Skeptic
a person in a state of terminal caution
Margaret Mahy

Why good doctors go bad

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content

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editorial

Culture wars heat up

THOSE of you with broadband might enjoy one of the latest shots in the US 'culture wars' over creation and evolution. Judgment Day: Intelligent Design on Trial, is a two-hour documentary on the famous Dover, Pennsylvania trial which ruled that Intelligent Design was merely creationism repackaged, and that teaching it in a school classroom violated the US's constitutional separation of church and state. It can be viewed on the Public Broadcasting Service website (**www.pbs.org/wgbh/nova/id/program.html**).

It took about a century from the publication of The Origin of Species for an organised creationist movement to arise, and then a couple of decades before the scientific community realised it wasn't going to go away and started to produce detailed responses to creationism. This has expanded in recent years to include more general critiques of religion, from such authors as Richard Dawkins, Sam Harris and Daniel Dennett.

Now, we may be starting to see the beginnings of another swing of the pendulum. February sees the release of Expelled: No Intelligence Allowed, a film by economist and game-show host Ben Stein. Its thesis is that scientific institutions across America are in the grip of an atheist cabal who persecute anyone who dares to suggest the universe may have had a designer. In one much-publicised case, astronomer Guillermo Gonzalez, co-author of The Privileged Planet, was denied tenure at Iowa State University. More recently, one Nathaniel Abraham has filed a US$500,000 suit for wrongful dismissal from Woods Hole Oceanographic Institution. He was fired in 2004 after declaring he rejected evolution – when his job specification required him to work on evolutionary aspects of zebrafish embryology.

Set against that is the case of Christine Comer, the Texas Education Agency's director of science, who was forced to resign in December after forwarding an email advertising an upcoming talk by Barbara Forrest, co-author of Inside Creationism's Trojan Horse. This was deemed incompatible with the agency's avowed neutrality on the creation/evolution issue. Her boss, chairman of the State Board of Education Don McLeroy, has retained his job despite having lectured favourably about intelligent design.

Francis Collins, author of The Language of God: A Scientist Presents Evidence for Belief and director of the National Human Genome Research Institute, has told the New York Times that many of his scientific colleagues were "a bit puzzled" by his faith, but generally were very respectful. If the problems claimed in Expelled actually existed, he was certain he would know about it, he said. Ben Stein claims open debate is being shut down; the reality is that there is more debate on this issue than ever, and the creationist/ID side, for now at least, is finding the scrutiny uncomfortable.

David

Why do some good doctors become bad doctors?

John Scott & Des Gorman

In NZ Skeptic 82, John Welch wrote that there was something about general practice which attracts an interest in complementary and alternative medicine (CAM). Is it acceptable for medical graduates with a science degree to be allowed to carry on in this manner? Should we amend the medical registration so they can't? Is legislation needed to alter the culture – of doctors and society generally? This article is based on a presentation to the 2007 NZ Skeptics Conference.

SOCIETY confers upon the medical profession certain privileges, as it does upon lawyers, clerics, JPs and those entitled to issue warrant of fitness certificates. For the past 150 years or so the privileges enjoyed by doctors and those practising within the so-called orthodox health professions, have been granted and maintained upon the assumption that they undergo rigorous scientifically based education and maintain a scientific basis for their entire careers. The privileges can be quite rewarding in monetary and other terms.

We agree that the scope of such rewards implies an added burden of responsibility in understanding the nature of science and the requirements for application of scientific principles to clinical medicine. In modern society that is not as easy as it sounds. What follows is not a defence for doctors who may be failing to meet the assumed standards but rather our perceptions of why, so often, we doctors do as we do. We examine what we perceive to be a subculture which has always been present, but which may now be something of an epiculture.

For several thousand years doctors under various guises functioned independently of governments but not independently of the ruling classes. Various forms of Robin Hood-style financing kept the system going. Science, which essentially disproves current dogma progressively, infiltrated the healing arts. Medical education at university level in its present form dates back about 150 years. Paradoxically, junior doctors at Auckland City Hospital function much the way their forebears did at the Edinburgh Royal Infirmary 150 years ago. Old-style apprenticeships still guide aspirants to the various specialties and subspecialties within medicine. In most of the western world, consultants split their time between private practice, which they regard as a no-go area for government, and their hospital duties which enable them to keep up to date with new ideas and with young people. Conversely, most full-time hospital doctors are employees of the government.

WHERE NEXT: Students may leave medical school with a firm grounding in science, but are subject to other influences.

This pattern had its beginnings in the 1790s. The industrial revolution brought social and demographic changes which had catastrophic effects on the health of the community. The politicians, perforce, had to react. Thus began the moves towards what we can loosely term socialised medicine. Third parties came into the doctor-patient relationship.

A crucial event occurred in 1938. Sensing the advance of socialised medicine ideas in Europe, the all-powerful surgeons of the American Medical Association sent a delegation to Europe which met with the surgeons of Nazi Germany, France and England. It was agreed that big insurance agencies, largely

owned and controlled by the medical profession but attracting private finance, should be established immediately. The important corollary was that remuneration for the doctors would be on a procedural basis.

Patients would pay for a particular procedural process and not for the time spent in performing it. Such remains the basis for private practice throughout the western world and for much general practice. It is a crucial controlling factor on the way doctors practise and a powerful formative influence on the aspirations of young entrants to the profession. The net effect is that the bigger economic rewards occur outside and separately from the government. Possession of a particular technique, plus some entrepreneurial flair, is good for business.

There will always be some imbalance and mismatch of information between patients and their practitioners. So-called third parties have tried to intervene between patient and practitioner to modify the system. These third party ploys have largely failed, spectacularly in the case of US medicine. In what other industry would a cataract operation of brief duration secure a fee greater than that for key-hole surgery for gallbladder removal involving a much longer duration?

Over the last 50 years medical technology and basic medical science have advanced at the expected accelerating growth rates. What is not so obvious is the devastating effect this has had on general medical practice. A very powerful health-disease oriented industry now operates within the western world. The financial success of the doctors generally has been studied carefully by non-medically qualified people and a parallel or alternative medicine system has mushroomed. Its power is quite obvious in New Zealand when it is faced with threatening legislation based on calls for proven efficacy. The scientific concepts that knowledge is continually changing and must be continually reassessed, and that efficacy should be the basis for change of therapy and professional remuneration, play little part in the world of complementary and alternative medicine (CAM).

... the environment into which students are released and the power of particular personalities can override what teachers believe they have inculcated into the minds of their students.

Checking a myth

About ten years after the first graduates emerged from the Auckland Medical School there was a widespread myth that Auckland students, having had more behavioural medicine in their undergraduate course, were much better at taking histories from, and establishing empathy with, patients. Conversely, Otago students were alleged to be much better at practical procedures.

