The Hoax Of The "Proven" Cancer Cures

Chapter 10 from World Without Cancer by Edward Griffin

The effects of surgery and radiation in the treatment of cancer; a comparison showing that those who receive no treatment at all live just as long, if not longer, than those who are treated.

The advocates of Laetrile therapy have always emphasized that there is no cure, as such, for cancer. Since it is essentially a deficiency disease, one can only speak of prevention or control but not cure. Among the advocates of orthodox therapies, however, there is no such restraint. Official spokesmen for the cancer industry tell the American public, without batting an eyelash, that they have proven cures for cancer, and that anyone who resorts to such nostrums as Laetrile is merely wasting valuable time in which he would be far better off availing himself of these proven cures. What are these cures? They are surgery, radiation, and drugs. The following report carried in a Los Angeles paper is typical:

Warnings of a mounting scale of cancer quackery activity affecting the San Fernando Valley were issued today by the American Cancer Society.

Mrs. Stanley Grushesky, Education Chairman of the Society's Valley area, said she is concerned over the possibility that some local residents have been deceived in recent weeks by propaganda issued on behalf of unorthodox practitioners with claims of unproven cancer cures.

She declared that "under the banners of freedom of speech, with the slogan of freedom of choice, advocates of unorthodox cancer remedies have been making wild claims which could easily lure unsuspecting victims into a quackery mill."...

Mrs. Grushesky said that surgery and radiation are the only known methods for successfully treating cancer, although some beneficial effects have been obtained in certain cases through the administration of chemicals or hormones....

"Cancer quackery kills many unsuspecting patients because time wasted on phony devices and treatments delays effective treatment until it is too late to save the patient's life."1

Echoing the same theme, Dr. Ralph Weilerstein of the California Department of Public Health declared:

The use of Laetrile in early cancer cases to the exclusion of conventional treatment might well be dangerous since treatment with acceptable, modern curative methods-surgery or radiation-would thereby be delayed potentially until such time as metastases had occurred and the cancer, therefore, might no longer be curable.2

Public Library reference volumes on cancer often contain bookmarks distributed by the American Cancer Society. One of these depicts an ace of spades along with the slogan: THE UNPROVEN CANCER CURE. DON'T BET YOUR LIFE ON IT. On the back it says: "For more information on proven cancer cures, write or phone the American Cancer
Society." In response, the author sent a letter to the ACS headquarters expressing surprise at the assertion that there is any cancer therapy successful enough to warrant being called a proven cure. This is the reply received:

To Mr. G. Edward Griffin:

Thank you for your note. There are proven cures - if detected in time-surgery and/or radiation and, more and more, chemotherapy is playing its part.

This, then, is the position of orthodox medicine. Therefore, let us take a look at the results and benefits of the so-called cures obtained through surgery, radiation, and chemotherapy. Surgery is the least harmful of the three. In some cases, it can be a life-saving, stop-gap measure-particularly where intestinal blockages must be relieved to prevent immediate death from secondary complications. Surgery also has the psychological advantage of visibly removing the tumor. From that point of view, it offers the temporary comfort and hope. However, the degree to which surgery is useful is the same degree to which the tumor is not malignant. The greater the proportion of cancer cells in that tumor, the less likely it is that surgery will help. The most highly malignant tumors of all generally are considered inoperable.

A further complication of surgery is the fact that cutting into the tumor—even for a biopsy—does two things that aggravate the condition. First, it causes physical trauma to the area. This triggers off the healing process which, in turn, brings more trophoblast cells into being as a by-product of that process. (See Chapter IV.) The other effect is that, if not all the malignant tissue is removed, what remains tends to be encased in scar tissue from the surgery. Scar tissue tends to act as a barrier between the cancer cell and the rest of the body. Consequently, the cancer tends to become insulated from the action of the pancreatic enzymes which, as we have seen, are so essential in exposing trophoblast cells to the surveillant action of the white blood cells.

