NEW BEGINNINGS
CISS
Newsletter of The Cancer Information & Support Society
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... let us be the light at the beginning of your journey

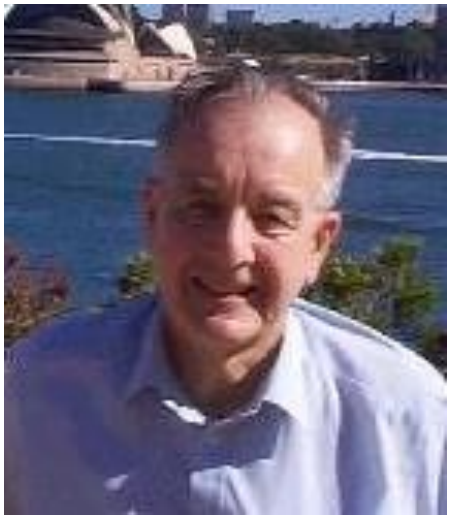
Self-Medication: the Treatment of Cancer with Phenergan [promethazine] and Calcium

The following is a December 2008 update of an article by the late Dr Robert Jones that appeared in the CISS January/ February 2009 Newsletter. Robert and his wife Brenda visited Sydney from 5-9 November 2002 (see picture) and Robert spoke at a CISS public meeting at North Ryde on Saturday 9th. Robert died in June 2016 of a recurrent heart condition.

The following are extracts from the latest update of the Phenergan protocols. A copy of the full update is availabe from the CISS Office

Introduction: The cancer therapy set out here aims to destroy both primary and secondary (metastatic) growths in two stages; first, by bringing about extensive tumour destruction over a period of a few hours, and then by a process of attrition. This new approach marks a revolution in cancer treatment. In marked contrast with conventional treatments the procedure is highly selective. These are early pioneering days; not all cancers have been found to be sensitive. The present text is to be regarded as a simple prototype, in the same light as the primitive earliest cameras, motor cars or aeroplanes. Patients are asked to be realistic and not to allow hopes to rise too high. Although a great deal of experience has been incorporated into the advice, there is still room for improvement....

Caution: To date the question of safety has not been an issue, but Phenergan treatment with calcium can cause slight tumour enlargement which may initially cause problems, especially if the disease has reached an advanced stage. For example, in a patient with obstructive carcinoma of the oesophagus swallowing became more difficult on the following day but gradually returned to normal during the following weeks. In instances where growths obstruct natural functions difficulty may be encountered. In these circumstances the original schedule (**Procedure I. Phenergan alone**; see below) would be preferable.



Robert Jones MA PhD

Side Effects: When Phenergan is taken without calcium, the side effects are confined almost entirely to a drowsiness which wears off over the course of a few days. When Phenergan is combined with calcium, patients tend to feel very sleepy after an hour or so, and may need to be woken up to complete the treatment. Sensations of nausea are uncommon, and can be suppressed by drinking. Restlessness of arms and legs, described by one patient as `twitching', on the first day is interpreted as a response to destruction of malignant tissue. Fatigue and soreness can occur, and may persist for a day or two more. In sharp contrast a subject who was free of cancer noticed only a slight drowsiness at 8-10hr. For those with experience of the fiercer forms of chemotherapy and radiotherapy the differences will be welcome.

No instances of pain resulting from the therapy have been reported, but paracetamol would be a suitable analgesic....

Contra-Indications: Cancer patients are unlikely to benefit if:
[1] Steroids are being administered in high doses. This form of interference with anti-cancer activity is unstable, and therapy with Phenergan can be commenced three days after cessation of steroids.

[2]There has been brief or inter-mittent exposure after the onset of disease to phenothiazines or to certain chemically-related drugs possessing similar anti-cancer properties.

[3] Analgesics classified as non-steroid anti-inflammatory drugs (aspirin, ibuprofen, diclofenac, etc) are being taken. Here the advice is to wait for a week before commencing.
Serious pain calls for professional attention. Paracetamol, temporarily and in moderation, is suitable; so are opiates (for example, morphine given on prescription). Provided the pain is not too severe, a TENS (transcutaneous electrical nerve stimulation) device can provide limited measures of relief.

[4] The patient is deficient in essential fatty acids. This is an uncommon condition of which scaly skin, especially on the backs of the hands, can be an indicator. Polyunsaturated fatty acids are micro-nutrients and are required for normal health. Acids participating in the process of tumour destruction still await identification.

[5] There is dietary supplementation with vitamin E. The question of vitamin E calls

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IN THIS ISSUE

Back Pain — Is It All in Your Head?

…The late Dr. John Sarno, a professor of rehabilitation medicine, used mind-body techniques to treat patients with severe low back pain. His specialty was those who have already had sur-gery for low back pain and did not get any relief. This is a tough group of pa-tients, yet he claimed to have a greater than 80 percent success rate using techniques like the Emotional Freedom Techniques (EFT).

A recent Vox article6 discusses Sarno's unconventional treatment strategies for back pain, citing feedback from enthusiastic patients:
"'Thousands of people, including myself and my husband, cured our chronic back pain using [Sarno's] methods,' wrote Karen Karvonen.

Another Sarno devotee, Steven Schroeder, said the doctor changed his life. Schroe-der's back pain flared whenever he was stressed — a busy time at work, an illness in his family. After he absorbed Sarno's books, the discomfort mostly vanished. 'I still sometimes have pain now in times of stress — but I can literally make it go away with mental focus,' Schroe-der, a lawyer in Chicago, wrote in an email. 'It is crazy.'

Though he may not be a household name, Sarno is probably America's most famous back pain doctor. Before his death on June 22, a day shy of his 94th birthday, he published four books and built a cult-like following of thousands of patients … Many of them claim to have been healed by Sarno, who essentially argued back pain was all in people's heads."…

The Psychological Underpinnings of Pain

One of the most controversial aspects of Sarno's theory is that spine and disc abnormalities have no bearing on pain. In this 20/20 segment, Sarno dismisses these issues as "normal abnormalities" that are unrelated to any pain you may be experiencing. Many with back pain have no detectable abnormalities or structural problems while some that do have them suffer no pain.

According to Sarno, you unconsciously cause your own pain. In a nutshell, the pain you're experiencing is your brain's response to unaddressed stress, anger or fear. When these kinds of emotions are suppressed, your brain redirects the emotional impulses to restrict blood flow to certain parts of your body, such as your back, neck or shoulder, thereby triggering pain.

This pain acts as a distraction from the anger, fear or rage you don't want to feel or think about. The pain essentially acts as a lid, keeping unwanted emotions from erupting. You may feel anger at the pain, but you won't have to face the fact that you're actually

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Free Psych-K & Emotion Code for CISS members

CISS members can receive Psych-K and Emotion Code to identify and change negative belief systems—free of charge. Ring the Office to try it.

Supplements for CISS Members

Low Dose Naltrexone all strengths 1.5mg to 4.5mg
100 compounded capsules (Doctor's prescription needed)
Look up "Low Dose Naltrexone" Homepage
Stabilised electrolytes of oxygen 50ml—$15 (Chlorine Dioxide)
Visionary Health Compounding Chemist (02) 4969 5081

New Members: January/February:
Kate Caine, Andrea Byrge, Lindsey Whitelaw, Sue Chillingworth;

Donations to CISS: January/February:
Nil

DVDs for Sale from the CISS Office

CISS Seminar "Cancer & Hope - Survivors share their Lessons" are available for $29.50 plus postage for members or $39.50 + postage for non-members

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OVERSEAS & LOCAL NEWS

OVERSEAS NEWS

The 5G network is being rolled out overseas in most countries often with little or opposition. However a group of concerned scientists called the 5G Appeal have expressed their concerns and CISS has followed the up locally.

