How to Sort Out Medical Advice from Medical Nonsense: A Special Interview with Dr. Malcolm Kendrick

By Dr. Joseph Mercola

DM: Dr. Joseph Mercola

MK: Dr. Malcolm Kendrick

DM: There’s so much confusion about health information in the media. How do you resolve it? Hi, this is Dr. Mercola, helping you take control of your health. Today I am joined by Dr. Malcolm Kendrick, who wrote the book Doctoring Data: How to Sort Out Medical Advice from Medical Nonsense – phenomenal book – to help you answer that question. He is a physician, and like myself, he is trained in family practice. We practice about the same amount of time. He’s also written The Great Cholesterol Con: The Truth About What Really Causes Heart Disease and How to Avoid It, which is another great book.

But today, we’re going to talk about how to simply and easily apply some principles to help you decipher some of the information that you’re being given, which is generally hogwash in the media, and that’s being polite. So, welcome and thank you for joining us, Dr. Kendrick.

MK: It’s always lovely to be on. Thank you very much for asking me.

DM: Yeah. You’ve done a magnificent job with this book. Anyone who’s a serious student of being healthy and who wants to take advantage of the enormous benefit of these researchers who spend the vast majority of their professional life digging through these truths, could seriously benefit from reading your book, because it will help them identify were the flaws are in many of these researches and help sift through the nonsense. Why don’t you give us some background on yourself, you know, how you became such an opponent of the conventional medical paradigm just like I did?

MK: Well, I think it becomes a journey and I suppose you have the same journey. You start as a young man, thinking what you’re taught is what is, and you kind of go with that. I have told some people that my father, who died fairly recently unfortunately, was a very brilliant mathematician. I remember he was trying to teach me math, which I’m rubbish at. He looked into a textbook, he just ripped a page out, threw it in the bin, and said, “Well, that’s nonsense.” I thought, “That’s a textbook. You can’t do that.”

DM: Well, math is one of the hardest sciences. I have a great respect for people who are proficient in that discipline.

MK: Oh, yeah. When it comes to statistics, I really struggle. I need to know it. I know the basic principles when it comes to the little squiggly signs, sigmas, and things. I start going, “Hmm… I couldn’t help.” But luckily, I think I’ve got a reasonable grasp of what goes on, on a more global perspective.

DM: Were there any epiphanies that you had or any catalyst that caused you to abandon much of what’s being promoted in conventional therapies?

MK: The first time it really hit home, I was at a conference actually in Gleneagles where Dr. William Castelli in fact, who was the director of the Framingham Heart Study, came over to give a talk. I was interested in heart disease. But at that meeting, they came out. The results of the first ever trial on treating
mild to moderate hypertension came out. Prior to that, no one has done a study. It was done in the UK under the Medical Research Council.

When the results came out, there was a great fanfare. I went through it. Once I teased out all the figures, and you know how difficult that can be in clinical studies, it worked out that the total number of deaths from stroke and heart disease in the placebo group was 124, and in the treatment group, it was 124. I thought, “Well, nothing happened. This was a complete waste of time.” I was sitting in the room. Everyone else just carried on, going, “Blah, blah.” I thought, “Where has everybody gone? I’m left at the bus stop here and you’re already gone.”

At that point, I thought, “Actually, the data doesn’t seem to have an impact on anybody, except me in this case.” I’ve already been questioning the whole heart disease thing at that time. I realized that basically, research, data, facts, and figures are just, you know. They seem to have no effect on some people. I think that was a part of the point when I suddenly thought, “Hold on, this is nonsense.”

DM: It can have an effect. Typically, it’s a manipulation effect that’s designed by the people who funded these studies or put them together. You’ve developed over the years 10 tools that the average person can use to help identify what really is the truth in these studies. Just a phenomenal set of resources to help people tear apart, if they’re so inclined, the study that’s being currently promoted in the media as a breakthrough, when in fact it may not be. Maybe you can start reviewing some of those tools.

MK: I always say to people these are not like [inaudible 05:03], etc. It’s not. It’s not really like that. It’s just ways of looking at the data. But I think the first thing I always say to people is the whole association-causation thing. People will look at a group of people – say, the Women’s Health Initiative (WHI) study – and they study what they eat, what they do, what exercise, and what they drink over years and years and years. Then they say, “Oh, look, they drink red wine and they don’t get heart disease.” They immediately come out and say, “Red wine protects you against heart disease.”

I always go, “No. What it means is… It could mean that. But what it probably means is that people who drink red wine maybe they’re better off, maybe they’re more educated, maybe they exercise, maybe they eat vegetables as well, maybe they don’t smoke, or maybe they do a hundred of other things.” You cannot say, “This is it,” and yet, day after day, week after week, we get this nonsense.

Another way around: If I could eat two sausages, I’m more likely to get bowel cancer. They go, “Sausages cause bowel cancer.” I’m like, “No.” What that means is potentially people who eat sausages, they might be able to smoke more, they might be able to drink far too much, etc. We get this initial kind of fanfare of “This causes that.”

Immediately, I say, well, if it’s an association and if it was found in an epidemiological study, basically unless the association was gigantically powerful – such as smoking and lung cancer because that’s always a [inaudible 06:24] subject to a clinical trial – you just go, you get the paper, you crumple it up into a small ball, and you go, “Weeh!” You throw it over in the bin, because it means nothing. I’ll use the example of hormone replacement therapy (HRT). You probably went through that saga, where it was…

DM: Actually, I just recently interviewed the lead investigator for that a few weeks ago.

