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## A HISTORICAL PERSPECTIVE

# Cancer and quackery

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### Key words

history of medicine, oncology, complementary medicine.

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Received 25 January 2012; accepted 7 February 2012.

doi:10.1111/j.1445-5994.2012.02744.x

### Abstract

The *Internal Medicine Journal* published an article by two senior oncologists who were contesting the supposed miracle cure of a cancer survivor. This paper draws on the history of medicine to explore the conflict between biomedicine and alternative therapies. I suggest that the *Internal Medicine Journal* article, written about an episode that occurred more than 30 years ago, can best be explained by some oncologists' discomfort with losing their authority to dictate patient choices. I propose a compromise that rejects paternalism but accepts the possibility of worse patient outcomes.

In January 1975, a young Australian man underwent a full-leg amputation for osteogenic sarcoma. Tragically, he subsequently developed radiological and clinical changes in his bones and lungs that were diagnosed, without biopsy confirmation, as metastatic disease. When he failed to improve with conventional chemotherapy, the patient sought out other healing traditions, including meditation. In a curious twist, he was also diagnosed with tuberculosis and was given effective anti-tuberculous treatment in 1978. The patient's health improved dramatically, and this success was hailed as a triumph of meditation over a presumed death sentence from cancer.

The contours of this story are widely known – indeed, Dr Ian Gawler has been described as ‘Australia’s most

famous cancer survivor’. Gawler remains a controversial figure, advocating for the efficacy of ‘Mind-Body Medicine’, even for patients with advanced disease.<sup>1</sup>

Readers of the *Internal Medicine Journal* may be familiar with Gawler's story from an article by senior oncologists Ian Haines and Ray Lowenthal, from the Melbourne Oncology Group and the Royal Hobart Hospital respectively.<sup>2</sup> In a matter of days, the article was taken up by local news media and published on the front page of *The Age* newspaper.<sup>3</sup>

The thrust of Haines and Lowenthal's argument was that Gawler's diagnosis of metastatic sarcoma was, in fact, unrecognised disseminated tuberculosis. Drawing upon published literature about Gawler's case, the authors highlighted the absence of a firm diagnosis of metastatic disease in 1976 (no biopsies were taken), the failure of chemotherapy to improve the presumed metastases and Gawler's rapid clinical improvement following successful treatment of his tuberculosis in 1978. Put simply, the

Funding: None.

Conflict of interest: None.

critical intervention was anti-tuberculosis therapy, not meditation.

But why did the authors feel compelled to write this article?

Their stated aim is to highlight the need for biopsy confirmation of presumed metastatic cancer; but this is now common practice. Instead, the article can best be understood as a manifestation of persistent paternalism, and nagging discomfort, within the medical profession vis-à-vis non-biomedical healing. These attitudes are most evident in *The Age* interview. Haines' response, in particular, is worth quoting at length:

Professor Haines said he was 'distressed' at seeing terminal cancer patients who had chosen alternative therapies over conventional medicine after diagnosis. 'I've seen beautiful young girls with their whole lives ahead of them and they go into these holistic therapies and spend hundreds of thousands of dollars and then in the end we have to look after them. They all eventually get to us,' he said.<sup>3</sup>

As clinicians, we often share stories about the distress and frustration they feel when patients decline treatments or consult non-biomedical therapists. For example, some obstetricians object to lay midwifery because it is the obstetricians who are called when a home birth does not go according to plan. However, there is a selection bias embedded in this experience – obstetricians are not exposed to the cases of successful home births overseen by lay midwives. Despite Haines' claim that 'they all eventually get to us,' some patients who are satisfied with complementary medicine may not return to their oncologist.

Some physicians will disagree with Haines and Lowenthal's reading of the evidence. Their methodology largely rests on arguing that Gawler's symptoms and disease course can be better explained by a diagnosis of tuberculosis, rather than sarcoma. Demonstrating that one diagnosis is more typical than another, however, does not provide conclusive evidence, particularly for such an unusual clinical presentation. Moreover, such evidence would only indirectly invalidate Gawler's claims of therapeutic efficacy.

The larger issue is Haines and Lowenthal's discomfort with challenges to biomedical authority. They believe that Gawler's approach has no benefit, and that oncology is always in the best interests of the patient. In the authors' view, 'complementary' therapies are fine, as long as they remain only that – supplementary to conventional medicine.

But even within medical circles, the jury is still out on the value of therapies not currently embraced by the mainstream. Conventional medical trials have

begun to demonstrate the possible advantages of non-pharmacological palliative and holistic care, similar to the strategies used by Gawler.<sup>4</sup> In addition, Gawler has been careful to state that his therapies can be used alongside conventional medicine.<sup>1</sup>

Many alternative practitioners do not wait for the imprimatur of biomedical science. Some have pointed out that their therapies are not suited for evaluation in double-blind, randomised, controlled trials. Although some physicians dismiss this as snake-oil salesmanship, proponents argue that they prescribe complex regimens based on multiple patient factors: the absence of a single 'intervention' makes it hard to structure a study that compares active treatment to placebo.<sup>5</sup>

Finally, the history of medicine reminds us that values like 'benefit' and 'best interests' are not neutral: to use only one example, many surgeons were sceptical about early anaesthesia, in part because patients' response to pain was thought to improve surgical outcomes.<sup>6</sup> The potential for disagreement over values is only compounded by genuine limits in our understanding of disease, therapeutics and the human body.

