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Submission: Australian Federal COVID-19 Response Inquiry

AUSTRALIA'S COVID-19 RESPONSE: REFLECTIONS ON WESTERN MEDICINE AND EPISTEMOLOGICAL IMPERIALISM

The long history of conquest by nation states has been driven, not merely by lust for power, but also by beliefs and practices thought to be superior than those of their victims. In the High Middle Ages, the Christian Crusades, which were aimed primarily at rescuing the Holy Land from Islamic rule, were driven by religious zeal, and the three Spanish armadas sent to invade Britain were fired by Philip II's devout determination to rid Europe of Protestants, whom he thought of as vermin. Today, in Australia, one still hears, casually at the dinner table: "And, think of this! Where would they [the Australian aborigines] be now, if we had not invaded and colonised them?"[1], raised as if the answer is obvious and justifies the atrocities of colonisation.[2]

We are witness, today, an attempt at conquest of the world, driven by what I shall call epistemological imperialism. This consists in the belief that Western medicine has superior scientific ways of attaining medical truth. The principal instrument of that belief is that of the controlled trial in whatever form, from the simplest use of a singularity as its own control to the most complex of double-blind crossover trials. Its use of such trials is widely proclaimed as the "gold standard" of Western medicine.

Whether by force or persuasion, appeal to this "standard" is used today to justify the imposition of medical procedures against the will of recipients, frequently making offers that are difficult to refuse.[3] One might think that a recent example is the exaggerated response to the recognition of "*Covid*". Yet, it seems that our medical juggernaut, having established its credentials *via* its "gold standard", is happy, when the chips are down, to abandon its standard and act out of a sense of its own superior understanding. Let us examine, in note form, the question whether the so-called "gold standard" can sustain the responsibility accorded to it.

A. **The concept of the *placebo* is part of the litany associated with the "gold standard."** The word is Latin for "I please." It came into use in the nineteenth century in order to deal with patients who insisted upon being given pills when the doctor either believed that the patient's symptoms were hysterical, or imaginary or that there was nothing effective that could be prescribed to alleviate them. To satisfy such patients the practitioner might prescribe pills of sugar of milk in without medical purpose, but in order to please. If such patients felt better on taking the pills, it was assumed that this was a product of belief rather than any potency in sugar of milk.[4]

B. **In its subsequent history, the concept of *placebo* has undergone various stages of evolution.** As just described, the connection *placebo* and belief is clear. This connection becomes less so. With the advent of controlled trials. In such a trial, subjects are not chosen because of an expressed belief in the desirability, or power of the remedy being tested. Such trials are statistical in structure. A suitably large sample for participants is chosen, then divided randomly into two groups: one of which is genuinely given the remedy: the other is given what is believed to be a medically inert *placebo*. This is no longer being given to someone who believes in the necessity of the remedy. In fact, the goal is to deceive the control into believing that they have received the remedy being trialled, when they have not.

C. **It is at this point that medicine needed to abandon any pretense,** either at being scientific, or developing a strategy for management of difficult patients. For no study has been ever made of the belief profile of participants in controlled trials. It has just been quietly assumed that, if the control group showed an improvement in some way comparable with that of the test group, it was a measure of their belief in, or positive mental attitude towards the medical procedure. By way of contrast, am one who was born into a culture which held a healthy skepticism towards medicine and, especially in anything designated as a trial. Our attitude would have been to wait and see, not belief. In those days, it is to be noted, the doctors were referred to as quacks: now it is the naturopaths and homoeopaths who're portrayed in that way. Moreover, no attempt has ever been made to distinguish nuances of attitude such as the difference between belief in efficacy ion a proposed remedy and desire for relief.

D. **The role of *placebo* now is even more difficult to comprehend.** There are two reasons: (1) The use of *placebos* is now so widely known, at least in literate communities, that a significant number of participants can be expected to know in advance that they may not be receiving the trial substance. Such participants could not be said to have any belief at all in the substance they are taking. Again, you would expect the attitude to be: wait and see. A particular question that would be expected is: "Is what I am receiving doing something, or not?"; (2) In some jurisdictions it has become unethical to deceive patients: they are required to be informed of the use of *placebos* in any trial that uses them.

In spite of these anomalies, the old litany of *placebos* continues. In a recent trial in Great Britain, half were injected with a vaccine and the other half with something seen as neutral, perhaps just water or a saline solution. However, for the reasons mentioned, all had to be informed that they may, or may not, be receiving the vaccine. By this stage, the procedure has gone mad. The mantra continues: yet, since belief cannot be assumed (in fact, the more reasonable assumption is a state of not knowing, rather than belief) why not just administer the vaccine and compare the results with an unvaccinated population. That, of course, is being done by others as well, but the purpose is here to exhibit absurdities of the use of *placebos*.

· Always in the mouth of one of the colonisers.
· Note the inclusion of the word "colon" in "colonisation".
· By requiring workers, for example, to submit to vaccination or lose their jobs.
· It is, perhaps, amusing that sugar-of milk was regarded as medically neutral, when it was, and is well-known that giving sweets can calm a cantankerous child.