One of us (JS) didn't believe this and received a grant to compare the performance at hospital level of graduates from the two schools. The pervasiveness of the myth was fully confirmed by the consultants, matrons and hospital superintendents who still existed at the time, and by many of the former students themselves. However, I did not restrict my study to gaining the opinions of administrators, chief doctors and chief nurses. I went to telephone operators, the women in charge of the residences, laundries, kitchen staff, orderlies and charge nurses on the wards. I knew many of the Auckland graduates on an individual basis pretty well. What pained me deeply was learning that bright young people, both men and women, whom I had known fairly well as undergraduates and whom I regarded as sensitive, intelligent and obviously well fitted for medicine, had turned into arrogant, sometimes rude, aggressive, insensitive, awkward creatures who often were destructively disruptive of team functioning. Conversely, many of that group were highly successful in terms of acquisition of postgraduate diplomas and remunerated positions. I felt my own judgment had been severely challenged in terms of my starting opinion of these emerging graduates. I went back to Auckland with my tail between my legs but decided to analyse the situation further, knowing also that the myth was a myth.

Emerging pattern

A clear pattern emerged between the aberrant behaviour as I saw it of these young people and their attachments to clinical teams in the fifth and sixth years of their training. This clear-cut

relationship involved role modelling, inspired somewhat by the personality of the emerging graduates themselves. More importantly, role models of the aberrant group demonstrating what I thought was unsatisfactory behaviour, had been adopted particularly from some surgical specialty teams led by powerful personalities who demonstrated essentially egotistical, flamboyant and at times outrageous behaviour, which was accompanied by affluence and considerable medico-political power.

Within North America and the British Commonwealth, and to a large extent in Europe, based on the leadership of a few doctors, patterns of medical profession behaviour have survived by resisting waves of political pressure from sociologists, politicians and economists. The great medical registration Acts of mid-nineteenth century Great Britain, are touted as wonderful examples of the altruism of the medical profession. But the transcripts of the Westminster proceedings and the antics of the medical profession at that time, particularly those of some prominent surgeons, reveal how the medical profession adroitly preserved its position. Conversely, the divide between general practitioners and emerging specialists was ensured. Nevertheless, a great deal was gained for the population generally, in terms of paving the way for more scientific application to the practice of medicine. In 1945, with the introduction of the NHS, the specialists or consultants in Great Britain again feathered their nest at a time when the whole framework of state-supported practice was changed. In the late 1990s matters came to a head when for the first time a general practitioner was made Chair of the Greater Medical Council of Westminster. Things have changed since then but, in our opinion, the essential reform steps have yet to be undertaken.

Answering John Welch

We have now set the ground for our first response to John Welch. No, it is not acceptable for medical graduates with science-based degrees to be allowed to carry on earning considerable sums from some forms of CAM without analysing or acknowledging what they are doing, and all practised with apparent conviction that something unique or specific is being proffered. In so doing they have abandoned science – to what extent depends upon one's perspective.

If such practice is reasonably widespread, how has this come about? We would argue that the environment into which students are released and the power of particular personalities can override what teachers believe they have inculcated into the minds of their students. In turn this means that the teaching has not been powerful or sustained enough, to carry sufficient clout. In keeping with changes in wider society, students are becoming more demanding of Faculty. Students are demanding more facts and less waffle. 'Facts' are equated with ephemeral knowledge, itself a sacrosanct entity which is essential for passing various hurdles. 'Waffle' refers to sections of the curriculum devoted to community issues, public health, communication matters and so forth. We are not aware of any satisfactory studies to back our belief that students in general are not particularly interested in lectures on the nature of science or induction into Bayesian concepts to which they theoretically subscribe. We know that many students still believe it is the business of government and administrators to find the money and resources for them to exercise their particular forms of practice, and thus for them to expend those resources freely and independently of audit or censure.

What do patients want?

The concept is abroad amongst some students and younger doctors, that patients always require something tangible from a practitioner and their problems cannot be dismissed without some tangible transaction. Students in turn interpret this as the need for them to manipulate highly visible props for reinforcement of the placebo effect.

When general practitioner incomes fall, offering homeopathy or chelation for a fee becomes attractive, particularly within a culture wherein needs and expectations are being expressed increasingly by members of a public who are increasingly influenced by advertising, non-scientific articles and spurious claims.

CAM at Med School

In the Auckland School of Medicine there are brief sessions devoted to the topic of CAM. The general approach offers the students a broad brush introduction to principles in common forms of CAM, why these appeal to the public, how

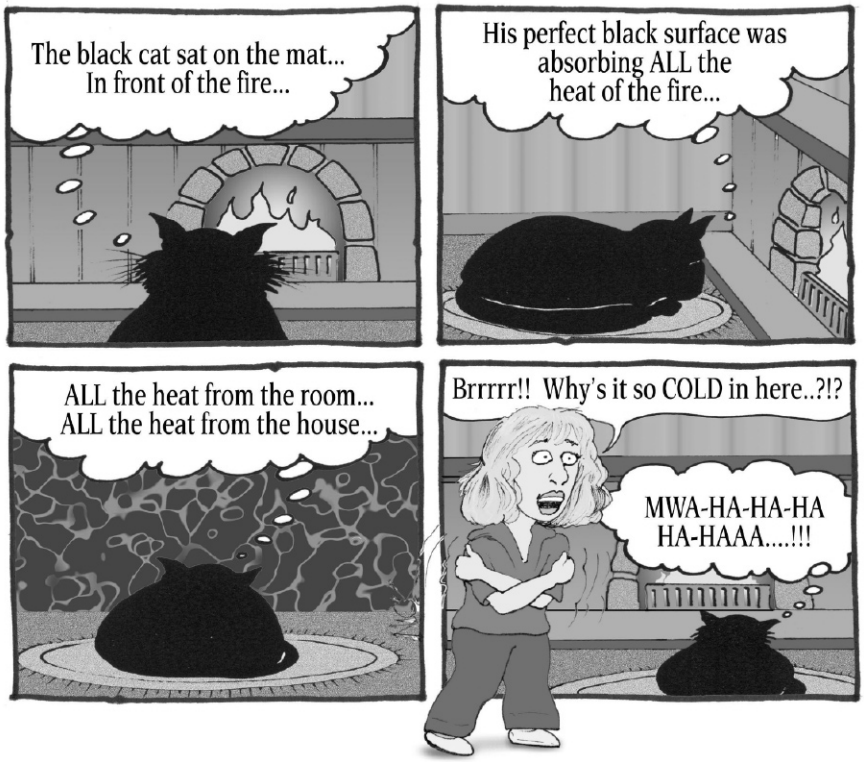
the efficacy could be judged, and some attention is paid to identifying potential interactions with orthodox medicine. The topic is introduced in Years 2 and 3, and reviewed in Year 5.

Given the present situation we believe there is considerable scope for providing a more detailed history of CAM within the curriculum, including scientific criticisms thereof, together with reinforcement at other stages of the course, concerning the nature of the conflict between science and non-science, the role of the doctor's personality and projection thereof, and what they are contributing to the therapeutic interaction.

In the New Zealand Medical Journal of May 2007 Rosemary Wyber and Tony Egan set about elucidating the views and experiences of a group of general practitioners and a group of current junior doctors one or two years out from graduation. To quote: "… A poor relationship with medicine is thought to be an area of considerable unconscious influence of role models. This may contribute to the well documented decrease in idealism during student and early clinical years."