LOCAL NEWS

Hazards of the 5G network

As reported on page 8 of the January Newsletter CISS made a submission late last year to the Australian Parliament's Standing Committee on Communications and the Arts on the subject of Deployment, adoption and application of 5G in Australia. During February I was invited by the Committee to take part in a hearing by the Committee to expand on and discuss the Society's submisison. This was held in Perth on Monday 17 February and I took part with two others via a teleconference. (see page 9)

Research Assistant for CISS

As we approach the second and third stages of the Dr Laurence Cox Alternative Cancer Paradigm Project we are faced with the problem that the project has progressed much more slowly than planned. This is because our Research Project Manager suffered two whiplash injuries in 2018 which seriously reduced her capacity to work. Her recovery has been slow but it has recently picked up.

Last year we had a further delay of at least 4 months figting off the attempted take-over.

To accelerate the completion of the Project the Committee has decided to recruit a Research Assistant. Interviews of the four applicants shortlisted from among 186 applications were held from 5 March to 11 March. The successful candidate was Ali Gholamrezaei who has both a recently obtained PhD in Biomedical Sciences from KU Leuven in Belgium and an MD from Isfahan University of Medical Sciences in Isfahan in Iran. We welcome him to CISS. He started on Monday 30 March on a 6 months contract to assist Anta Adhitya our Research Project Manager.

CISS Committee positions

Members of CISS are invited to nominate for one of the three vacant positions on CISS' governing Committee.

One of the positions is that of Honorary Treasurer whose job is to monitor CISS' income and expenditure, advise on suggested changes and prepare and monitor the annual budget.

The other two positions are ordinary Committee members who advise on how the Society can best promote its message among the general public. Meetings are monthly, typically on a Monday at 7pm.

For further details contact Don Benjamin, General Manager, on 0416 121 140.

Don Benjamin, Editor

Update on Radical prostatectomy trial

Michale Shirley has drawn my attention to ther latest update to the Radical Prostatectomy vs watchful waiting trial after 21 years folliow-up. There was still no significant benefit found in terms of lives saved (ie any reduction in deaths from all causes) (See page 5).

Letter in BMC Pulmonary Medicine

Late last year I responded to a paper published in this Journal that specialises in lung conditions. The paper essentially claimed that lung cancer screening is superior to usual care (ie no screening); in other words early detection saves lives.

I wrote a Letter to the Editor pointing out that the conclusion of the paper "Low Dose Computed Tomography (LDCT) lung cancer screening is superior to usual care" was not consistent with the data presented "There was no significant reduction in deaths from all causes from the screening".

Like most researchers the authors claimed that a reduction in deaths from lung cancer among the screened group meant a saving of lives. Whereas if there is no reduction in deaths from all causes as well it means that many of those treated after screening died from the treatment instead of the lung cancer.

After obtaining peer review from two external referees they have accepted the letter for publication.

COVID-19 (Corona) Virus

Since the last Newsletter the COVID-19 (Corona) Virus has essentially changed the way we live—hopefully not for too many more months. Many people in authority are putting it at a minimum of six months before we can expect things to start to return to normal. But the econmy might take a lot longer to recover, especially because most countries are affected.

The more affluent Western societies have been hit harder than others mainly because their citizens have been travelling the most, including on cruise ships and returning from overseas by plane.

See page 7 for a different perspective on the potential dangers from the Corona virus. It seems that only the "ëxperts" issuing the most dire warnings are being listened to. See p.6 for a possible reason for this.

COVID-19 Virus Treatments

There are several propsed treatments that people are talking about while waiting for the vaccine, that could take over a year, by the time it has been tested on humans. Then, like most vaccines, it might be effective in about 30% of cases. See page 7 for those being discussed.

MMS sounds like the best proposition when taking into account cost, ease of access and likely effectiveness based on anecdotal reports. Jim Humble, MMS' proponent reports that 14 people who were confirmed cases of COVID-19 (in Europe), took MMS and have recovered their health. All of these tested positive and when re-tested after taking MMS, they came out negative for COVID-19.

"CISS Corner" blog

For those of you who have provided us with your email address we are sending out a blog called "CISS Corner" during the months between the Newsletters. This contains brief articles, sometimes with a common theme and often recipes. If you want to receive these blogs either email Claudine (support@ciss.org.au) or ring Claudine on 9906 2189 and give her your email address. We will then include you in the next blog mailout. See page 8 for the content of the latest blog. The real thing is much more attractive to read with pictures.

(continued from page 1)

for special mention. Most diets already contain amounts adequate for a healthy life style. For individuals free from cancer, dietary supplementation (50-100iu daily) is beneficial, offering protection against coronary heart disease. Unfortunately the same beneficial properties are exploited by cancerous growths, which accumulate vitamin E as a protection against pharmacological attack.

Some dietary schedules drawn up for cancer patients include substantial amounts of vitamin E. The wisdom of these recommendations is questioned. While it is known that vitamin E protects against the development of cancer, there is nothing to suggest any benefit is to be gained once malignant disease is established. Indeed, several patients on vitamin E supplements (400-1200iu daily) failed to respond to Phenergan. Current advice is therefore to stop supplementation immediately and to wait 7-10 days. Likewise, selenium supplementation above the recommended dietary allowance (RDA) is not recommended.

[6] Multi-drug resistance can arise during radiotherapy, from treatment with certain cytotoxic drugs, or spontaneously. It is not generally recognised that a mutation in a cancerous cell may result in partial or complete disable-ment of the cytotoxic mechanism. Clones of these mutant cells are generally insensitive to therapy. Pre-liminary data suggest that patients who have not been exposed to radiotherapy have a better chance both of respon-ding positively and also of avoiding relapse.

[7] The disease is prostatic cancer, melanoma or mesothelioma. At the present time it is not known whether these early findings reflect the presence of an intrinsic mechanism of resistance in these particular tumours or whether some other cause was responsible for failure. The idea that a high glucose content might offer tumours a measure of protection is considered feasible.

Patients with certain brain tumours (astrocytomas) have benefitted from prolonged survival, but the chances of full recovery would appear to be remote. Anafranil (clomipramine) may be a more suitable drug in such instances, but is available only on prescription. Patients are advised to search the web for advice (Google; enter the words: brain cancer clomipramine).

Practical Steps - Self-Medication Procedures:

Pre-Treatment

1. First, polyunsaturated fatty acids (the so-called omega-3 fatty acids) of fish origin are needed. Flax oil may also be taken. The purpose of the polyunsaturated fatty acid supplement is to provide cancerous cells with the means to assist in bringing about their self-destruction. Patients should aim at a minimum of a gram daily; more is advisable, but the intake can be cut back if bowel looseness is experienced. Should it be noticed that bleeding, say, from a cut or injury, lasts for longer than usual, the supplement may need to be stopped for a few days and the amount halved on resumption. Medical assistance should be sought.

2. Second, patients are advised to take 250mg each of inositol and choline daily. These naturally-occurring substances are available from health stores. Inositol hexaphosphate (IP6), which contains only 23% inosi-tol and has the disadvantage of forming insoluble precipitates with calcium within the bowel, is not recommended.