Perhaps the greatest indictment of all against surgery is the gnawing suspicion among even many of the world’s top surgeons that, statistically, there is no solid evidence that patients who submit to surgery have any greater life expectancy, on the average, than those who do not. This is an area which desperately needs intensive and unbiased study. The first statistical analysis of this question was compiled in 1844 by Dr. Leroy d’Etoilles and published by the French Academy of Science. It is, to date, the most extensive study of its kind ever released. Over a period of thirty years, case histories of 2,781 patients were submitted by 174 physicians. The average survival after surgery was only one year and five months—not much different than the average today.

Dr. Leroy d’Etoilles separated his statistics according to whether the patient submitted to surgery or caustics, or refused such treatment. His findings were electric:

The net value of surgery or caustics was in prolonging life two months for men and six months for women. But that was only in the first few years after the initial diagnosis.
After that period, those who had not accepted treatment had the greater survival potential by about fifty percent.\(^4\)

1844 was a long time ago, but more recent surveys have produced nearly the same results. For example, it long has been accepted practice for patients with breast cancer to have not only the tumor removed but the entire breast and the lymph nodes as well. The procedure sometimes included removal of the ovaries also on the theory that cancer is stimulated by their hormones. Finally, in 1961, a large-scale controlled test was begun, called the National Surgical Adjuvant Breast Project. After seven-and-a-half years of statistical analysis, the results were conclusive: There was no significant difference between the percentage of patients remaining alive who had received the smaller operation and those who had received the larger.\(^5\)

A similar study conducted between 1984 and 1990 at the University of California-Irvine College of Medicine produced the same conclusion: "All other factors being equal, there is no difference between BCS [breast-conserving surgery] and total mastectomy in either disease-free or overall survival."\(^6\)

One of the nation's top statisticians in the field of cancer is Hardin B. Jones, Ph.D., former professor of medical physics and physiology at the University of California at Berkeley. After years of analyzing clinical records, this is the report he delivered at a convention of the American Cancer Society:

In regard to surgery, no relationship between intensity of surgical treatment and duration of survival has been found in verified malignancies. On the contrary, simple excision of cancers has produced essentially the same survival as radical excision and dissection of the lymphatic drainage.\(^7\) That data, of course, related to surgery of the breast.

Turning his attention to surgery in general, Dr. Jones continued:

Although there is a dearth of untreated cases for statistical comparison with the treated, it is surprising that the death risks of the two groups remain so similar. In the comparisons it has been assumed that the treated and untreated cases are independent of each other. In fact, that assumption is incorrect. Initially, all cases are untreated. With the passage of time, some receive treatment, and the likelihood of treatment increases with the length of time since origin of the disease. Thus, those cases in which the neoplastic process progresses slowly [and thus automatically favors a long-term survival] are more likely to become "treated" cases. For the same reason, however, those individuals are likely to enjoy longer survival, whether treated or not. Life tables truly representative of untreated cancer patients must be adjusted for the fact that the inherently longer-lived cases are more likely to be transferred to the "treated" category than to remain in the "untreated until death."

*The apparent life expectancy of untreated cases of cancer after such adjustment in the table seems to be greater than that of the treated cases.* [Emphasis added]
What, then, *is* the statistical chance for long-term survival of five years or more after surgery? That, we are told, depends on the location of the cancer, how fast it is growing, and whether it has spread to a secondary point. For example, two of the most common forms of cancer requiring surgery are of the breast and the lung. With breast cancer, only sixteen percent will respond favorably to surgery or X-ray therapy. With lung cancer, the percentage of patients who will survive five years after surgery is somewhere between five and ten percent. And these are optimistic figures when compared to survival expectations for some other types of cancers such as testicular chorionepitheliomas. When we turn to cancers which have metastasized to secondary locations, the picture becomes virtually hopeless—surgery or no surgery. As one cancer specialist summarized it bluntly:

A patient who has clinically detectable distant metastases when first seen has virtually a hopeless prognosis, as do patients who were apparently free of distant metastases at that time but who subsequently return with distant metastases.