In the same issue, Tim Wilkinson, the Associate Dean of Medical Education at the Christchurch School of Medicine & Health Sciences, drew attention to the importance of getting the learning environment right. He wrote: "If learning occurs first within an environment of trust and respect … good role modelling will mean effective learning will not be undermined." This line of reasoning is further reinforced in the same journal by an article by Kathleen Callaghan, Graham Hunt and John Windsor from the University of Auckland. They draw attention to failure of medical training to provide time for exposition of the non-technical aspects of competency.

We agree with their conclusion that professional training programmes need to be radically revised. Professional competency needs redefinition. Such definition must be team-orientated.



Attitudes and aptitudes

Of relevance to John Welch's first question is an issue raised by Callaghan and her colleagues. "Should there be testing of relevant attitudes and aptitudes prior to selection for postgraduate training?" Again, should we select prior to *undergraduate* training for a wider array of attitudes and aptitudes which would then be integrated and progressively monitored throughout undergraduate training, to ensure a differentiated work force of doctors based on society's needs? These authors suggest some fundamental questions should include, "What are the patient outcomes that society expects us to deliver?" And "What are the professional competencies required to ensure that these outcomes are achieved?"

Attitudes towards (and use of) CAM in New Zealand were also studied by Poynton and colleagues in the NZ Medical Journal (2006). They found that the number of general practitioners using complementary and alternative medical therapies had decreased but the number referring patients to the unorthodox system had increased. They called for increasing information on CAM to be included in medical education and for attention to earlier research.

A call for reform

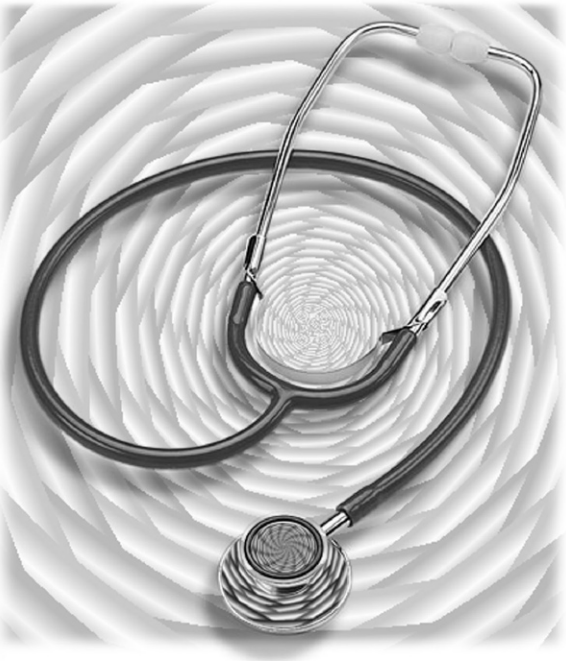
A Lancet editorial by Baker in 2005 stated that the time had come to explore the need for a

major reform of medical institutions to make them fit to sustain professionalism and respond to the changing expectations of society. In so responding the medical profession and those who educate its entrants needed to have sound perspectives and the ability to challenge some of the false expectations within society.

A key point in relation to false expectations is the utilisation of the placebo effect by both orthodox medicine and CAM. When properly handled, there is general recognition that the placebo effect is a boon to busy clinicians and their patients. However, such responses vary considerably between different diseases. Time heals a great deal. Some chronic diseases remit spontaneously. The first thing we educators need to do is to emphasise and demonstrate to students the natural history of disease. In so doing we need to place that in the context of the placebo effect and point out that such effects are notoriously fickle and may occur on one occasion and not on another within the same patient. Use of placebo effects varies across disciplines. We need to point out that large fees are not necessary for inducing a maximum placebo response – but time spent does require reasonable recompense nevertheless.

Scientific medicine and personal influence

Dr John Ellard, a prominent psychiatrist in Australia, has summed it all up in an article entitled, What can be learned from a curing of warts? To quote him: "… in most therapeutic situations there are two important aspects: scientific medicine, and the influence of one person on another. To ignore either is imprudent because the best outcome will be obtained only if both are considered ... many remedies work quite well without a scientific basis. My argument is that one should strive for the best of both possible worlds – the greatest benefit from scientific medicine … and the greatest benefit from the healing power of concern for the person. Concern about the disease is not enough". Moreover, adherence to medication *or placebo* was associated with lower mortality rates in a Canadian survey of 21 studies; patients' psyche and personality are very much factors in determining outcomes.



"... large fees are not necessary for inducing a maximum placebo response – but time spent does require reasonable recompense nevertheless."

The important point about Dr Ellard's comment is that the mystique element is removed from the doctor-patient interaction associated with placebo effects. We believe there is no point in studying any mythical homeopathic mechanism, for instance, independent of the placebo effect. Observations of such therapies should be submitted to the same disciplines as evolving treatments in orthodox medicine. They should be controlled for consequences of the passage of time, that is of natural history, observations should be standardised and raw data made available for scrutiny by independent researchers at no extra cost to the subjects of such new (or old) treatments.

Social contracts

In reviewing social contracts much will be required in public education through public involvement and, to some extent at least, through lobbying and other manipulations of the legislature and the legal environment. Increasingly it will be in the interests of our nation as a whole, to review remuneration of time spent by health professionals and what balance should be set between expenditure within essentially a state-run system versus the proportion of national resources expended within an uncontrolled private sector. We believe some curbs will be required in future concerning irresponsible actions within the media, but unless the medical profession and public perceptions alter it will be impossible to develop a common culture and we will all fail together.

Within our present structure of cultures lie the medical students we select for the Otago and Auckland schools. The late Frank Haden pointed out at a previous Skeptics conference in Christchurch: "a doctor told us matter-of-factly that seven percent of the school's 1997 fifth year students believed in creationism." There is work to be done. We face an aggressive, burgeoning non-science or anti-science culture. Some of our students lie within awkward subcultures and some enter these after graduation. In finishing, we quote a 1995 Lancet editorial. "The intellectual strength of science lies in its essentially subversive character." That same editorial quoted Freeman Dyson: "There is no such thing as a unique scientific vision … science is a mosaic of partial and conflicting visions. But there is one common element in these visions. The common element is rebellion against the restriction imposed by the locally prevailing culture."

To this we can add the conclusion of a paper titled Health Delusions, written by Denis Dutton in 1988. "I am disturbed by a *Listener* editorial not long ago on the topic of alternative medicine which has gone so far as to call for government funding for fringe medical services. And this editorial ought not to be dismissed as an insignificant aberration: in the present user-pays climate of medical policy decisions it is possible that there will be increased pressure to turn our back on expensive, science-based medicine in favour of popular but worthless pseudoscientific placebos. I think it is imperative that health professionals throughout New Zealand work to resist such pressures. Our stretched public health resources must be directed towards valid, effective science-based care. Anything less will prove expensive and dangerous."

List of references available from the editor.

Professor Sir John Scott is Professor Emeritus of Medicine at Auckland University. Professor Des Gorman is Head of the Occupational Medicine Department at the Auckland University School of Medicine.

circumcision

Circumstitions

Hugh Young

Intersecting as it does sex, religion, blood, medicine and masculinity, circumcision is a subject that is hard to discuss rationally.