3. Third, certain micro-nutrients are recommended with the intention of protecting the white cells of the blood against rare side-effects (blood dyscrasias). A multi-vitamin/mineral preparation containing the RDAs of copper (2.5mg), manganese (4mg), zinc (15mg) and selenium (50mcg, or 0.05mg) is advised. Minor deviations from these amounts, which should be taken daily, are unimportant. Vitamin supplements in excess of RDA values, especially vitamin C (RDA 60mg) and vitamin E (RDA 10-15 international units), must be avoided as far as possible.

If the patient has been on supplementary vitamin E, intake should be terminated immediately and treatment delayed for ten days. Because the intention is selec-tively to induce peroxidation within cancerous cells, anti-oxidant prepar-ations, especially those of Chinese origin, should also be avoided. The supplements need to be continued for the entire duration of the therapy.

4. Before commencing, patients should preferably consume at least 3g of omega-3 polyunsaturated fatty acids daily together with the recommended supplements for at least three days. Where circumstances are pressing there may be no time for pretreatment, and Phenergan therapy together with the supplements should be inaugurated immediately.

Procedure I. Phenergan alone

Treatment is initiated by taking Phenergan as a 50mg dose one evening at retiring. On the next day a total of 3x25mg needs to be taken every eight hours in divided doses of 25mg (7am, 3pm, 11pm are suitable times) and thereafter for as long as necessary (see below).

Procedure II. Phenergan with Calcium The first day of therapy should be designated free of activity. Most of the side effects will be experienced on this day; two further days of rest should be planned. Patients cannot be expected to follow the instructions by themselves. It is essential to have a partner or close friend present at all times on the first day for ensuring the therapy is complete.

The first day of treatment is unique. Meals should be light and carbohydrate-free. Omelettes, vegetables, bran preparations and sugar-free fruit such as grapefruit are all suitable. Apart from alcohol there are no fluid restrictions; drinking is to be encouraged. Tea, coffee and fruit juices should contain no sugar. For convenience treatment may be commenced at 9am. The schedule is as follows:

0hr: 50mg Phenergan.
1hr: 800-1200mg soluble calcium in 100-150ml (4-6fl.oz.) water.
2hr: 400-600mg soluble calcium in 100-150ml water.
4hr, 7hr and 10hr: as for 2hr.
12-14hr (the exact time is not important): 25mg Phenergan.

The total amount of calcium is 2.4-3.6g over a period of 9hr. The precise amounts are not critical.

On the following day it is necessary to continue thereafter as in Procedure I with 25mg Phenergan every eight hours (7am, 3pm, 11pm are suitable times). In addition calcium, 200-300mg once daily, may also be taken in the evening. During the first day it is anticipated that products of tumour destruction will be excreted in the urine. Patients with close hospital connections might be able to commission measurements of metabolite excretion, especially of uric acid and urea.

Procedures I and II.

Success depends on consistently maintaining destructive pharmacological pressure against the cancer over an appropriate length of time.

The protocols need to be continued beyond the apparent disappearance of disease. At present this period is arbitrarily put at six months, but should be extended if any doubt exists over the elimination of disease. The reasons are discussed below (see Duration of Treatment and Outcome). Efforts should be made to keep to the eight-hour timing between Phenergan doses. An hour or so either way is not critical, but if a dose happens to have been missed, it should be taken immediately. Even if the treatment fails to halt the progress of disease, Phenergan can enhance quality of life and extend survival. In other words, the therapy places the patient in a no-lose situation.

In most countries Phenergan can be freely purchased in the form of 10mg and 25mg tablets....

Soluble calcium is widely available as tablets in a variety of preparations, many of which are effervescent....

Duration of Treatment and Outcome: The therapy works slowly; just how long is necessary to keep taking Phenergan will depend, among other factors, on tumour type, the extent of disease at the commencement of treatment and on the state of nutrition. With Procedure I it may be necessary to stay with Phenergan for two years or more, especially where there are secondary deposits in the bone....

No matter how hopeless the situation may appear, some positive outcome from Phenergan is not necessarily out of the question. **Phenergan treatment should not be prematurely discontinued without good reason. Poor compliance has been responsible for failure on several occasions. Of those who decided to abandon the therapy prematurely, none survived. If treatment is interrupted before the growth is wholly eradicated, resid-ual tumour cells acquire resistance and Phenergan will be found to have no anti-tumour effect second time round.** No reason is known for this peculiar behaviour, and no means of resensitisation is known at the present time. The maxim is: if in doubt, don't drop out.

Action: If, after reading the above, uncertainty persists, the question remains: is this a chance worth taking? Experience has shown that when a point of no return is reached, little more can be done. However, benefit in terms of improved quality of life and extension of survival is not necessarily out of the question. Now is the time to decide whether or not to go ahead, and if so, to make plans this very moment.

What is certain is that the sooner the treatment begins, or, put another way, the smaller the tumour burden is, the quicker the patient may become cancer-free. Delay confers no advantage whatsoever. The big error that patients commonly make is to believe that time is on their side and to adopt a wait-and-see attitude. Nothing could be more mistaken. Time is never on the side of the cancer patient. The overriding aim must be, as a matter of pressing urgency, to begin to get well as soon as possible.

Once more, then: what is there to lose?

Update on Benefits of Radical Prostatectomy

Michael Shirley has passed on the latest update of the randomised controlled trial comparing radical prostatectomy with observation/watchful waiting after 22 years.

After 12 years follow-up there was a slightly reduced but not statistically significant number of deaths from all causes in the radical surgery group.

After 19.5 years follow-up there was still a slightly lower mortality among those who received the surgery 223/364 vs 245/367 but the difference was still not statistically significant.

After 21.1 years follow up the figures were 246/364 (wrongly reported as 246/346) vs 269/367 so in the intervening years the difference in deaths had increased from 22 to 23 and remained not statistically significant.

It is likely that the slightly fewer deaths (23) is biased in favour of the surgery group because observation doesn't mean no treatment. In fact there were 97 more treatments added to the those in the observation group than in the surgery group—about twice as many (219 vs 122) - mainly to treat tumour progression. This confounds the result because most treatments cause some harm, including deaths. If a significant number of the 23 extra deaths in the observation group resulted from the 97 extra interventions, this would completely nullify the apparent benefit from the surgery.

Randomised controlled trials are not supposed to allow treatments to be added unequally in the two groups because of this potentially confounding factor.

There were also about double the added treatments in the treated group than the observation group to deal with the adverse results of the surgery (161 vs 77) ie erectile dysfunction and incontinence, but these were less likely to result in extra deaths.

As an example of how this confounding factor can affect the results, most of the eight trials evaluating breast cancer had a protocol that resulted in a lot more radiotherapy being used in the screened group than the control group. It was later found that many of the screened women who received the radiotherapy had died of heart failure resulting from the radiotherapy – so this reduced the deaths from breast cancer among the screened women. The protocol also resulted in more chemotherapy being used in the control group increasing deaths from breast cancer. Both failures in the initial design resulted in the false conclusion that the screening had save lives from breast cancer and mammography screening wrongly became accepted as proven to save lives despite the fact that the total deaths in both screened and control groups was unchanged by the screening.

In the trial evaluating radical prostatectomy the potentially harmful treatments that were added unevenly in the surgery and observation groups included radiotherapy, brachytherapy, cryotherapy, androgen suppression, other hormonal treatment, or chemotherapy.

These were often added in the observation group if disease progression was observed, thus undermining the comparison of treament with no treatment.

Don Benjamin

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Wilt, T et al Follow-up of Prostatectomy versus Observation for Early Prostate Cancer. N Engl J Med. 2017 Jul 13;377(2):132-142. doi: 10.1056/NEJMoa1615869.

Politics and the misuse of science

by Don Benjamin

The recent panic about the COVID-19 (Corona) Virus highlights a growing problem with the misuse of science by people with a political or even ideological bias.