MK: All right. The whole interesting thing was obviously HRT protect women from heart disease.

DM: Right.

MK: And of course, it didn’t. I mean, it doesn’t have very much effect one way or the other. But we had a point where I believe in the States, it was medical malpractice not to give women HRT to protect them against heart disease.
DM: Oh, sure. And you know, the interesting component of that is they’re still, maybe even the majority of OB-GYNE physicians still prescribe it.

MK: That’s another example of, “Here’s the data. Oh, I don’t believe it. I’m just going to carry on anyway.”

DM: Yeah. That study though, when it was announced I think in 2002, 13 years ago, did bring some hope that the system does respond to truth. I mean, because it was really surprising that that data got published and promoted, and it was widely spread through the media. A rare example of truth going out.

MK: Well, it was promoted and trumpeted, as you say. Normally, you get a study that doesn’t show what they wanted to, and it’s all quiet on the Western front, as I say. That expression works in the States. I mean, it’s just amazing because I look at…

There’s a study done in Norway called the HUNT2 Study. It’s been going on for years and years. It’s a bit like the Framingham Study. Fifty thousand people over 15 years. What they find is the higher your cholesterol level is, the less likely you are to die of heart disease, stroke, or indeed anything. It’s a pretty strong association.

Also as association, as I’ve already said, can’t prove causality; lack of association definitely disproves causality. We have studies like that. There’s a huge study in Austria of a 150,000 people, which showed that the higher your cholesterol level was, the longer you lived. And the lower your cholesterol level was, the shorter you lived. These things just don’t see the light of day. I mean, they are published, but silenced, you know. Tumbleweed you have in the States. We don’t have it here. But all you get is tumbleweed sometimes.

DM: That’s one of the primary principles: correlation does not equal causation.

MK: Yeah.

DM: Even though it’s something highly correlated, it could be the cause, but it doesn’t mean it is. You have to be really careful about that. People can also use that even for good things that you think might be beneficial. It arrows both ways I think.

MK: Well, it does. I mean, if I eat portions of fruit and vegetables, you try and find the data for that. It’s like tumbleweed again, except a little more tumbling across. That was just essentially made up. I did an article recently in the UK talking about alcohol consumption: three units a day for men, two units a day for women, and anything above that is dangerous. I don’t know if that’s the same in America. In the UK, that’s the law.

It was admitted by Dr. Richard Smith, who’s the editor for the *British Medical Journal* (BMJ). He said, “We just plot these figures from thin air. We have no idea what was healthy or not. Now they have become gospel as if they were carved in stone and handed down from the mountain.” It’s now in question. Anyone goes, “No, these guidelines are absolutely true,” you go, “No, they were just made up.”

DM: Sure. And what constitutes the serving?

MK: Well, nobody knows. In my view, one unit is above the line, or maybe two. But no, I mean, no one knows how much they eat or drink really, so these things are pointless anyway.

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DM: Sure. Maybe you can review some of the other tools, the other 10.
MK: I think one other thing I try and say to people is this thing of risk, absolute risk versus relative risk, which is again used… It’s used to make things sound more scary and it’s made to make things sound more beneficial. I always try and simplify it. Because people don’t believe me, but I’ve asked a hundred doctors what the difference between relative and absolute risk is (maybe not a hundred but a lot), and none of them have been able to tell me, not in any way that actually was correct.

So I say right. You get 100 people and you put them on a blood pressure-lowering medication, and you get 100 people and put them on a placebo. After a year, two people have died in the placebo group; one person has died in the blood pressure-lowering group. That’s an absolute difference of one percent and a relative difference of one versus two. That’s 50 percent. That’s fine.

But you get a thousand people and you do the same. In the thousand-people group, one person dies in the blood pressure arm and two people die in the placebo arm. The difference is absolute. It’s 41 percent. The relative risk difference is one versus two. It’s 50 percent. You can keep doing this to 10,000 to 100,000, to one million, to 10 million.

When it comes to things like statins, which they say reduces the risk of heart disease by 40 percent, you say, “What was the underlying risk? Was it one in 10,000, one in two, one in a million?” Unless you know that, that statistic is absolutely meaningless. You tend to find this kind of thing trumpeted and trumpeted, “It will reduce the risk of this by 40 percent, 30 percent, or 60 percent.” And I always say, “Unless I know what the underlying risk was, that figure has no meaning at all.”

I used to use the example of the chances of being struck by lightning, whereby if you wore my special copper-o-matic device on your head, it reduced your risk for 50 percent, from one in 10 million to one in five million or one in five million reduction in risk. Again, these things are pointless. They’re stupid and shouldn’t be allowed. I think relative risk should never be mentioned in any clinical study. It should be absolute risk all the time.

DM: But it’s very common. It’s more or less the standard.

MK: It is the standard. It is. And it shouldn’t be because it’s just ridiculous. In fact, I’ve read recently a whole lot of papers looking at how a study should be presented. I mean, they do the thing called NNT. But again, NNT, which is number needed to treat, is slightly absurd. If you say you have to treat 100 people over one year to prevent one thing or stop one thing from happening, that’s an NNT of one in 100 or NNT of 100. But if you’ve got to treat a thousand people, the NNT would be a thousand.