THE male human foreskin or prepuce is a remarkable structure. Far from being "just a flap of skin," it amounts to about 100 cm^2 (15 sq in) or about half the outer surface of the adult penis. It is rich in specialised sensory nerves, and has a unique way of unrolling out over itself to uncover the glans and cover the shaft during intercourse. Men who have involuntarily lost their foreskins in adulthood compare the effect with going colour-blind.

The more remarkable, then, that human history is rife with crazes for cutting the foreskin off. Three cultures originated male genital cutting: in Africa, Australia and the Pacific. The African custom seems to have been taken through Egypt to the Middle East and then to Europe, and in the 19th century in England and the US it was medicalised with the aim of preventing masturbation, becoming widespread throughout the English-speaking world. It continues to be claimed as a panacea for whatever ailment people most fear at the moment.

Christchurch skeptic Jay Mann wrote (NZ Skeptic 84), "One thing that activates my BS-meter is a miracle treatment with too many claims." Mine too. I started collecting bad reasons to circumcise ("circumstitions") in 1998. There seemed too many to be reasonable, and I thought a complete list of as many as 30 would make Jay's point. I now have *340* reasons, in 30 classes, and they show no sign of stopping – see Table 1. The classes are so bafflingly varied that something else has to be going on.

Skeptics will, I hope, dismiss out of hand the many obviously irrational reasons for circumcising such as 'tradition' and 'to look like his father' (conformity), but medicine has the seductive respectability of science.

Aesthetic	Instructive	Revenge
Anti-sexual	Irrational	Reward
Cleanliness	Medical	Sexual
Concealment	Mistake	Status
Conformity	Non-conformity	Submission
Control	Pity	Symbolic
Convenience	Pre-emptive	Sympathetic magic
Financial	Prudery	
Iatrogenic	Punitive	To benefit someone else
Ignorance	Religious	
Initiation	Reproductive	Vague

Table 1. Reasons given for circumcision (And yes, some of those do contradict each other).

Medical reasons for circumcision include the prevention or cure of the conditions listed in Table 2.

Alcoholism	Headaches	Penile cancer
Arthritic hips	Hernia	Plague
Asthma	HIV	Phimosis
Balanitis	HPV	Posthitis
Bedwetting	Hydrocephaly	Prostate cancer
Blindness	Hydrocoele	Rectal prolapse
Boils	Hypertension	Rheumatism
Cervical cancer	Insanity	Schistosoma
Chicken pox	Kidney disease	Spinal curvature
Epididymitis	Kleptomaina	Stomach infection
Epilepsy	Leprosy	Tuberculosis
Gallstones	Moral depravity	Urinary tract infections
Gout	Paraphimosis	Yeast infections

Table 2. Medical conditions for which circumcision has been claimed as a cure.

Some of those are obviously bogus – the others, less obviously so. In each case the science is non-existent, flawed or misinterpreted, but these few look plausible:

STDs: A 2006 study in Christchurch by Fergusson et al, gained headlines around the world before Fergusson admitted his result was anomalous and it would take at least 20 circumcisions to prevent one minor STD. (He found no major STDs.) His retraction was not widely reported.

Urinary Tract Infection: It would take more than 170 circumcisions to prevent one boy contracting a UTI, according to To et al (1998). The rate among girls is several times that of boys. The major study (by US army paediatrician Thomas Wiswell) showing a protective effect -

- was entirely based on boys born in military hospitals
- used different means of collecting urine samples in the two groups
- assumed that any bacteria cultured from a sample represented a UTI
- neglected the effect of premature birth postponing or cancelling circumcision, and leading to intensive care and catheterisation - which causes UTIs.

Penile cancer: one of the rarest of cancers (with a lifetime incidence of less than one in 600, less common than male breast cancer), generally occurs only in old men. The rate is higher in the circumcised US than non-circumcising Denmark.

Cervical cancer (in partners): The main study on which this claim relies (Castellsagué et al, 2002), pooled data from five different countries. Almost all the circumcised men were in the Philippines, most of the intact men in the other four countries (Brazil, Colombia, Spain and Thailand). Naturally, there are many other demographic differences between those countries. The evidence boiled down to

- **1** circumcised man in Brazil,
- **1** in Colombia and
- **3** in Spain who didn't have HPV,
- nobody in Thailand, and

To Page 12

Compiled by David Riddell

Exorcism leads to charges

The death of Wainuiomata woman Janet Moses during an attempt to lift a Maori curse, or makutu, was very widely reported (eg NZ Herald, November 12). Now six women and three men have been charged with her manslaughter (Dominion Post, 12 December). One of the accused women and another man are also charged with cruelty to a child after a 14-year-old was injured in the same ceremony and was treated in hospital for an eye injury.

Police say the 22-year-old mother of two drowned after she was held down and had water poured down her throat in a ceremony.

The paternal family of Janet Moses say it is a relief that those accused of her death have been arrested and charged. The accused have been granted interim name suppression and bailed to reappear on February 12.

Detective Senior Sergeant Ross Levy said the accused were members of Ms Moses' extended family. As many as 40 people were at the house during the ceremony and more came and went throughout the day after she died. Police said she had been dead for about nine hours before they were called and have since interviewed dozens of people in relation to the death.

Anglican Maori Church archdeacon Hone Kaa says 'lifting ceremonies' were often used to cleanse victims.

The curse was believed to have been linked to a relative stealing a taonga (treasure). He said water was often used in such ceremonies, but not the amounts understood to have been involved in Ms Moses' case.

He said lifting curses was a difficult process and was wary of doing it. In some cases victims needed to be held down by several people as the spirit fought, but he was not familiar with injuries such as the scratches and grazes found on Moses being inflicted.

'Psychics' misbehave

An Auckland 'psychic' who claims to heal sex abuse victims has been accused of inappropriate sexual remarks to clients following an investigation by undercover Herald on Sunday reporters (4 November). John Clarke, who charges $60 an hour for "acupressure, internal health, emotional problems, spiritual readings, distant healing, or horse and greyhound advice" reportedly had a client leave in tears after he told her "your granddad is telling me to keep my hands off you."

He also told the woman her grandfather thought her father was a w*****, that her current relationship would fail, and insinuated that she slept around.

Clarke repeatedly told one of the reporters sent by the paper how attracted he was to her, and both noted his readings were incorrect. He told the first reporter her grandfather's dead (and nonexistent) brother was giving him messages. She became uncomfortable when Clarke told her he did healing and started pressing his fingers into the back of her left shoulder, saying, "I love touching women."

He three times called the other reporter a "little bitch", asked if her boyfriend was "oversexed", and talked about how aroused he had become while doing a reading for another client.

When the Herald on Sunday put these statements to Clarke he said he couldn't remember seeing the reporters, even though one had visited just days before.

The Herald on Sunday broke the story of North Shore counsellor and healer Geoffrey Mogridge who is alleged to have had sex with paying women clients last year. Mogridge is currently before the Human Rights Review Tribunal facing damages claims totalling $175,000.

If someone is charging a fee and professing to be a healer they are responsible under the Health and Disability Commissioner Act, and the Privacy and Consumer Guarantee Act, according to Patrick Fahy of the New Zealand Charter of Health Practitioners.

