicule and 'other' complementary medicine as a whole, with the implication that it warrants exclusion because it is underdeveloped, unsophisticated and absurd.

Accompanying this are sweeping statements that describe a mythical practice that is unable to be scientifically assessed. These act as rhetorical accomplishments that aim to persuade the audience of the compromised state of complementary medicine. FSM reiterate this proposed inadequacy when they assert that these practices are dangerous to public health. These are propositional statements that have a superficial appearance of logic. However, they are not presented with evidence to underpin their allegations, which undermines their validity.

Patients – A Literature-based Description

Australian public use of complementary medicine occurs across all ages, genders, races, and health conditions. It is said that 44 percent of adults and 24 percent of those with chronic disease access practitioners and products (Xue et al., 2007; Lin

et al., 2009; Armstrong et al., 2011). Research from different regions of the globe reveals a higher degree of subjective suffering for many users, and describes those with chronic ill health forming the larger portion of long-term patients (Rossler et al., 2006; Grzywacz et al., 2007; Bishop and Lewith, 2008). Use of complementary medicine increases proportionally with higher levels of educational attainment (Briggs, 2010).

This use is associated with a variety of push and pull factors. Push factors away from biomedicine include dissatisfaction with the doctor-patient relationship, concern over pharmaceutical side-effects, and the perception of a lack of efficacy of treatment. Patients are pulled to complementary medicine due to its holistic orientation and their desire for an active role in shared treatment decisions within an inter-subjective and caring relationship (Bishop et al., 2010; Berger et al., 2012).

The FSM Representation of Patients

Patients are regarded by FSM as naive and susceptible to mythology. They state that '(p)eople should be free to choose what they like, and they always will' and '…. if they believe in the mythology, that's up to them, they can go…'. They go on to say there is '…ill informed choice from patients…' who are 'either gullible themselves or they are victims…' (Radio Adelaide, 2012; 2SER's Razors Edge, 2012; The Skeptic Zone, 2012). They describe patients lacking in critical thought where '… when they tell you that they've got evidence for their treatment, it usually means something like, well it helped my grandmother' and they warn patients that '…whilst they can keep an open mind about therapies when they first investigate them, their mind should not be so open that their brain falls out' (Token Skeptic, 2012; The Skeptic Zone, 2012).

FSM portray patients as uneducated and needing information, protection, and guidance. They say '…the public needs to be educated...' and authorities should be '…informing consumers and protecting them', particularly 'from what has absolutely no chance of helping them' (The Skeptic Zone, 2012; ABC Breakfast, 2012). To validate their viewpoint they quote examples describing negative patient experiences and say that '…hundreds of emails … have been flooding in…' describing mistreatment by practitioners (ABC Breakfast, 2012).

Analysis of the FSM Representation of Patients

FSM use paternalistic language towards patients, who are belittled and viewed as uneducated. The intention is to describe those using complementary medicine as lacking judgment and having underdeveloped critical faculties. The FSM lexical style portrays complementary medicine patients in the same way as practice: backward and unscientific. Throughout this portrayal, the public are rhetorically presented as unreasonable in their use of complementary medicine. The FSM

discussion contains propositional statements that assert knowledge and understanding of patient's agency. These assertions contradict the literature and are at odds with current evidence.

Demarcation – A literature-based Description

Demarcation discourses attempt to differentiate and separate practices that fall outside specified criteria. The philosopher of science, Karl Popper (1959), describes scientific demarcation as identifying selected characteristics to distinguish science from other kinds of intellectual activities. Various authors identify numerous influencing factors in demarcation attempts that include socio-cultural forces and contextual elements of culture, language, and history. These combine to form rhetorical demarcation strategies, notably in the use of evidence as a tool of differentiation (Taylor, 1996; Zerbe, 2007).

Attempts at demarcation of biomedicine from complementary medicine are documented. These tend to follow similar lines of reasoning, with propositions of implausibility and absurdity being commonplace (Sampson and Atwood IV, 2005; Greasley, 2010). This reasoning is socio-cultural and ideological, and resides in what Hansen and Kappel (2012, p. 17) term 'pre-trial belief' or 'beliefs held prior to empirical investigation into the effectiveness of a particular treatment'. This is further described by Jenicek and Hitchcock (2005, p. 125) as the rationale that 'researchers will justifiably refuse to accept even positive results from apparently impeccable meta-analyses of apparently impeccable randomized trials of proposed remedies grounded in scientifically false theories'. This position is considered to be problematic for valid review of complementary medicine evidence (Ernst, 2004; Linde and Coulter, 2011; Rutten et al., 2012).

The FSM Representation of Demarcation

FSM present a clear demarcation strategy within their discourse. This is expressed in their desire to '…realise clearly where the line that distinguishes good medicine from pseudo medicine is' and '… fundamentally, what lies at the heart of it is not whether this university's good or that university is bad, it's what exactly does evidence-based mean' (Token Skeptic, 2012; The Skeptic Zone, 2012). They define demarcation criteria when they refer to complementary medicine and say '…it's not about knowledge, it's about the presentation of absolute anti-science… ' and '(t)hey are pseudoscience, or at best they are anti-science or non-science' (ABC Breakfast, 2012; Token Skeptic, 2012).