You can more rapidly see that the NNT, as it gets bigger, it means the benefits get less and less. Unfortunately, it’s the opposite way around in other things. The bigger figure means worse. But again, these figures can be manipulated because what the industry does is it tends to… In statin studies, it says, “Well, let’s look at the risk of death, the risk of vascularization, the risk of hospital admission, the risk of an angina attack, and the risk of this, that, and that. You have about 10 things together. You can end up with an NNT of about three, which is really good. But actually, that covers the fact that it didn’t have any impact on mortality.

That’s another one that I get you with. They start talking about specific causes of death. As I say, if I wanted to do a study on pushing people off cliffs to prevent dying from cancer, if I push people off a 500-foot cliff, every single one of them, none of them would die of cancer. I could have a study entitled “The Benefits of Pushing People Off Cliffs to Prevent Cancer.” We should use this technique around the world because no one dies of cancer if you push them off a cliff. Do it. That may not be a really good way of doing it.

The used to have studies before statins showing that they could lower people’s cholesterol and reduce the risk of heart disease, but they died more of other things. That’s another issue as well. If you die of other
things, you can’t die of heart disease. The more people dying of this, the less people can die of this. And yet what they do is they cut it down. When you get a figure saying, “20 percent more risk of bowel cancer if you eat two sausages,” I immediately say, “Yeah. But what other sorts of cancer are they not getting, for instance? And are they protecting themselves against heart disease, etc.?”

It’s this overall mortality thing you’ve got to look at, which is overall. Looking at all causes of possible death. What was the impact? When you look at, say, the alcohol thing, it increases the risk of mouth cancer, esophageal cancer, stomach cancer, and the various cancers that it increases the risk of. But when you look at the overall figures, it reduces the overall mortality risk. You can take all of these things, add them together, and basically ignore them on the basis that you’re going to have to die of something.

If it reduces your risk of 50 percent of this and increases your risk of two percent in this, well, I’ll take the 50 percent and I’ll ignore the two percent. They don’t do this. They just section off the different types of things that you can die of and don’t tell you what the overall benefit was.

**DM:** Yeah. That’s another important principle: know what the overall mortality is typically over benefit.

**MK:** Absolutely.

**DM:** Not this one specific isolated area. It’s the reductionist view. It’s so pervasive because of this tendency in medicine to subspecialize. There are less and less people like us who are primary care physicians who are generalist.

**MK:** I have said to people, this sun exposure thing, the dermatologists have taken over the world on sun exposure and said, “Oh, my God, people are having skin cancer so you must never allow a photon go straight to your skin.” To which I say, well, I’ve seen studies, the study at the *Journal of Epidemiology*, where women who have higher sun exposure are 50 percent less likely to get breast cancer. Men who have higher rates of sun exposure have are 50 percent less likely to get aggressive prostate cancer. Men and women who have higher rates of sun exposure are 75 percent less likely to get colorectal cancer. These are diseases that affect...

**DM:** The three most common cancers. And skin cancer is like...

**MK:** And skin cancer is like this.

**DM:** And skin cancer is like...

**MK:** You’ll say “Skin cancer from this to this. Oh my God. I’ve reduced this from this to this.” The thing is I’ve reduced an enormous risk for you, but I have increased a very small risk for you. Even if I have, because frankly, the research that I’ve looked at says that sun exposure protects against malignant melanoma; it doesn’t cause it. Therefore the whole thing is a crook.

Also, as you probably know, sun exposure protects against heart disease, improves bone strength, reduces osteoporosis, and reduces your chance of developing multiple sclerosis and Parkinson’s disease. I mean, we’re looking at benefit after benefit after benefit. Huge overall benefits. And we’re all terrified by this stupid, little thing here, because we’ve been programmed into this.

**DM:** Manipulated by the fear-mongering dermatologists and the media who follow them.

**MK:** Yup.

**DM:** And it doesn’t help when you have a Surgeon General in the US who’s a dermatologist spewing the same garbage.
MK: The other problem, which I didn’t write about, is this kind of... It’s the fear. Someone says, “Oh, I went out in the sun, and suddenly, I got malignant melanoma.” They go, “That’s your fault. We told you not to do that.” If you go in the sun and you don’t get colorectal cancer, no one’s going to go, “Wee! You didn’t get colorectal cancer because went out in the sun,” because you can’t see a thing that doesn’t happen.

DM: Right.

MK: That’s another problem: you see things that happen, but you can’t see things that don’t happen. People are terrified of these things happening, but they can’t see the things that are not happening. I sometimes have talked to people about using a cycle helmet. Because the evidence seems to be that if you wear cycle helmets, you’re more likely to get run over. It may protect you slightly once you’re run over, but you’re more likely to get run over.

People will say, “How can that happen?” I say, “The evidence shows that if you wear a cycle helmet, motorists are more likely to get close to you because they think you’re safer.” But if you want to protect yourself on a bicycle, get a really crummy bicycle, where there’s a basket at the front and cute little puppy sticking out at the front, wobble on your way down the road, and everyone will give you a really wide berth. But if you strap yourself with cycle helmet in, everything aggressive, people would drive very close to you. It’s like, “Oh, so you feel safer?” Bang!

It’s counterintuitive very often. It’s what didn’t happen. You get knocked off. You bang your head, because you weren’t wearing crash helmet, everyone goes, “You should be wearing a helmet.” No one sees the people not wearing helmets who weren’t knocked off because they weren’t wearing a helmet. I have this other thing. The perception is very easy in certain things, but you can’t see things that don’t happen.

DM: Yeah, that’s highly counterintuitive. Now, I think one of the examples you illustrated in the book was the Framingham Study, which was one of the largest studies ever done in the world.