The problem stems from the use of computer modelling. Most such modelling provides a range of risks of a particular situation developing from the current situation, sometimes referred to as ranging from the best case scenario through the most likely scenario to the worst case scenario.

Mathematicians develop the computer models based on the wide range of factors that might contribute to the different scenarios, usually based on the most popular theories about what are the most likely factors to bring about a change.

For example the many computer models developed to predict the rate of global warming over the next 50 years assume the most important contributory factor is the rising CO_2 level – as suggested by the Intergovernmental Panel on Climate Change (IPCC). The scientists supply the mathematicians with estimates and theories of how CO_2 changes might be linked to global warming eg sensitivity of warming to a CO_2 increase. To simplify the model the other likely contributory factors are minimised, as are the possible interactions between these various factors.

The computer models designed to predict the contagion rate of COVID-19 in a particular population rely on estimates of how many people in a local area pick up the virus (how transmissible), how quickly it is likely to spread (how infectious), how many are likely to die from it (how serious) and how long it might last. Estimates of these inter-relationships come from countries experiencing the contagion, such as China, Italy and Spain and more recently the UK and US.

In both of the above examples, politics resulted in the worst case scenario gaining the most support as politician concluded that if they don't do enough they will be criticised and not be re-elected. So doing more than necessary becomes the norm – even if it causes more harm than good.

Regarding the predictions of global warming none of the 102 computer models used by the IPCC predicted that the global warming would drop to about a third of what was predicted. Scientific principles state that if observations do not conform with the predictions based on an hypothesis, the hypothesis needs to be changed. But there is no demand for changing the computer models so that they correctly predict what is actually happening, eg by giving other factors more influence rather than mainly CO_2 (such as changes in solar radiation, effects of volcanos, the earth's orbit around the sun, temperature transfer between the oceans, change in cloud

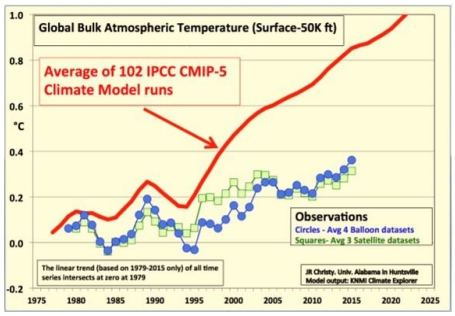

Fig. 1: Five-year averaged values of annual mean (1979-2015) global bulk (termed "mid-tropospheric" or "MT") temperature as depicted by the average of 102 IPCC CMIP5 climate models (red), the average of 3 satellite datasets (green - UAH, RSS, NOAA) and 4 balloon datasets (blue, NOAA, UKMet, RICH, RAOBCORE).

Observed global warming (lower graphs) vs predictions from 102 computer models (top)

formation, etc). That would be an admission that their conclusion, that it was 95% likely that CO_2 caused by humans was the main cause of global warming, was not correct.

So currently most countries are closing down coal-fired power stations and thereby increasing the cost of living based on inaccurate computer models based on false assumptions.

Regarding the predictions of the mortality rate from the Corona virus, intervention strategies were influenced by a computer model developed by scientists from Imperial College London that produced a dire scenario. It was based on Chinese statistics for Hubei province that assumed a 3% death rate. Other experts claimed that the death rate would not be ~3% because the Chinese were not including many positive cases, especially children, who did not show symptoms.

Including these, as another group of scientists from Oxford University have since done, would reduce the rate to ~1.9% and the situation would not be as dire as previously predicted.

Other experts such as Dr John Lee (a recently retired professor of pathology and a former UK NHS consultant pathologist) have pointed out that the figures for those with the virus is likely to be greatly underestimated because there is a shortage of test kits. So the number of positive tests could be far lower than the number of people who have had the disease. Also there is a difference between those who die f*rom* the COVID-19 virus and those who die *with* it. Many are likely to die sooner due to other life-threatening diseases; many of these have weak immune sytems and are more likely to succumb to the virus. So when they die they are tested for the virus and, if poisitive, this gets listed as the cause of death. These experts suggest that up to two-thirds of so-called COVID-19 deaths are in this category. So these are not extra deaths.

Allowing for these two extra factors (not including positive cases for lack of testing; and misclassification of cause of death) could reduce the actual mortality rate even further to that of seasonal flu.

As of Saturday 28 March there were 13 deaths in Australia out of about 3,000 cases, a death rate of about 0.4% - about one tenth of what was being predicted. Australia has a very high testing rate so this is likely to be an accurate figure. In the US there were 1296 deaths out of 85,840 cases, a death rate of 1.5%.

By contrast seasonal flu has a death rate of about 0.1%. In Australia there are about 2,000 deaths from seasonal flu each year. So on these figures there could be an extra 6,000 deaths from the COVID-19 virus, not 60,000. As with the global warming prediction, drastic actions based on earlier predictions are not justified.

The question then becomes: should the government shut down the economy for 6 months and put more than 1 million people out of work, causing a recession, to save a possible 6,000 deaths? To say nothing of the increase in stress and domestic violence.

As Tony Blakely from the Australian Finacial Review said on 31 March: "Where are the estimates of the total cost to society for different scenarios of managing this pandemic?"

In some countries such as Sweden there is not the same panic. Shops and schools are not being closed and most people are still going to work.

The results of both the above over-reactions driven by politics, not science, is that the world economy is likely to grind to a halt for a few years. It is possible that many millions more will die throughout the world as a result of less money being available for health in the future – due to the misuse of science for political purposes.

Coronavirus no more deadly than seasonal flu

by Bryan Hubbard

March 5th 2020

Despite the coronavirus (Covid-19) hysteria, it is probably no more lethal than the seasonal flu virus, researchers say.

Its fatality rate is likely to be around 0.1 percent, 20 times lower than the current reported rate of 2 percent. Some hospitals are already supporting this revised view and have reported fatality rates of around 1.4%.

But the true rate could be lower still, and that's because the symptoms can be so mild that people never realise they have been infected; in fact, the true rate of infection could easily be double that being recorded.

Interestingly, there have been no cases reported among children under the age of 15 at the time of writing, suggesting either they have special immunity or that symptoms are even milder in children.

As with the seasonal flu, those at risk include elderly people with existing health problems such as asthma or with compromised immune systems.

The incubation period seems to be an average of 12 days, and an infected person is, on average, spreading the virus to just over two other people. Researchers say the outbreak will be contained only when an infected person passes it on to just one other person.

But with the seasonal flu claiming around 650,000 lives globally every year, the coronavirus will need to be 20 times more lethal to be even comparable. Far more lethal were the SARS virus, which claimed the lives of around 10 percent of sufferers, and the MERS (Middle East respiratory syndrome) virus, which has a fatality rate of 36 percent.

References

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FROM: WDDTY

Calmer assessment of COVID-19

The following letter was sent to The Australian in response to an editorial on 10 March. Apart from the last sentence it was published on 12 March.

Your editorial suggests that "Advice on COVID-19 must be prompt, calm and clear" (March 10). Then you quote an expert suggesting that the death rate in Australia from the virus could by proportionally higher than the 2.3 per cent rate of confirmed cases seen in China.

This is not a calm assessment and is likely to add to the irrational panic.