This places the FSM interpretation of science as a primary demarcation fixture. However, this position is conflicted because they dismiss the current positive complementary medicine evidence-base when they proclaim '… don't tell me it's evidence-based. It's not!' (Token Skeptic, 2012). Conversely, they promote research when they say '(t)he evidence-base we know can only come from research,

no disagreement with that' because they want to '… make sure the public gets the very best in the most scientific of all ages of evidence-based medicine' (ABC Breakfast, 2012).

Marginalisation of complementary medicine appears within the demarcation strategy when FSM say '… there are many alternative practitioners, naturopaths and things, who give perfectly sound advice about lifestyle management and the like'. These types of statements particularly target chiropractic when FSM say '(t) here may be a physiotherapy aspect to chiropractic and backs' because '...there is an evidence-base that's similar to that for physiotherapy' and '…more reasonable chiropractic performers are doing what is essentially stuff like physiotherapy' (ABC Breakfast, 2012; Radio Adelaide, 2012; ABC Brisbane, 2012; Science on Top, 2012).

Analysis of the FSM Representation of Demarcation

These FSM statements intend to differentiate between what they describe as scientific biomedicine and unscientific complementary medicine. Their lexical style consistently references 'evidence-based' and they portray complementary medicine as pseudoscientific. Statements of non-science status for complementary medicine are rife, which contributes to a marginalisation discourse. The suggested lack of evidence compared to biomedicine is referenced to the Cochrane research database, where complementary medicine holds a minuscule percentage of total data. Thus, the FSM propositions of demarcation criteria are dubious due to severely disproportionate comparisons and pre-trial belief negating impartiality towards evidence.

DISCUSSION

Collating the findings from the thematic areas provides an overview of the FSM representation of complementary medicine. There are three main characteristics within the discourse that make up this representation.

Firstly, FSM universalises distinct complementary medicine disciplines to circumvent difference. This strategy has been criticised as responsible for rhetorical constructions rather than factual representations. These are said to reflect an ideological attitude as opposed to accurate empirical observation. This is because they create fictional portrayals that constitute targetable entities for demarcation discourse and maintenance of professional dominance (Caspi et al., 2003; Stone and Katz, 2005; Shroff, 2011).

Secondly, demarcation is attempted through what Gieryn (1983, p. 781) terms 'boundary work'. This is the use of science to differentiate practices that challenge professional domination. Here FSM apply positive scientific qualities to biomedicine and negative non-scientific qualities to complementary medicine.

As Derkatch (2012) says, efforts to demarcate biomedicine from complementary medicine are processes that use constitutive rhetoric, where agents of language represent complementary medicine for their own ends. Taylor (1996) also states that definitions of science within such discourses are intentionally constructed to exclude non-scientific practices. This construction is operationalised by FSM through interpretations of science and evidence that act to sustain professional dominance and power.

Finally, evidence-based medicine is rhetorically applied to develop normative statements for healthcare education and delivery. Numerous authors say this carries an inherent risk of fundamentalism, intolerance of alternative views, and the use of evidence as a symbolic weapon (Jadad and Enkin, 2007; Derkatch, 2008). These comments reveal the rhetorical value of evidence as ideological symbolism, and this discourse uses this strategy to forcefully promote a certain type of science. However, the inability to provide proof for statements, combined with the presence of pre-trial belief, undermines this approach. This is said to be a common error in such discourses (Astin, 2002; Ernst, 2004).

What emerges from these findings is a discourse strategy that allows negative statements to be applied in an attempt to delimit complementary medicine. However, because FSM portray their subject matter in a manner contradictory to the literature their argument is symbolic rather than factual. This makes their discourse a 'strategic manipulation of symbols to support a preconceived end' (Hyde and Bineham, 2000, p. 211). The result is a rhetorical construction of complementary medicine that is an expression of ideology and power concealed behind scientific and evidence-based objectivity. This finding reinforces the viewpoint of those who have previously commented on this discourse.

CONCLUSION

The paper has asked whether FSM deploy power and ideology within their discourse, and if their portrayal of complementary medicine is accurate and impartial when compared to the literature. CDA techniques have been used to analyse a selection of FSM statements across a range of media events, and have explored and illuminated underlying motivations for FSM speech acts. The findings have shown that FSM contradict the literature in their viewpoint of complementary medicine and its use, and manifest ideology and power within their discourse.

The implications of this are that FSM are using a style of language that promotes their own beliefs to suppress alternative voices. This leads to FSM having an inaccurate understanding of complementary medicine and patients because they have an interpretive bias originating from an ideological perspective. Their underlying desire to maintain power overrides any potential positive outcomes from

within their view of complementary medicine, and contributes to a discourse that presents as diatribe.

The statements that FSM use have no respect for complementary medicine or its patients, create no potential for the application of science to this healthcare field, and leave no room for equitable scholarly debate. The negative implications of the presence of this type of imbalanced argument within the public sphere are not limited to the complementary medicine field. The knowledge community needs to carefully review these voices and conduct an ongoing critical analysis of the expressed demands. If this type of ideological discourse is allowed to flourish unchallenged, the possible consequences for freedom of knowledge and unfettered access to healthcare are significant.