MK: Longest, maybe not largest.

DM: Longest. Yeah, it is the longest. It’s been... How many years now? Four or five decades?

MK: 1948, it started.

DM: ‘48, oh, geez, seven decades.

MK: Yeah.

DM: All right. One of the conclusions they reached is that... I believe it was the weight. If you’re overweight... It was weight or cholesterol. I think it was weight though.

MK: Well, there are several things that came out of Framingham. The most interesting fact that came out of Framingham, which has not been published... Well, there were several very interesting things that came out of Framingham. But the one that most interest me is, because this thing has been going on for so long, it’s got length of time data. I would say data. Sorry.

DM: Either way works. They’re both correct.

MK: I say tomato. Or was it tomato? I can’t remember. Anyway, they monitored people’s cholesterol levels and those people whose cholesterol level fell over 18 years, in the first 18 years of the... (I’m not actually sure why they selected 18 years) over the next 14 years were... I’m using European statistics here: we use millimoles per liter; you use milligrams per deciliter.
DM: Right.

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MK: A millimole per liter fall in cholesterol, which would be about 40 milligram per deciliter. There was a 500 percent increase in the risk of dying of heart disease in the next 14 years. The most important risk factor in Framingham was a falling cholesterol level. You have to go and search for that in musty libraries, because you just can’t find that stuff out otherwise.

DM: And no one’s publicizing it.

MK: The other thing they found at Framingham was that the more saturated fat you have, the lower your cholesterol level was during the whole part of the study. Again, Dr. William Castelli was in charge of this study at the time. He came to the meeting I was at in Scotland and said, “When you’re eating eggs, eat just the whites and don’t eat the yellow bit in the middle because that will kill you.” He knows that’s rubbish. You know that’s rubbish, and yet here you are telling everyone to do the most stupid thing possible. I was a bit annoyed at the time.

DM: Yeah. It’s easy to come to that conclusion. Wasn’t there one with an association with weight though with respect to the longevity issue?

MK: Well, the whole weight thing, I’ve written about this recently. I don’t think it came from Framingham. I hate to contradict.

DM: Okay. That’s fine.

MK: But the whole thing about obesity, I was looking into it and saying that, well, I know at a certain point, if you’re overweight, really fat, it’s going to be bad for you. Where is that point? It’s remarkably difficult to find that out. And then I started saying, “When do we define obesity? Where did that come from?” You can’t actually. A body mass index (BMI) of 30, that’s what you use in the States I presume.

DM: They do. It’s worthless. It’s commonly used in studies just because it’s the standard.

MK: It’s the standard.

DM: But it’s almost a worthless measure.

MK: All you need is your pen or whatever. It is a worthless measurement. They find that people who are overweight – BMI between 25 and 30 – lived the longest. This is being found in study after study after study. It was found in the National Health and Nutrition Examination Survey (NHANES) study that’s done in the States.

DM: NHANES I think.

MK: NHANES, yes. Well, up until 1987, they defined obesity as over 32.8, and then suddenly it became 30. I mean, that whole area is just… I say to people, “When it comes to blood pressure, the linear model for blood pressure was made up.” It was just made up. That was supposed to come from the Framingham Study. That’s possibly where we’re coming from. They said that basically, the higher your blood pressure is in the linear fashion, the higher your risk of dying of things. That model was disproved by Ancel Keys actually, believe it or not, and has been previously disproved by the…

Alcohol limits were made up. Cholesterol or what’s a healthy cholesterol, as you probably know, was made up in 1984 at a conference in the United States. And obesity levels as to where they’re healthy or
not were made up. If you go into it (I think this is the thing more people are finding hard to believe), is a lot of the stuff is just made up.

**DM:** It is. But people, if they don’t investigate it and if they don’t look into it more deeply, they have no idea that this is what’s happened.

**MK:** None of them are going to try to go back and say, “Where was the first study?” I mean, when I started looking at HRT, because I was interested in heart disease, women got less heart disease than men when they were younger. And then everyone said, “Well, after they’ve menopause, it accelerates and therefore women are obviously protected by their sex hormones.” I started saying, “Where was that study? Presumably somebody did the study.”

The only studies I could find were negative. I found a study where a woman had a hysterectomy plus oophorectomy and a hysterectomy without an oophorectomy. People who looked at them over a period of time had found that there was no difference in the heart disease rates. No sex hormones made no difference. They weren’t given any additional hormone at that time, because that study started in about 1962. There was a study on rabbits and then there was a study on something else. That was about it.

I thought, “Well, it makes no sense any way,” because if you find in certain countries, there is no difference between the heart disease rate in men and women so it’s clearly not a biological difference. But yet, that was just made up. Five portions of fruit and vegetables made up. And these things become set in stone and everyone goes, “Oh, my goodness, this must be true.” This is one of the strongest things I say to people, “Don’t believe it. They just made it up.”

**DM:** Sure. With the hormone therapy, it’s interesting, because as I said, I just interviewed the chief investigator of the Women’s Health Initiative. As you know, they stopped the study in 2002. But it was done with artificial hormones. Artificial hormones! It wasn’t even done with regular ones because they were so convinced that was the case. There was no portion of the study that differentiated between artificial and bioidentical human hormones. We still don’t know. There’s no definitive data on it. But intuitively, it makes sense to use human hormones to replace it rather than artificial, synthetic, or ones derived from animals.