"People who practise psychic healing and aren't members of any particular register don't adhere to any code of ethics until such time as something goes wrong," Fahy said. "Some people have real psychic ability, but there are some whose practices are possibly questionable. It's

quite a lucrative type business for some of these people."

'Bodyfinder' misses out

The parents of missing British child Madeleine McCann have been warned not to put their faith in a DNA tracking device developed in South Africa (**www.mirror.co.uk**, 8 October). Danie Krugel, a self-styled "bodyfinder", says his device has pinpointed a stretch of beach just 500 metres from Kate and Gerry McCann's apartment in Praia da Luz, Portugal. But South African mother Varenda Gouws, who was sent on a fruitless trek after hiring Krugel and his device to track down her missing son urged the McCanns not to trust him.

She said she gave Krugel a hair from her son Rayno's razor, after he disappeared on a hiking holiday. Krugel fed it into his Matter Orientation System, which he claims combines DNA testing and GPS satellite technology to track down missing people anywhere in the world.

"It was an endless track," Gouws said. "We drove through South Africa for 4,300 miles. He absolutely convinced us, saying 'Rayno is moving'. He said he must be in a truck or a car because he was moving so fast. Every time we left our jobs and packed up and went to these places and put articles in the newspapers. It cost us a fortune."

Rayno's remains were eventually found eight months after he vanished, in a forest near where he was last seen. It is thought he died from a snake bite.

"It was clear that he had been dead for eight months because there was no flesh on the bones and there were ferns growing through the body. But when I phoned Danie to tell him, he was really aggressive. He said it was not possible. He blamed me. He said, 'This is a lie. Nobody can tell you how long a body is dead.'"

Judge calls on elves

A Philippines trial court judge who lost his position after he acknowledged he regularly sought the counsel of three elves only he could see is now trying to get his job back (Wall Street Journal, 17 September).

Florentino Floro says his invisible companions are a neutral force called Angel, a benign influence known as Armand, and Luis the avenger, whom Floro describes as King of Kings.

Floro has become a regular on Philippine television, and is often asked to make predictions with the help of his invisible friends. "They say your show will be taken off the air if you don't feature me more often," was Floro's reply to one interviewer.

The day after his first appearance on television last year, hundreds of people turned up at his house in a dusty Manila suburb hoping he could use his supernatural powers to heal their illnesses.

The Supreme Court says its medical clinic determined Floro was suffering from psychosis. Even so, a series of disturbing incidents appear to have the nation's top jurists rattled.

According to local newspaper reports, a mysterious fire in January destroyed the Supreme Court's crest in its session hall, and several members of the court or their close family members developed serious illnesses or had car accidents. In July, the Supreme Court issued a resolution asking Floro to desist in his threats of "ungodly reprisal".

Floro says Luis, not himself, is to blame for the incidents, and is bent on cleaning up what he says is the Philippines' corrupt legal system.

Creationists want to teach science education

As if education in Texas didn't have enough trouble (see p2), the Institute for Creation Research wants to offer an online master's degree in science education (Dallas Morning News, 15 December). A state advisory group has already given its approval; the Texas Higher Education Coordinating Board will consider the request this January.

The ICR has offered science degrees in California for years, with graduate courses since 1981, and online courses in the last two years, taken by "more than 50" students worldwide. It was necessary to get approval from the Texas authorities to offer degrees in that state after the ICR moved from San Diego to Dallas in 2006.

"It just seems odd to license an organisation to offer a degree in science when they're not teaching science," said Dan Quinn of the Texas Freedom Network, which opposes teaching creationism in public schools.

From Page 9

- **1** intact man in the Philippines who did have HPV –
- a total of **6** men.

After all that, it referred only to Human Papilloma Virus (HPV) (of which there are a number of varieties, only some of which are linked to cervical cancer), not to cervical cancer itself.

HIV

It was inevitable that HIV/AIDs would fall under circumcision's spell. It would take hundreds or even thousands of circumcisions to prevent one transmission of HIV in a country with a low incidence like New Zealand, *if* the three African random controlled trials (Auvert et al, 2005; Bailey et al, 2007; Gray et al, 2007) were correct. In fact, they have multiple flaws; for example:

- they were not double-blinded or placebo-controlled, and they were conducted by circumcision enthusiasts, at least one of whom had campaigned for mass circumcision before the trials were ever held;
- the men were not a random sample of the population, but volunteers given a substantial reward;
- the circumcised experimental groups were given safe-sex advice that the intact control groups were not;
- the trials were cut short, so we will never know what the long-term effect will be, and they can probably never be replicated;
- at least 380 (10 percent) of the circumcised men dropped out of the trials – those who found they had HIV would feel let down and be more likely to do so. Only a few such men would reduce the results to non-significance;
- the studies' significance would be diluted by sex with men and non-sexual transmission, believed to amount to about 40 percent of transmission in Africa because of "needle men" - amateurs who offer injections for any and every complaint, using the same needle;
- the *non*-circumcised control group in Uganda got less HIV than the *circumcised* experimental group in Kenya, probably because Uganda had campaigns against promiscuity ("zero grazing"), while the Kenyans were mainly fishermen on Lake Victoria with 'girlfriends' in every port.
- Earlier, cross-sectional studies were confounded by such factors as religion – the circumcised men were largely Muslim, with different sexual customs and prohibitions.

In spite of this, an invitation-only meeting in Montreux, Switzerland (whose participants have not been publicly listed but seem to have included those same circumcision enthusiasts) has mobilised WHO and UNAIDS to "roll out" mass-circumcision campaigns in Africa – using a manual that was in preparation before the trials began.

The Gomco clamp is one of the most widely employed instruments for performing non-ritual circumcisions. It is used to restrain the foreskin so that it can be removed with a scalpel.

Risks and costs

A baby can afford to lose only about two tablespoons of blood before he needs a transfusion. Modern absorbent nappies such as Treasures can easily conceal this much blood loss. Circumcision presents a real risk of MRSA or VRE infection. A recent death in Ontario was due to the device Prof Sitaleki Finau of Massey University calls "non-surgical" blocking the baby's urethra. Ablation of part or all of the penis can occur – in the most famous case, Bruce/Brenda/David Reimer of Winnipeg, Canada, was unsuccessfully reassigned as female, and eventually committed suicide. There are many lesser complications and adverse outcomes that may not be noticed until the victim reaches adulthood. The pain reaction is measurable for months afterwards; for decades, babies were circumcised without anaesthetic.

Sexuality

It should be self-evident that cutting part of the penis off has a detrimental effect on sexuality – this was known for centuries before circumcision became widespread. Incredibly, the most widely reported studies of penile sensation (Masters & Johnson, 1966; Payne et al, 2007), both claiming circumcision had no effect, didn't measure the foreskin. One that did (Sorrells et al, 2007) found a striking difference. Circumcised men insist that "if I was any more sensitive, I'd have a heart attack" (a claim that itself suggests something is amiss) yet intact men do not fill our cardiac wards. Such a claim mistakes quantity for quality. The answer demands closer study of the neurology.