An objective appraisal, therefore, is that the statistical rate of long-term survival after surgery is, on the average *at best*, only ten or fifteen percent. And once the cancer has metastasized to a second location, surgery has almost no survival value. The reason is that, like the other therapies approved by orthodox medicine, surgery removes only the tumor. It does not remove the cause.

The rationale behind X-ray therapy is the same as with surgery. The objective is to remove the tumor, but to do so by burning it away rather than cutting it out. Here, also, it is primarily the non-cancer cell that is destroyed. The more malignant the tumor, the more resistant it is to radiotherapy. If this were not so, then X-ray therapy would have a high degree of success—which, of course, it does not.

If the average tumor is composed of both cancer and non-cancer cells, and if radiation is more destructive to non-cancer cells than to cancer cells, then it would be logical to expect the results to be a reduction of tumor size, but also an increase in the percentage of malignancy. This is, in fact, exactly what happens. Commenting on this mechanism, Dr. John Richardson explained it this way:

Radiation and/or radiomimetic poisons will reduce palpable, gross or measurable tumefaction. Often this reduction may amount to seventy-five percent or more of the mass of the growth. These agents have a selective effect—radiation and poisons. They selectively kill everything except the definitively neoplastic [cancer] cells.

For example, a benign uterine myoma will usually melt away under radiation like snow in the sun. If there be neoplastic cells in such tumor, these will remain. The size of the tumor may thus be decreased by ninety percent while the relative concentration of definitively neoplastic cells is thereby increased by ninety percent.

As all experienced clinicians know—or at least should know—after radiation or poisons have reduced the gross tumefaction of the lesion the patient's general well-being does not substantially improve. To the contrary, there is often an explosive or fulminating
increase in the biological malignancy of his lesion. This is marked by the appearance of diffuse metastasis and a rapid deterioration in general vitality followed shortly by death.\textsuperscript{10}

And so we see that X-ray therapy is cursed with the same drawbacks of surgery. But it has one more: It actually increases the likelihood that cancer will develop in other parts of the body!

Excessive exposure to radioactivity is an effective way to induce cancer. This was first demonstrated by observing the increased cancer incidence among the survivors of Hiroshima, but it has been corroborated by many independent studies since then. For example, a recent headline in a national-circulation newspaper tells us: FIND 'ALARMING' NUMBER OF CANCER CASES IN PEOPLE WHO HAD X-RAY THERAPY 20 YEARS AGO.\textsuperscript{11}

The *Textbook of Medical Surgical Nursing*, a standard reference for Registered Nurses, is most emphatic on this point. It says:

This is an area of public health concern because it may involve large numbers of people who may be exposed to low levels of radiation over a long period of time. The classic example is of the women employed in the early 1920's to paint watch and clock dials with luminizing (radium containing) paints. Years later, bone sarcomas resulted from the carcinogenic effect of the radium. Similarly, leukemia occurs more frequently in radiologists than other physicians. Another example is the Hiroshima survivors who have shown the effects of low levels of radiation....

Among the most serious of the late consequences of irradiation damage is the increased susceptibility to malignant metaplasia and the development of cancer at sites of earlier irradiation. Evidence cited in support of this relationship refers to the increased incidence of carcinoma of skin, bone, and lung after latent periods of 20 years and longer following irradiation of those sites. Further support has been adduced from the relatively high incidence of carcinoma of the thyroid 7 years and longer following low-dosage irradiation of the thymus in childhood, and from the increased incidence of leukemia following total body irradiation at any age.

In 1971, a research team at the University of Buffalo, under the direction of Dr. Robert W. Gibson, reported that less than a dozen routine medical X-rays to the same part of the body increases the\textsuperscript{12} risk of leukemia in males by at least sixty percent. Other scientists have become increasingly concerned about the growing American infatuation with X-rays and have urged a stop to the madness, even calling for an end to the mobile chest X-ray units for the detection of TB.\textsuperscript{13} And these "routine" X-rays are harmlessly mild compared to the intense radiation beamed into the bodies of cancer patients today.