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E. **To advance our evaluation of the controlled trial** we need the notion of what I will call an epistemological trigger: this can be an observation, or an intuition. Very often both are involved, and not easily distinguished.

INTUITION: To be as successful as a species, we must have highly developed intuitions as to what is good for us, and what not. Such an intuition may lead a cat, for example, to eat grass when it is feeling ill. It does not need a double-blind, randomised, controlled trial to find the connection: sensibility and intuition find it.

OBSERVATION: Similarly, for powers of observation. I may observe that whenever I approach a particular plant my nose begins to itch: I may, even, sneeze. This is what David Hume would have called a constant conjunction. I therefore surmise that something about proximity to the plant causes my sneeze.

Consider now the question what is it that prompts the application for funding to set up a trial? It would be sheer madness to choose any two randomly selected elements for study. There are too many possibilities. The choice must be guided by intuition or by observation, or both. Now intuition and observation are in the realm of what is called by the medical establishment "anecdotal evidence." No researcher, in their right mind, would seek support to study connections for which there was no anecdotal evidence.

Anecdotal evidence is, thus, the life-blood of medical research, yet it is summarily, and frequently, dismissed as "merely anecdotal', as though it is of an epistemological status inferior to that of the controlled trial. Let us examine this: (1) A trial does not advance medical understanding at all. At best, when the trial group scores better than *placebo,* it guides a government as to what the benefits might be of applying the remedy to a population larger than that present in the trigger. (2) A negative result in a trial does not show that the original attribution of causality in the trigger was false. (3) In constructing a gold standard trial, there is problem in symptomatic matching of samples. In fact, insistence on a method that requires matching samples seriously limits the kinds of study that can be conducted. Consider, for example, the following trigger[5].

The subject has suffered twenty years of pain with chronic *lumbago*[6]. He was taking five pain relief tablets[7] daily, but complained regularly that the failed to do much good. A friend had recently acquired a book on *shiatsu* pressure. He looked up the index, found "*lumbago"* then spent twenty minutes applying pressure to the recommended points. The pain disappeared immediately, an improvement lasting many years.

It is reasonable to suppose that the pressure was responsible. But now suppose that we wished to apply the "gold standard" of research to the use of pressure for *lumbago.* It is immediately obvious that matching samples, both for practitioners and patients would be almost impossible. Initial conditions in the patients, even with closely similar symptoms, would be expected to vary considerably and practitioners could not be constrained always to use the same pressure and in the same way, either as each other, or in the same way by the same practitioner at different times. No population sufficiently large to yield a statistically significant result could be satisfactorily matched.

It is now clear that the insistence on controlled trials across a large population favours only those medical practices that can be satisfactorily standardised. It favours especially the testing of pills, which can be assumed closely to resemble one another, and the devices of double-blind crossover used to minimise the effect of *placebo.*[8]

F. **There is a classical proof that, from a contradiction, one can prove the truth of any proposition whatsoever**, for example, that the Moon is made of green cheese, or that iron melts at -10 degrees Centigrade. Hypocrisy is a form of contradiction: it is living by words that do not match actions. Hypocrites are to be feared because they can justify any action whatsoever by the contradiction in which they live. The practice of medicine lives under such contradictions, as is illustrated by the immediate abandonment of its "gold standard" in the face of Covid. The consequences are to be feared. The double standards of medicine make discussion of the issue difficult and itself full of apparent contradiction, for I wish to show that proclamation of the "gold standard" both overstates and understates its significance. As we have noted, the standard is used to exalt the significance of controlled trials beyond their station, and to denigrate anecdotes as an inferior form of a lower station. The truth is otherwise. The anecdote has exactly the same logical structure as that of the larger scale trial. Both are premised upon John Stuart Mill's method of difference: observe the consequences that a difference makes.

Earlier in this paper I referred to singularities in controlled trials. What I call a singularity is a trial in which a subject is used as its own control. In realms other than medicine, physics, for example, or bio-psychology this method is accepted freely without question. I have participated in experiments of both kinds, one in the physics department of Birkbeck College in the University of London and the other in the psychology department at La Trobe University. I elaborate the Birkbeck experiment. It was conducted by [redacted] and a team of other physicists. It could be described as an experiment in sub-molecular psycho-kinesis. A transistor diode was hooked up to a cathode ray tube which was being used to scan the diode's resistance characteristics over an interval of fifty milli-amperes, displaying these on its screen. I sat a distance of two or three metres away from the transistor and was asked to focus my attention upon it. Then I was instructed to imagine that I entered it mentally to set about changing germanium and silicon atoms, the one into the other. I did so imagine for fifteen minutes: it was quite fun, partly because of the bizarreness of the situation. At the end of that time an uproar of excitement arose amongst the research team. They were hoping for a new graph that would cross over the original graph, thereby showing a change in resistance characteristics. The new graph crossed over in six places. The graph had been monitored without observable change

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· From an actual case.
· An old term for lumbar back pain, now not much in use.
· *Induced.*
· For this part of the discussion I am setting aside reservations about *placebo*.

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for five or six hour before exposure to my gaze. There had been radical changes of a magnitude not easily attributed to chance. A difference had been introduced, and these were the observed consequences.