**MK:** Well, yeah. Absolutely. The ones you do… You’ve done the same thing. I mean, I know I read your blog and stuff that you write. You know yourself that this stuff is weirdly… It just comes to be, then it becomes the truth, and if you try to stand up against it… I looked at the history of the radical mastectomy, for instance. That was a terribly sad indictment of…

**DM:** That was a long time. It was over a century when it was started by Dr. William Stewart Halsted.

**MK:** William Stewart Halsted in 1894. He said, “Yes, to get rid of it, you must get rid of the breast, the underlying tissue, and the arm.” It was almost like how much can you get rid of and the woman still lives at the end of it and become a competition? Well, I can take your entire arm off and the leg. You’re just left with two eyes and a brain. I remember there was a Steve Martin film. And you just think, “Well, this is just…” But the people who tried to stand up against were crushed even though there was no evidence to support it. And you see this happen…

**DM:** And it’s progressed even more insanity. Now you’ve got famous celebrities in the United States like Angelina Jolie who has both of her breasts lopped off, not because she has cancer but because she has risk for it. She’s got a genetic increased risk.

**MK:** I know.
DM: It’s just like… They’ve just been so effective at manipulating and deceiving the vast amount of people.

MK: Well, you just remove all from the waist down, and get rid the prostate and anything out there. I mean, it is ridiculous. We’re living in a sense of fear almost now. One of the reasons I wrote the book is to say, “You know, we can be healthy. We can live. Yes, we can get hit by a bus a bus, you might develop a cancer, or something horrible might happen to you. But honestly, you’re much better with just carrying on. If you get a symptom you don’t like, go on see someone because at that point, you might need something done.”

The prostate cancer screening thing as well, it’s just a waste of time. And all the cancer screening initiative were just started because someone said, “I say stitching time saves nine.” That’s just scientific rationale for cancer screening, you know, “Oh, if we can pick it up early, we can treat it early, and everything will be fine.” But we have no idea how cancer actually grows or progresses over anything really.

In fact, if you look at women... I’m never quite sure whether to say this, this statement, because a lot of women run around screening in terror but I’ll say it. They did a study where they looked at women who died of other things, examined their breast tissue to find out if they had signs of breast cancer, and all ages, right about 40 percent of women, you can find things that you could define as being a cancerous tissue.

I say the more accurate our screening becomes and the more detailed it becomes, we will find that 40 percent of women have something that you could say you’ve got cancer. Now, we know that 90 percent of those things will never do anything. But, of course, once you said, “You have…”

DM: It’s the same thing for prostate cancer too.

MK: Same thing for prostate cancer. We slice the tissue, find them, and hold it up. The other thing I say to people is, “It’s not like red and green where a pathologist goes cancer, not cancer, or benign.” You can show 100 samples to one pathologist and he’ll say, “Sixty-five of them got cancer.” Or one will say, “Thirty-two of them have cancer.” Another one will say, “Eighty-six have got cancer.” It’s not an exact science. It is not like that. There’s a little thing that goes “buzz” on cancer cells. Again, you’re reliant on…

DM: People have no clue that that’s the case, that there’s this wide difference in pathologists’ interpretations. It’s a human assessment.

MK: It becomes almost a human assessment.

DM: Or subjective. Actually that was the description.

MK: They say it’s objective, but of course, if you’re a natural risk-taker, you might… The whole thing is a nonsense really. It’s as almost as if somehow we can take a sample of and there it is. It’s absolutely cancer. It absolutely can be treated. You absolutely won’t die of cancer. This thing definitely would have grown. From start to finish, this is just nonsense.

The main issue, of course, is picking up people who don’t have cancer really and who were told that they do. You got a woman. You tell her she’s got a lump, a bump, or something. Well, the terror and anxiety that you create with that. Then you do a biopsy. There are some people who think that when you do a biopsy, you trigger the cancer to spread. It just sat there doing nothing and you’ve attacked it with a needle. I don’t know the truth of that, but it sounds that could happen. And then you maybe remove the entire breast and you think… I really find this stuff disturbing.
DM: I think you wrote about mammograms, too, which is a sort of an extension of that. Because here, we have a known tool, a diagnostic tool, which is ionizing radiation, uncontroversial, that increases the risk of cancer. That’s the very tool they’re using to diagnose it.

MK: We might as well do a bilateral mastectomy because they probably triggered cancer in you. I don’t know. The odds are difficult to establish.

I’ve spoken to maybe 50 people who are numbers and statistician theorists about this. I’ve said to them, “How does the risk go?” Say, there’s one in 2,000 risk when you do mammography, you trigger cancer. Does that mean if you do the next one, it’s one in 32,000 plus one in two-third or one in 1,000 then? What is it? What is the risk? The next time, is it one in 500, or is it one in 250? Is it one in 125? You have several down to one in whatever it is. Everyone says, “Well, we really can’t answer that question.” It’s quite an important question to answer, isn’t it?

DM: It’s a pretty basic one.

MK: It's a big Russian roulette saying whether you clicked or missed, and then the next time you spin it, clicked and missed. If you keep doing that, the odds are that eventually you're going to blow your brains out and they’ll become smaller and smaller over time.

DM: Sure.

MK: Assuming that the risks are not additive. But no one will answer that question, and I think that’s absolutely fundamental. So these are the sort of things that I go, “Excuse me, what is…” No one can answer this. I’ve never gotten anyone to answer this question. I think it’s kind of…

DM: And yet it’s accepted as a standard of care. If anyone seeks to oppose that viewpoint, they are vilified. In my case, I’ve been writing articles on it and the US Food and Drug Administration (FDA) sent me a warning letter for writing them. Then my state medical board says, “Oh, we’re going to remove your license.”