In contrast the Director of the US National Institute of Allergy and Infectious Diseases, Dr Anthony Fauci, and the Director of the US Centers for Disease Control and Prevention, Dr. Robert Redfield stated in the prestigious New England Journal of Medicine recently that

> "there were no cases in children younger than 15 years of age. Either children are less likely to become infected, which would have important epidemiologic implications, or their symptoms were so mild that their infection escaped detection, which has implications for the size of the denominator of total community infections.
>
> If one assumes that the number of asymptomatic or minimally symptomatic cases is several times as high as the number of reported cases, the case fatality rate may be considerably less than 1%. This suggests that the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza (which has a case fatality rate of approximately 0.1%) or a pandemic influenza (similar to those in 1957 and 1968) rather than a disease similar to SARS or MERS, which have had case fatality rates of 9 to 10% and 36%, respectively."

Your readers deserve to hear a calmer assessment by another expert.

Don Benjamin
St Leonards

Treatments for COVID-19

There are several claims about treatment for the COVID-19 virus. The most common ones are

1. chloroquine/hydrochloroquine.

Chloroquine is a medicine used to prevent and treat malaria, a red blood cell infection transmitted by the bite of a mosquito, and to treat some conditions such as liver disease caused by protozoa (tiny one-celled animals).. Tests in the lab suggest it kills the COVID-19 virus.

I understand it is available via the internet. I think it normally requires a doctor's prescription. It comes as tablets that cost about $2 each. A search of the internet will find the various sources who claim it is in stock.

2. MMS. This is a remedy based on Chlorine Dioxide. It is one of the treatments claimed to help people with cancer and other chronic diseases. It was developed by Jim Humble.

It is also available via the internet but if you get it, you need to prepare it for use. (Australia's TGA says it is marketed at a water purifier and should not be consumed. It has not been approved for therapeutic use.) You have to mix several drops of the MMS (sodium chlorite) with an equivalent number of drops of an acid activator and then drink the mixture in water. Jim's email contact is mmsnews@mmsnews.org
You can order it from MMS Australia. It cost about $25 for a pack of the two bottles: the MMS and the activator: http://www.mmsaustralia.com.au/index.php?act=viewinfo&docId=22

If you want a copy of the recent email that summarises how to prepare the dosages and the recommended doses contact the CISS Office. The email has the instructions and the recommended dosages for COVID-19.

3. Superinfection Therapy (SIT)
This is decribed by Ralph Moss in a recent email as follows: The basic idea is that if someone has a viral infection, you can sometimes knock it out by giving them a second albeit harmless viral infection.

The idea came from observing that an infection by one type of hepatitis virus is often terminated after accidental infection by a different hepatitis virus.

CISS Corner blog

Earlier rhis month CISS introduced its first Blog for members. It was sent only to members who have supplied an email address. So if you want to receive a copy of the "CISS Corner" blog during the months between the CISS Newsletters email Claudine at the office at support@ciss.org.au and she will include you in future blogs. The actual blog looks much better than that below as we only have room for the text.

Cancer Information & Support Society is happy to introduce our first CISS Corner blog. This first issue has a "sweet" theme. Enjoy your read of these original research summaries and do request references if wanted. Please also feel free to contribute to future blogs by emailing your content suggestions, comments and questions of general interest to Claudine at support@ciss.org.au

1. Cancer's sweet tooth may also be its Achilles heel.

The majority of cancers have a "sweet tooth" in that, unlike normal cells, cancer cells depend on a unique oxygen-free means to extract their high energy requirements from glucose in order to grow aggressively. Glucose is a form of sugar from carbohydrate metabolism and our blood levels are tightly controlled through insulin signalling. A "ketogenic diet", is low in carbohydrates and high in fats. Fats can be metabolised to produce "ketones" which can be used by normal cells for energy instead of glucose. Most cancer cells can't use ketones effectively.

This diet has shown promise in preventing the growth of some types of established brain tumours in both animal and human clinical trials, sometimes combined with hyperbaric oxygen therapy. Rich sources of whole plant healthy fats include avocados, coconut & other nuts. "Paleo" versions of ketogenic diets will usually include free-range eggs, organically raised grass fed meats and unhomogenised dairy products (preferably unpasteurised) as rich sources of dietary fats. A short summary of the current state of the science behind the use of ketogenic diets in cancer prevention and treatment can be found here.

Weber DD, Aminazdeh-Gohari S, Kofler B. Ketogenic diet in cancer therapy. Aging (Albany NY). 2018;10(2):164–165. doi:10.18632/aging.101

2. Spiced Curcumin Coffee Recipe

Berberine and Curcumin are both plant compounds that inhibit cancer cells ability to use glucose for fuel and so may prove to be synergistic with a ketogenic diet. Berberine also can inhibit tumour growth by selectively suppressing glutamine uptake, without which cells cannot survive. Both these compounds have many other well-researched anti-cancer proper-ties, but lack "bioavailability" for effective use within the body. This recipe improves curcumin's bioavailability:

First blend contents of two 'bio-curcumin' capsules with one teaspoon of a neutral-tasting oil or cream (like cold-pressed almond oil or coconut cream). Then set this curcumin-oil blend aside.

Mix and blend with hot water:

1 rounded teaspoon Green Coffee

2 rounded teaspoons roasted dandelion root

1 heaped teaspoon dried turmeric powder

8+ shakes ground cinnamon, 4+ shakes cardamom, 2+ shakes nutmeg

Add 1 teaspoon organic raw honey and coconut cream or unhomogenised milk to taste.

Black pepper will further improve curcumin's bioavailability

Last, add pre-blended bioavailable curcumin & oil mix.

Adjust the recipe to your own taste and needs. EG. Contents of 1 berberine capsule could be added while mixing the curcumin & oil blend, but this does have a bitter taste. You could also add a small pinch Himalayan pink salt, double the cinnamon if diabetic, and double the nutmeg if needing pain relief.

3. Chocolate Sunscreen Anyone?

Cocoa solids are rich in compounds called flavanols which can work as a natural sunscreen aid. For chocolate lovers, eating around six small squares of "bitter" chocolate per day should be plenty to provide some resilience to the damaging effects of mild UVB over-exposure. Other skin protective foods include beta-carotene rich foods such as carrots, kale and spinach, and lycopene rich foods such as tomatoes and watermelon. Topical sesame oil is also considered to be a natural sunscreen aid due to its zinc content.

4. Summer sunlight - Health fact

Low levels of Vitamin D are strongly linked to skin cancer and many other types of cancer, as well as depression, increased stress response, high blood pressure & high blood sugar, heart disease, and multiple sclerosis. The best source of natural Vitamin D is sufficient sunlight exposure. Early morning sunlight exposure also helps normalise our circadian rhythms and can increase melotonin levels for health-promoting sleep rhythms.

5. Sweet summer berries

Raspberries, blackberries, blueberries and other summer berries are still in season. Berries and their phytochemicals have been shown to promote the anticancer effectiveness of our immune system's Natural Killer Cells and T-cells.

Many promising anticancer plant compounds have still only ever been tested in cell studies, but this is gradually changing. Here is a **link** to an interesting review of cancer pre-clinical studies and clinical trials studying the effects of black raspberries on cancers.

Kresty LA, Mallery SR, Stoner GD. Black raspberries in cancer clinical trials: Past, present and future. J Berry Res. 2016;6 (2):251–261. doi:10.3233/JBR-160125 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5008867/

Pan P, Huang YW, Oshima K, et al. An immunological perspective for preventing cancer with berries. J Berry Res. 2018;8 (3):163–175. doi:10.3233/JBR-180305

(continued from page 2)

angry at your spouse, your children or your best friend, or that you hate your job, or the fact that you feel taken advantage of.