Psychology

How, you may wonder, can a practice so bizarre, abhorrent even, have become so popular? A good question, not yet fully answered, but we can look at power and control, sympathetic magic, a multi-faceted memeplex that has a momentum of its own, money, and men's refusal to admit that they have lost anything, but rather a determination to ensure that nobody may have more penis than they do. Some circumcision enthusiasts (who call themselves 'circumsexuals') have an unwholesome interest in the procedure itself. Intersecting as it does sex, religion, blood, medicine and masculinity, circumcision is a subject it is hard to discuss rationally. Much scientific writing on the subject is tainted by these biases.

Human rights

Many men are so outraged that part of their penis was cut off, that they go to considerable trouble to replace it. (A good aesthetic effect can be achieved by slowly encouraging the skin to grow by applying tension – not 'stretching' – but the sensory effect can never fully return. Surgical means are not advised.)

It should be obvious that cutting an integral part of a healthy baby's body off is a human rights violation. It is obvious when the baby is a girl, and an amendment to the Crimes Act outlaws female genital cutting specifically and totally, regardless of degree, under all circumstances (except medical need), with no exception for religion or culture, or even the adult woman's own consent.

Male vs female genital cutting

The objection is often vehemently raised that there is no comparison between male and female genital cutting (MGC, FGC). But both cover a range of practices, and the mildest of FGC is milder than the most severe of MGC. MGC may be carried out under conditions similar to FGC (with nearly 40 deaths a year in Eastern Cape Province alone). As ethical issues, as human rights violations and as invasions of a person's most personal space, they are equivalent.

Recent history

Infant circumcision became near-universal in New Zealand by the 1950s. (It is not true that many men had to be circumcised in the North African desert campaign of World War II, though that reason was commonly given. I am grateful to Manfred Rommel for taking the trouble to enquire of his father's surviving troops.) It declined to near-zero through the rest of the century, the main exceptions being Pacific Islanders, Muslims and Jews. This apparently happened top-down, National Women's Hospital refusing to offer circumcision at public expense from the day it opened in 1962. In the mid 1970s, it became policy not to offer it to new parents (the 'sleeping dogs' policy), and some time during that decade it was taken off Social Security. The result is that most New Zealand men over 35 are circumcised, most under that age are not. (In England, the probability goes up with class, in the US, as you go north and east.)

In August 2007, Victorian public hospitals banned the operation, South Australia announced a review of its policy and the Children's Commissioner for Tasmania called for the female genital cutting ban to be made gender-neutral.

Yet in October 2007, Prof Finau called for infant male genital cutting to be offered in New Zealand public hospitals again.

The movement to oppose non-consensual (male) genital cutting (Intactivism) is small and unpopular, and generally regarded as eccentric, yet we know we are the rational ones.

List of references available from the editor.

Hugh Young is a long-term human rights campaigner and sceptic. Yes, he prefers to spell it that way.

Yet another military syndrome

John Welch

I IMAGINE that most people joining the Armed Forces would expect the likelihood of a posting to an area of conflict. I know I did. I spent six months in Iraq between the two Gulf Wars. I admit that it was stressful but it was also one of the most exciting and interesting experiences that I have ever had. But that's another story.

It appears however, that many would prefer a safe posting at home, typing memoranda or serving tea in the mess. The only risks from these activities are RSI or perhaps a minor burn from slopping the tea.

When military personnel are posted to an area of conflict this comes as a shock. Compensation is fortunately available. It appears that shell shock and post traumatic stress disorder are passé. The new 'buzz diagnosis' is MTBI, or 'mild traumatic brain injury'.

The cause is blast from roadside bombs and this can lead to "memory loss, depression and anxiety". The US has instituted a screening programme for those returning from active service and they estimate as many as 20 percent may be at risk of MTBI. The UK MOD remains skeptical and is quoted as saying: "It is a very complex area. We have no way of knowing whether (the US assessment) is accurate because there is a level of dispute as to what constitutes MTBI." You could apply the same logic to stories of alien abduction.

Skeptics could note that the diagnosis is largely subjective but should be alarmed that therapists such as Kit Malia are poised to cash in: "If the American figures are correct, this is massive, absolutely massive." More work for the army of counsellors.

As the saying goes, war is hell. Many returned servicemen will tell you that and they fervently wish for an end to all conflict. Instead of pursuing this aim, we continue to send young men and women to various hell-holes and wonder why they fall apart. It is hardly surprising that they choose to fall apart in culturally acceptable ways with diagnoses such as GWS, PTSD and now MTBI. Screening programmes, websites and a telephone help line will ensure that those suffering from MTBI are suitably coached into supplying the right symptoms of this disorder.

When I read about these daft syndromes, I often think of my late father who experienced combat as an infantryman in World War Two. He came home, resumed his career and the only disability he had was spinal tuberculosis, contracted in Japan while serving with the occupation forces. The only compensation was the opportunity for resuming academic studies. Perhaps we could retrospectively label this 'mild tubercular back injury'.

Today's military personnel are not conscripted. They have a choice. I say, take the money and accept the consequences. Let's either call an end to absurd diagnoses such as MTBI, or have the moral courage to eschew warfare and refuse to send our men and women on such missions.

The Guardian Weekly Vol 177 No 20 p11

Sensory Processing Disorder

Some children become upset when confronted with new sounds or places. They scream and misbehave. This behaviour

is set to become yet another disorder of childhood – 'Sensory Processing Disorder'. Advocates are pressing the American Psychiatric Association to include this condition in its manual of mental disorders. Sound familiar?

Therapists have already set up clinics to deal with this new 'disease'. One such clinic is Paediatric Potentials, where children experience play therapy including a spandex cocoon that can calm them.

The condition was studied in the 1960s by a psychologist who called it 'Sensory Integration Dysfunction'.

This has all the hallmarks of a fad diagnosis. The symptoms and signs of the condition are completely subjective. The condition relies on interpreting extremes of behaviour as being pathological. Physician enthusiasts are recruited to popularise the condition. Pressure is put on the relevant authorities to endorse it. This is precisely the path that led to the diagnostic labels of PTSD and ADHD. It appears that some academics are incapable of understanding normal human behaviour.

I'm still waiting for alien abduction to follow the same pathway to recognition. It's just as valid as Sensory Processing Disorder.

Marlborough Express 15 November 2007

Are your children reaching their full potential?

So reads the advertisement from a local pharmacy. Perhaps this is the solution to SPD? For only $20 you can get 60 capsules of 'Clever Kids Omega 3'. This product has been designed to "help support brain development and learning ability, including concentration, memory and problem solving, and may assist in the temporary relief of mild anxiety and irritability."

This is the perfect product for families where parents are too busy to have time to interact with their children. If anybody could be bothered to test this useless product, I predict it will have no advantage over placebo.

Ritalin Substitute

Pharmac, the Government's drug buying agency, is constantly looking at saving money on our huge national drug bill. Ritalin (methylphenidate) has been supplanted by a cheaper generic equivalent, Rubifen, which is one million dollars a year cheaper. Methylphenidate is used in the treatment of ADHD, another fad diagnosis like SPD. Parents remain unconvinced and many are demanding a switch back to Ritalin. This is typical of placebo dependence where people become convinced that the new small yellow pill is somehow inferior to their familiar big red pill. Given that ADHD is an entirely subjective disorder it is not surprising that there is a subjective obsession over the familiar drug versus a generic equivalent.