MK: Yes.

DM: You know, for saying the truth. No patient complaints or anything. Nothing. It’s just telling them like it is. You have to spend tens of thousands, hundreds of thousands of dollars in legal fees to sort through it all. Of course, they never win, but geez.

MK: This is not my book, by the way, that I’m advertising. This is a researcher from Denmark. He runs the Cochrane Collaboration. He’s written a book on mammography screening called Mammography Screening: Truth, Lies, and Controversy. He’s been studying it for years and years and has come to the conclusion that it probably does more than harm than good. Boy, does he get that.

DM: Why don’t you just mention a bit about the Cochrane Collaboration because, I think, a lot of people aren’t familiar with it.

MK: Well, it’s a group. It was set up in fact. I think his name was Archie Cochrane. That’s his name. He’s from Britain, I think. He tried to get researchers from around the world who have no actual connections with the industry to review the evidence on an area and then come to a conclusion. The Cochrane Collaboration is a wide collaboration. If you’re going to do an analysis of the data, you have to use all sorts of different statistical techniques, etc.

DM: And not using relative risk.
MK: Yes. They sort of do. Well, there use number needed to treat. I don’t like number needed to treat either, but it’s better than other things. They produce these reports, which are generally very good, I think although they did produce reports saying that statins are wonderful. At which point, I decided I didn’t like them anymore. I used to think they were correct.

To be truthful, there’s also a background story to this. They can only use a data that’s provided. They probably know or maybe don’t know that all the data on statins is held by one unit in Oxford called the Cholesterol Treatment Trialists’ (CTT) Collaboration. They have all the data and the clinical studies. They won’t let anybody else see it.

The Cochrane investigators try to go over and have a look at it. Actually, the University of British Columbia sent a researcher to review the data for themselves and was told, “We’re not going to show you the data.” So there’s only one group in the whole world that have the data, and the Cochrane Collaboration have to use the data they say they’ve got. It’s completely mad.

DM: Well, that’s another strategy they use. They manipulate what’s published. Maybe you can address that because that’s a really big area. They don’t publish negative results that don’t support their claims.

MK: They now say they do.

DM: I think in the book she talked about that. There was effort for the journals to say, “Listen, if you’re going to start a study, you’ve got to sign up for this law. This way, if it doesn’t turn out, then we know that you’re falsifying or something.” But everyone abandoned it.

MK: It’s one the wonderful things. They say, “I’m going to do very nasty things to you if you don’t do…” I’m like, “What nasty things?” They go, “Well, we’ll do something. We’ll thank about it.” They show you horrible attitude but nothing happens. It’s a bit like, “Disclose your conflicts of interest now. If you don’t disclose, you’ve got conflicts of interest.”

And to mention one name, Paul Ridker, who wrote a paper on the use of statins saying they were wonderful, did not mention at the time he was a board member of Merck. I can say this because it had to be published in the journal. Someone showed me his name and said, “I don’t think all these people disclose their conflicts of interest, you know.” It turned out that there 70 undisclosed conflicts of interest in the paper, including board membership.

When it comes to rules of publishing papers, I don’t know if you have the same in America. You probably have more than what we have here. I’ve got one that produces new tax rules. As they do it, there’s a bunch of tax lawyers working out how to get random. I could work out how to get it run… You have to publish these things in about five seconds. Well, we call it an investigation, not a study. We didn’t realize that an investigation was the same thing as a study. I mean, that’s being facetious. But there is no way you’re going to stop them from doing this. They know a million ways of doing stuff that you will never even know happened.

The magician’s tricks. The best tricks in medical research happened long before you even know that they happened. They create, you know. You’re looking for someone cheating on the football field. I say, what you don’t realize is they made the field, they bought all the players, they put these sticks up, and they hired the umpires. Frankly, all that’s going on, you don’t even know that’s happening. Your chances of stopping this from happening are zero. I don’t know.

In the States, they have the non-disclosure of negative data on antidepressants. As you know, they only publish positive studies, and the negatives, therefore aren’t published. You then have a bias of infinity. That was only found out I believe because they were forced in the court of law to bring out the studies
that they’ve done, which they haven’t bothered to reveal. There are just hundreds of these things that go on.

The first ever statins trial was the AFCAPS/TexCAPS study, which they didn’t even finish. They just said, “Well, it wasn’t really a study; we were just looking at something else. And actually you’re not interested in this. Go away. Goodbye.” The only study done on statins that was not funded by the pharmaceutical industry was the ALLHAT. That was the ALLHAT, wasn’t it?

**DM:** Uh-huh.

**MK:** At that time, there was no benefit to taking statins. You have all these studies on statins, and wonderfully one that’s not funded by the industry, which says “We couldn’t find it any good.” At which point, everyone says, “Well, that was a rubbish study. We’re not paying any attention to that. Meantime, we’ll look at these other studies that we’ve done.” I mean, the whole area I’m afraid is driven with despise.

I used to say to people that I don’t really blame the industry for doing this. I mean, they have to make money. It’s like if you put a bunch of sheep in the field and then said to the wolves, “Don’t eat the sheep. I’m going away and I’m coming back tomorrow. Don’t eat the sheep.” You come back and all the sheep were eaten, and you go, “I said don’t eat the sheep.” The wolf looks at you and go, “I’m a wolf. What do you expect?” A proper shepherd should say, “I’m building a bloody great fence, electrified so you can’t eat the bloody sheep because I know if I turn my back you’re going to.”