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VIEWPOINT

Reversals of Established Medical Practices
Evidence to Abandon Ship

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IDEALLY, GOOD MEDICAL PRACTICES ARE REPLACED BY BETter ones, based on robust comparative trials in which new interventions outperform older ones and establish new standards of care. Often, however, established standards must be abandoned not because a better replacement has been identified but simply because what was thought to be beneficial was not. In these cases, it becomes apparent that clinicians, encouraged by professional societies and guidelines, have been using medications, procedures, or preventive measures in vain. For example, percutaneous coronary intervention performed for stable coronary artery disease and hormone therapy prescribed for postmenopausal women cost billions of dollars and supported the existence of entire specialties for many years. Stable coronary artery disease accounted for 85% of all stenting in the United States at the time of the Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation (COURAGE) trial.[1] Large, well-designed randomized trials that tested whether these practices improved major patient outcomes revealed that patients were not being helped. Defenders of these therapies and interventions wrote rebuttals and editorials and fought for their specialties, but the reality was that the best that could be done was to abandon ship.

How many established standards of medical care are wrong? It is not known. Medical practice has evolved out of centuries of theorizing, personal experiences, bits of evidence, expert consensus, and diverse conflicts and biases. Rigorous questioning of long-established practices is difficult. There are thousands of clinical trials, but most deal with trivialities or efforts to buttress the sales of specific products. Given this conundrum, it is possible that some entire medical subspecialties are based on little evidence. Their disappearance probably would not harm patients and might help salvage derailed health budgets. However, it is unlikely that specialists would support trials testing practices that constitute their main source of income. Instead, the research community performs studies of modest incremental value without even knowing whether the basic standards of care are appropriate.

Rarely, some investigators find the courage to test established "truths" with large, rigorous randomized trials. When this happens, empirical evidence suggests that "medical reversals" may be quite common. In an evaluation of 35 trials that were published in a major clinical journal in 2009 and that tested an established clinical practice, 16 (46%) reported results consistent with current beneficial practice, 16 (46%) reported evidence that contradicted current practice and constituted a reversal, and another 3 (9%) were inconclusive.[2] Perhaps high-profile general medical journals are more prone to publish unusual results and less inclined to defend a clinical practice or specialized turf than specialty journals. However, it is unlikely that the selection filter in favor of reversal publications is stronger than the selection filter favoring the validation of standard of care. The mere testing of a standard of care generates interest because many standards of care are never tested. In another evaluation of trials published in 3 major general medical journals or high–impact factor specialty journals,[3] of the 39 most-cited randomized trials published in 1990-2003 that found a significant benefit of a clinical intervention, 9 (23%) found effects stronger than those found in subsequent studies and 19 (49%) found results replicated in subsequent studies, but 11 (28%) remained largely unchallenged, with no large trial conducted on the same question.

Many medical reversals involve conditions for which the standard of care has been promoted over the years based primarily on pathophysiological considerations. Often one or more trials exist, but they have not tested clinically relevant outcomes or have been biased. For example, vertebroplasty—the injection of polymethylmethacrylate cement into fractured bone—gained popularity in the early 2000s for the treatment of osteoporotic fractures. Initial studies addressed the pathophysiology of this therapy, delineated the technical skills required to optimally perform the procedure, and furthered the discussion about the benefits of vertebroplasty. Claims of benefit were strongly contradicted in 2 randomized trials[4,5] that included a sham pro-

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cedure, which alone might have been responsible for pain relief. Trials without sham control might continue to show benefit, but it is difficult to justify performing invasive, expensive operations simply to obtain placebo effects. Despite the evidence, many specialists will not abandon the procedure. A study of vertebroplasty utilization at one institution showed little reduction in referrals after publication of studies contradicting current practice and in fact even showed that increasing percentages of referred patients were offered the procedure.[6]

Similarly, the results of COURAGE have done little to improve optimal medical management of stable coronary artery disease prior to invasive intervention. Stenting may not improve mortality, but the procedure apparently diminishes angina.[7] However, more than 50 years ago, Cobb et al[8] demonstrated that large improvements in pain with internal mammary artery ligation were comparable to results obtained with a sham procedure. As is the case with vertebroplasty, stenting performed in patients with stable disease is probably widely used as an expensive placebo for pain control.

The increasing use of surrogate end points and short-term outcomes has also affected the credibility of clinical trial results. Reversal of important research findings is more common when pragmatic clinical outcomes are not used for initial approval and licensing of interventions. For instance, bevacizumab exploited an accelerated approval process for treatment of metastatic breast cancer. Approval was granted based on preliminary data on disease progression, an end point that may not necessarily translate into improved life expectancy or quality of life for patients. After accrual of further data, on November 18, 2011, the US Food and Drug Administration revoked its prior approval for this indication.

Because medicine is in part a statistically driven science, a certain amount of reversal of standards of care is inevitable. However, what is currently tolerated is far greater than the uncertainty of statistics. Reversal of established practices implies at least 3 grave consequences besides unjustified cost. First, patients who undergo the therapy during the years it is in favor receive all the risk of treatment and, ultimately, no real benefit. Second, contradicting studies do not immediately force a change in practice; the contradicted practice continues for years.[9] Third, contradiction of mainstream practices undermines trust in the medical system.