Given this margin of uncertainty, the patient, and not the physician, should bear the principal responsibility for deciding between therapies. If patients have the right to refuse medical treatment, they also have the right to select alternative therapies.

Whether or not Gawler was able to cure his own illness, he has a large number of satisfied clients. Even those who make no claims to be cured of terminal illness can still report benefits, either from psychosocial adjustment, improved quality of life, slowed disease progression or the sense of empowerment derived from actively tending to their own health.

I concede that this is treacherous ground. When people are sick, they may weigh costs and benefits differently. Many physicians feel uncomfortable with the idea of private entrepreneurs making money from such 'vulnerable patients,' even if they often do not balk at the doctors' fees.

But how vulnerable are our patients? In practice, few people make serious health-related decisions in isolation – they are supported by family, friends and professionals, who help them to choose between therapeutic options. Indeed, many physicians see this as their key role in the doctor-patient relationship. It may be that the snake-oil bogeyman is less of a threat than we fear.

In my view, we are faced with two options. We can place our emphasis on protecting vulnerable patients from exploitation – advocating some degree of paternalism and asserting the superiority of biomedicine – a 'doctor knows best' approach. Or we can remain agnostic about the limits of knowledge – biomedical and otherwise – and place

greater faith in the capacity of our fellow citizens to choose for themselves. My preference for the latter approach should be clear. In this context, Haines and Lowenthal's mission to debunk Gawler's cure runs the risk of sounding like a paternalistic attack on a therapeutic competitor.

## Acknowledgement

The earlier article is all my own work, and I have no conflicts of interest to declare.

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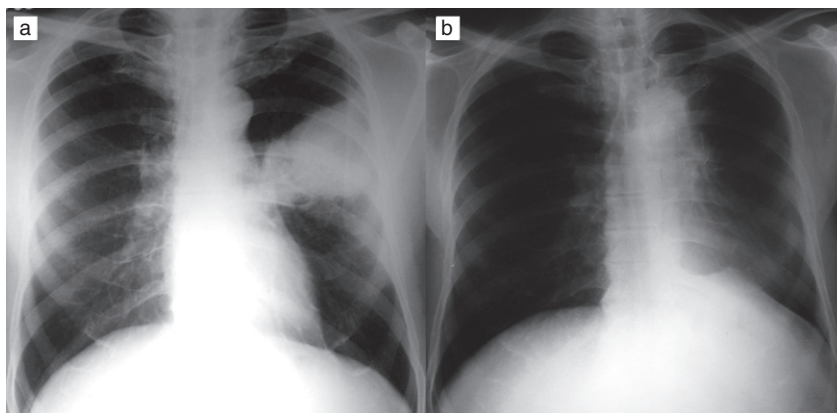
## IMAGES IN MEDICINE

### Unusual lung mass

A 63-year-old man presented with intermittent fever and cough of 3 months' duration associated with weight loss. He smoked about 12 cigarettes per day but denied any history of alcohol or drug abuse. Chest radiograph revealed a mass lesion (Fig. 1). Computed tomography (Fig. 2) confirmed the presence of a peripherally situated mass in the left upper lobe ( $8 \times 6$  cm) abutting the chest wall with no evidence of chest wall or mediastinal invasion. HIV-enzyme-linked immunosorbent assay was non-reactive, and CD4 counts were normal. Bronchoalveolar lavage fluid was negative for acid-fast bacilli, fungi and malignant cells. Ultrasound-guided Trucut biopsy revealed intracellular and extracellular yeast forms of

*Cryptococcus spp.* (Fig. 3). Culture of the biopsy specimen confirmed *Cryptococcus neoformans*. Serum cryptococcus latex agglutination was positive. The patient was treated with amphotericin B desoxycholate (900 mg). He remained febrile without weight gain or radiologic resolution at 4 weeks. Left upper lobectomy (Fig. 2b) was done, and he was continued on oral fluconazole for 6 months. He has remained asymptomatic, gained 4 kg and has no evidence of local or systemic recurrence.

Pulmonary cryptococcosis has three distinct forms: air-space collection without inflammation; granulomatous infection with infiltrating masses and airway colonisation.<sup>1</sup> Pseudotumoral presentation of pulmonary



**Figure 1** Composite figure of chest radiograph showing a large mass in the left mid-zone extending from the hilum and abutting the chest wall (a). No cavitation, pleural effusion or rib erosion was seen. Post-operative chest radiograph (b) shows volume loss on the left side. No evidence of any residual mass is seen.