While I'm on the subject of useless products ...

Red Bull OD

An Australian man drank eight Red Bull energy drinks in five hours and suffered a cardiac arrest while competing in a motocross event. This equated to a caffeine intake of 400mg which is close to the toxicity level for an average adult. The label warned against consuming more than one to two cans or bottles of the product per day. The victim was quoted as saying he drank four Red Bull drinks per day because "With the work I do I don't have a lot of time to eat." On the day of his acute illness he suffered a cardiac arrest and required defibrillation. He admitted to consuming eight Red Bull drinks over a five-hour period as follows: "It was to get a bit of a buzz and keep down my reaction times."

It is difficult to feel sympathy for such moronic behaviour. Red Bull is a useless and unnecessary product which has been successfully marketed for idiots.

While I'm on this topic how about ...

Cold medicines

The US Food and Drug Administration (FDA) commissioned some outside experts to advise on medicines used by parents to treat their children's coughs and colds. The conclusion was that products such as cough suppressants do not work and may cause side effects in young children. I recall that Consumer has reported on these products and the evidence is that they are not worth the money. This is the familiar placebo effect at work.

Ultrasound: Why so popular?

Robin McKenzie

Despite a series of studies showing it to be ineffective, ultrasound continues to be widely used by physiotherapists.

ULTRASOUND is one of the most frequently applied treatments used by physiotherapists. It is used mainly in the treatment of strains, sprains and soft tissue injuries and other musculoskeletal disorders including arthritis. Yet in multiple scientific studies it has been found to provide no useful benefit. A few studies have even found that its use can be detrimental. Many in the physiotherapy profession are aware that this situation is unacceptable and have ceased to apply ultrasound. However there are even greater numbers of therapists who continue using ultrasound knowing full well that evidence justifying its use does not exist.

The overwhelming evidence should long ago have convinced clinicians, especially physiotherapists using this outmoded device, that its continued use is worthless. Health authorities responsible for controlling the dispensation of treatments have a responsibility to ensure that resources are used according to evidence-based principles. Indeed the Physiotherapy Board and Health Department have been campaigning recently to ensure that physiotherapists comply with a programme intended to ensure the maintenance of clinical competence. Clinical competence is not achieved by permitting the continued use of apparatus long ago found to be of no benefit to the patient. How many thousands of patients are every day receiving and paying for this useless treatment? How much is the Accident Compensation Corporation paying annually for it?

The use of electro-physical modalities by physiotherapists raises serious issues for the profession and cannot remain unchallenged. Ultrasound is but one of the many ineffectual treatments applied by physiotherapists in practice in New Zealand.

Given that there now exist six systematic or substantial reviews of ultrasound, which are consistently negative in conclusion, it seems worthwhile re-iterating the point made in The Human Extremities: Mechanical Diagnosis and Therapy (McKenzie and May 2000): "It is not that there is a lack of evidence, rather the evidence categorically shows the lack of efficacy of ultrasound."

The evidence

Holmes and Rudland (1991) conducted a systematic search for articles on ultrasound and found 18. Almost all contained serious methodological flaws, such as lack of a control group, failure to use a double blind design, and lack of statistical analysis. They concluded: "The case for ultrasonic treatment of soft tissue injuries is not well founded at present."

In 1995 a meta-analysis of ultrasound for musculo-skeletal disorders was conducted (Gam & Johannsen 1995), in which 22 papers fulfilled the inclusion criteria of the review. In 16, ultrasound was compared to sham treatment, and in 13 the results were presented in a way that made data pooling possible. Analysis of these trials showed there was no evidence that ultrasound provided pain relief, so further trials were not evaluated:

> "The use of ultrasound is based on empirical experience, but is lacking firm evidence from well-designed controlled studies."

In a systematic review (van der Heijden et al 1997) of a range of physiotherapy interventions for shoulder pain, ultrasound was evaluated in six studies and was found to be ineffective in all:

> "There is evidence that ultrasound therapy is ineffective in the treatment of soft tissue shoulder disorders."

By 1999 a systematic review (van der Windt et al 1999a) located 38 studies into a variety

of disorders, 18 of which were placebo-controlled. Of 13 placebo-controlled trials scoring at least 50 percent validity score, 11 found no evidence for clinically important or statistically significant results. For ankle and shoulder disorders, and as an adjunct to exercise therapy, they concluded that there is evidence that ultrasound is ineffective:

> "There seems to be little evidence to support the use of ultrasound therapy in the treatment of musculoskeletal disorders."

The same group also reviewed the use of ultrasound for acute ankle sprains (van der Windt 1999b):

> "The results do not support the use of ultrasound in the treatment of ankle sprains."

A further placebo controlled trial published since that review came to the same conclusion (Nyanzi et al 1999).

Reviews of effectiveness studies (Robertson & Baker 2001), and on the biophysical effects of ultrasound (Baker et al 2001) found 35 English language RCTs published between 1975 and 1999. The authors applied six methodological filters so that only the 10 highest quality studies were included. In eight out 10 studies there was no difference between groups treated with active or placebo ultrasound:

> "There was little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing.'

The only two studies that favoured ultrasound over placebo were both conducted by the same research team (Ebenbichler et al 1998, 1999). However in both studies blinding was either not addressed or not properly enforced, and if the methodological filter concerning blinding had been strictly applied in the review both studies would have been excluded. As noted earlier failure to enforce blinding over-inflates the reported treatment effect.

Other studies evaluating the role of ultrasound for the same conditions, calcific tendonitis and carpal tunnel syndrome, have failed to show a positive effect for active ultrasound (Downing & Weinstein 1986, Oztas et al 1998). Other concerns about Ebenbichler et al's (1999) study have been raised (Herbert & Maher 2000). A mean reduction in pain that is greater than the mean initial pain score is reported, which is impossible. The intervention involved almost daily interventions for three weeks and then thrice weekly for three weeks, a total of 24 treatments. The sham group had similar outcomes at nine months. The role of calcific lesions in shoulder pain is unclear, the prevalence is the same in asymptomatic populations, and so the abnormality may be an incidental finding.

Regarding the biophysical effects of the intervention (Baker et al 2001):

> "There is currently insufficient biophysical evidence to provide a scientific foundation for the clinical use of therapeutic ultrasound for the treatment of people with pain and soft tissue injury."

Conclusion

Evaluation of the efficacy of certain modalities can generally be done with a rigorous scientific methodology. Issues of compliance, double blinding and sham treatment are considerably easier to control when investigating ultrasound than, for instance, exercise protocols or manipulation. It is thus likely that the interpretation of these reviews is based on scientific evidence, rather than the arbitrary outcome of poorly constructed research.

Not only are these findings based on rigorous research, but also they are almost entirely consistent. A few trials suggest that ultrasound can be effective, but there are problems with their findings. The overwhelming weight of evidence demonstrates that with active or inactive ultrasound the outcome is the same. It is not a useful adjunct to other interventions.