Given the slow rate of abandonment of ineffective medical practices, the standards governing drug and device approval must be strengthened. This means that newly proposed innovations should be evaluated in sufficiently large randomized trials that demonstrate improvement in important clinical end points before being widely disseminated. Such an insistence on well-designed, large studies may be seen as overly costly during times of financial hardship. However, the costs of permitting widespread use of ineffective interventions are much greater. In the case of vertebroplasty, a few million dollars used to conduct a proper clinical trial before regulatory approval might have saved nearly a billion dollars a year over the course of a decade.[10] For unnecessary hormone therapy and coronary stenting, the cost has been even greater. Large trials of new innovations should be designed and conducted by investigators without conflicts of interest, under the auspices of nonconflicted scientific bodies. Instead of designing, controlling, and conducting the trials, manufacturers may offer the respective budget to a centralized public pool of funding, keeping the trial design and conduct independent. Asking corporate sponsors to conduct pivotal trials on their own products is like asking a painter to judge his or her own painting so as to receive an award. If a manufacturer can be allowed to manipulate the system to create a blockbuster product from an ineffective drug, the temptation is hard to resist.

Besides the need for better evidence for new interventions, medical reversals also suggest that reality checks should be encouraged for established practices that constitute the core of medical care. Priority should be given to testing practices having limited or no prior randomized evidence for their use, reassessing old evidence that may no longer be relevant for current clinical settings, and evaluating therapies and interventions that are most expensive. If almost half of these practices are wrong, as empirical studies suggest,[2] the principle of equipoise is fully satisfied and randomization is indicated.

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APPENDIX 3

Following are testimonials from clients with significant health conditions who have experienced treatments with the esoteric healing modalities of Universal Medicine as part of their overall treatment program.

1. Dr. Jane Barker
2. Ingrid Langenbruch
3. Paul Moses
4. Denise Morden
5. Lee-Ann Bailey
6. Tony Parkes
7. Judith McIntyre

1. Testimonial - Dr. Jane Barker

Submission for investigation into non evidenced based practice

I have worked as a medical practitioner for over forty years, 27 years as a GP in Australia. Over this period of time I have made certain observations

- There has been an increased interest in complementary therapies, which are considered more natural and less invasive than Western Medicine.
- Patients expect doctors to respect their choice to use alternative or complementary therapies.
- Patients are attracted to doctors who themselves embrace complementary therapies.

Both the RACGP and The AMA promote the concept of patient centered care. The core of this practice is to respect the patient's ability to make informed choices.

Independent research into alternative and complementary therapies is necessary to investigate their efficacy. However research is expensive and, as the medical profession is aware, is not always valid if undertaken by a body with a vested interest in the product under investigation. This ultimately means that there are therapies which if independently investigated could possibly be effective but do not at present have an evidence base.

I practice medicine in a very traditional way, but respect patient's choices to embrace complementary therapies, and am willing to monitor their medical progress when asked to do so.

I have acted in such a way for several patients who have been treated by practitioners of Universal Medicine.

I have observed that the Universal Medicine practitioners

- Respect and value Western Medicine
- Do not offer an alternative to Western medicine, but rather complement it.
- Are taught in their training to encourage their clients to seek the assistance of a medical practitioner. I have observed patients who had been very reluctant to follow what Western Medicine has recommended, change their minds and undertake treatment while supported by Universal Medicine modalities. I have observed patients who have been refused treatment until such time as they seek medical advice-as in the case of a woman with a breast lump.
- Offer support while their client is undertaking radiotherapy or chemotherapy. These patients have tolerated these treatments better than many other patients. (This is anecdotal evidence only)
- Are encouraged to undertake basic research into the efficacy of the modality they practice.

I myself received Chakra-puncture after undergoing radiotherapy with very beneficial results.

Anecdotal evidence suggests that these modalities are effective beyond any placebo effect. While I do understand that these modalities have a strong placebo effect, I believe that since this includes the effects of dignity, loving tenderness, respect and being valued, this placebo effect is in itself valuable. I look forward to the time when well-designed research can confirm these effects.

The improved well-being of several hundreds of people is testimony that the simple lifestyle changes recommended can have profound benefit.

Dr. Jane Barker
MBChB MRCP MGP Dip Counselling

12 December 2013

2. Testimonial - Ingrid Langenbruch

Experience as a Cancer Patient

by Ingrid Langenbruch

I have lived for 10 years with breast cancer, my 4th recurrence was at the end of 2011. Over the first 5 years – till about 2007 - I tried each and every natural, alternative way to heal myself. Having experienced 2 severe medical mistakes in my family in Germany and having studied natural healing and nutrition for years, I have had no trust or confidence in conventional medicine at all since I was a teenager. (I am now 59).

I was not successful in healing the cancer and chose to have a mastectomy in 2007. By then I started going to Serge's presentations, workshops and having esoteric healing sessions. Since I felt so 'right' being anti medicine I was surprised to hear Serge saying in several presentations that he is pro conventional medicine. Having failed for 5 years with my alternative efforts to heal I needed to have a truthful look at my emotionally driven aversion to doctors and anything to do with conventional medicine, and esoteric counselling has been very helpful with this. Slowly my view of the medical world changed and I chose to trust it more. At the end of last year - having the 4th recurrence - I agreed for the first time to have radiation therapy. The years before I rejected anything medical except surgery.