This experiment is a perfect example of two things: (1) of what a genuine attempt to investigate the relationship between belief and physical well-being would look like and (2) of just how far such an investigation stands outside of 'normal' scientific paradigms and prejudices. Hasted, himself, fell from scientific grace and suffered opprobrium because of such experiments: I have run the risk of losing credibility with many readers simply by recounting one of them and asking for it to be considered seriously.[9]

G. **Healing anecdotes are typically singularities as I have defined them**, the subject of the anecdote using himself as his control. We have already looked at a case where, after twenty-five years of pain, a sufferer receives *shiatsu* pressure and finds relief from pain. What is not commonly recognised by control idealists is that singularity is itself part of the most elaborate double-blind cross-over trials. The crossover enables participants to act as their own control, in addition to having a designated control group of others who receive *placebos*.

Let us sum up by looking at the issue of the prohibitions on the use of Ivermectin in the recent Covid crisis. This can be seen as an extreme case of the gradual transformation of the wise family doctor into a petty bureaucrat, spending more time at the computer screen during a consultation than attending to the client, studying the protocols in fear of being chastised for not following procedures which are being steadily more and more narrowly prescribed. The doctor has become the slave of the "gold standard". He, or she, has fewer and fewer options for exercising discretionary intuition: the anecdotal roots of medicine in observation and intuition have been cut off. The doctor is no longer free to be nourished by them, and may be required to act against them. One of my best medical experiences was, some twenty years ago when, facing by-pass surgery, I asked the cardiologist what were my chances. He looked at me warmly and replied to the effect: "You don't want to know your chances: you want to know whether you will survive and do well. I think that you will." We need to re-humanise medicine, respect the anecdotes and abandon an essentially gambling approach to medicine. My cardiologist could easily have said: "Studies have shown that 76.5% of patients in roughly your condition survive and do well. That is your chance." But he did not. I am so grateful.

THE AUTHOR.

I have written this in response to a request for submissions concerning the management of the recent Covid crisis. It is perhaps to the point to show some of my credentials. I am a philosopher who spent twenty-eight years teaching philosophy at La Trobe University. I am a trained acupuncturist and have been adopted as an Elder and Medicine man by the Wirradjuri people in New South Wales under the skin-name Bippi, which means "spirit" or "aura." I taught many different philosophical subjects in that time, including a number associated with philosophy of science, some of which were innovations. The most striking of these was my subject: *Epistemology and Medical Methodology*. In that subject I became the first to introduce Chinese medicine into an Australian University. This paved the way for friends and colleagues to get the School of Chinese Medicine established at RMIT University. It is to my great sorrow that RMIT has decided to close that Department. I am not privy to their reasons, but it would surprise me if they did not include that Chinese Medicine cannot be regarded as 'properly' scientific, because it does not satisfy the "gold standard." That is why I have devoted so much attention in this paper to puncturing the inflated image that standard cuts. It has been visible that there is a move amongst the Medical Fraternity in Adelaide to discredit Chinese Medicine on those grounds. RMIT is likely to have similar motives.

All knowledge is grounded in intuition, even the recognition of the "gold standard" as the ideal form of True Medical Knowledge is an intuitive recognition. The irony is that, whilst this standard is used to discredit anecdotes and medical systems in other cultures and alternative therapies in our own culture, the Method of Difference (that is: the "gold standard" under another name) is common to all, to find what makes a difference and put that to work. The worship of false idols (the specialised, randomised controlled trial) serves only to limit both the range of options available for investigation and the way in which those options can be exploited. The logic of the method of difference is available to everyone: it is put to regular use in everyday life. It is not the exclusive property of experts, or of just one culture. It is as much in use by the aboriginal carving a boomerang as it is by a researcher in the most erudite medical institution. To forbid the use of Ivermectin to treat Covid is to deprive individuals of the right to follow intuition, see where it leads find its fruits. And, what if, after all, part of the reason why a treatment works should be an attitude of belief? Would that be a reason not to use it?

CODA:

There is at least one very good *a priori* reason for thinking that there may be something in Chinese Medicine in spite of its not having evolved under the gold standard. Traditionally, the Chinese doctor's job was to keep the patient well and to treat them when well. It was generally believed, for example, that once the patient was ill, it was too late for acupuncture. Acupuncture would be administered four times a year at the changes of season to help adjust harmoniously to those changes, not because of illness. This is highlighted by the role of the Emperor's physician, whose job was to keep the Emperor well. Should he fail, and the Emperor fall ill, the physician would be executed. With such a threat behind it, is it not likely that a method would evolve which would work effectively at preventing illness? The contrast with the fundamental principles of Western Medicine could not be more stark. Chinese medicine is aimed at sustaining harmony between body, mind, spirit and nature. Western Medicine is aimed at putting the right molecule in the right place at the right time. Many times, over the years, I have asked Western doctors how much of their practice is aimed at building immunity, how to stay well. The question usually puzzles: I have never found a ready answer.

Appreciatively, Melvyn Cann

[9] There is much more of this story to be told, and many questions to be answered, but not here: they stand too far outside the purposes of this submission.