X-rays induce cancer because of at least two factors. First, they do physical damage to the body which triggers the production of trophoblast cells as part of the healing process. Second, they weaken or destroy the production of white blood cells which, as we have seen, constitute the immunological defense mechanism, the body's front-line defense against cancer.
Now to the question of statistics. Again we find that, on the average, there is little or no solid evidence that radiation actually improves the patient's chances for survival. The National Surgical Adjuvant Breast Project, previously mentioned in connection with surgery, also conducted studies on the effect of irradiation, and here is a summary of their findings:

From the data available it would seem that the use of post-operative irradiation has provided no discernible advantage to patients so treated in terms of increasing the proportion who were free of disease for as long as five years. This is an embarrassingly difficult fact for a radiologist to face, for it means, quite literally, that there is little justification for his existence in the medical fraternity. If he were to admit publicly what he knows privately, a guy could talk himself right out of a job! Consequently, one does not expect to hear these facts being discussed by radiologists or those whose livelihood depends on the construction, sale, installation, use, or maintenance of the multi-million-dollar linear accelerators. It comes as a pleasant surprise, therefore, to hear these truths spoken frankly and openly by three well known radiologists sharing the same platform at the same medical convention. They were William Powers, M.D., Director of the Division of Radiation Therapy at the Washington University School of Medicine, Phillip Rubin, M.D., Chief of the Division of Radiotherapy at the University of Rochester Medical School, and Vera Peters, M.D., of the Princess Margaret Hospital in Toronto, Canada. Dr. Powers stated:

Although preoperative and postoperative radiation therapy have been used extensively and for decades, it is still not possible to prove unequivocal clinical benefit from this combined treatment. Even if the rate of cure does improve with a combination of radiation and therapy, it is necessary to establish the cost in increased morbidity which may occur in patients without favorable response to the additional therapy.

What Dr. Powers means when he speaks of "increased morbidity" is that radiation treatments make people ill. In a study at Oxford University dealing with breast cancer, it was found that many women who received radiation died of heart attacks because their hearts had been weakened by the treatment. Radiation also weakens the immune system which can lead to death from secondary causes such as pneumonia or other internal infections. Many patients whose death certificates state heart failure or pulmonary pneumonia or respiratory failure really die from cancer-or, to be more exact-from their cancer treatment. This is another reason that cancer statistics-based as they are on data from death certificates-conceal the truth about the failure of orthodox cancer therapy.

At the medical convention of radiologists previously mentioned, Dr. Phillip Rubin reviewed the cancer-survival statistics published in the Journal of the American Medical Association. Then he concluded:

The clinical evidence and statistical data in numerous reviews are cited to illustrate that no increase in survival has been achieved by the addition of irradiation.
To which Dr. Peters added:

In carcinoma of the breast, the mortality rate still parallels the incidence rate, thus proving that there has been no true improvement in the successful treatment of the disease over the past thirty years, even though there has been technical improvement in both surgery and radiotherapy during that time.

In spite of the almost universal experience of physicians to the contrary, the American Cancer Society still prattles to the public that their statistics show a higher recovery rate for treated patients as compared to untreated patients. After all, if this were not the case, why on earth would anyone spend the money or undergo the pain and disfigurement associated with these orthodox treatments? But how can they get away with such outright lies?

The answer is that they are not really lying—just bending the truth a little. In other words, they merely adjust the method of gathering and evaluating statistics so as to guarantee the desired results. In the words of Dr. Hardin Jones:

Evaluation of the clinical response of cancer to treatment by surgery and radiation, separately or in combination, leads to the following findings:

The evidence for greater survival of treated groups in comparison with untreated is biased by the method of defining the groups. All reported studies pick up cases at the time of origin of the disease and follow them to death or end of the study interval. If persons in the untreated or central group die at any time in the study interval, they are reported as deaths in the control group. In the treated group, however, deaths which occur before completion of the treatment are rejected from the data, since these patients do not then meet the criteria established by definition of the term "treated." The longer it takes for completion of the treatment, as in multiple step therapy, for example, the worse the error.... With this effect stripped out, the common malignancies show a remarkably similar rate of demise, whether treated or untreated.¹⁷