The question to be asked at this point is how many systematic reviews and RCTs that consistently demonstrate the lack of efficacy of ultrasound does it take for physiotherapists to abandon this useless practice.

List of references available from the editor.

Robin McKenzie is a Kapiti Coast-based physiotherapist and founder of the McKenzie Institute. He received an OBE in 1990 and in 2000 was made a Companion of the New Zealand Order of Merit for services to physiotherapy.

From NZCSICOP to NZ Skeptics and beyond

Vicki Hyde

FOLLOWING on from online discussion and debate in the NZ Skeptic, a set of proposed motions to alter the society's constitution were mailed to all financial members four weeks before the conference, and voted on at the conference's AGM. Proxies were received from 24 members, all voting in favour of all four motions, and from two members giving their votes to the Chair.

The name of the Society was changed from 'New Zealand Committee for Scientific Investigation of Claims of the Paranormal Incorporated' to the more commonly used 'NZ Skeptics Incorporated'.

A proposed amendment to change the spelling of Skeptic to Sceptic was discussed and voted against. It was felt that use of the alternate spelling reinforced the difference between someone who is a member of the Skeptics and someone who says things like "I used to be a sceptic but then I saw a ghost…".

A specific place for the registered office is no longer enshrined in the constitution but will be at such a place as the Committee shall from time to time appoint. That has seen it shift from the Dunedin law firm who handled our establishment 20-odd years ago to being held by the current Chair. This will ensure that official correspondence does not go astray.

We've approved the addition of a set of general definitions to define our areas of interest:

'Paranormal' means any phenomenon that in one or more respects exceeds the limits of what is deemed physically possible according to current scientific assumptions.

'Pseudoscience' means any body of knowledge, methodology, belief, or practice that claims to be scientific or is made to appear scientific, but does not adhere to the basic requirements of the scientific method.

And, after some discussion from the floor, the Objects have been lightly modified to read:

(a) To investigate scientifically and objectively claims and events that are of an apparently paranormal nature and/or which are apparently based on pseudoscience.

(b) To report the results of these investigations and where possible to provide rational scientific analysis and/or scientific explanations.

(c) To provide reliable information about paranormal and pseudoscientific claims.

(d) To encourage a more critical attitude to pseudoscience and to paranormal claims, and to alert people to the dangers of uncritical acceptance.

(e) To increase public awareness of the difference between legitimate science and pseudoscience.

(f) To investigate the psychological, social, and ideological factors behind belief in the paranormal and pseudoscience.

Our thanks to all who participated in the discussions and who provided proxy votes.

Do we understand it all?

IN NZ Skeptic 85 Alison Campbell discusses teaching evolution in the school curriculum with particular reference to the influence of local creationist pressures opposing this as a sole 'theory'. If New Zealand Skeptics are to be true to their cause they must also take a hard look at their own basic assumptions. My concern from an informed amateur perspective is that in teaching evolution it is important to be intellectually honest to students. The fact of the development of life forms over billions of years and their gradual divergence from earlier morphological templates is beyond question to any rational inquirer even if it cannot demonstrated in the traditional hypothesis/experimental test

paradigm. Furthermore, Darwin's concept of natural selection is most obviously applicable to those life forms we are most familiar with and on which he based his inductive studies. At this level of macro development for instance, some morphological changes are clearly adaptive for predation or escape, and auditory or visual cues evolve to serve the attraction of mates or camouflage. However there is still substantial debate whether this paradigm can cover all stages in the evolution of life on Earth. It is when we get to the question of the origins of life or the complex operations within a single cell that questions arise. Such intricate developments are crucial to the central concept of Neo-Darwinism.

In the Middle Ages all sorts of complex theological problems were contemplated without seriously examining the basic assumption, the existence of God. We may be in a parallel situation now, assuming that the basic premises of Neo-Darwinism are beyond question as an explanation of life on Earth. Some day in the future explanations based on a hypothetical God or current Neo-Darwinism may be seen as equally quaint. Teaching evolution in schools must stay honest and show where there are still questions to be asked at a fundamental level. It would be ironic if after freeing young people from the irrationality and dogma of many religious systems we then indoctrinated them in a new secular orthodoxy.

Ian McKissack
Raglan

Another view...

what a bunch of closed minded,negative pricks people you are!!Paranormal things happen often!.Hey Stuart Landsborough I sent u an email about enhancing ones psychic ability,I still haven't heard from U!!Have U studied remote viewing??wake up to the possibilites,go and read a book called the Super Self and this has nothing to do with magic!!

Jenny Hyde,check out Jesse Marcels testimony about Roswell,and the nature of the unusual metal that scientist can't explain.I read your book called the oddzone and it's full of rubbish based on ignorance and lack of experience!!

Paul Leeks
Wellington

(Punctuation and spelling as received - ed.)

book review

Fundamentalism from the inside

Religion Gone Bad, by Mel White, Penguin, 2006. Reviewed by Bob Metcalfe.

WHITE is a Gay Christian who has worked for many US evangelical movements. At least, that is, until he came to terms with the fact that he was gay, whereupon he was shunned. He still often attends Jerry Falwell's Church in order to silently protest at fundamentalism's treatment of homosexuality. The man must have balls of iron. I myself tend to treat fundamentalists as if they were rattlesnakes.

He writes from an insider's point of view about fundamentalism and its attitude towards gay people. He knows the fundamentalist mindset, because at one time he was close to it himself. He talks us through the major leaders of fundamentalist sects, and the methods by which they intend to "reclaim America for Christ", but of course concentrates mostly on their attempts to fight the "Homosexual menace".

This is not a particularly well organised book; it tends towards pedantry and repetition. The author also makes a few silly statements like, and I paraphrase – only an hysteric would compare fundamentalists to Nazis – but then goes ahead and does it anyway. But this is an important book, and not just for gay people. It should be read by everyone who has the remotest interest in fundamentalism and the way it works. There are comparisons to be made with fascism; fundamentalists do not respect democracy, freedom of speech, or for that matter the US Constitution.

The society they want to see for all its superficial Brady Bunch appearance does have many similarities with a fascist state. The methods they use do bear comparison with those used by Hitler – violence, playing on fear, and creating scapegoats for the condition of society. White himself has founded an organisation that fights religious bigotry against gay people, and doesn't take them at all lightly as we tend to do here. In many ways an annoying read, but I think a very necessary one.

If undelivered, return to:

NZ Skeptics
PO Box 29-492
Christchurch 8540

New Zealand
Permit No. 3357
Permit

Sensing Murder 'Psychics' get chance to earn even more money

Easy money is there for the taking at Stuart Landsborough's Puzzling World in Wanaka, for Sensing Murder stars Kelvin Cruickshank, Sue Nicholson, Deb Webber and Scott Russell Hill. Stuart is offering a $50,000 prize for any of these psychics able to pass an agreed-upon demonstration.

And in a separate offer, they can each win $20,000 just by correctly identifying the gender of 20 pre-selected famous dead people. Given that they have been able to identify the gender of murder victims at least 32 times with a 100 percent success rate on Sensing Murder, apparently by purely psychic means, this should not be a problem.

www.psychicchallenge.co.nz

www.smpi.co.nz