I mean, if you give people any opportunity and you don’t police it properly… In the States, I hate to say, I blame the FDA. I don’t think they do their job properly. I think they’re toothless. I think they’d look the other way and they don’t ask for all the data. Frankly, these are the people I blame. I don’t blame the industry. Well, I sort of blame them, but I can understand why they do it, if you like.

**DM:** The industry is smart enough. They’ve got this revolving door, which I think you also addressed in the book.

**MK:** Oh, yeah.

**DM:** This is a magnificent collusion. They work in the government and then they go into the industry. A classic example is the vaccines. Julie Gerberding, who is the head of the Centers for Disease Control (CDC) for six or seven years, now is the president of the Merck vaccine division.

**MK:** I know. You should be banned forever from working with the industry if you’re in the position of authority making decisions about drugs and medications. It’s a worldwide problem I suppose. And not just in medicine, I mean, you can see it in all sorts of areas.

**DM:** Sure.

**MK:** I’m making decisions on building aircraft carriers and then next I come working in an aircraft manufacturing company, sitting as an executive vice-president and getting paid a million dollars a year for doing who knows what for basically making that decision. I think we have to [inaudible 39:56]. We have to stop this from happening. If we have to get opinion leaders and experts, people running studies, that’s fine you can do that if you like. But you cannot sit on the guideline committee. You cannot be the person who then says, “This is how we’ll be treating X.”

[----- 40:00 -----]
You look back at the cholesterol-lowering guidelines. How many conflicts of interest are there? Last time I looked at the guidelines that were made in 2004: 107 conflicts of interest, 70 directly with statin manufacturing companies. How can this be? This is nonsense. Can you imagine if a bunch of judges at the Supreme Court making a decision on, say, some sort of law or competition law and said, “Oh, by the way, I’m being paid five million pounds or dollars a year by Lockheed Martin. I think Lockheed Martin is the company that should be doing this. We should be using their products.”

People would howl with outrage. And yet somehow in the medical profession, the people who do the studies, who work with the industry, who are being paid by the industry, and who claim that makes no difference to what they say or think should never be the people sitting on guideline committees, and yet almost exclusively they are. This is just a huge inherent bias, which needs to be gotten rid of.

**DM:** But it’s going to be a challenge to get rid of it, as you mentioned. It’s almost impossible because if you change the rules and say, “Okay, handle this conflict of interest,” they’ll creatively have some workaround and donate to some charity that they’re the direct beneficiary of. It’s just the human nature. There’s no way around it.

**MK:** I agree in a way, but in another way, I disagree. You know that if you’re a high-level, famous cardiologist, and you’re in charge of the charity called Heart UK, which is a charity funded entirely by the pharmaceutical industry, that does stuff – educational things and meetings – then they pay these guys to do it. They say, “Oh, I don’t have a conflict of interest. I’m paid by a charity.” What I would do is I would say, “That’s fine.” You just take every cardiologist and you say you can’t do anything in cardiology guidelines. We’re going to bring in a bunch of urologists because it’s not difficult to understand this stuff. It’s not difficult for someone to present the information to them.

**DM:** Or maybe mathematicians.

**MK:** Maybe mathematicians. I thought about a scientific Supreme Court if you like, where there are these people who have no contacts or interest but they have… You’ll be the world’s greatest researcher in whatever. You’re going to sit there and you’re going to make these decisions. You’re paid for by the government. You have no interest. And if you have an interest in the area, you accuse yourself. I mean, this is the kind of dream I have. As you say, what are the chances of this happening?

But that’s how we should be doing it. People should be disinterested. They must be disinterested in the evidence, and yet the people we choose to review the evidence are the very people whose very existence is wrapped up with conflicts. That’s nuts.

**DM:** Well, you know, it can be discouraged by all those information. I think that’s a common tendency. I just like to point out that it’s important to understand that it’s really challenging. It’s just basically to pick up a copy of your book, to learn even more of the information so that you can be aware of how you’re being scammed by these professionals and develop strategies to take different perspectives and viewpoints.

As we’re recording this interview, an example I can give you, one that’s similar to the one we talked about is the industry-funded research in aspartame. It was like 85 percent of the industry-funded research proved that it was safe and 90 percent of the independent research proved that it was dangerous and had side effects. Today, as we’re recording this, Pepsi, because of the awareness that was generated about these dangers, has decided to remove aspartame from its diet sodas.

**MK:** Hurrah!

**DM:** Yeah. We’re making a difference. In general, the industry sales of artificial sweeteners have been down by five percent for the last few years. It’s billions of dollars in losses. I think that’s the encouraging
perspective: to know that there’s an issue out there, arm yourself with information, and vote with your pocketbook. You can change the system. You don’t have to be manipulated by these monsters.

**MK:** I agree. I mean, the reason for writing the book was to try and help people to at least see what’s going on. Knowledge is power if you like. As I said, I’m not suggesting that it is the ultimate book on things.

**DM:** But it’s a good start.

**MK:** I like to say it’s a good start. As I was writing, the book was supposed to be: go out in the sun, it’s good for you; eat stuff that’s healthy; saturated fat is good for you, etc. Then I thought, “Well, people ought to know this information from the other side.” I thought I was going to have an introduction saying: the reason why you shouldn’t believe this stuff is this. As I kept writing it, I realized there’s more and more and more stuff. It kept opening up. I said, “I’m never going to finish this bloody book.”