As noted by Sarno, working hard and constantly trying to do everything perfectly to keep everybody around you happy, "is enraging to the unconscious mind." The term Sarno coined for this psychosomatic pain condition is "tension myoneural syndrome," and he firmly believed most people can overcome their pain by acknowledging its psychological roots….

While many of Sarno's patients got well without psychiatric help, he would often recommend seeking out a psychotherapist to explore repressed emotions, or to take up journaling to put your feelings on paper. Dr. David Hanscom, an orthopedic surgeon, also uses expressive writing as a primary treatment tool for back pain. [To learn more about expressive writing contact CISS and ask about The Letter]…

Extracts from "Is Most Back Pain Caused by Repressed Emotions?" by Dr Mercola 25 October 2017

Teleconference on 5G—17 February 2020—extracts

BENJAMIN, Mr Donald, Research Director, Cancer Information and Support Society Inc.

MAY, Dr Murray, Private capacity

TONEGUZZO, Mr Stephen, Chair, Environment and Communities Safe from Radiation

Evidence taken via teleconference
[11:50]

CHAIR: Welcome. Is there anything you wish to add about the capacity in which you appear today?

Mr Benjamin: Our society is also a charity.

Mr Toneguzzo: We are a charity in New South Wales. We are seeking ACNC status nationally.

CHAIR: ...Mr Benjamin, would you like to make an opening statement? We will then go through the other participants if they have opening statements.

Mr Benjamin: Yes, there are three points I'd like to make. The first is that in 2011 the World Health Organization's International Agency for Research on Cancer classified the frequencies used for mobile phones as possibly carcinogenic to humans.

Over the past nine years since 2011, numerous studies have shown that the EMF effects below the non-ionising radiation protection guidelines have been real and effects go beyond brain tumours and include a wide variety of changes to cells, organs and functions for humans.

Some of these recent studies are on mobile phone use and brain cancer and have confirmed that this radiation 'is' carcinogenic—not just 'possibly'. So my first point is that, even before the introduction of 5G, there are signs of an increasing rate of brain tumours among young people and this is likely to result in an upgrade in the IARC's status from 'possibly carcinogenic to humans' to 'proven carcinogenic to humans'.

The second point is that the nature of 5G technology is to increase the human exposure to potentially harmful radio frequencies even further. This is because 5G is only effective across short distances, so many more transmission masts and antennas need to be erected—every 100 or 200 metres. That will massively increase the exposure to EMFs. So my second point is that we should use technology to find ways to reduce our current exposure to harmful radiation, not increase it. We would suggest a moratorium on its introduction.

My third point relates to comparing things like radiation to drugs. In the field of drugs, it's standard procedure in Western countries throughout the world to prove beyond reasonable doubt that the drug will not increase risk before you apply it to individuals. People then are given a consent form to sign before they accept the treatment.

Introducing 5G as proposed will result in an increase in exposure to a proven hazard for almost the entire Australian population. That will breach the concept of informed consent.

CHAIR: Thanks very much, Mr Benjamin. Mr Toneguzzo, can you give your prepared statement.

Mr Toneguzzo: Yes. Thank you for the opportunity. The Western Australian Inc royal commission observed that government is constitutionally obliged to act in the public interest, as are public officials. It would be unconstitutional to not include the public interest, including health and safety, in the terms of reference for this inquiry.

The committee is on notice of foreseeable risk of harm to the public interest from 5G. We seek a moratorium on the rollout of 5G and that all identified risks to the public interest are independently and genuinely assessed against a public benefit test. Selectively and solely relying on ICNIRP and ARPANSA to support claims when there is genuine controversy is a salacious appeal to authority.

The threshold for scientific uncertainty to trigger a precautionary approach to 5G has demonstrably been met. With 5G, the wireless industry reports suggest they will become the nation's biggest power consumer and polluter, negating all climate emission targets.

What if the mysterious increases in blood cancers and many other diseases are indeed RF related? The Commonwealth estimates blood cancer alone will cost the economy $500 billion over the next 15 years.

Is it in the public interest to understand and manage risk or to intentionally ignore and obfuscate risk? ARPANSA, in writing, recommends limiting children's exposure to RF to minimise risk of harm. Yet, through telco law and education policy, the public is prevented from doing so. Is placing children at foreseeable risk of harm, because it increases shareholder value, in the public interest? Is it in the public interest to restrict personal freedom of choice? ARPANSA tells us there is risk. Risk does not equal safe. Yet we hear government public servants and industry assure us and shareholders that 5G is safe. Insurance underwriters caution otherwise. These assurances of safety remind us of the landmark case by AFCO against the tobacco industry of Australia regarding deceptive and misleading conduct.

Is the committee aware that the Italian courts are reported to have identified ICNIRP as conflicted and the research on which it relied as biased in coming to the conclusion that cellphone use caused cancer? Is the committee aware of ARPANSA's written admission in document TR 182 of what ARPANSA calls 'an oversight'?

Perhaps this is in fact regulatory failure and 18 years of perception management exposed. I feel that the outcome of this parliamentary inquiry will determine if democracy takes precedent over marketing as a priority of the Australian parliament.

CHAIR: Thanks very much, Mr Toneguzzo. Dr May.

Dr May: I just want to make a series of quick dot-point statements. My background is in environmental health and over 30 years in the APS and UNSW Canberra. It's most unwise to progress 5G technology. It has not been adequately assessed from a public health and environmental perspective. There are many examples of lack of foresight shown by governments, with costs running into billions of dollars, such as asbestos and PFAS chemical contamination....

... Scientists involved long term in the EMR field state that there is very little research on the elemental ways it affects health. The research that has been done, such as adverse effects on skin and eyes, is sounding alarm bells. A recent paper suggests adverse systemic effects as well.

Millimetre waves have been used by the military for crowd control. How can Minister Paul Fletcher declare that the technology is safe when the research hasn't been done? For example, what are the health impacts of narrow beamforming technologies? As flagged in many submissions, ARPANSA and ICNIRP are deeply compromised. This is borne out by the Italian court ruling recently saying that the ICNIRP members' advice is less reliable

because of funding direct or indirect.

There are thousands of published peer review studies showing adverse non-plural biological and health effects. These are ignored and suppressed by industry and regulating bodies.

I'll conclude with two examples of misinformation and actual evidence. Minister Paul Fletcher suggests 5G is safe for humans and other life such as bees. The epidemiological evidence from the $30 million US National Toxicology Program is being reviewed by an expert review panel, and they back the call for reclassification to group 1 carcinogen.

Dr James Lennon, an ex-member, which the previous industry supported, now backs this call as well.

The other question about bees: Dr Mark Greco is an Australian expert on bees and a fellow of the Royal Entomological Society. In a recent published work by him and colleagues shows that the shift in frequencies involved with 5G has the potential to increase the body temperature of insects through much increased absorbed power. This has the potential to impact bees and is quite problematic. The economic impacts of loss of pollination services are massive.

CHAIR: Thanks very much, Dr May. Would any of you like to expand on your comments because we have a bit more time up our sleeve? I've got a question to any of you. Were you familiar with submissions to the committee from ACEBR? You alleged that there's an existing link with brain cancers. Whilst I'm no longer practising clinically as a doctor, I did practise for 33 years. I'm familiar with those allegations that ran in the press, but there were several studies refuting that there is no link between mobile phone use and brain tumours. So I'm a bit perplexed where you got that allegation from.

Mr Benjamin (wrongly attributed to Dr May)**:** As far as I'm aware, it's come from several epidemiological investigations which backed up the NTP study. The NTP study was relating to rodents and the epidemiological studies were separate from that. What they would suggest is that the mobile phone and brain cancer risks that they'd identified related to humans rather than rats.