But there is far more to it than that. Such statistical error is significant, but it is doubtful if it could account for the American Cancer Society's favorite claim that "there are on record a million and a half people cured of cancer through the efforts of the medical profession and the American Cancer Society with the help of the FDA."¹⁸

The answer lies in the fact that there are some forms of cancer, such as skin cancer, that respond very well to treatment. In fact, often they are arrested or disappear even without treatment. Seldom are they fatal. But they affect large numbers of people—enough to change the statistical tabulations drastically. In the beginning, skin cancers were not included in the national tabulations. Also, in those days, very few people sought medical treatment for their skin disorders, preferring to treat them with home remedies, many of which, incidentally seem to have worked just as well as some of the more scientifically acceptable techniques today.
At any rate, as doctors became more plentiful, as people became more affluent and able to seek out professional medical help, and as the old-time remedies increasingly fell into disrepute, the number of reported skin cancers gradually increased until it is now listed by the ACS as a "major site." So, all they had to do to produce most of those million-and-a-half "cures," was to change their statistics to include skin cancers-presto-chango!

As Dr. Hardin Jones revealed:

Beginning in 1940, through redefinition of terms, various questionable grades of malignancy were classed as cancer. After that date, the proportion of "cancer" cures having "normal" life expectancy increased rapidly, corresponding to the fraction of question-able diagnoses included.19

The American Cancer Society claims that cancer patients are now surviving longer, thanks to orthodox therapy. In truth, however, people are not living longer after they get cancer; they are living longer after they are diagnosed with cancer. The trick is that, with modern diagnostic techniques, it is possible to identify cancer at an earlier stage than before. So the time between diagnosis and death is longer, but the length of life itself has not been increased at all.20 This is merely another statistical deception.

When X-ray therapy is used, the body's white blood cell count is reduced which leaves the patient susceptible to infections and other diseases as well. It is common for such patients to succumb to pneumonia, for instance, rather than cancer. And, as stated previously, that is what appears on the death certificate-as well as in the statistics. As Dr. Richardson has observed:

I have seen patients who have been paralyzed by cobalt spine radiation, and after vitamin treatment their HCG test is faintly positive. We got their cancer, but the radiogenic manipulation is such that they can't walk.... It's the cobalt that will kill, not the cancer.21

If the patient is strong enough or lucky enough to survive the radiation, then he still faces a closed door. As with all forms of currently popular treatments, once the cancer has metastasized to a second location, there is practically no chance that the patient will live. So, in addition to an almost zero survival value, radio therapy has the extra distinction of also spreading the very cancer it is supposed to combat.

One of the most publicized claims by The American Cancer Society is that early diagnosis and treatment increases the chance of survival. This is one of those slogans that drives millions of people into their doctors’ offices for that mystical experience called the annual checkup. "A check and a checkup" may be an effective stimulus for revenue to the cancer industry but its medical value is not as proven as the hype would suggest. As Dr. Hardin Jones stated emphatically:

In the matter of duration of malignant tumors before treatment, no studies have established the much talked about relationship between early detection and favorable survival after treatment.... Serious attempts to relate prompt treatment with chance of cure
have been unsuccessful. In some types of cancer, the opposite of the expected association of short duration of symptoms with a high chance of being "cured" has been observed. A long duration of symptoms before treatment in a few cancers of the breast and cervix is associated with longer than usual survival.... Neither the timing nor the extent of treatment of the true malignancies has appreciably altered the average course of the disease. The possibility exists that treatment makes the average situation worse.  

In view of all this, it is exasperating to find spokesmen for orthodox medicine continually warning the public against using Laetrile on the grounds that it will prevent cancer patients from benefiting from "proven" cures. The pronouncement by Dr. Ralph Weilerstein of the California Department of Public Health cited at the opening of this chapter is typical. But Dr. Weilerstein is vulnerable on two points. First, it is very rare to find any patient seeking Laetrile therapy who hasn't already been subjected to the so-called "modern curative methods" of surgery and radiation. In fact, most of them have been pronounced hopeless after these methods have failed, and it is only then that these people turn to vitamin therapy as a last resort. So Dr. Weilerstein has set up a straw-man objection on that score. But, more important than that is the fact that the Weilersteinian treatments simply do not work.