Eventually, I did sort of finish. I made it as concise as I could. It provides all that. These are my views. But I am showing you some of the things I hope that you can see, then understand, and then change and understand where things came from. I just want to really empower people like yourself.

**DM:** Yeah. I think you’ve done it. Congratulations on compiling such a magnificent book. I mean, as I said at the beginning, anyone who’s a serious student of health needs to get a copy of this book and read it carefully, because it goes into far more details than we have in this interview. It’s really eye-opening. It will empower you. You don’t have to be fooled by this manipulation on a constant basis once you know some of the tricks that they’re using. I’m sure that you’ll agree that there are probably 10 times more tricks that you haven’t even discussed. But just to know that they’re there.

**MK:** Yeah. I think the best tricks are the ones I haven’t even noticed.

**DM:** Right. Because they’re so clever.

**MK:** They’re so clever. They are clever people. There’s no doubt about that. Some of them are far cleverer than me. There’s no doubt about that. But I think that if people can understand these things, they’re empowered to make the decisions for themselves. My next book’s going to be on why sunlight is good for you. No. That’s a joke. But I hope people enjoy it. Thank you for helping to spread the news about it.

**DM:** Well, it’s definitely one of the best books I’ve read this year. No question. It’s in the top five. That’s a pretty significant group. And as I said, it really should be in your library. It’s just a great resource. It will empower you and help you make healthy decisions because you don’t have to be fooled. You can avoid this nonsense. Your book goes into much more detail than we did in our interview. But are there any things you’d like to emphasize or close on as we finish our interview?

**MK:** I don’t know if you’ve ever read *The Hitchhiker's Guide to the Galaxy*.

**DM:** I never did.

**MK:** No. But the front cover had “Don’t Panic” written on it. I was thinking... I suggested this (but doubt it’d be stupid) putting “Don’t Panic” on the front, which means you’re not about to die, just be chill, be calm, and also believe in your own feelings. An awful lot of people have said to me when I read this book, “It’s like it’s confirmed all these things I really thought, but I thought maybe I was an idiot for thinking them.” I think that’s the other thing: have faith in yourself to understand these things. Because a lot of things you thought were bonkers, they are bonkers. It’s bonkers.
DM: Yeah. I like so much what you said previously, remember, they probably just made it up.

MK: They just made it up. In Chicken Little, he said, “The sky is falling.” Everyone’s panicked. He said, “Well, actually, the sky isn’t falling, guys. I just made it up.” Maybe I should call my next book, *They Just Made It Up.*

DM: Do you have a website or anything?

MK: I’ve got a blog, which I write on. It’s called DrMalcolmKendrick.org where I ramble on about various things.

DM: Is that doctor “D-R?”

MK: D-R. It’s DrMalcolmKendrick (all one word).org.

DM: Okay.

MK: But if you search “Malcolm Kendrick” my features appear on various webpages with various court cases from the pharmaceutical industry. But they haven’t yet. There isn’t anyone who has done me because I tend to be quite careful not making very specific allegations about them.

DM: Yeah, you’ve got to be careful. I remember when I wrote my book on Splenda called *The Sweet Deception.* I received a 20-page letter from this prestigious New York law firm saying, “If you publish this book, we’re going to sue you out of existence.” We did extra due diligence in our referencing. We published the book, and they never sued us.

MK: They’re threatening you, aren’t they? Because if you’re telling the truth, luckily in science still, if you’re stating a fact or truth, so long as you’re doing that, then it’s very difficult for them to get it out of you. One other thing you’ve got to remember is if they do attack you, they draw everyone’s attention to themselves. It’s not a good idea for them, say, “Attacking little ole’ me, you big horrible pharmaceutical company, you’re going to look stupid.” They much rather just keep quiet. They much rather that all things just shush down. Try not to worry about it too much.

DM: Sure. And they’ve got other clever ways to do it. They do it through front groups like the Science Media Centre. Have you ever encountered them?

MK: Nope.

DM: Oh, you should definitely look into them. They’re a front group for industry-paid conflict of interest professionals. They have this whole army, literally an army of these professionals who responded at the drop of a hat to anything, any new study that gets published in the media. I think they’re based in the UK, the Science Media Center. You’ve got to look at it.

[----- 50:00 -----]

MK: Is it that big building with boats floating around it?

DM: No. I don’t know what type of building they have. But it’s definitely a part of their strategy. One of their clever sophisticated attempts to manipulate and to confuse people about the truth.

MK: Assuming that is always easy to do I suppose if you’ve got enough money and enough resource. In all area, I think if you… In my case, I have no acts to grind here. I just tried to look at it and say, “Here as far as I know, as far as I can believe to be is the truth.” I don’t have any horse in this race at all.
DM: Sure.

MK: I’m just trying to be… I realize I must be wrong about some things. I tell my wife, “I’m not wrong; I’m right about everything. Remember that.” I was wrong once 10 years ago. Of course, I can be right. But I think, on yourself, if you’re honest, you’re really trying to just tell the truth, and you’re just trying to tell it as it is, I think people do come around to that. They do come to think, “Well actually you know, that sounds…

DM: You’ve done a magnificent job. I congratulate you for your perseverance and your dedication in putting together such a magnificent resource, which, as I said, should be in everyone’s library. I really thank you for what you’ve done and what you will do because you’re still young. All right. Very good. Get a copy of the book, *Doctoring Data: How to Sort Out Medical Advice from Medical Nonsense*. It needs to be in your library. All right

MK: Cheers.

[END]