I think it was an article in the *Scientific American* which also referred to this in a reference, suggesting that there has been an increase in brain tumour incidence over the previous years. That's under the 3G and 4G regimes. It's quite possible, now that it's mentioned in an article, that part of this increase could well have been due to the increase in exposure to radio frequencies. But I don't think they were denying there has been an increase in brain tumour incidence.

Mr Toneguzzo: If I may, the Ramazzini Institute out of Italy has also substantially conducted research that suggests a link to brain cancer. Whilst I believe overall statistics in relation to brain cancer are fairly level—that is, the treatment method used for traditional forms of brain cancer are successful, and that form of brain cancer is reducing—the data is masked by glioblastoma and, I believe, acoustic neuromas or something. But I'm not a medical expert. That's for other to speak to. From the perspective of data, the data suggests that the brain cancers that have been linked to microwave radiation are on the rise but, because the other cancers are down, at this stage we're seeing a net nil effect.

Dr May: The other point I could throw in there too is that Professor Lennart Hardell, who's an oncologist, is one of the people who has been working longest in this area. He has a whole series of published papers on case-control studies bearing this out—epidemiological evidence. Other people like neurosurgeon Vini Khurana in Canberra copublished with Charlie Teo on this years ago, but there has been further evidence in recent years through a series of papers from Lennart Hardell. The committee really should be talking with experts like Lennart Hardell, who's been working on this probably longer than most….

CHAIR: I do recall deputy chair we did have depositions in previous hearings, just for your reassurance, that are in complete contradiction to what you've alleged, including WHO analyses. Anyhow, I'd be very interested to see those.

Dr May: Could I just make the point that there are some good published papers on this reviewing the US National Toxicology Program in detail by Hardell and Carlberg. So there are a number of views. It basically brings out the fact that it was—they had 11 people on an expert review panel backing up the validity as research. It's a $30 million, 10-year program. You can criticise any form of research, but this really has been gone over with a fine-toothed comb by experts, and the evidence has really backed up well. It's a well-designed study and the results are very good.

Mr Toneguzzo: The courts overseas also are starting to determine the links.

Mr HUSIC: If I can speak absolutely directly, to be honest I don't share some of the positions that have been put forward by critics of the rollout, but I absolutely respect that a parliamentary inquiry, picking up on Mr Toneguzzo's introductory remarks, should fulfil a democratic function of allowing people to raise their concerns about proposals that will allow the introduction of technology that others have a concern might impact them from a safety point of view.

We do take very seriously claims that safety might be affected, because there is, I agree, a duty of care element to this that needs to be considered. The propositions that have been put forward about a moratorium are exceptionally serious, because, clearly, there's another side to the argument that says that this technology will have social and economic benefit. So saying that you deny people that through a moratorium has to be considered very deeply.

I don't want to put words in the mouths of my colleagues on this committee, but the problem we would have is that you have one group of people, be it ARPANSA, the World Health Organization or others, that put forward a view that they believe that the technology used for 5G is safe, whereas you have others, and you made the point, Dr May, that the research you've had that counters some of ICNIRP or ARPANSA views has been gone through with a fine-toothed comb by experts.

We have here a battle of experts: the ones that you will rely upon, as you have through the introductory summaries, or the coalition of the 230 signers, versus ARPANSA and ICNIRP. Who are we supposed to rely upon is one question, when you've got this battle of experts as I've categorised it? You've mentioned a number of studies through the course of the submissions or the oral submissions. The studies themselves can't necessarily refer in part as it was in the Cancer Information and Support Society submission, where, for example, it says

… that because 5G is only effective across short distances many more transmission masts need to erected that will 'massively' increase exposure to EMFs.

You reference the 5G Appeal but not the actual scientific study to back that up. Do you have detailed studies by experts that you can refer to and send to the committee to back up those claims?

Mr Benjamin: The particular point I was making there is that the people that have assessed those statements are the 230 or 240 scientists that make up the so-called 5G Appeal. The article I referred to from *Scientific American* looked at those experts to decide if they were better experts than other experts. Their comment was that the ones who made up that appeal constitute a majority of experts on the effects of non-ionising radiation and, arguably, are the best in that field because of the fact that that is the field they specialise in. It's non-ionising radiation and the results of that on humans.

Mr HUSIC: Sorry to interrupt, Mr Benjamin, but are you able to provide that? You referred to a *Scientific American* article. Are you able to provide that to the committee? You're obviously relying upon it to make this submission, so can you provide that to the committee?

Dr May: The *Scientific American* one was a sort of popular overview. Essentially, as to your question about the two kinds of evidence, ARPANSA and WHO, these are heavily conflicted and industry influenced organisations. When you say WHO, there's part of WHO that's also heavily industry influenced as well, the ICNIRP. There's another part of WHO, the IARC, which classified radio frequency radiation as a 2B carcinogens in 2011. Now there's a strong case for it to be a category 1 carcinogen. That's through IARC, which is separ-ate. So even within WHO there are differences, depending on how much influence the industry has on the outcome.

There's a vast literature. You could talk to people like Professor Beatrice Golomb, a professor of medicine at the University of California, or Lennart Hardell, an oncologist in Sweden. There's a vast literature about the adverse impacts. So the precaution—ary principle should be brought to bear, given that we're moving into higher frequencies and no-one seems to know what the impacts are. The research hasn't been done. There are papers that have already been done by Italian physicists about the impact on skin. This is just flying blind, as Richard Blumenthal said. No-one knows.

Mr HUSIC: But my issue is that you've made a number of references through your verbal submissions and through your actual submissions to studies or views expressed by experts or people who are in a position of authority to make those claims. All I'm asking, again, is if you can provide the actual detailed references to the committee so that they can be weighed up in our report. You can always refer to someone in some capacity, but we need to be able to test the basis of their advice with ARPANSA, as I said earlier, to deal with the arguments you've raised in good faith. Either the *Scientific American* article or any of these other points—

Dr May: There's a pile of review pa-pers. The problem is that ARPANSA subscribes to the thermal-only view of the world based on acute exposure, and all these other studies are looking at low-level expose and chronic exposure. It's got nothing to do with the ARPANSA standard; they set it high. With chronic exposure we're finding all these biological effects, but ARPANSA is sort of just saying, 'No thermal effect, no problem.' So you've got this big gap.

Mr HUSIC: I get that you would have that view, but you need to be able to provide that to the committee so that we can—

Dr May: There are heaps of reviews. ... It's a whole lot of evidence being suppressed and ignored.

Mr Benjamin: I can supply you with a copy of both the *Scientific American* of 17 October last year and a copy of the experts about the so-called 5G Appeal, because they provide the references as well.

Mr HUSIC: Thank you for that. I may have got this wrong, so you can correct me if I have, but I'm trying to get to the actual substance here. You said an Italian court had ruled that ICNIRP was conflicted. Can you provide the committee with the ruling that conclu-sively made that point, so which jurisdiction and in what case?

Dr May: Yes, I can provide that.

Mr HUSIC: Terrific. There was also reference to a particular doctor who had been with ICNIRP, a Dr James someone or other—

Dr May: James Lin, Professor of Bioengineering, University of Illinois.

Mr HUSIC: Right. And you're saying that now that he's left ICNIRP, he's taken a contrary view to those that he would have held when he was with ICNIRP? Again, are you able to substantiate that via a submission to the committee?

Dr May: Yes, I can provide a published paper on that.

Mr HUSIC: Thank you.