The radiation oncologist was wonderful and so was the hospital staff. During the 6 weeks of daily radiation treatments I had the most amazing, loving support of Serge and the practitioners at the clinic. I had regular (Esoteric Chakra-puncture) sessions from Serge to support my body through radiation. I was able to stay at UniMed House opposite of the clinic (I live too far away from the hospital in Lismore to drive every day) and was looked after also with meals while I was getting very tired and burnt from the radiation. And all this support without charging me!

I healed and recovered very well and quickly from the radiation.

Serge never tells me what to do. I sometimes wish he would when I find it very difficult to make a decision about a medical treatment or medication. But he always said when I asked that I have to feel for myself what's right for me. He often stresses this in his presentations too, that he never tells us what to do but that we have to feel what's true for ourselves.

I don't know if or when the cancer will come back. I do my best and I am less and less worried about it. What I do know is that I have support in a way I never experienced before, that I often feel amazing and loving within and with myself and I trust that I can hold that state should I have another recurrence.

With the support of UM I rarely suffer or worry anymore but am learning to love myself and my fellow human beings. I feel this is a much better contribution to human life than being a victim, suffering, miserable, worried and depressed, all of which I used to be.

My studies with UM and the esoteric healing sessions have immensely enriched my life.

3. Testimonial - Paul Moses

Testimonial for the NSW Parliamentary Inquiry into the promotion of false or misleading health-related information or practices.

I Paul Moses of Newrybar attest to the following:

I have lived quite an active life, however at the age of fifty years I started to struggle to feel vital. This was confirmed by regular visits to my Physician who measured my increasing blood pressure and found that my heart was losing its rhythm.

I ending up critically ill in hospital which obviously was a full-stop to the way I had been living. It also gave me time to contemplate my future and how I had ended up in a cardiac ward.

My wife, who is a doctor, and a friend and acupuncturist who had treated my family for 20 years had both been involved with Universal Medicine (UM) for more than a decade, but that had been their inspiration, not mine. Now, with the time and motivation to enquire, I started to see that they were not only vital but over time had become more and more vital and healthy and so I began to consider what UM offered more seriously.

There I found a simplicity that went hand in hand with everyday life and in no way forced any set of beliefs onto me or tried to what prescribe what I should or should not do.

The UM modalities I began to utilise, and still continue to use, offer me support with how I choose to live, simple choices around the responsibility I have towards my body and others. This certainly involves regular visits to my Physician and other medical practitioners as required. It is not an 'either or' situation for me.

In fact, now at 56 years I have normal blood pressure and heart rhythm, my heart chamber size and walls have returned to normal and a faulty valve is no longer leaking blood. I have no need to medicate and my vitality has returned in full. All this was summed up by my Physician in his words: 'I would call this a miracle but being a doctor I cannot. Your choices since hospital and the way you are living are proof in themselves.'

He and I have had lengthy discussions about 'true' medicine being how you chose to live, with conventional medicine and complementary modalities there to support us and allow us to live vital, fulfilled lives.

Paul Moses

12 December 2013

4. Testimonial – Denise Morden

In the year 2000 I was diagnosed with a severe form of a rare genetic lung condition Alpha 1 Anti-trypsin deficiency.

This disease causes severe emphysema and a wasting away of the lungs and I was told by 2 Lung Specialists in Sydney, that I would need a lung transplant within 5 to 10 years in order to survive.

There was not much I could do about this condition except use inhalers, and adapt and resign to the constant breathlessness.

Shortly after I moved to Byron Bay in 2002 I was extremely fortunate also to find an amazing Lung specialist who was able to treat me and continues to treat me.

I also came across the work of Universal Medicine and Esoteric Medicine in the form of the modalities they offer, which have been extremely helpful and supportive, in fact *essential,* to dealing with my condition and maintaining a quality of life.

I have survived for 8 years longer than predicted because of the care that I have received from both conventional medicine and complimentary medicine.

Universal Medicine has always encouraged me to undertake conventional medical treatment and works in conjunction with conventional medicine.

Using a combination of conventional medical expertise and self healing has allowed me to live a full and purposeful life in spite of a rare genetic lung disease. My sense of well being and health is better than it has ever been.

For me Esoteric Medicine is a true complementary practice that has helped me to maintain my health and well being by making choices that support my body and embrace treatment in a way that can maximize the benefits and potential for healing. The self responsibility and self empowerment that is offered in addressing my health and my issues, allow me to make better choices to heal and sustain my body in a new way of being and has also developed a way of living that optimizes my quality of life.

Denise Morden [60]

Byron Bay NSW 2481

5. Testimonial - Lee-Ann Bailey

On 30 March 2012 I was diagnosed with breast cancer - invasive ductal carcinoma of the right breast. The type of breast cancer was oestrogen receptor positive and as I was 44 years of age at diagnosis I was considered pre-menopausal.

