

Editorial

Ten Questions For Doctors: A UK Cancer Patient's Quest For Ascorbic Acid Therapy

"A new kind of scientific review is needed to evaluate the potential of anti-cancer modalities to work together systematically with geneticists and nutritionists working in tandem."

–Terri Mitchell

New Promise for Cancer Prevention and Treatment, *Life Extension*, Jan. 2004

These questions arise out of my experience of my local UK National Health Service (NHS) refusing to allow moderate-cost intravenous ascorbic acid infusions, which could be carried out in my local surgery, on the grounds that this treatment has not undergone a proper scientific trial. Ascorbic acid, about which some 48,000 medical papers have been written, is one of the most used, most safe and most advocated of substances. I challenge orthodox NHS oncologists to show how the testing of substances by double-blind placebo-controlled trials is almost exclusively the way to medical excellence, and to answer the following questions.

1. Do you believe that there is only one valid medical tradition for health improvement: the one which currently permeates the National Health Service?

2. Was orthodox health care ineffective before double-blind placebo-controlled studies became common? Richard Horton, editor of *The Lancet* (August 2006) made a complementary point, in connection with the treatment of HIV/AIDS: "Why does our definition of science still seem to include only the laboratory experiment and the clinical trial?"

3. With regard to drug safety, how do you account for the tens of thousands, perhaps hundreds of thousands, of iatrogenic deaths and harms that occur in the UK, many of them relating to drugs, while as far as I can establish no one anywhere has ever died from a high oral or intravenous

dose of vitamin C? We all have friends and relations who rely on and are grateful for medicines with high risk factors attached to them. Warfarin is a commonly dispensed orthodox substance that is also used to kill rats and, if it is not carefully monitored, can cause bald patches, purple toes, hepatic dysfunction, nausea, vomiting, hemorrhaging, jaundice and diarrhoea. Oral vitamin C takers risk only diarrhea. Kidney stones, as a much touted side-effect of megadose vitamin C, can be regarded only as a scare story used by people who have not read the literature. Hickey and Roberts (2004) write that the margin of safety for high-dose vitamin C is much greater than for aspirin, antihistamines, antibiotics, all pain medications, muscle relaxants, tranquilizers, sedatives and diuretics.

4. My experience of the insistence by doctors on random control trials (RCTs) suggests that this requirement laid down by the NHS has become routine, almost a dogma, in the NHS. Do you think that this should always come before informed patient choice, especially when cost is not the main factor? Also, is the practice of running RCTs on seriously ill patients ethical?

5. How would you justify the almost total ignoring by orthodoxy of the major successes with ascorbic acid, and the prosecution of good doctors who treat with ascorbic acid? Drs. Klenner, Pauling, Cameron, Stone, Levine, Levy, Cathcart and others must feature importantly and positively in twenty-first century medical practice. Their good science resulted in the saving of life and correction of the lamentable distortion of the early expectations for, and results of, vitamin C. This is the time to press home the reiterated refrain of its advocates, "dosage, dosage, dosage", in order to attain sufficiently high blood plasma levels for it to be effective. Hickey and Roberts (2004) cite the consistently positive clinical results that Dr Robert F. Cathcart III has had over two decades with thousands of patients with "massive" vita-

min C doses, ranging from 15 to over 200 grams up to the bowel tolerance limit and administered in up to 20-25 doses a day.

6. Random control trials frequently do not take into account the interactions of patients' other drugs and substances. Is it not true that when a patient is taking a second drug the trial becomes unscientific? The massive onslaught on the human body of both widely dispersed and localized industrial pollution of water and air, workplace stress, and multiple new sources of radiation? How can medical epidemiology, valuable as it is, deal scientifically with such complexities?

7. If the practice of orthodox western medicine is an unfolding and dynamic one, how does this observation square with the static dogma of random control trials as presently constituted? Hickey and Roberts write, "To object that a study is not double-blind and that treatment should be delayed for several years until such tests had been performed would be ridiculous." When a new treatment has a high safety margin and low cost, it could be made available to patients even before the results of follow-up studies were known, without medical, scientific or ethical objections. The development of penicillin proceeded in just this way.