Mr GORMAN: I'll be brief, because I know that we are pressed for time. The matters we've covered so far today have gone to the safety or otherwise of the technology. I agree with the deputy chair's comments; I think it is important people have the right to express their views on this. As many of the submissions that the committee has received show, it's important that people feel that we've looked at those concerns seriously and taken views from people and also advice from experts in the field on that matter.

The reality is that this technology is already being used in a number of areas. Eden Hill in my electorate of Perth is one of the test sites for Optus using 5G technology. I'd be interested if any of you on the panel joining us by telephone have views on a safer rollout. We've heard from Main Roads this morning about the impor-tance of making sure that you protect people from electric shock and things that can come from this technology. Obviously we've got technology that's going to be much more accessible; it's not always going to be on high towers and hard for people to reach. Do any of you want to make any comments on safer rollouts of such technologies?

Mr Toneguzzo: Yes. I come back again to the need for a risk assessment; to take a pause and really consider what risks does this present to the national interest in every respect: health, safety, security, power consumption, global warming—you name it. This is something that impacts the entire nation, and it's unusual in shall we say trade practices, if nothing else, to release products to market without testing. Previous devices, as I understand it, 3G and 4G, wi-fi et cetera, had been released to market without appropriate testing, without appropriate risk assessment. They were pushed into the market because of the blanket statements of 'no thermal effect from non-ionising radiation'. Wi-fi operates at the same frequency as a microwave oven. The power is far, far less than a microwave oven, but the analogy would be this: a tidal wave would be sudden impact, whereas the low, non-heating effect of this non-ionising radiation is more like the wave constantly lapping at the shore. The constant exposure is what is of concern here. ICNIRP have said—I'll paraphrase, but I think I can almost quote it—'It's impossible to do the testing,' and yet we're assured that this is safe.

And, yes, safety from electric shock: these 5G cells, unlike 3G and 4G, will not have power backup, so if a driver-

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Branches of CISS

NSW

CISS CENTRAL COAST

The Central Coast Branch is in RECESS over December & January. From February to May and October to November the Branch holds a general meeting on the third MONDAY of the month from 7pm - 9:30pm at the Arts & Craft Centre, Henry Kendall Gardens, Bellbird Drive (off Maidens Brush Rd), Wyoming. A Guest Speaker or Sharing of Information and Common Experiences is the agenda. (In Winter months (June-September) meetings are held at 2pm-4:30pm on the third Saturday of the month.)
An excellent library is available to members. ALL WELCOME. Information Mary Sponberg-Macready 02 4322 8767

What's Available from the CISS Office?

CHAMPION Juicer - $575 ($615 non-members)
OSCAR Juicer - $485 **DVD:** CISS 2007 Seminar : Cancer & Hope
Enema Kits: $12.00 $29.50 plus $5 postage
Water Purifier: Reverse Osmosis - $495. Other models avail.

Prices are subject to change. Items can be posted to you. There is a $15.00 postage/ packing fee for standard articles, $16-$18 for country and interstate, $18 Express Post. CISS Handbooks $13.50, $15 including postage.

CANCER SUPPORT GROUPS

NSW

ACTIVE WOMEN TOUCHED BY CANCER & CELEBRATING LIFE

Meets at Balgowlah RSL, Ethel St, Seaforth on 2nd Tuesday of the Month at 7pm. $5 donation. Guest speakers. Contact Robin 9938 6128 or Kate 8902 0196

CANHELP CANCER SUPPORT GROUP

Based on the Ian Gawler approach. Meets 1st & 3rd Tuesday each month from 6.00-8.00pm at Level 3, 280 Pitt St. Enjoy meditation, sharing and support. Ring Sue Saxelby 0408 442 030 or just turn up.

HILLVIEW COMMUNITY SUPPORT GROUP

Meets each Tuesday 1.30-3.30pm at 1334 Pacific Highway Turramurra. Includes a meditation. No charge. Phone 9449 9144 and ask for Patricia Krolik.

NAMBUCCA VALLEY SUPPORT GROUP

Meets every Wednesday, Agnes Grant Centre, Macksville & District Hospital, 11 am – 1 pm. Phone 6568 2677.

NSW (Continued)

NEWCASTLE CANCER SUPPORT GROUP

For information contact Make Today Count, 44 Dudley Road, Charlestown, NSW 2290. Phone 4943 8462.

QUEST FOR LIFE FOUNDATION

Based on 30 years of delivering exceptional retreat experiences for people living with cancer, our 5 day residential retreats deliver the latest research on health, healing and neuroscience. Contact 02 4883 6599 or visit www.questforlife.com.au

SYDNEY ADVENTIST HOSPITAL CANCER SUPPORT CENTRE

Meets each Wednesday 10-12 noon at Jacaranda Lodge, 185 Fox Valley Rd, Wahroonga. . Also special support groups for different cancer types and for carers. Contact Nerolie on 9487 9061.

VICTORIA

CANCER NATURAL THERAPY FOUNDATION

Support group meets on Tuesday nights at 7pm at 531 Elizabeth Dr, Sunbury, Victoria 3429. Meeting includes discussion, relaxation therapy and Reiki Healing. Certified organic produce available these nights. The Foundation operates a resource library, workshops and guest speaker program. Personal Counselling available. Contact Sandra Givca Maqueda (03) 9740 9921; mobile 0411 100 947.

VICTORIA (Continued)

GAWLER FOUNDATION

Learn how to create wellness in the face of cancer at our 5-day and 10-day Cancer Retreats in Victoria's beautiful Yarra Valley. Call 1300 651 211 or visit www.gawler.org to learn more.

WESTERN AUSTRALIA

Solaris Cancer Care (formerly Cancer Support Association of WA)

Cancer Wellness Centre, 80 Railway St Cottesloe WA 6011. Counselling hours: Tues-Thurs. Phone (08) 9384 3544. The CSAWA Inc is a non profit organisation with the primary objective to provide support services, information and self-help activities in a safe and caring environment for people affected by cancer, to enhance their emotional, physical, spiritual and mental well being. Emphasis on self-help and development, teaching life skills that enable individuals to better cope with the fear and uncertainty of a cancer diagnosis. Website: https://solariscancercare.org.au/page/support/support-services

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less car is relying on this and the power goes out, then what happens? There are massive insurance implications in all of this as well. The insurance industry should be consulted. Where is the economic analysis that proves—okay, we understand this will bump up shareholder value because they'll be selling billions of gadgets, but where is the economic analysis that shows it's actually financially viable in terms of infrastructure? One of the chairs of the FCC has said that outside rural industries it won't be, simply because of the density of antennas and the costs involved. Is this something the public has to then fund? As the ECSFR mentioned in its submission, the Productivity Commission should be brought into this. It's far bigger than just—

Mr GORMAN: I might just stop you there. I'm conscious that we're limited for time, and I'd be keen to hear if any of the other participants have comments on that broader question on a safe rollout of this technology and some of the safety issues around it as it is.

Mr Benjamin: One of the things the previous speaker referred to was insurance. My understanding is that Lloyd's of London has refused to insure 5G on the grounds that the risk is too high. That's just one comment. You did ask about insurance.

Mr HUSIC: Okay, but, Mr Benjamin, you need to validate that.

Mr Benjamin: Yes, I can send you a copy of the report.

CHAIR: Okay; thanks very much. I would like to thank all of you for your attendance via teleconference here today. If you have been asked to provide any additional information, would you please forward it to the secretariat by 24 February 2020. You will be sent a copy of the transcript of your evidence and will have an opportunity to request corrections to transcription errors. I also thank all witnesses for attending today.