Since March 2012 I have undertaken an extensive surgical/medical/esoteric healing regime to treat my cancer beginning with a mastectomy of the right breast. From the date of diagnosis to the surgery date of 10 April 2012, the cancer had grown from two lumps to a nest of five lumps, confirming the cancer was a rapid growth type.

The oncologist recommended chemotherapy to follow this surgery and after consultation with him and esoteric practitioners from Universal Medicine, in May 2012 I commenced treatment consisting of five cycles of Docetaxel and Cyclophosphamide taken intravenously at 21 days apart. This treatment completed in September 2012.

In October 2012 I underwent a breast reconstruction and as the cancer was oestrogen receptive positive I took the advice of the surgeon and oncologist including consultation with esoteric practitioners from Universal Medicine and chose to have my ovaries removed to avoid recurrence.

Under the referral of my oncologist I attended at a genetic specialist appointment in December 2012. During this consultation I was informed of my family history having the BRCA2 susceptibility gene. From this consultation my understanding is my family history forms the basis of the work of Professor Allan Spigelman and the research facility kConFab Australia. Of the families registered with kConFab, my family has the highest mortality rate from breast or prostate cancer in Australia. Genetic testing of my blood confirms I have inherited the BRCA2 gene.

As a result of this information and in consultation with the oncologist, surgeon and counselling with esoteric practitioners from Universal Medicine, I chose to undergo a mastectomy of my left breast in July 2013 and am scheduled to undergo further reconstruction surgery in 2014.

I have recently been diagnosed with Hypothyroidism and under the care of my GP currently take medication and receive esoteric healing sessions to further support this condition along with my general well-being.

As can be seen from above, I have assumed a committed approach to treating my breast cancer. My healing process has been as a result of the professional, dedicated and ongoing loving care from my oncologist, surgeon, hospital medical staff, my local GP and distinctly, the esoteric practitioners from Universal Medicine.

Throughout my process I have undertaken regular esoteric healing sessions, initially to support the shock and devastation of being a healthy active woman with a clean lifestyle being diagnosed with breast cancer. At our first attendance at the Universal Medicine Clinic it was made clear to me and my family that Universal Medicine would do all possible to support my medical treatment and ongoing energetic and bodily wellbeing as a member of their cancer care program.

During this two year period I have received quality and ongoing support and at no time felt my health care was compromised by any ill feeling or judgment toward conventional medical treatment.

It is factual that it was I who was preferring to take an idealistic alternative approach at various times and as a result of consistent care and discussions with Michael Benhayon in particular, along with the insight gained during my healing sessions, I was able to commit more to the medical treatment being offered.

Many of these esoteric healing sessions formed the basis of my capacity to continue committing to the emotional, mental and physical trauma of chemotherapy, the many ongoing ill side effects of the diagnosis, treatments, related surgeries, life and body changing circumstances.

In spite of the ill side effects I presented with, the oncologist was regularly impressed with my pathology results which were clearly as a result of choices I was making relative to how deeply I was caring for my body with healthy food choices, no gluten, no dairy, no alcohol, no caffeine, deep resting periods, and vigilant attention to prescribed medication.

There were many times I felt I couldn't continue with chemotherapy as a result of the traumatic symptoms and I recall communicating on two separate occasions to my oncologist that I wanted the treatment to cease. It was as a result of the ongoing support from practitioners at UM that during my esoteric healing sessions I was able to express my fears and discuss at depth the emotional and physical effects I was experiencing throughout my treatment. From these sessions I was able to maintain and build upon my sense of wellbeing, clarity and self-understanding. During these healing sessions I gained an immense common sense approach relative to accepting my circumstances and making the wisest of choices to allow my body its fullest recovery.

There is no doubt that a cancer diagnosis is a life and body changing event, and as is my example, with loving family support, professional quality care from medical staff and other health practitioners it is possible to live a more healthy full life from a body that is deeply cared for. The latter mention of deep care, I dedicate to my ongoing wise choices, my commitment to a healthy body and the understandings gained from esoteric healing sessions.

Lee-Ann Bailey

12 December 2013

6. Testimonial – Tony Parkes

TO WHOM IT MAY CONCERN

I injured my right elbow several years ago when I fell off a garden wall.

The injury curtailed the use of my right arm to some degree. It was moderately painful from time to time, particularly during and after lifting heavy objects. The pain was relieved by paracetamol.

The condition improved significantly with monthly chakrapuncture treatment over a period of about two years.

However, the condition deteriorated after moving heavy cases in and out of trains and cars on a trip in July 2013.

I then sought treatment from an esoteric therapeutic massage practitioner at the Universal Medicine Clinic at Goonellabah NSW in August and September. Two sessions of this treatment completely resolved the condition, which has not recurred. I have not felt any pain whatsoever during or after lifting heavy objects with the affected arm.

I have the highest regard for the skill and professionalism of the esoteric medicine practitioners from whom I have received treatment. Based on my experience I consider their healing modalities to be a legitimate and valuable component of complementary medicine. I have always been encouraged by them to consult medical practitioners when the need arises.

For your information I am 84 years of age and lead an active life. I have a BSc with 1st Class Honours and a PhD in Organic Chemistry. I also hold the Postgraduate Certificate in Business Administration (a precursor of an MBA) from the London School of Economics.