8. What ethical stand does a doctor take with regard to the "need" for high profit levels in the pharmaceutical industry, and all the injustices that spring from this? One wonders why there is such readiness to accept expensive and frequently ever more unsafe drug treatments. Fortunately I have had orthodox NHS doctors confessing to me that they had no solution to my problem and encouraging me to seek one elsewhere. Indeed, in my own case, an NHS Nurse Practitioner is able to carry out this work only 300 yards from my house, as a cost of only a few hundred pounds depending on the protocol adopted. A typical course of cancer chemotherapy costs between £4,000 and £5,000. There is little or nothing to lose

in allowing a treatment, which is having widespread success, as a second line of defence to orthodox treatment, which is eventually liable, even likely, to fail. It would seem sensible to combine the apparent but limited success of a hormone therapy such as Zoladex (my own present treatment) with intravenous ascorbic acid megadosing. This is what I am seeking for myself.

9. How am I to proceed with my health care when few if any are prepared to read the new and optimistic unorthodox work, and many happy to dismiss and debunk it? I have been receiving high-quality orthodox medical attention from my local general practitioners for many years, as well as from hospital doctors, and I consider myself fortunate in the care that I receive. In my recent serious medical condition, however, I have discovered a resolute inability on the part of doctors who treat me to have a proper awareness of the achievements of other doctors and scientists who work outside the NHS. Perhaps this is due to high work loads or burn-out. I recognize that many doctors, especially in inner urban practices, have an impossibly large health care task. Yet even my hospital has written to say that it cannot find the time to read the clinical documents that I sent through the post. My general practitioner investigates some studies of mutual interest, but there is of course a limit to this. He has written to me that I would be "hard pushed to get any sensible doctor to prescribe" the treatment that I legitimately seek.

10. On what basis do doctors still insist on toxicity testing for vitamin C? Practitioner and researcher Dr Brian A. Richards states: "There is no need for toxicity testing: ascorbate is one of the least toxic substances known. Similarly, double-blind testing (DBT) is not required. We are assessing a gross effect, using large doses. DBT is not required any more than it was, at the time, to test say either anesthesia or surgical asepsis. The dramatic responses require no such subtleties of assessment."

Why We Are Still Waiting?

Figures released from the Department of Health, and a King's Fund report, Future Trends and Challenges for Cancer Services, show that one in three will soon be contracting cancer and one in four dying from it. "Thousands of new treatments are in development but many are high-cost and currently of marginal benefit...We need a public debate with informed media coverage," says the report. There might be a case for making decisions "at a local level, with public involvement in policy-making and developing local criteria for clinical eligibility." Don't we have in the case of ascorbic acid just the kind of treatment, alone or with other substances, and moderate cost at that, which this report might be calling for?

Ascorbic acid is a crucial biological substance in the human body: we all once made it. Almost all other animals make it but a genetic fault somewhere down our ancestry caused us to stop doing so. If a great scientist like Pauling thinks vitamin C is thus the most important substance in the medical world, cannot we "give it a go"?

It is rare to see a local NHS medical centre with a good small library that would encourage self-help and patient co-learning from, for example, the texts mentioned here. My own surgery cannot find space for a small shelf of important self-help medical books, even though there is a table packed with used books on sale for charity. Complementary and NHS practices are described by Dr Rosy Daniel in her excellent and wide-ranging book *The Cancer Directory* (2005). Dr Daniel was an early medical director of the Bristol Cancer Help Centre. My own health centre appears reluctant to make available such an inspiring book.

In referring to the known success of vitamin C with many chronic and currently "incurable" diseases, Hickey and Roberts write: "We still await well-designed experiments to determine the biological proper-

ties of the vitamin. Several researchers have suggested to us that the reasons for this are that the questions are not particularly interesting, or are unlikely to produce positive results. To these, we would point out that it is unscientific to assume the results of experiments before they have been performed. Others suggest that commercial, institutional and financial forces actively prevent such research, at the expense of a sick population. Some critics have gone as far as to describe the actions of these influences as genocide." Strong words, but hardly stronger than the vehemence and ease with which many doctors dismiss the substance under discussion.

References Which Should Be Required Reading For Doctors

Steven Hickey and Hilary Roberts. *Ascorbate: the Science of Vitamin C*, Lulu Press, 2004.

Thomas E. Levy. *Vitamin C, Infectious Diseases and Toxins: Curing the Incurable*. Xlibris, 2002.

Rosy Daniel. *The Cancer Directory*. Harper Thorsons, 2005.

Padayatty et al. Intravenously administered vitamin C as cancer therapy: three cases. *Canadian Medical Association Journal*, 2006. 174(7), March 28, p 937-942. <http://www.cmaj.ca/cgi/reprint/174/7/937>

Dedication

To Stanley Switala, PhD, TCM practitioner and osteopath of the Kangda Clinic, Bradford, UK, for his kindness, his generosity of spirit and his wide-ranging medical intelligence.

–Graham Carey

(Edited by Andrew Saul)