Battling as a lone warrior within the enemy stronghold, Dr. Dean Burk of the National Cancer Institute repeatedly has laid it on the line. In a letter to his boss, Dr. Frank Rauscher, he said:

In spite of the foregoing evidence,..., officials of the American Cancer Society and even of the National Cancer Institute, have continued to set forth to the public that about one in every four cancer cases is now "cured" or "controlled," but seldom if ever backed up with the requisite statistical or epidemiological support for such a statement to be scientifically meaningful, however effective for fund gathering. Such a statement is highly misleading, since it hides the fact that, with systemic or metastatic cancers, the actual rate of control in terms of the conventional five-year survival is scarcely more than one in twenty..

The statistics of the ACS are fascinating to study. They constitute page after page of detailed tables and complex charts telling about percentages of cancer by location, sex, age, and geography. But when it comes to hard numbers about their so-called "proven cures," there is nothing. The only "statistic" one can get is their unsupported statement: "One out of three patients is being saved today as against one out of five a generation ago." This may or may not be true, depending on one's definition of the word saved. But even if we do not challenge it, we must keep in mind that there also is a correspondingly larger gain in the number of those who are getting cancer. Why is that?
Here is the official explanation:

Major factors are the increasing age and size of the population. Science has conquered many diseases, and the average life span of Americans has been extended. Longer life brings man to the age in which cancer most often strikes—from the fifth decade on.

All of which sounds plausible—until one examines the facts: First, the increasing size of the population has nothing to do with it. The statistics of "one out of three" and "one out of five" are proportional rather than numerical. They represent ratios that apply regardless of the population size. They cannot explain the increasing cancer rate.

Second, the average life expectancy of the population has been extended less than three years between 1980 to 1996. That could not possibly account for the drastic increase of the cancer death rate within that time.

And third, increasing age need not be a factor, anyway—as the cancer-free Hunzakuts and Abkhazians prove quite conclusively.

For a brief moment in 1986, the clouds of propaganda parted and a sun-ray of truth broke through into the medical media. The New England Journal of Medicine published a report by John C. Bailar III and Elaine M. Smith. Dr. Bailar was with the Department of Biostatistics at Harvard School of Public Health; Dr. Smith was with the University of Iowa Medical Center. Their report was brutal in its honesty:

Some measures of efforts to control cancer appear to show substantial progress, some show substantial losses, and some show little change. By making deliberate choices among these measures, one can convey any impression from overwhelming success against cancer to disaster.

Our choice for the single best measure of progress against cancer is the mortality rate for all forms of cancer combined, age adjusted to the U.S. 1980 standard. This measure removes the effects of changes in the size and age composition of the population, prevents the selective reporting of data to support particular views, minimizes the effects of changes in diagnostic criteria related to recent advances in screening and detection, and directly measures the outcome of greatest concern—death....

Age-adjusted mortality rates have shown a slow and steady increase over several decades, and there is no evidence of a recent downward trend. In this clinical sense we are losing the war against cancer.... The main conclusion we draw is that some 35 years of intense effort focused on improving treatment must be judged a qualified failure.

It is clear that the American Cancer Society—or at least someone very high within it—is trying to give the American people a good old-fashioned snow job. The truth of the matter is—ACS statistics notwithstanding—orthodox medicine simply does not have "proven cancer cures," and what it does have is pitifully inadequate considering the prestige it enjoys, the money it collects, and the snobbish scorn it heaps upon those who do not wish to subscribe to its treatments.
2. As quoted in College of Mann Times (Kentfield, Calif.), April 26, 1972.
22. Letter from Dean Burk to Frank Rauscher; Griffin, Private Papers, op. cit., p. 3.
23. Letter from Dean Burk to Congressman Frey; Griffin, Private Papers, op. cit., p.5.