Edward Anthony Parkes

Binna Burra NSW 2479

12/12/2013

7. Testimonial - Judith McIntyre

Experience as a Cancer Patient

by Judith McIntyre

I understand that certain allegations have been made about Serge Benhayon and Universal Medicine, in particular claiming that Serge and the practitioners associated with Universal Medicine are in opposition or competition with conventional medical practitioners. This completely contradicts my experience as a cancer patient over the past year since my diagnosis in early June 2011 and in my association with Serge and Universal Medicine since early August 2011. During this past year I have had continuous treatment medically and also since early August, weekly sessions with Serge or other Universal Medicine practitioners. I am grateful to both my conventional and complementary practitioners for the life saving and caring support that I have received.

Before my diagnosis I had had chronic fatigue and chronic digestive symptoms. I had for years sought both medical and complementary advice and treatment. Generally there was not much either sphere could do to alleviate my symptoms. I had a strong preference for taking good care of myself in terms of diet, exercise, vitamins, regular check-ups, as well as massage, acupuncture and healing. I wanted to avoid needing any medical treatment if possible.

After I was diagnosed with breast cancer, I was shocked and terrified. I learned it was aggressive and I accepted that I could not avoid major and immediate treatment. I had an initial surgery in July which removed all the lymph nodes under my left arm and a lump from my left breast. I was advised that I would be needing chemotherapy and radiotherapy and hormonal drug treatment as well. When I considered chemotherapy I felt that in my debilitated state from years of low energy, that I would suffer more than most people. I dreaded it and felt it might be the death of me before the cancer. The first surgery did not achieve clear margins around the lump and I was booked for a second surgery, a wide excision, in August.

Before the second surgery, although I rarely went out at this time, I attended the Byron Writers Festival for one afternoon. I went into a talk on words and energy by Serge Benhayon. He spoke of how people say they love coffee when they mean they need coffee. He said that if people were honest and said they needed the coffee then they might ask themselves how they were living so that they needed coffee to get through their day. They might make better choices to improve their energy. I appreciated his reasoning. He also spoke about the rising numbers of women getting breast cancer. I became very interested. I had not thought of myself as being part of a cohort. His comments about being true to ourselves as a way to be healthy made sense to me. I knew I had many times looked after others even when exhausted.

I saw Serge in early August before the second surgery. I talked to him about death and how I had been living my life for others rather than for myself. I could see how I had squandered my life energy and made myself vulnerable to cancer in spite of my 'healthy' lifestyle. From my first visit with him, the intense, exhausting emotion I had been living with reduced dramatically. I told him how I optimistically believed that I wouldn't need a mastectomy although the surgeon had warned me that it was possible if the second surgery did not get clear margins. The surgeon had said I could choose a mastectomy

this time instead of just another excision. I was shocked and said "No!" Serge somehow communicated to me a sense that I would be alright, even if a mastectomy was necessary.

He didn't minimize the loss rather he acknowledged the fear and sadness that I felt. He helped me to feel that I didn't need the breast. After the second surgery I told him the results showed I would need a mastectomy. He told me that he was willing to see me throughout my cancer treatment and that other cancer patients who came to him usually did very well with their treatment.

I had also heard this quite independently from a physiotherapist who was recommended by the hospital. She said that women who had the esoteric acupuncture treatment along with the same medical treatment that I had and would be having, did "remarkably better" than those who didn't have this particular complementary treatment.

She had seen a lot of breast cancer patients and had great respect for Serge and his work. She had attended some of his lectures.

Going into the third surgery, the mastectomy, I was almost calm, certainly accepting and even grateful, since my surgeon had told me that provided I had the recommended treatment, I had a very good chance of surviving.

Beforehand I had some thorough cries over my breast. Since I emerged from the surgery, I never felt any further need to mourn it. My healing went well, and I was amused to have compliments from physios and nurses on my 'beautiful' scar.

I was given a month to recover from my surgery before I began chemotherapy. I was seeing Serge weekly for counselling and esoteric acupuncture and began to feel so well physically that I could take longer and more lively walks than I had been able to do for many months before my diagnosis. I had also ended a destructive relationship and felt so positive that I told Serge that maybe I wouldn't need chemotherapy. He said immediately that he would never advise that I not have the chemo. He simply encouraged me to keep looking at my life and my choices and feel for myself what was right. I cried over this because I definitely didn't want to have chemo and had misunderstood and thought he might back that choice. Again, he gave me support through counselling and acupuncture and taught me to "rest deeply" as I went into my chemo sessions, fully choosing to be there since I had decided that I would have it.

I have told my oncologist about the esoteric acupuncture sessions and how helpful I find them. He has told me several times that I have been doing very well and even said "keep up the acupuncture". As with the surgery, I found that I handled the chemo treatments well, having generally only fatigue and no vomiting or pain, and minimal side effects. I did make a choice after four months of chemo, to stop a little early from the second type because of side effects that suddenly got much stronger and could have been irreversible. I made this decision with my oncologist who said that I had had a lot of chemo and he didn't think that the slighter shorter treatment would affect my life expectancy. I told Serge about this decision after I had made it.

After the chemotherapy treatment, I was due to see a professor of radiotherapy. Yet again I hoped that I didn't need to have treatment but he said I did. I live alone and have not been well enough to manage without regular help. The radiotherapy treatment was nearly an hour's drive from my home, five days a week for five weeks.

I didn't know how I could get myself driven back and forth and how I would cope with that much travel even if I had a driver. Universal Medicine provided me with a beautiful and nurturing space in which to stay within a short distance of the hospital so that I was able to drive myself to the treatment even though I was still tired and became more so. This accommodation and much of my sessions with Serge have actually been free of charge. Again, my treatment went easily and the main nurse who treated me said "you obviously heal well".

At this stage, I am beginning to recover some energy after the radiotherapy but am still easily tired probably because of the herceptin infusions that I still have three weekly at the chemo ward. I am continuing to have weekly treatments at the UniMed clinic and always feel a profound sense of peace and rest at these times.

I have also had treatment from a physiotherapist at the UniMed clinic, who gave me simple exercises that immediately helped and within a couple of weeks completely relieved the cording that had developed in my left arm months after the lymph node removal. These gentle movements were somewhat different to those shown me by the other physiotherapist. The main distinction in her method was that it depended on beginning with and developing a deep connection with the body, not just mechanical movements while the mind might be elsewhere.

I hope it is obvious that Serge works very well with conventional medicine and is not at all opposed to it. In fact, he has often said that we have never had better medical treatment and he has particular praise for surgeons.

I believe that his work is truly a complement to the conventional methods and when the two are combined, the patient is very fortunate indeed.

One of the most significant things to understand about Serge and other practitioners at Universal Medicine is that they first take great care of themselves. They heed the old dictum: "Physician, heal thyself."

APPENDIX 4

When “Healing Hands” Start Grasping

By John Dwyer

Esoteric breast massage claims “to heal many issues such as painful periods, polycystic ovaries, endometriosis, bloating/water retention, and pre-menstrual and menopausal symptoms”.

Much adverse publicity has descended recently on a “New Age” healing service based in Lismore, NSW, called Universal Medicine. Serge Benhayon, a one-time tennis coach with no health care qualifications, leads the organisation.

Perhaps the most sensational therapeutic modality on offer is referred to as “esoteric breast massage”. Even though Benhayon’s claims about esoteric breast massage have been examined by the Therapeutic Goods Administration (TGA), the Health Care Complaints Commission (NSW) and the Australian Medical Registration Board, Universal Medicine is continuing its unacceptable practices unfettered by any sanctions from regulatory bodies.

What is on offer? Let’s look at a description of the benefits of esoteric breast massage from Benhayon’s website (www.esoteric-breast-massage.com).

The Esoteric Breast Massage assists to heal many issues such as painful periods, polycystic ovaries, endometriosis, bloating/water retention, and pre-menstrual and menopausal symptoms.

A woman benefits from a series of EBMs to help clear the imposed ills that come from herself and from those who impose on her. How many EBMs are beneficial will depend on how much is in the breasts to be cleared. We recommend at least 10 to 12 to start with, but you may feel it is right to have more. It is, after all, a choice to bring the whole of you back to yourself. At the end of the first series of EBMs, we recommend having them every 2 to 3 months to maintain clear breasts or whenever a woman feels impulsed [sic] to clear more from her breasts as it has been clearly shown that there are many layers to get to and eventually clear.

It continues:

... an EBM cream ... has been esoterically designed by Serge Benhayon, the founder of this healing process that is available for women to purchase from their EBM practitioner after their fourth massage... It is a self-nurturing gesture to apply this unique cream to your own breasts as the EBM cream has been specifically designed to lovingly support this self-nurturing process.

As if those ludicrous claims were not enough...

Period pain comes from the lack of stillness and self-nurturing and the ill-quality of spleen energy. The EBM thus plays a vital role in the process of healing this widespread ill condition in women.

On and on it goes. When the TGA was informed that numerous herbal preparations and ”EBM cream” were being sold but had not been “listed” with the TGA, it sprang into action, ordering Universal Medicine to list their products and remove therapeutic claims from their promotion of the products. This Universal Medicine did, and the TGA patted them on the back for complying. Proof of efficacy was never mentioned! Esoteric Breast Cream is still available from that website.

One former patient became alarmed when Benhayon told her he was having a “psychic consultation with her ovaries”. She complained about Universal Medicine to the NSW Health Care Complaints Commission – an organisation charged with overseeing a code of practice for unregistered health practitioners – but was told they could not act as they had not received a report of harm to any patient! This same patient noted with alarm that six local doctors – registered medical practitioners – were publically supporting the modalities used by Universal Medicine and actually referring patients to the service.

She then complained to both the Health Care Complaints Commission and the National Medical Registration Board, asking if it was not unacceptable for doctors to be giving credibility to this nonsense. She was told that individual doctors can express their personal opinions and, for the Board to act, patient harm as a consequence of their support would need to be documented. The doctors in question would not even receive a reprimand of any kind.

Adequate consumer protection from misleading and often fraudulent practices remains disappointingly inadequate, both at the state and national level. In Australia in 2013, vulnerable patients deserve much better than that.